Psychosocial assessment in dental practice

Prof. dr. Corine Visscher
PTBCCT, epidemiologist, director dental school
ACTA, the Netherlands

Original Contributions

Benefits of implementing pain-related disability and psychological assessment in dental practice for patients with temporomandibular pain and other oral health conditions

Corine M. Visscher, PT, PhD; Lene Baad-Hansen, DDS, PhD, Dr Odont; Justin Durham, BDS, PhD, MFDS RCS Ed, FDS RCS (OS); Jean-Paul Goulet, DDS, MSD; Ambra Michelotti, DDS Orthod; Carolina Roldán Barraza, DDS, PhD; Birgitta Häggman-Henrikson, DDS, PhD; EwaCarin Ekberg, DDS, Dr Odont; Karen G. Raphael, PhD

ABSTRACT

Background. Evidence in the field of dentistry has demonstrated the importance of pain-related disability and psychological assessment in the development of chronic symptoms. The Diagnostic Criteria for Temporomandibular Disorders offer a brief assessment for the diagnostic process in patients with orofacial pain (Axis II). The authors describe relevant outcomes that may guide general oral health care practitioners toward tailored treatment decisions and improved treatment outcomes and provide recommendations for the primary care setting.

Methods. The authors conducted a review of the literature to provide an overview of knowledge about Axis II assessment relevant for the general oral health care practitioner.

Results. The authors propose 3 domains of the Axis II assessment to be used in general oral health care: pain location (pain drawing), pain intensity and related disability (Graded Chronic Pain Scale [GCPS]), and psychological distress (Patient Health Questionnaire-4 [PHQ-4]). In the case of localized pain, low GCPS scores (0-II), and low PHQ-4 scores (0-5), patients preferably receive treatment in primary care. In the case of widespread pain, high GCPS scores (III-IV), and high PHQ-4 scores (6-12), the authors recommend referral to a multidisciplinary team, especially for patients with temporomandibular disorder (TMD) pain.

Conclusions. The authors recommend psychological assessment at first intake of a new adult patient or for patients with persistent TMD pain. The authors recommend the pain-related disability screening tools for all TMD pain symptoms and for dental pain symptoms that persist beyond the normal healing period.

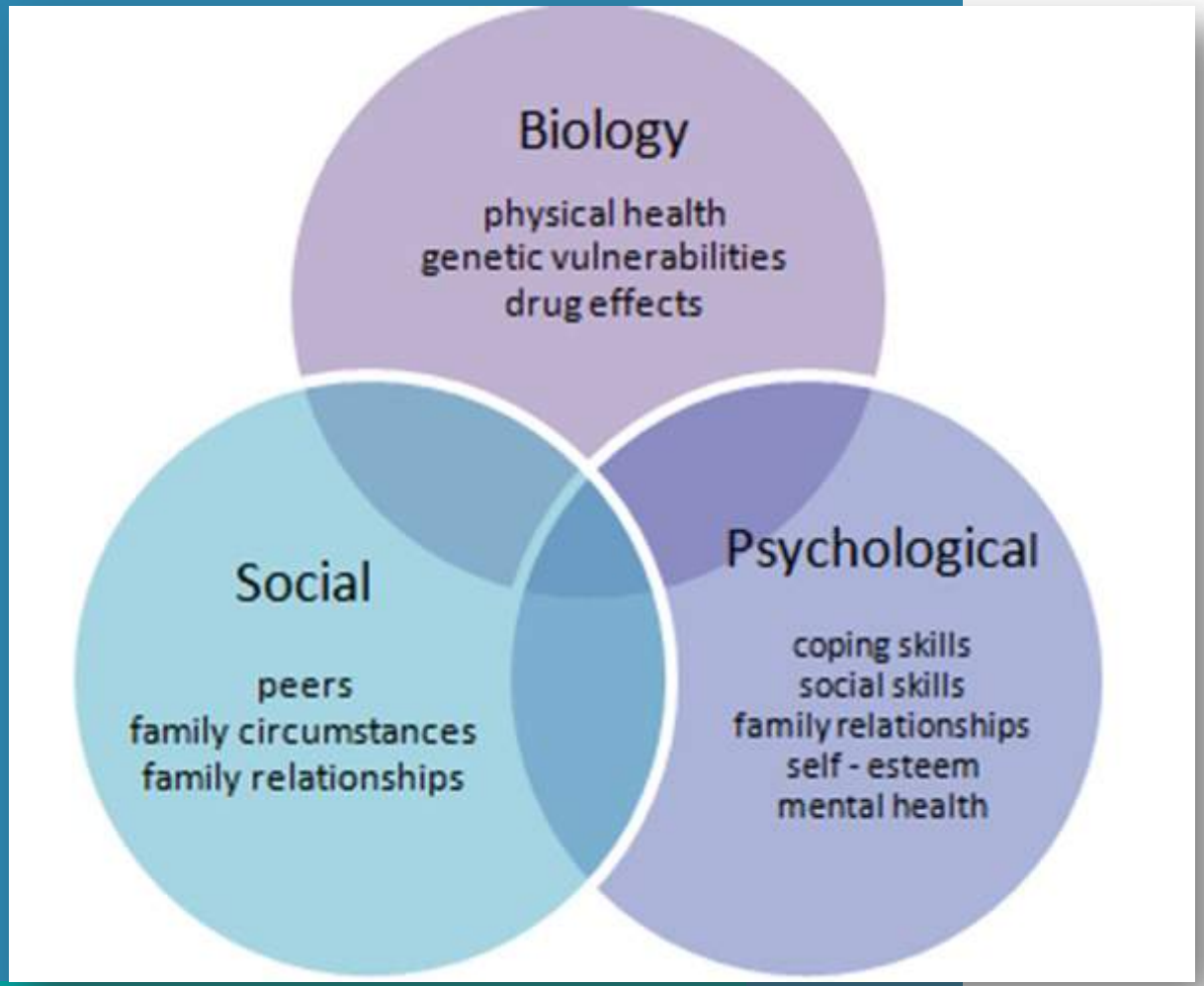
Practical Implications. A brief psychological and pain-related disability assessment for patients in primary care may help the general oral health care practitioner make tailored treatment decisions.

Key Words. Orofacial pain; primary health care; general practice.

JADA 2018:149(6):422-431
https://doi.org/10.1016/j.adaj.2017.12.031

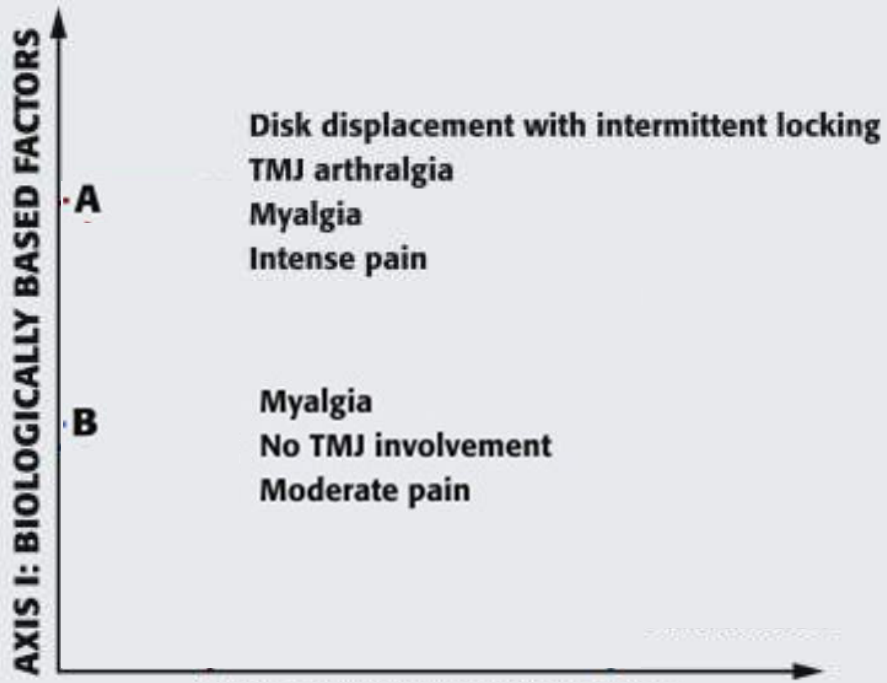
Goals of this lecture

- Update on the scientific evidence for psychosocial assessment in orofacial pain patients
- Know which screening tools for psychosocial assessment can be implemented in dental practice
- Implement the outcomes of the screening tools in care decisions



Biopsychosocial model

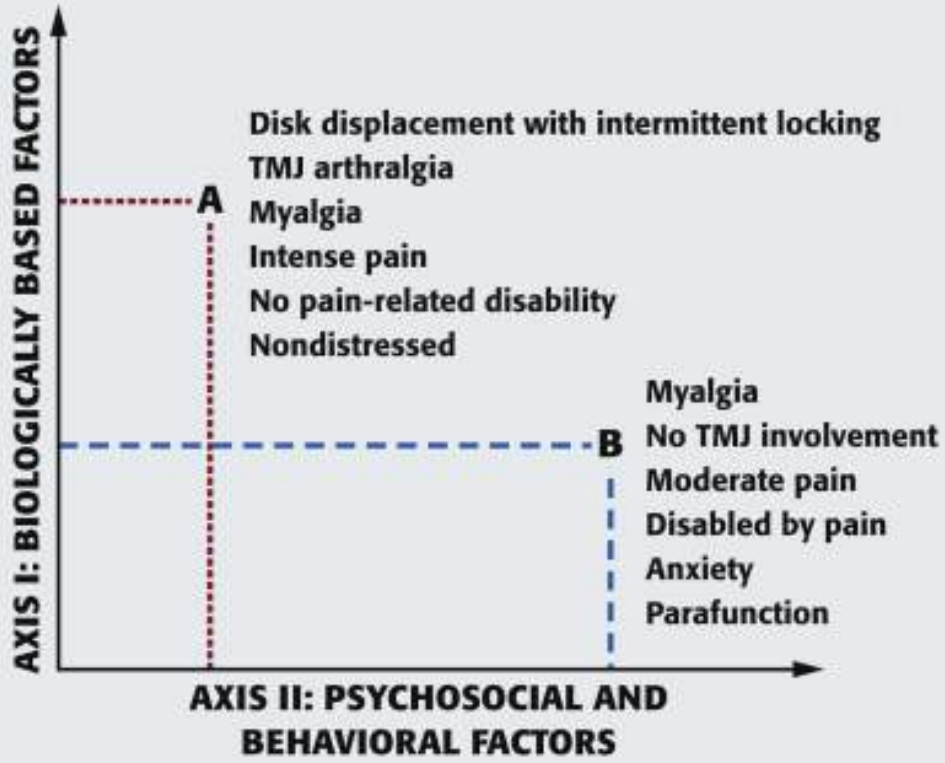
- Chronic pain patients
- Diagnostic process
- Treatment plan



Diagnostic Criteria for TMD

- Dual-axis approach
  - Physical
  - Psychosocial

Schiffman & Ohrbach, JADA, 2016



Diagnostic Criteria for TMD

- Dual-axis approach

Schiffman & Ohrbach, JADA, 2016

Diagnostic Criteria for Temporomandibular Disorders (DC/TMD) for Clinical and Research Applications: Recommendations of the International RDC/TMD Consortium Network* and Orofacial Pain Special Interest Group†

Eric Schiffman, DDS, MS
Richard Ohrbach, DDS, PhD
Edmond Truelove, DDS, MSD
John Look, DDS, PhD
Gary Anderson, DDS, MS
Jean-Paul Goulet, DDS, MSD
Thomas List, DDS, Odont Dr
Peter Svensson, DDS, PhD, Dr Odont
Yoly Gonzalez, DDS, MS, MPH
Frank Lobbezoo, DDS, PhD
Ambra Michelotti, DDS
Sharon L. Brooks, DDS, MS
Werner Ceusters, MD
Mark Drangsholt, DDS, PhD
Dominik Ettlin, MD, DDS
Charly Gaul, MD
Louis J. Goldberg, DDS, PhD
Jennifer A. Haythornthwaite, PhD
Lars Hollender, DDS, Odont Dr
Rigmor Jensen, MD, PhD
Mike T. John, DDS, PhD
Antoon De Laat, DDS, PhD
Reny de Leeuw, DDS, PhD
William Maixner, DDS, PhD
Marylee van der Meulen, PhD
Greg M. Murray, MDS, PhD
Donald R. Nixdorf, DDS, MS
Sandro Palla, Dr Med Dent
Arne Petersson, DDS, Odont Dr
Paul Pionchon, DDS, PhD
Barry Smith, PhD
Corine M. Visscher, PT, PhD
Joanna Zakrzewska, MD, FDSRCSI
Samuel F. Dworkin, DDS, PhD

Author affiliations are listed at the end of this article.

