

Persistent Idiopathic Facial Pain: Psychotherapeutic Tactics

Aleksey Igorevich Melehin*

Associate Professor, Psychoanalyst, Clinical Psychologist of the Highest Qualification Category, Somnologist, Cognitive Behavioral Therapist, Humanitarian Institute Named After P. A. Stolypin, Moscow, Russia

***Corresponding Author:** Aleksey Igorevich Melehin, Associate Professor, Psychoanalyst, Clinical Psychologist of the Highest Qualification Category, Somnologist, Cognitive Behavioral Therapist, Humanitarian Institute Named After P. A. Stolypin, Moscow, Russia.

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Recently, the number of patients with persistent idiopathic facial pain has been increasing, which includes a number of conditions: temporomandibular disorders, burning mouth syndrome, persistent dentofacial pain, trigeminal neuralgia, and atypical facial pain. Iatrogenic damage to the trigeminal nerve can also lead to persistent orofacial pain.

Due to the complex anatomy of this area, the difficulties in diagnosing and treating chronic pain conditions (low response to painkiller therapy, partial response from botulinum toxin type A), pain is often felt by patients as recurrent, persistent and disabling. It does not have a specific etiology, and before the final diagnosis, it is necessary to exclude other pathologies. It can be confused with TMJ-a pathology defined by a set of clinical problems associated with both the masticatory muscles and the temporomandibular joint. Atypical facial pain is usually unilateral, located in the upper jaw area, and is described as dull, aching, throbbing, or "burning" [4].

Here are examples of complaints of patients with facial pain: constant "tightening", "cotton wool", "aching", piercing pain in the face, tingling like needles. Uncomfortable sensations do not occur immediately after "stress" (at work, neighbors), or eating hard food, but after 2 - 4 hours. Wakes up in 3 - 4 nights "fever on the legs". Difficulty falling asleep. Overreacts in the form of panic to other people's screams and raised voices (started with the mother "her scream is like a chokehold").

The diagnostic criteria are: 1) Facial pain, daily and high persistence; 2) Deep and poorly localized pain, limited to the area bounded by the hemiface; 3) Pain without loss of sensitivity or other physical signs; 4) Radiography of the face and jaw without corresponding anomalies [4].

In 50% of cases, patients have a history of psychological factors [3]. For example, the pressure on work, the death of his mother (who was "hot-tempered and pressured", "emotional vampire"), moving to a new apartment (where "provocateurs neighbors").

In its chronic form, pain ceases to perform the biological function of warning and, instead, often causes changes in the physiological (sleep disorders, appetite), emotional (depression, anxiety, obsessive-compulsive manifestations), behavioral (physical disability, dependence on others) and social (family conflicts, professional problems) spheres. It is more difficult to diagnose and treat compared to acute pain. Its main long-term consequence is the formation of a behavioral repertoire, depleted and supported by aversive stimuli (consistent attempts to control and avoid pain in the form of constant wearing of a mouth guard, applying cold to the face, constant treatment of dentists) and the growth of avoidant behavior [1,3].

Orofacial pain is multifactorial, and along with the pathology in the dental clinic, we mental health professionals need to take into account psychological factors.

PET showed in patients with atypical facial pain increased activity of the contralateral cingulate gyrus (and a decrease in the prefrontal cortex), in response to heat and nociceptive stimuli, this indicates an exaggerated perception of pain in response to peripheral stimuli. The presence of anxiety, excessive attention to bodily sensations lead to the formation of a hyperexcited mode (endure, bdi, fight, run, do not let go, solve problems).

Using the TCI, PCS, and YSQ scales, we have shown that these patients have the following symptoms:

- High rates of pain catastrophization;
- Strict Standards, i.e. you can always do even better. Pickiness. The belief that it's never good enough and the fear of wasting time;
- Negativism, pessimism. Focusing on problems, possible failures, devaluing the good in the present;
- Egocentrism. Privilege, that is, "Everything will be my way", the feeling of being chosen and the belief that you should always get your own, regardless of reality. This leads to increased attention to pain and to self may play a role in chronicling and in initiating pain crises or treatment resistance;
- Low tolerance to frustration;
- A tendency to uncontrollable fear, shame, and shyness.

It is interesting to note that in clinical practice, three women were described in whom psychotic symptoms were detected 24 - 48 hours before the prescribed neurosurgical procedures for atypical facial pain; all had extensive dental reconstruction and attempted nerve blockage, but without pain relief [3].

Psychological examination of patients with atypical facial pain is recommended using: Personal and Professional Life History Interview; DSM-V open-ended interview for anxiety and depression; LIPP's Stress Symptom Inventory for adults (LSSI); Hospital Anxiety and Depression Scale (HADS); Quality of Life Scale (SF-36); Pittsburgh Sleep Quality Index (PSQI-BR).

We will not touch on psychopharmacological aspects (pregabalin, venlafaxine, benzodiazepine regimens, and TCA), but will focus on psychotherapeutic approaches in the treatment of facial pain [1]:

- Second-wave cognitive behavioral therapy protocols for fibromyalgia have also been adapted for facial pain, aimed at breaking the vicious cognitive behavioral circle. The use of these protocols for patients with orofacial pain, including temporomandibular dysfunction, has been shown. There were improvements in beliefs related to pain, catastrophization, and coping in patients treated with CBT compared to the control group. Patients with burning mouth syndrome have also been shown to experience improvements in the severity of pain and discomfort after 12 to 16 CBT sessions, and these effects persist 6 to 12 months after therapy [3].
- Acceptance and commitment therapy (Acceptance and commitment Therapy), aimed at strengthening the psychological flexibility of the patient with the help of a "hexaflex" of six skills. This protocol made it possible to reduce catastrophization in these patients [2].
- Mindfulness - based stress reduction therapy. This protocol is less well understood, but also shows early promise in reducing pain catastrophization [1].

Thus, the treatment of facial pain should be managed by a multidisciplinary/interdisciplinary team that seeks to develop a therapeutic plan aimed at reducing crises and pain symptoms, as well as maintaining patient autonomy and quality of life. This means avoiding iatro-

genic procedures, which, without positive results, ultimately cause discomfort and suffering in the patient, contributing to delayed identification and poor prognosis in the development of facial pain. In a step-by-step model, the routine application of psychotherapeutic measures can help decide which level of treatment is best for a particular patient. This can help distinguish between people who are suitable for simpler, manual treatment packages, and those who require more personalized interventions due to the higher level of complexity.

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