Biopsychosocial Dentistry: The Interface With Psychiatric Assessment

Conventional medicine and dentistry have narrowed their focus by defining "cure" as synonymous with the "eradication of symptoms." It is only when faced with symptoms that defy organic explanation and conventional treatment that most doctors focus on encouraging the patient to "learn to live with the problem." Only then are important psychosocial parameters and the patient's internal experience of living with illness given much consideration in the overall process of treatment. However, traditional healers have long recognized that bodily infirmities are an integral dimension of life itself.[1]

Within a biopsychosocial model, it is recognized that physical symptoms may be caused or exacerbated by emotional distress, and that organic disease may give rise to conflicts in adjustment that cause secondary psychological dysfunction.[2] Referral for psychiatric evaluation may be appropriately considered when the dentist suspects that physical symptoms are caused by preexisting psychological problems and/or if the patient is not coping well in reaction to physical disease. The referral process is often triggered by an emotional shift in the doctor; what was once "a challenging case" or "a difficult problem" is now a more personal struggle with a "difficult patient."

At other times, the shift is more subtle and the dentist may have no immediate recognition that the situation has become problematic. However, whenever the clinician finds himself/herself taking exception to usual procedures; feeling more zealous or invested in a particular patient's care; being more self-disclosing, solicitous, or concerned to ensure the patient's favorable disposition and personal regard for the dentist; such positive attitudes and behaviors should alert the dentist (as much as our negative emotions) to explore the possible relevance of psychological factors to the patient's overall condition.

The emotions of the practitioner, when used appropriately to heighten our sensitivity to the patient's psychological state, can be a useful clinical tool, in conjunction with direct patient interview, to alert the dentist to those situations when psychiatric consultation should be considered.

When considering referral, some doctors would wish or assume that primary care will shift to a new provider, a situation often causing many "difficult" patients to feel rejected or abandoned. Referral to a psychiatrist carries even worse connotations of problems being "all in their head," which most patients internalize as being told that they are crazy, that their physical problem is imaginary, or that they are seeking to benefit from other alleged "secondary gain." At best, such patients come to psychiatric attention angrily and with conviction that their original care provider doesn't care or just wants to be rid of them.

Occasionally, insensitivity and lack of professional responsibility accurately describes the referring doctor's attitude. Mostly, however, distortions and rifts in the doctor-patient relationship arise out of the manner in which psychiatric referral was presented to the patient. Several ingredients account for these blunders, including possible lack of formal education and clinical training in behavioral medicine. Many practitioners feel duped or deceived once they realize that the patient's complaints have no definable organic cause. Behind the scenes, the dentist may shrink from acknowledging that some problems defy explanation and cure by even the most competent clinicians, the attendant risk being that the doctor masks a personal sense of "failure" by being angry with or faulting the patient.

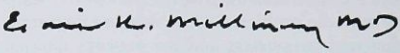
In addition, "difficult patients" often kindle difficult emotions within ourselves; the greatest impasses in treatment occur when reciprocal feelings and attitudes become mutually deadlocked between patient and health care provider. In such an impassioned climate, whether feelings are openly displayed or covertly expressed, how can the delicate subject of psychiatric consultation best be introduced? The most appropriate and effective discussion will ensue if the dentist thinks of psychi-

atric assessment as an investigative tool or diagnostic procedure. Implicit in the concept of "gathering more data" are fundamental assumptions that facilitate patient compliance: *(1)* that there is no preconception about the presence of psychopathology and that the request is only for the purpose of thorough evaluation; *(2)* that the dentist will remain the primary care provider and be responsible for coordinating the comprehensive, ongoing care; and *(3)* that if psychiatric treatment is indicated, the care plan will be implemented with the dentist's approval and input.

If these assumptions are highlighted, many difficult patients will appreciate the dentist's effort to be thorough in understanding how well they are coping with their ongoing frustrations, and whether emotional factors (at times outside their conscious awareness) may be causing or contributing to their *very real* physical symptoms.

It is particularly important for dentists to know the clinical orientation of mental health professionals before making a referral. Some are skilled in helping patients to cope more successfully with stressful life circumstances, and others may be more adept in exploring psychoneurotic conflicts and character pathosis. Unfortunately, many psychiatrists have been trained to focus narrowly on target symptoms and to equate treatment with psychopharmacologic intervention. Although medications may play an adjunctive role, it is particularly important that the psychiatric consultant evaluate dental symptoms in the context of each patient's total life experience by assessing and understanding his or her inner world of perceptions and emotions.

It is strongly recommended that dentists develop personal communication with mental health professionals. By discussing cases in advance, the dentist can inquire about the psychiatrist's or psychologist's orientation and sense whether a workable alliance is likely to develop between a given patient and intended consultant. The orientation of the mental health professional is generally the most important ingredient in determining whether patients will benefit from psychiatric consultation.



Eric K. Milliner, MD

References

1. Hammerschlag CA. The Dancing Healers: A Doctor's Journey of Healing with Native Americans. New York: Harper Collins, 1988.
2. Engle GL. The need for a new medical model: A challenge for biomedicine. Science 1977;196(4286):129–136.