Aims: The original Research Diagnostic Criteria for Temporomandibular Disorders (RDC/TMD) Axis I diagnostic algorithms have been demonstrated to be reliable. However, the Validation Project determined that the RDC/TMD Axis I validity was below the target sensitivity of ≥ 0.70 and specificity of ≥ 0.95. Consequently, these empirical results supported the development of revised RDC/TMD Axis I diagnostic algorithms that were subsequently demonstrated to be valid for the most common pain-related TMD and for one temporomandibular joint (TMJ) intra-articular disorder. The original RDC/TMD Axis II instruments were shown to be both reliable and valid. Working from these findings and revisions, two international consensus workshops were convened, from which recommendations were obtained for the finalization of new Axis I diagnostic algorithms and new Axis II instruments. **Methods:** Through a series of workshops and symposia, a panel of clinical and basic science pain experts modified the revised RDC/TMD Axis I algorithms by using comprehensive searches of published TMD diagnostic literature followed by review and consensus via a formal structured process. The panel's recommendations for further revision of the Axis I diagnostic algorithms were assessed for validity by using the Validation Project's data set, and for reliability by using newly collected data from the ongoing TMJ Impact Project—the follow-up study to the Validation Project. New Axis II instruments were identified through a comprehensive search of the literature providing valid instruments that, relative to the RDC/TMD, are shorter in length, are available in the public domain, and currently are being used in medical settings. **Results:** The newly recommended Diagnostic Criteria for TMD (DC/TMD) Axis I protocol includes both a valid screener for detecting any pain-related TMD as well as valid diagnostic criteria for differentiating the most common pain-related TMD (sensitivity ≥ 0.86, specificity ≥ 0.98) and for one intra-articular disorder (sensitivity of 0.80 and specificity of 0.97). Diagnostic criteria for other common intra-articular disorders lack adequate validity for clinical diagnoses but can be used for screening purposes. Inter-examiner reliability for the clinical assessment associated with the validated DC/TMD criteria for pain-related TMD is excellent (kappa ≥ 0.85). Finally, a comprehensive classification system that includes both the common and less common TMD is also presented. The Axis II protocol retains selected original RDC/TMD screening instruments augmented with new instruments to assess jaw function as well as behavioral and additional psychosocial factors. The Axis II protocol is divided into screening and comprehensive self-report instrument sets. The screening instruments' 41 questions assess pain intensity, pain-related disability, psychological distress, jaw functional limitations,

Diagnostic Criteria for TMD

- Published in 2014
- Updated version of the RDC/TMD
- Focus on dentists in primary care
- Axis II - 2 options:
  - Brief assessment
  - Expanded assessment

Schiffman et al., JOFPH, 2014

IADR GENERAL SESSION
SEOUL, REPUBLIC OF KOREA • JUNE 22-25, 2016

94TH GENERAL SESSION & EXHIBITION OF THE IADR
3RD MEETING OF THE IADR ASIA PACIFIC REGION
35TH ANNUAL MEETING OF THE IADR KOREAN DIVISION

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IADR 2016: workshops organized by INFORM*

- Goal of workshop on axis II: 'optimizing the usefulness of Axis II in clinical assessment and decision making in general dental practice'
- Workshop participants/authors: dentists, psychologist, orthodontist, jaw surgeon, epidemiologists, physical therapist

Visscher et al. JADA, 2018; *INFORM: International Network for Orofacial Pain and Related Disorders Methodology

DC/TMD Axis II – 5 domains

I. Pain Location	II. Pain intensity and related disability	III. Psychological distress
Pain drawing	Graded Chronic Pain Scale (GCPS)	Patient Health Questionnaire (PHQ-4)

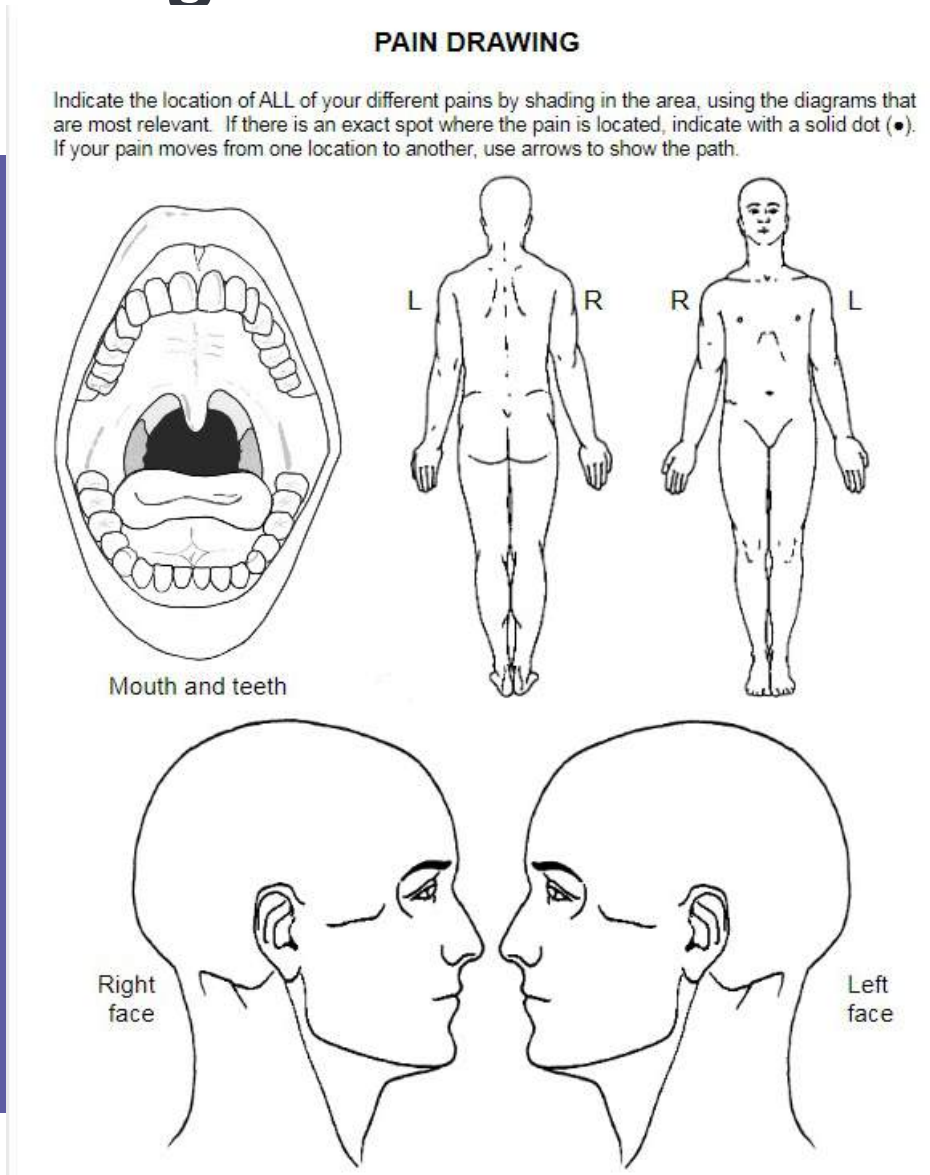
DC/TMD: Pain drawing

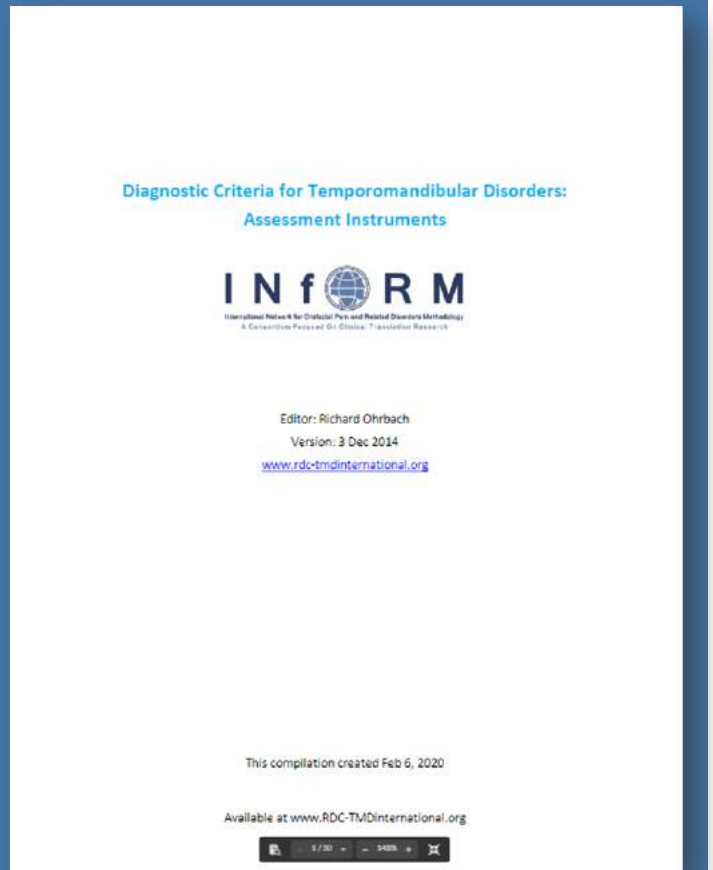
Instruction:

'Indicate location and spreading of your pain, in the mouth, orofacial region and other sites'

Classification:

- Local (intraoral and facial)
- Regional (orofacial and neck)
- Widespread (other sites as well)





https://ubwp.buffalo.edu/rdc-tmdinternational/tmd-assessmentdiagnosis/dc-tmd/

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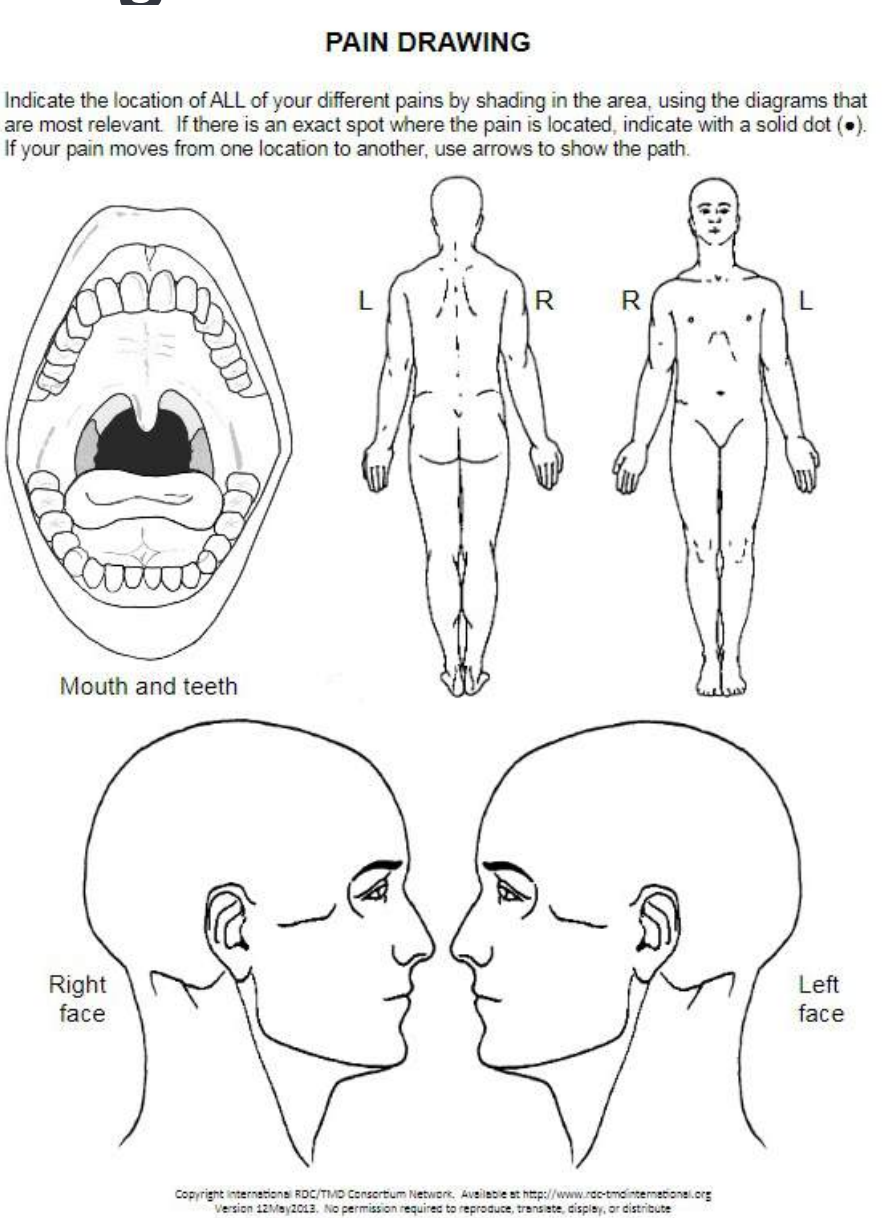

Why is this important?

…2 examples

- 180 TMD patients (RDC/TMD)
- Measures :
  - TMD pain intensity (0-10)
  - TMD pain duration (years)
  - Comorbidity (0-5)
    - Migraine
    - Chronic fatigue syndrome
    - Irritable bowel syndrome
    - Interstitial cystitis
    - Restless leg syndrome

RESEARCH ARTICLE Open Access

Specific and number of comorbidities are associated with increased levels of temporomandibular pain intensity and duration

Haissam Dahan[1*], Yoram Shir[2], Ana Velly[1,2,3] and Paul Allison[1]

(J Headache Pain 2015;16:47)

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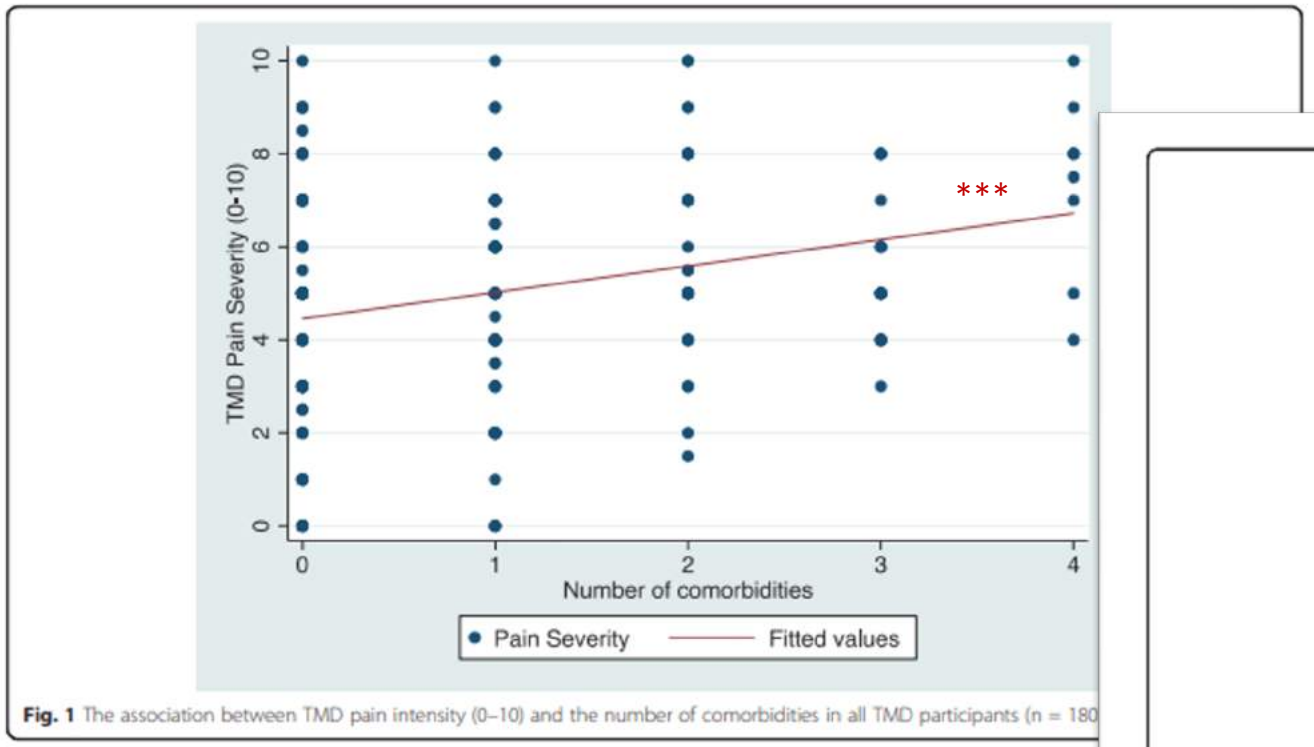


Fig. 1 The association between TMD pain intensity (0–10) and the number of comorbidities in all TMD participants (n = 180

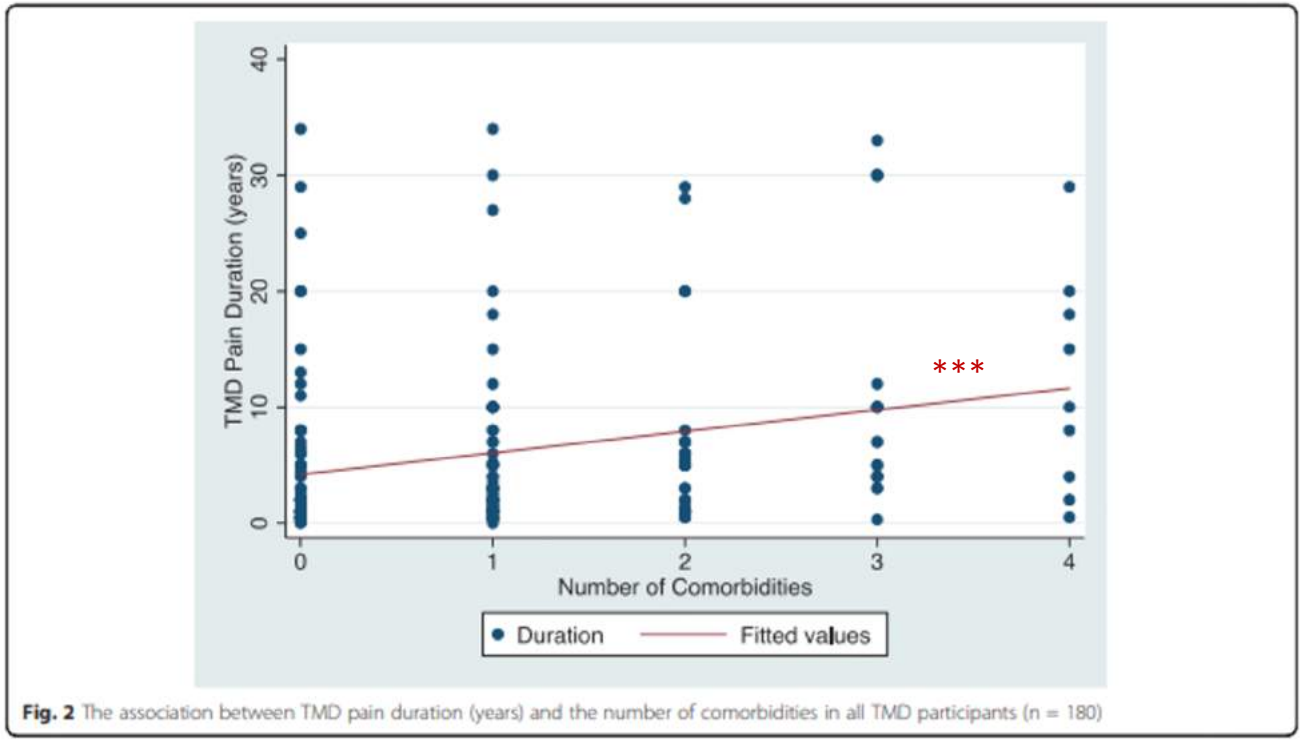
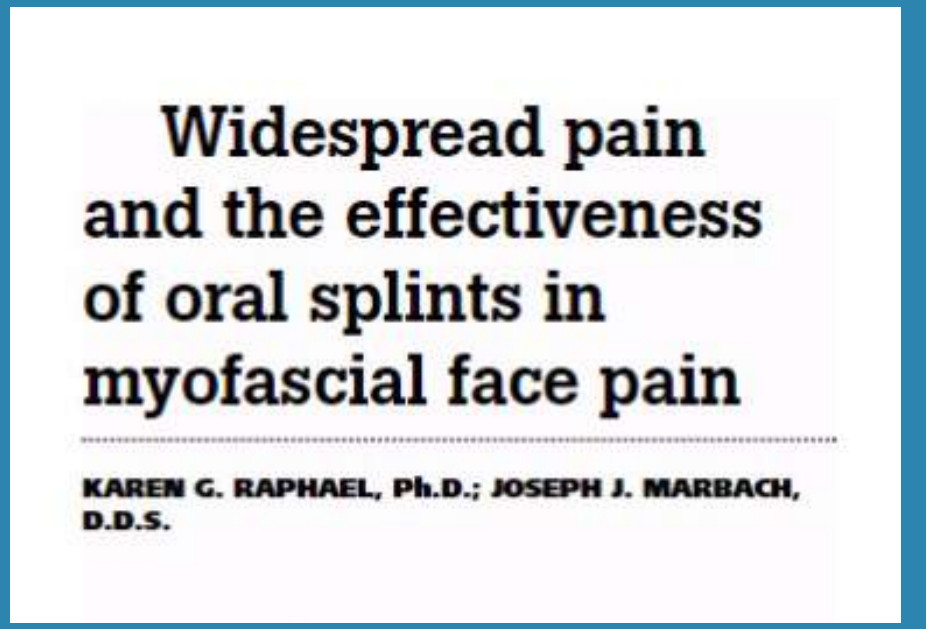


Fig. 2 The association between TMD pain duration (years) and the number of comorbidities in all TMD participants (n = 180)

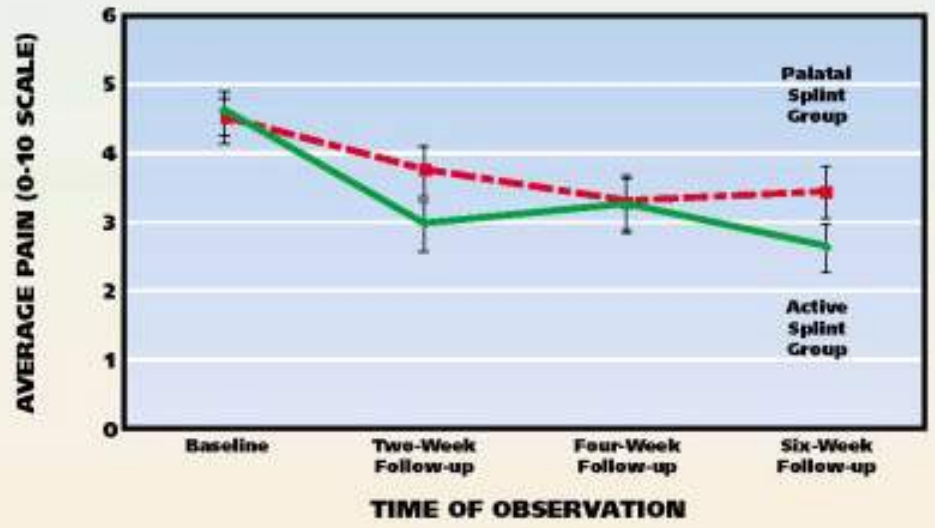
(J Headache Pain 2015;16:47; ***p<.001)



(JADA 2001;132:305-316)

(initial) aim: to explore the overall efficacy of a full-coverage hard-acrylic splint

- 63 female patients with myofascial pain (RDC/TMD)
- RCT: full-coverage splint vs. palatal splint
- 6-week follow up:
  - Average pain
  - Worst pain
  - Least pain



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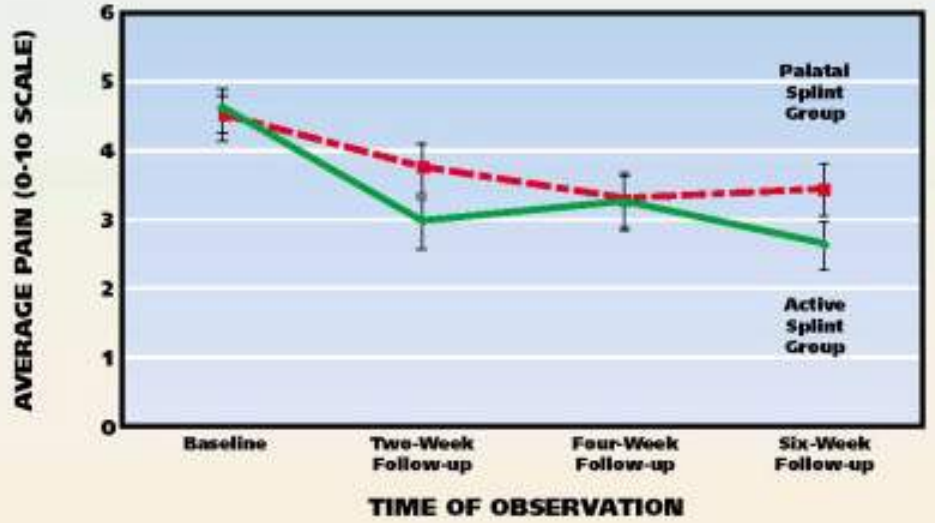

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(adjusted) aim: to explore whether patients with localized pain are more likely to respond to treatment as compared to patients with widespread pain

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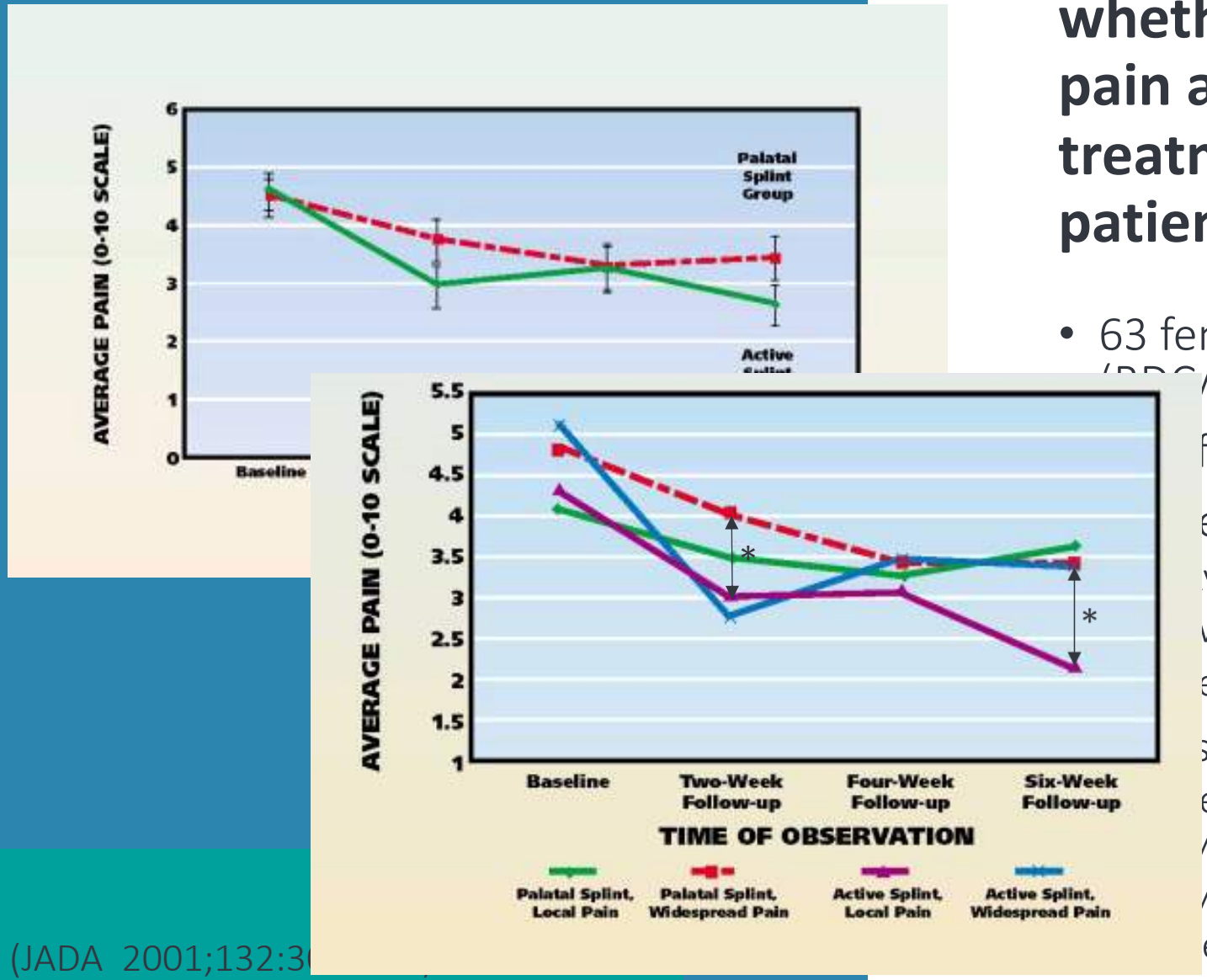
- RCT: full-coverage splint vs. palatal splint
- 6-week follow up:
  - Average pain
  - Worst pain
  - Least pain
- Widespread pain (at least one of the following):
  - Self report of fibromyalgia
  - Moderate to severe muscle soreness (SCL-90)
  - Moderate to severe pain on palpation of neck muscles (by pain clinician)



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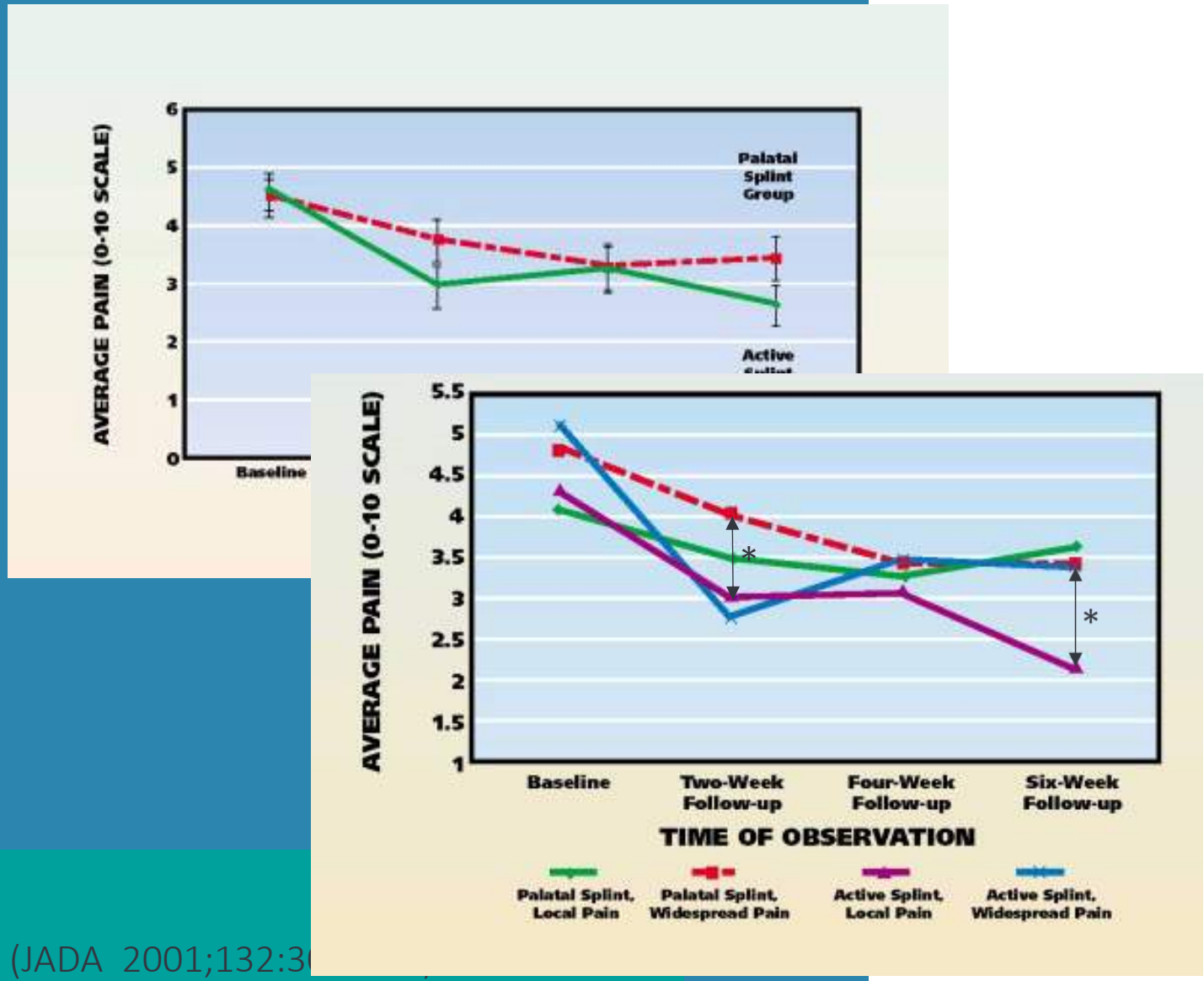


- Patients with local myofascial pain are likely to experience some pain reduction when treated with oral splints
- Patients with myofascial pain and widespread pain are unlikely to receive much benefit from oral splints.

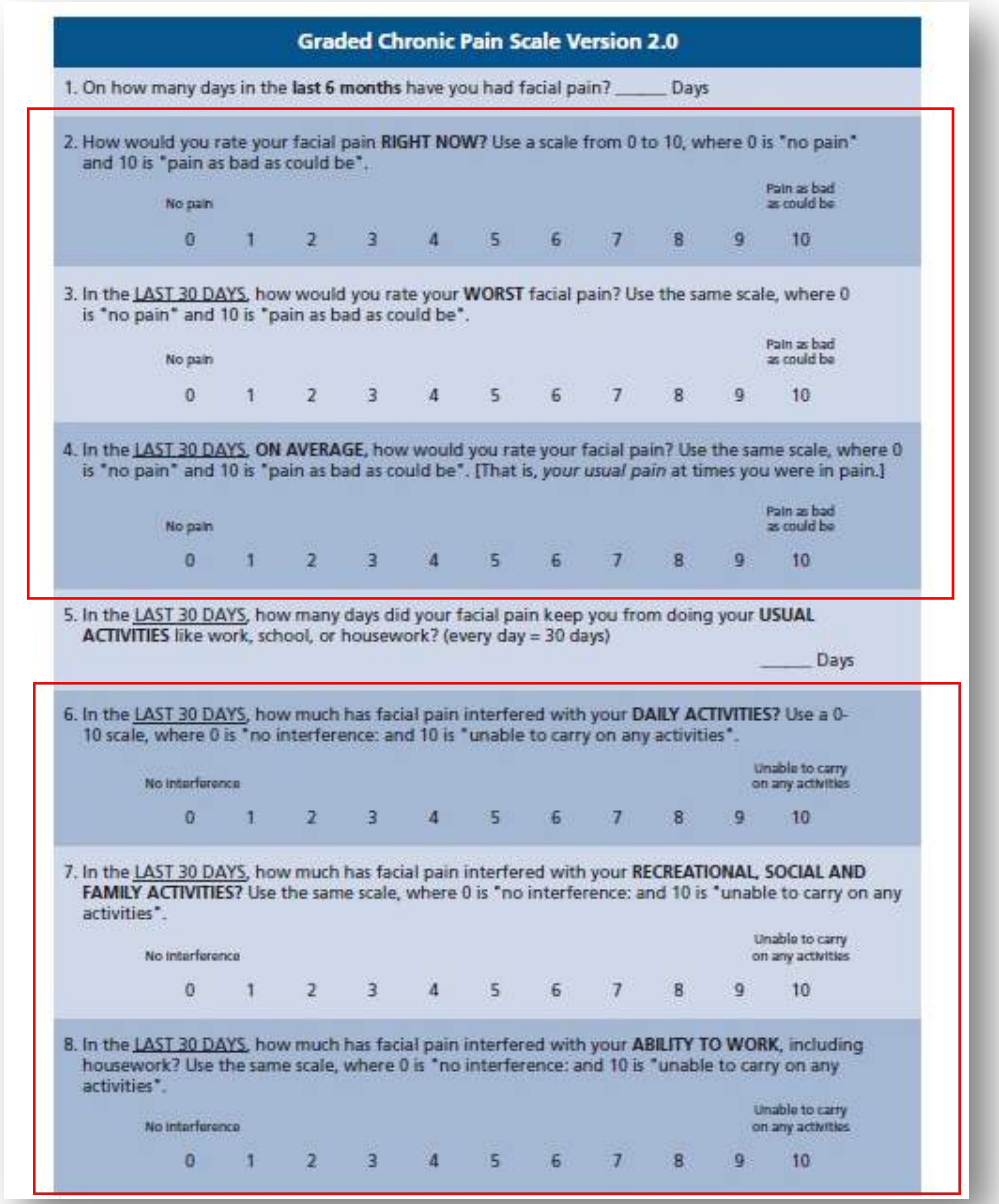
(JADA 2001;132:3

DC/TMD Axis II – 5 domains

I. Pain Location	II. Pain intensity and related disability	III. Psychological distress
Pain drawing	Graded Chronic Pain Scale (GCPS)	Patient Health Questionnaire (PHQ-4)

DC/TMD: Graded Chronic Pain Scale (GCPS)

- Assesment of pain intensity and related disability
- Embedded in many medical fields
- Scores on 3 subdomains:
  - Characteristic Pain Intensity (CPI; 0-100)
  - Number of days w. interference
    - 0: 0-1 days
    - 1: 2 days
    - 2: 3-5 days
    - 4: 6-30 days
  - Pain-related interference (0-100)
    - 0: 0-29
    - 1: 30-49
    - 2: 50-69
    - 4: 70-100



Graded Chronic Pain Scale Version 2.0

1. On how many days in the **last 6 months** have you had facial pain? _____ Days

2. How would you rate your facial pain **RIGHT NOW?** Use a scale from 0 to 10, where 0 is "no pain" and 10 is "pain as bad as could be".

No pain — Pain as bad as could be

0 1 2 3 4 5 6 7 8 9 10

3. In the LAST 30 DAYS, how would you rate your **WORST** facial pain? Use the same scale, where 0 is "no pain" and 10 is "pain as bad as could be".

No pain — Pain as bad as could be

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4. In the LAST 30 DAYS, **ON AVERAGE**, how would you rate your facial pain? Use the same scale, where 0 is "no pain" and 10 is "pain as bad as could be". [That is, *your usual pain* at times you were in pain.]

No pain — Pain as bad as could be

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5. In the LAST 30 DAYS, how many days did your facial pain keep you from doing your **USUAL ACTIVITIES** like work, school, or housework? (every day = 30 days)

_____ Days

6. In the LAST 30 DAYS, how much has facial pain interfered with your **DAILY ACTIVITIES?** Use a 0-10 scale, where 0 is "no interference: and 10 is "unable to carry on any activities".

No interference — Unable to carry on any activities

0 1 2 3 4 5 6 7 8 9 10

7. In the LAST 30 DAYS, how much has facial pain interfered with your **RECREATIONAL, SOCIAL AND FAMILY ACTIVITIES?** Use the same scale, where 0 is "no interference: and 10 is "unable to carry on any activities".

No interference — Unable to carry on any activities

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8. In the LAST 30 DAYS, how much has facial pain interfered with your **ABILITY TO WORK**, including housework? Use the same scale, where 0 is "no interference: and 10 is "unable to carry on any activities".

No interference — Unable to carry on any activities

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CPI

Days (N)

Pain-related Interf.

DC/TMD: Graded Chronic Pain Scale (GCPS)

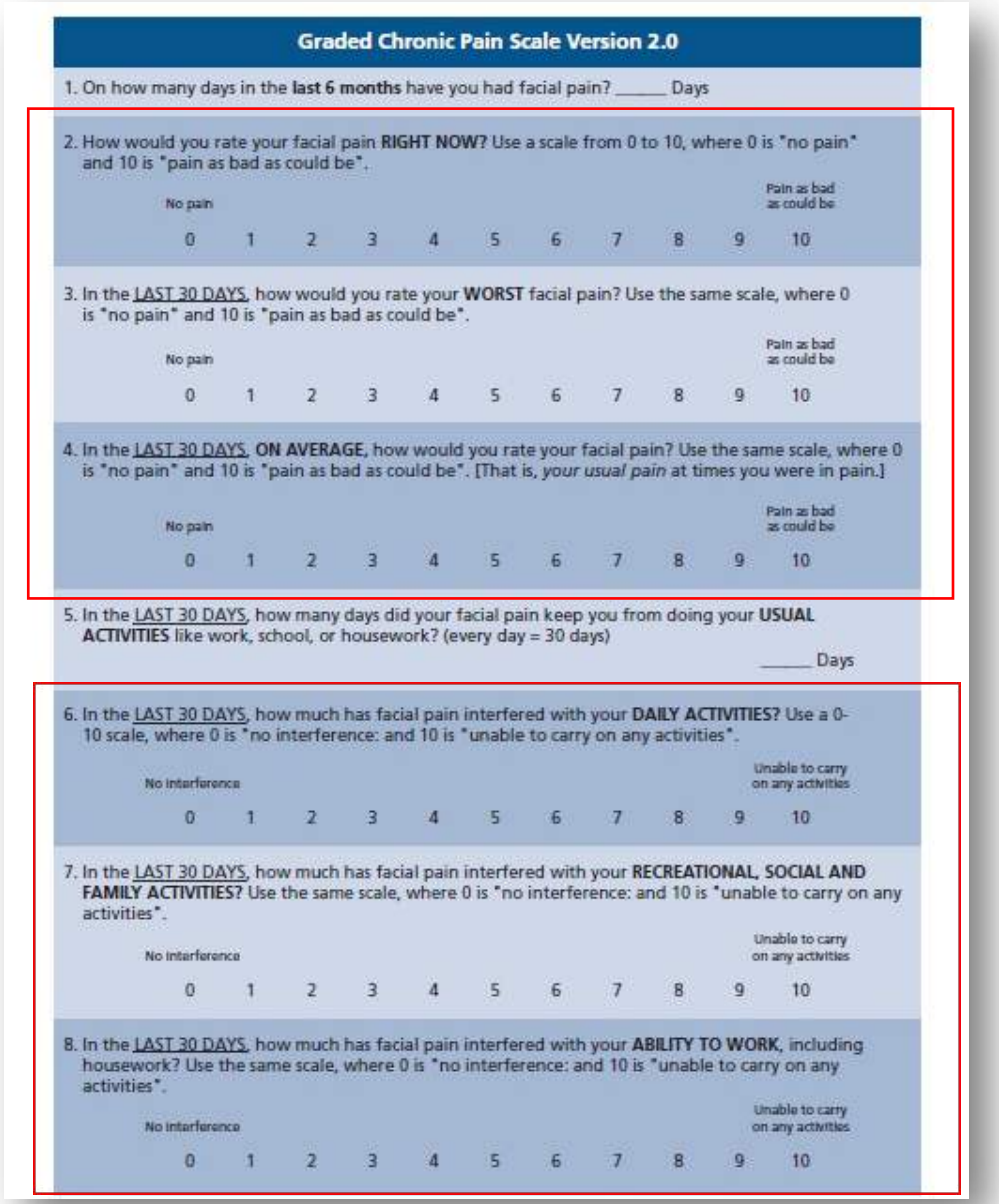
- Classification

Table. Scoring of Graded Chronic Pain Scale.

GRADE	LABEL	CHARACTERISTIC PAIN INTENSITY	DISABILITY POINTS*
0	None	0	NA†
I	Low-intensity pain, without disability	< 50	< 3
II	High-intensity pain, without disability	≥ 50	< 3
III	Moderately limiting	NA	3-4
IV	Severely limiting	NA	5-6

* Points for pain-related interference plus days with interference. † NA: Not applicable.

- Why is this important?



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CPI

Days (N)

Pain-related Interf.

Subtyping Patients with Temporomandibular Disorders in a Primary Health Care Setting on the Basis of the Research Diagnostic Criteria for Temporomandibular Disorders Axis II Pain-Related Disability: A Step Toward Tailored Treatment Planning?

Ulla Kotiranta, DDS
Clinical Teacher
Institute of Dentistry
University of Eastern Finland

Aims: To use the Research Diagnostic Criteria for Temporomandibular Disorders (RDC/TMD) Axis II and additional pain-related and psychosocial variables to identify subtypes of TMD patients in a primary health care setting based on

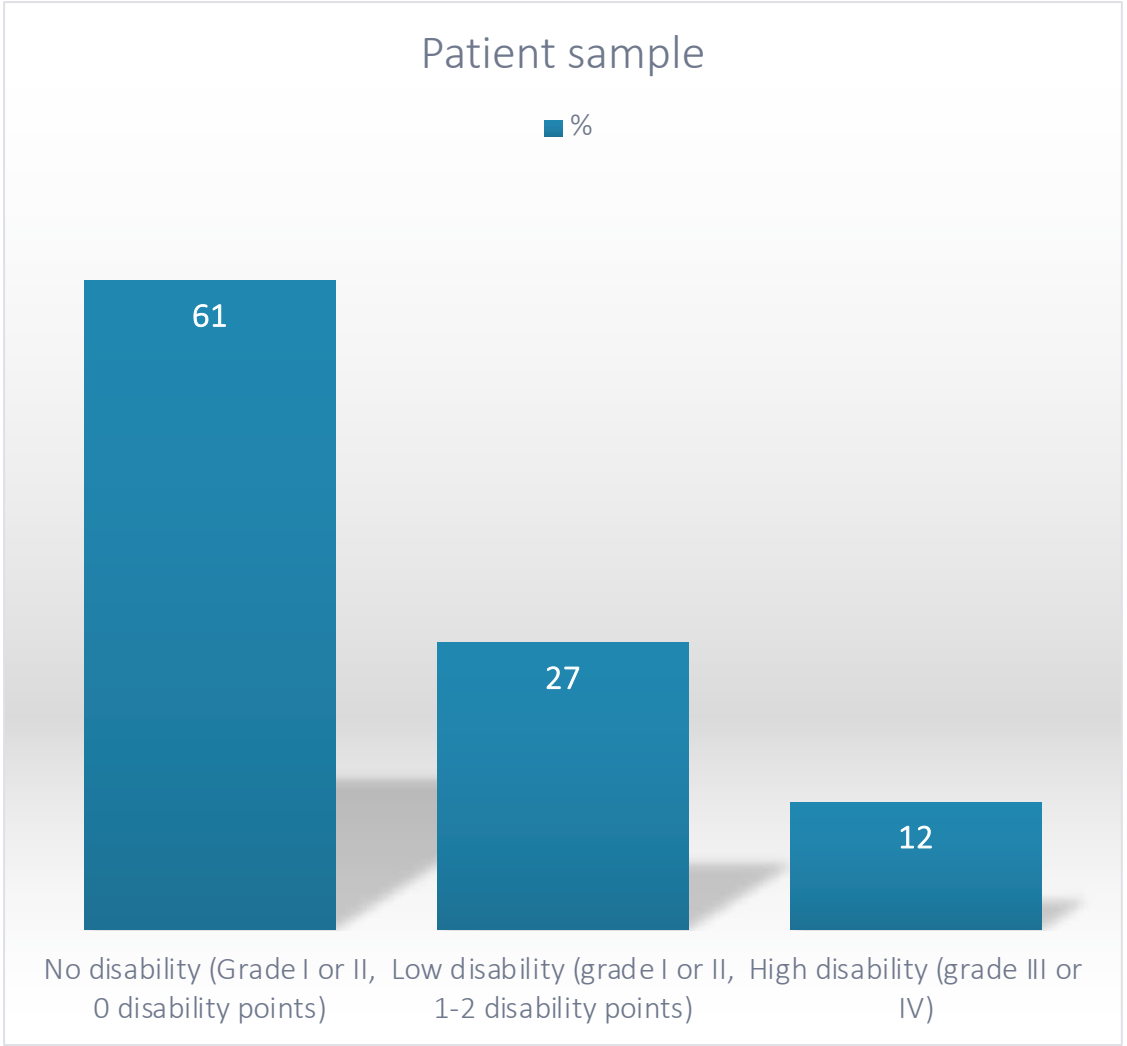
...an example

(Kotiranta et al, JOFPH 2015)

Subtyping patients with Temporomandibular Disorders […]

Kotiranta et al., JOPH 2015:29;126-134

- Aim: Identify subtypes of TMD patients in primary health care setting based on GCPS
- Methods:
  - 399 consecutive TMD patients from primary oral health care in Finland
  - Inclusion: >18 years, TMD pain (RDC/TMD) in the last month
  - Disability score (GCPS)
  - Psychosocial variables (RDC/TMD)



Subtyping patients with Temporomandibular Disorders […]

Kotiranta et al., JOPH 2015:29;126-134

Table 2 Psychological Variables: Group Differences Among TMD Patient Subtypes with No, Low, 0r High Disability

	Median (IQR)				Group differences (*P*)		
Psychological variable	All	No disability	Low disability	High disability	No vs Low disability	No vs High disability	Low vs High disability
SCL-90-R depression scale scores	0.6 (0.4–1.2)	0.5 (0.3–0.9)	0.7 (0.4–1.3)	1.2 (0.8–1.8)	.0008	<.0001	.0142
SCL-90-R somatization scale scores							
With pain items	1.0 (0.6–1.5)	0.8 (0.5–1.2)	1.2 (0.8–1.8)	1.7 (1.2–2.3)	< .0001	< .0001	.0033
Without pain items	0.9 (0.3–1.3)	0.6 (0.3–1.0)	1.0 (0.6–1.4)	1.4 (0.9–2.0)	< .0001	< .0001	.0106
SCL-90-R sleep dysfunction scores	1.0 (0.3–2.0)	1.0 (0.3–1.7)	1.0 (0.7–2.0)	2.0 (1.0–2.7)	.0829	.0001	.0351
Anxiety	1.0 (0.0–3.0)	1.0 (0.0–2.0)	2.0 (0.5–5.0)	3.0 (1.0–6.0)	.0013	< .0001	.0563
Pain-related worry	5.0 (2.0–7.0)	3.0 (1.0–5.0)	6.0 (4.0–8.0)	8.0 (8.0–10.0)	< .0001	< .0001	< .0001
Tension and stress	3.0 (1.0–6.0)	2.0 (1.0–4.0)	4.0 (2.0–7.0)	6.0 (2.0–8.0)	< .0001	< .0001	.1628
Catastrophizing (ruminative thoughts)	2.0 (1.5–2.5)	1.8 (1.3–2.3)	2.0 (1.5–2.5)	2.6 (2.3–3.1)	.4933	< .0001	< .0001
Patient-perceived risk of chronicity	7.0 (5.0–9.0)	7.0 (4.0–9.0)	7.0 (5.0–9.0)	8.0 (6.0–10.0)	.4840	.0482	.5892
Coping with pain							
Ability to control pain	4.0 (3.0–5.0)	5.0 (4.0–5.0)	4.0 (3.0–5.0)	4.0 (2.0–5.0)	< .0001	< .0001	.8837
Ability to decrease pain	4.0 (3.0–5.0)	4.0 (3.0–5.0)	3.0 (3.0–4.0)	3.0 (2.0–4.0)	.0020	.0508	1.0000

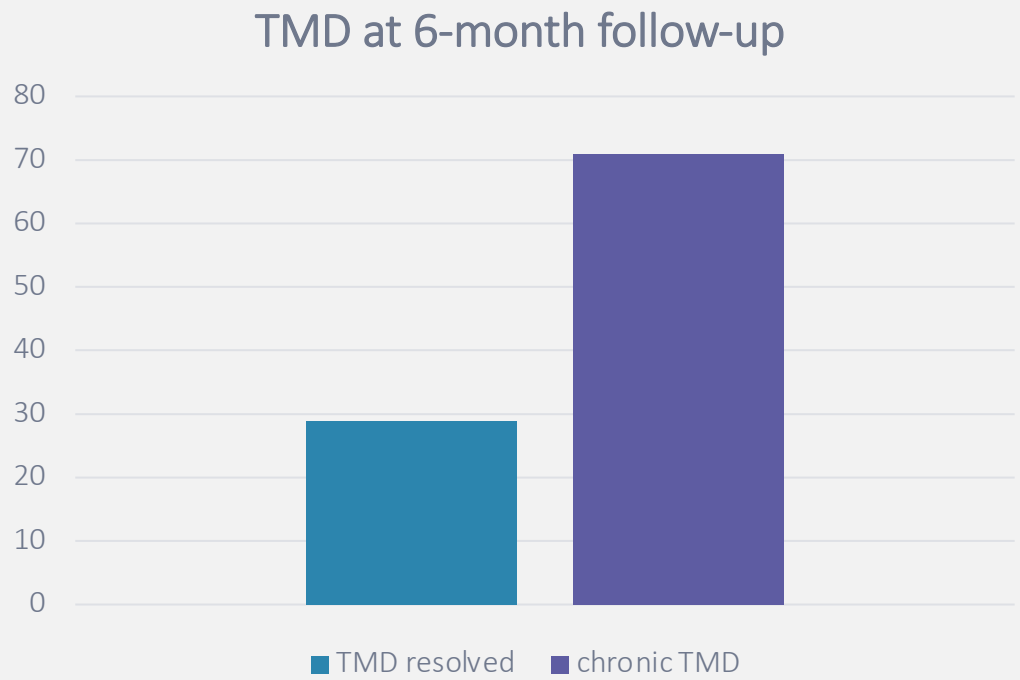
IQR = interquartile range; SCL-90-R = Symptom Checklist-90 Revised.

A MODEL FOR PREDICTING CHRONIC TMD:
PRACTICAL APPLICATION IN CLINICAL SETTINGS

JAKE EPKER, PH.D.; ROBERT J. GATCHEL, PH.D.; EDWARD ELLIS III, D.D.S.

- Aim: which variables best predict chronicity in TMD patients?

- 204 acute TMD patients (RDC/TMD)
  - Definition: no TMD-treatment in the 6 months preceding the study
- 6-month follow-up:
  - TMD was resolved (N=60)
  - chronic TMD (N=144)



(JADA 1999;130:1470-1475)

A MODEL FOR PREDICTING CHRONIC TMD:

PRACTICAL APPLICATION IN CLINICAL SETTINGS

JAKE EPKER, PH.D.; ROBERT J. GATCHEL, PH.D.; EDWARD ELLIS III, D.D.S.

- Logistic regression: which variables best predict chronicity in TMD patients?
  - Axis I and Axis II data

TABLE

LOGISTIC REGRESSION ANALYSIS COEFFICIENTS AND RELEVANT STATISTICS.

VARIABLE	B (SLOPE OF LINE)	STANDARD ERROR	WALD χ^2 STATISTIC	*df**	*P* VALUE
CPI†	-0.0624	0.0111	31.5761	1	<.001
Myofascial Pain	0.7802	0.2617	8.8846	1	.003
Constant	0.7985	0.5367	2.2138	1	.137

* *df*: Degrees of freedom.
† CPI: Characteristic pain intensity.

(JADA 1999;130:1470-1475)

DC/TMD Axis II – 5 domains

I. Pain Location	II. Pain intensity and related disability	III. Psychological distress
Pain drawing	Graded Chronic Pain Scale (GCPS)	Patient Health Questionnaire (PHQ-4)

DC/TMD: Patient Health Questionnaire (PHQ-4)

- Developed for general medical care practitioners
- Screening for major psychological disorders
  - Anxiety (Q1, Q2)
  - Depression (Q3, Q4)
- Classification:
  - ≥6
  - ≥9

Patient Health Questionnaire - 4

Over the last 2 weeks, how often have you been bothered by the following problems? Please place a check mark in the box to indicate your answer.

	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
1. Feeling nervous, anxious or on edge	☐	☐	☐	☐
2. Not being able to stop or control worrying	☐	☐	☐	☐
3. Little interest or pleasure in doing things	☐	☐	☐	☐
4. Feeling down, depressed, or hopeless	☐	☐	☐	☐

TOTAL SCORE =

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Why is this important?

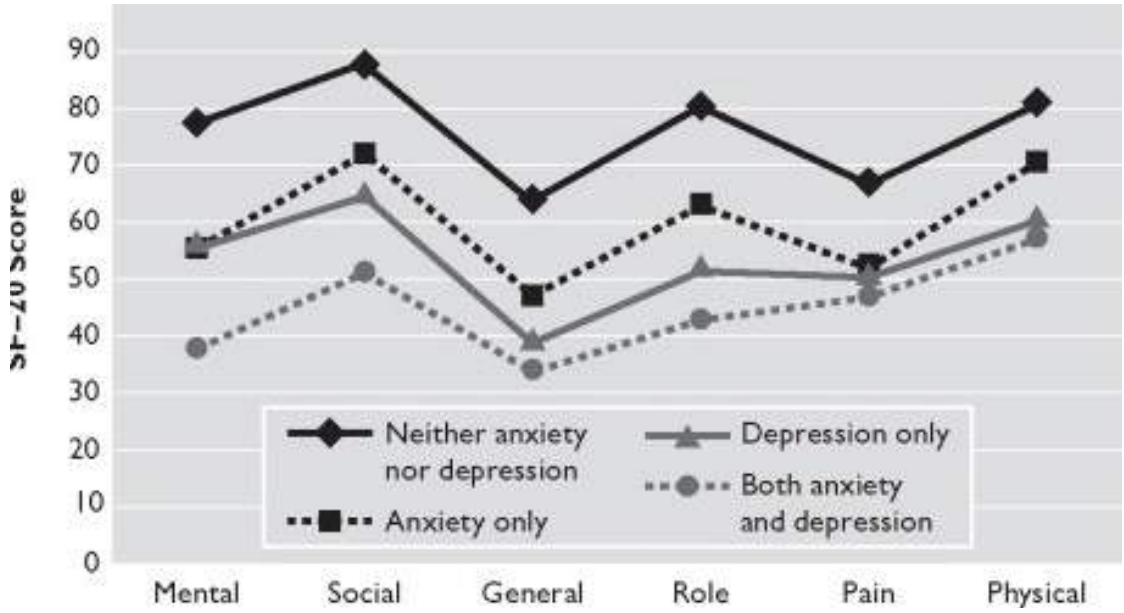
- TMD patients with a depression in the initial phase of their symptoms are at risk to develop chronic complaints

(Dahan et al., J Headache Pain 2015; Manzoni et al., Neurol Sci 2017)

An Ultra-Brief Screening Scale for Anxiety and Depression: The PHQ–4

Kurt Kroenke M.D. [1], Robert L. Spitzer M.D. [2], Janet B.W. Williams D.S.W. [2], Bernd Löwe M.D., Ph.D. [3]

- Validated the PHQ-4 as ultra-short tool to screen for anxiety and depression
- Studied the association with functional impairment
  - 2,149 patients from primary care (USA)
  - Short-Form General Health Survey (SF–20)
- Conclusion:
  - Both anxiety and depression have a substantial effect on functioning, and even more so when both present.
  - Screening for both anxiety and depression, rather than either alone, is advisable.



(Kroenke et al., Psychosomatics 2009; 50: 613-621)

Clinical Implications

A Randomized Clinical Trial Using Research Diagnostic Criteria for Temporomandibular Disorders-Axis II to Target Clinic Cases for a Tailored Self-Care TMD Treatment Program

- 124 TMD patients (RDC/TMD) with GCPS score 0, I or II-low
- Randomly assigned to:
  - Usual Treatment(UT):
    - Any combination of physiotherapy, patient education (e.g., parafunctions, diet), medication, occlusal appliance
    - As much visits as needed, approx. 3 months
  - Self Care (SC):
    - Education (e.g., biopsychosocial model), feedback, stress management, self-monitoring, personal self-care plan, exercises, relapse prevention
    - 3 visits, 2 telephone calls, 2,5 months

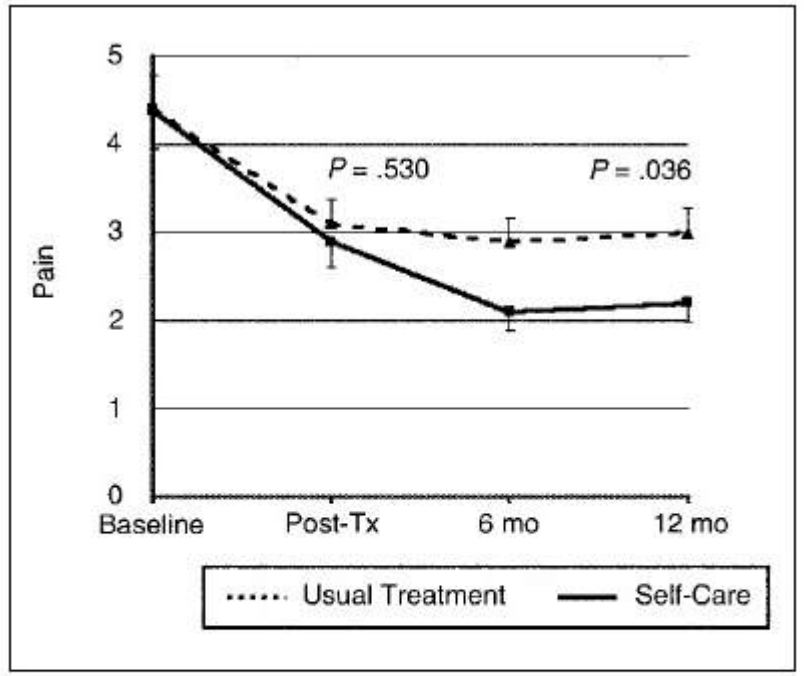


Fig 1 Mean (± SE) Characteristic pain intensity on a scale of 0–10. Self-care group (SC) versus usual treatment for TMD group (UT), analyzed by ANCOVA (adjusted for baseline levels of pain intensity and education).

(Dworkin et al., JOFPH 2002;16:48-63)

A Randomized Clinical Trial Using Research Diagnostic Criteria for Temporomandibular Disorders-Axis II to Target Clinic Cases for a Tailored Self-Care TMD Treatment Program

- Number of dental visits post-treatment:
  - Usual Treatment(UT):
    - 40% sought no treatment after treatment phase had finished
    - 30% visited a dentist more than 2 times, up to 9 visits (9%)
  - Self Care (SC):
    - 80% sought no treatment after treatment phase had finished

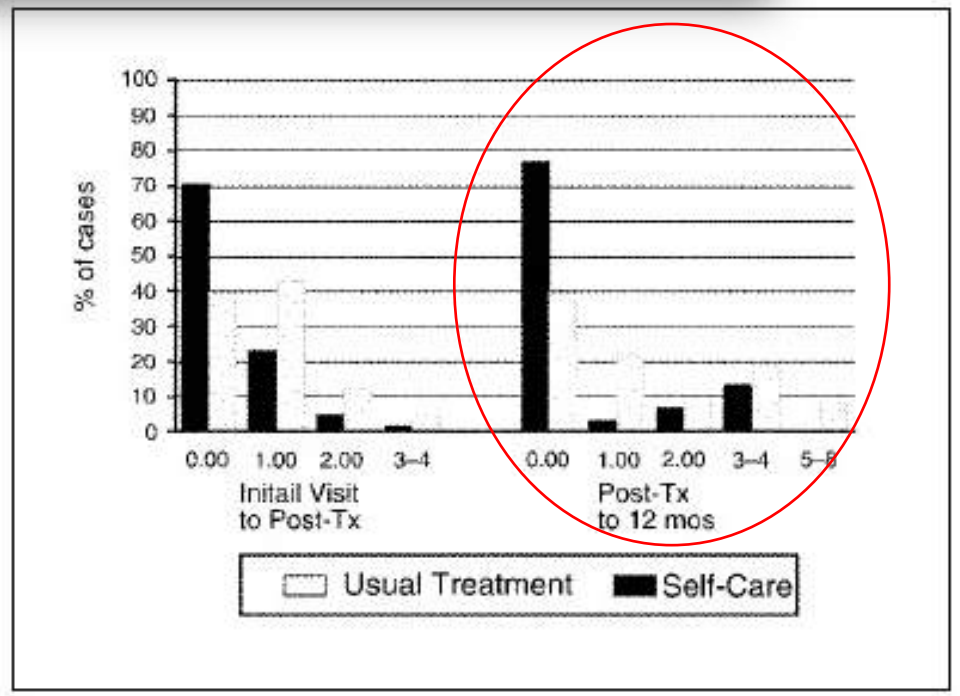


Fig 6 Number of dental visits for TMD after baseline visit (% of cases). Self-care group (n = 63) versus usual treatment group (n = 61).

(Dworkin et al., JOFPH 2002;16:48-63)

A Randomized Clinical Trial Using Research Diagnostic Criteria for Temporomandibular Disorders-Axis II to Target Clinic Cases for a Tailored Self-Care TMD Treatment Program

Table 3 Posttreatment Measures of Helpfulness of Self-Care and Usual TMD Treatment Received for Reducing TMD Pain, Increasing Ability to Cope with Pain, and Increasing TMD Knowledge, and Overall Treatment Satisfaction (Adjusted for Education Level)

	Self-care		Usual treatment		
Self-report measure	Mean	SE	Mean	SE	*P*
How helpful was treatment you received in reducing pain (0–10)	7.6	0.5	5.7	0.4	.0002
How helpful was treatment you received in ability to cope with pain (0–10)	8.4	0.5	5.4	0.4	< .0001
How much did treatment increase your knowledge about TMD (0–10)	9.1	0.3	7.2	0.3	< .0001
How satisfied were you with the treatment you received (1–5 scale)	4.5	0.2	4.1	0.1	.0280

(Dworkin et al., JOFPH 2002;16:48-63)

A Randomized Clinical Trial of a Tailored Comprehensive Care Treatment Program for Temporomandibular Disorders

- 117 TMD patients (RDC/TMD) with GCPS score II-high, 3 or 4
- Randomly assigned to:
  - Usual Treatment(UT)
  - Comprehensive Care Group (CC):
    - In addition to UT
    - 6 sessions:
      - 1 engagement
      - 2-5 education and cognitive behavioral treatment
      - 6 maintenance
    - Clinical psychologists

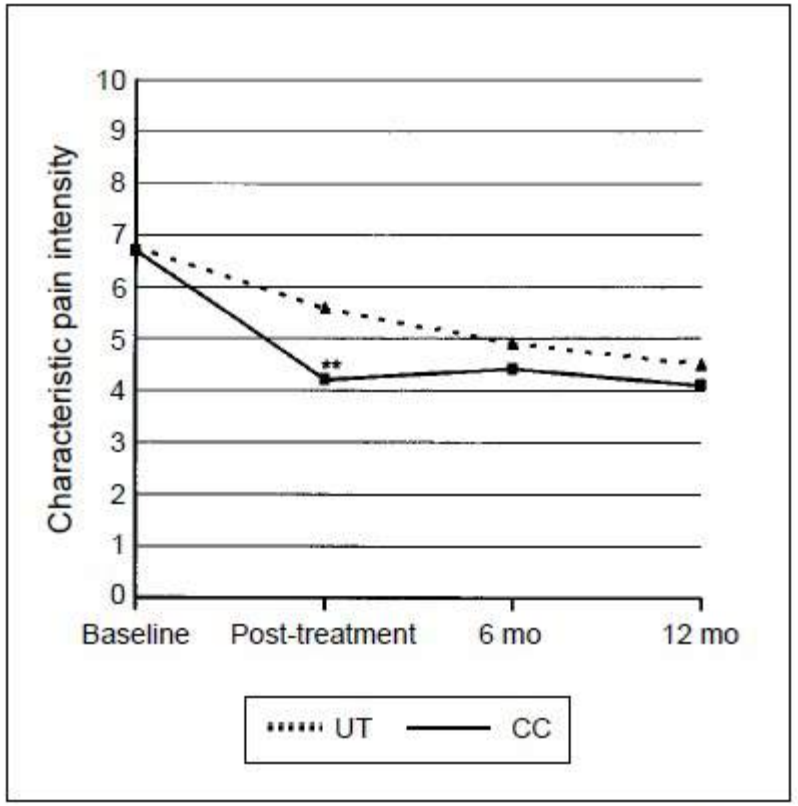


Fig 1 Comprehensive care versus usual treatment: Mean characteristic pain intensity (scale of 0 to 10). $^{**}P = .02$ (ANOVA comparing groups at post-treatment and 1-year follow-up).

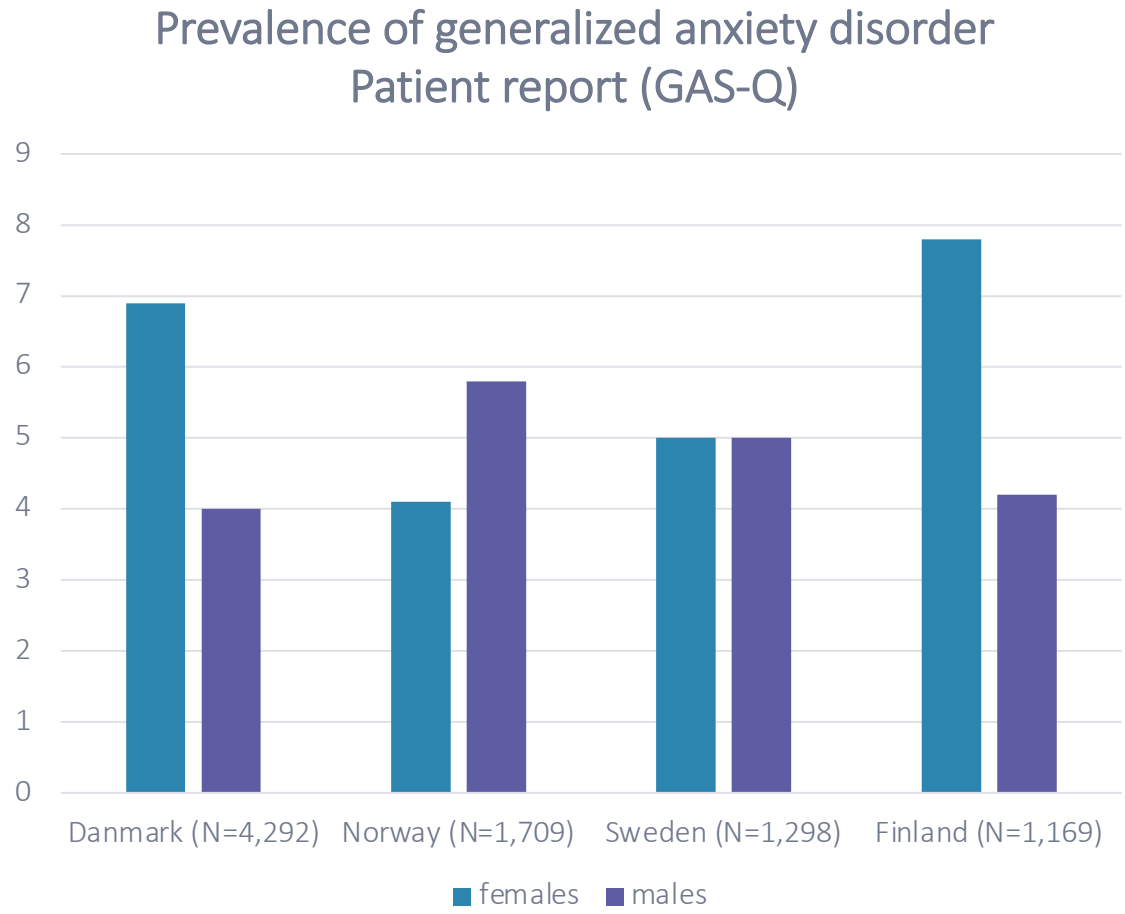
(Dworkin et al., JOFPH 2002;16:259-276)

Do we need to use these tools?

Can’t we tell when a patient has a psychological problem? We know most of them already for a long time?

Prevalence of Generalized Anxiety Disorder in General Practice in Denmark, Finland, Norway, and Sweden

- General practices in Scandinavia
- Patients filled in self-report questionnaires:
  - Anxiety (GAS-Q)
  - Depression (DSQ)
- General practitioners were asked whether their patients had:
  - Anxiety disorder
  - Major deppresive episode
  - Other mental disorders



(Munk-Jørgensen et al., Psych Serv 2006;57:1738-1744)

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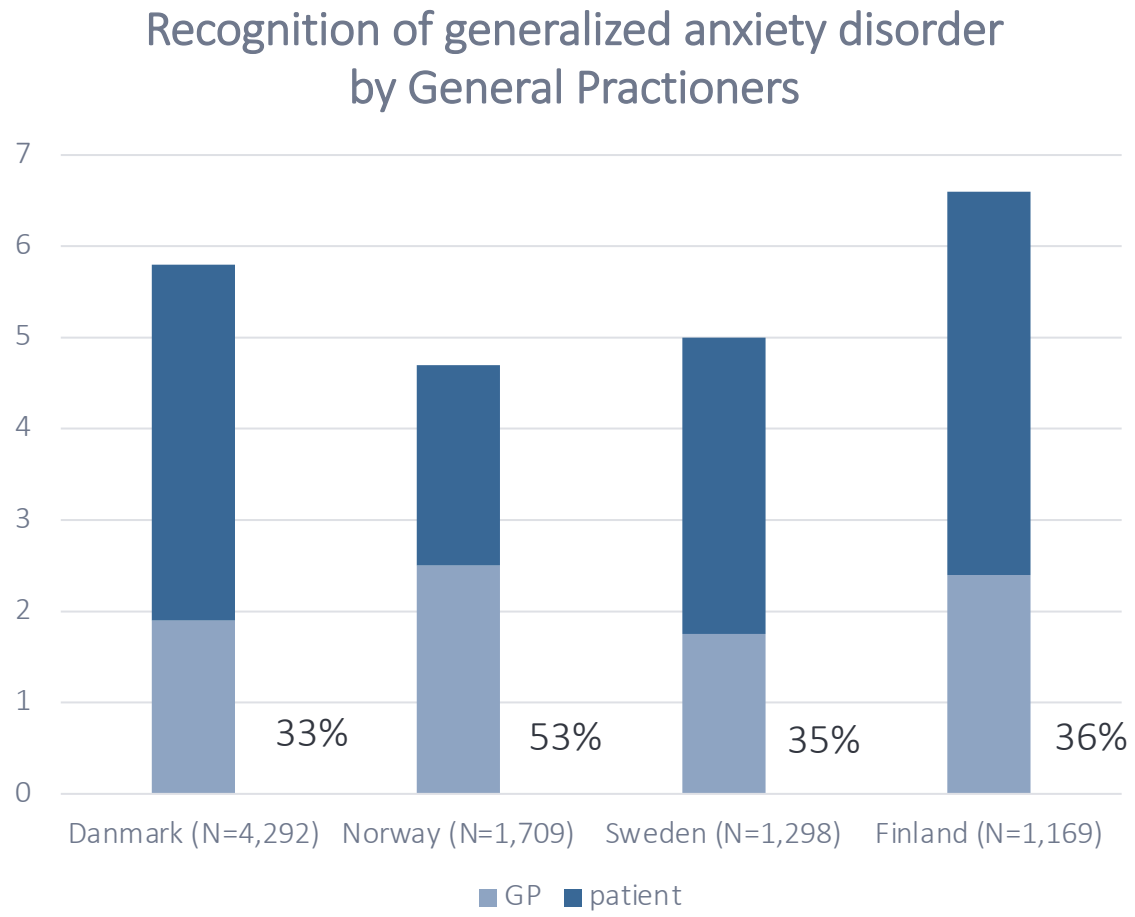

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TABLE 5 Variables associated with general practitioners' recognition of generalized anxiety disorder in Denmark, Finland, Norway, and Sweden (Table view)

Table 5

Variables associated with general practitioners' recognition of generalized anxiety disorder in Denmark, Finland, Norway, and Sweden

Variable	Univariate analyses			Logistic regression analysis stratified on country and clustered by physician		
	OR	95% CI	p	OR	95% CI	p
Sociodemographic factor						
Female	.75	.51–1.11	.168			
Aged 35 years or older	1.02	.68–1.52	.927			
Employed	.59	.39–.90	.008			
Country						
Denmark	.70	.47–1.05	.069			
Norway	2.44	1.41–4.19	<.001	2.25	1.24–4.08	.005
Reason for visit to the doctor						
Physical symptoms	.55	.36–.84	.003	.44	.25–.71	<.001
Anxiety problems	4.04	2.60–6.28	<.001	3.06	1.96–4.78	<.001
Depression problems	1.91	1.24–2.95	.004			
Health						
Disabled days (psychological)	2.18	1.46–3.26	<.001			
At least mildly inhibited psychologically	2.04	1.28–3.26	.002			
Worries are difficult to handle	2.02	1.32–3.09	.001			
Former diagnosis						
Panic disorder	2.78	1.50–5.16	<.001			
Generalized anxiety disorder	3.85	2.30–6.46	<.001	2.83	1.60–5.01	.001
Phobia	2.57	.87–7.60	.085			
Depression	2.16	1.48–3.16	<.001			
Psychosomatic disorder	1.96	.94–4.10	.076			
Anxiety neurosis	3.44	1.98–5.97	<.001	2.60	1.40–4.83	.003
Any of the above	3.04	2.04–4.53	<.001			
Presently in treatment for anxiety or depression	1.94	1.28–2.94	.002			
General practitioner is a professional psychotherapist	.44	.21–.94	.036			

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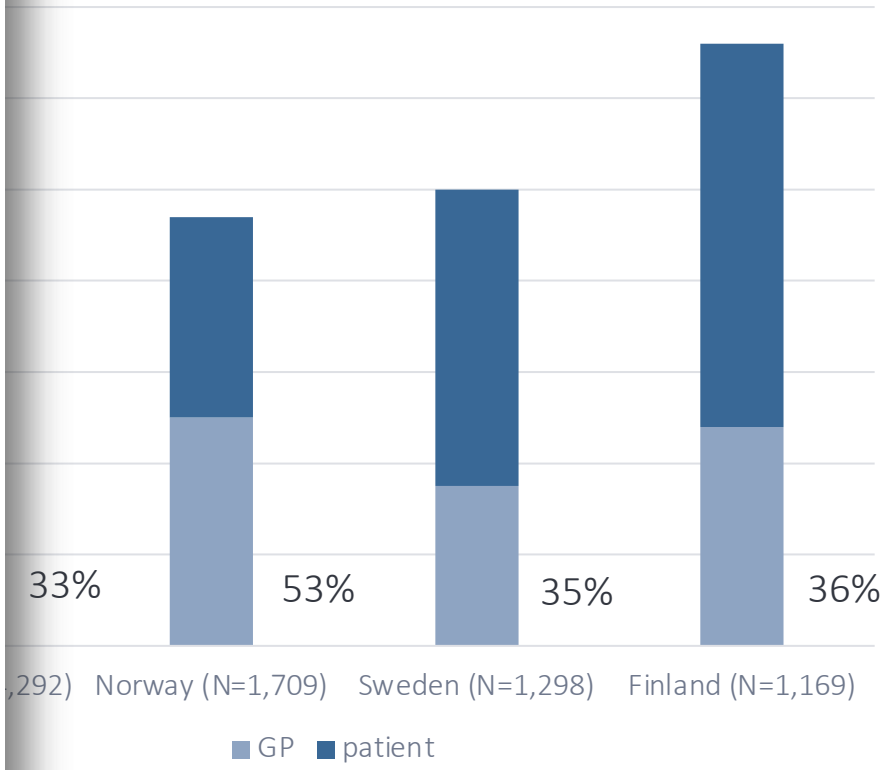

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Can't we tell when a patient has a psychological problem? We know most of them already for a long time?

Recommendations for the care of TMD patients

General Oral Health Care

- Anxiety/depression (PHQ-4): every new patient and new TMD complaint
- pain drawing and GCPS: new TMD complaint

Recommendations for the care of TMD patients

General Oral Health Care

- Low anxiety/depression (PHQ-4: 0-5),

AND

- Local pain (pain drawing),

AND

- Low disability (GCPS: 0-2)

Orofacial Pain Specialist/Multidisciplinary team

- High anxiety/depression,

OR

- Widespread pain,

OR

- High disability

Thank you for your kind attention