ISSN: 2755-0192

Journal of Psychiatry Research Reviews & Reports

SCIENTIFIC Research and Community

Mini- Review Article

Open Access

# Idiopathic Burning Mouth Syndrome: Specifics and Tactics of Cognitive Behavioral Therapy

**Melehin AI**

Clinical Psychologist of the Highest Qualification Category, Moscow, Russia

***Corresponding author**
Melehin AI, Clinical Psychologist of the Highest Qualification Category, Moscow, Russia.

**Received:** August 26, 2023; **Accepted:** August 29, 2023; **Published:** August 31, 2023

## Introduction

Over the past few years, burning mouth syndrome has caused confusion among mental health professionals worldwide due to the fact that there are no definitive clinical guidelines for the examination and management of patients due to the complexity in pathophysiology and multifactoriality [1]. Management is a problem for clinicians, especially when patients have concomitant psychological illnesses such as anxiety, depression and personality disorders. Patients with also report a significant decrease in sleep quality. This syndrome, according to the definitions of IASP, IHS, WHO and MICDH-III, refers to a form of pain syndrome, or rather a form of chronic orofacial pain (glossodynia, glossopyrosis, glossalgia, stomatodynia), which can be combined with other forms of somatization, for example, functional disorders of the gastrointestinal tract, headaches, abacterial cystitis, CSTB [2].

The patient has an intraoral burning sensation or dysesthetic sensation, which is repeated daily for more than two hours a day for more than three months in the absence of clinically obvious lesions. The discomfort is bilateral, and the mucous membrane of the mouth and tongue is most severely affected, although on examination they seem healthy, but there are still changes. Patients often describe discomfort as “tingling”, “numbness”, “itching”, “feeling of dryness/tightness”, “feeling of redness”, as a “wound on the tongue”. Concomitant symptoms include dry mouth (xeostomy), taste changes (dysgeusia) and oral paresthesia. Psychological stress (perception of the situation as stressful) can change the perception of taste and, consequently, increase the burning sensation in the mouth, as well as other oral symptoms of this disorder.

The diagnosis of burning mouth syndrome is often made by exclusion, and the diagnostic process should include an interview to analyze the specifics of uncomfortable manifestations; clinical examination, including analysis of mucous membranes and possible local and systemic causes; measurement of saliva flow and taste function; microbiological smears to confirm suspicions of bacterial (or viral or fungal) lesions; allergens; gastric reflux examination; blood tests to assess nutritional status; hormonal tests; and examinations to exclude autoimmune diseases [2].

Observing these patients from the position of a clinical psychologist, we noted the presence of parafunctional oral habits in them:

- Compression, bruxism and tongue sticking out
- Biting/biting of cheeks/tongue;
- Lip biting + clenched fists, raised shoulders, breath holding
- Often drink water at a specialist’s appointment
- Daytime bruxism
- In the morning or during the day, the tongue is examined in the mirror. Oral search with the desire to quickly seize the sensation.
- The presence of a sensitive gag reflex (they can not always brush their teeth, visit the dentist).

In patients, parafunctional oral habits are largely associated with waiting anxiety. Psychological problems can cause parafunctional oral habits, which can eventually lead to neuropathic changes in the oral mucosa due to damage to small nerve fibers [1].

It should be borne in mind that CSF affects more women than men, with a ratio of 7:2. The average age at the time of diagnosis was 59.4 years (range: 25-83 years), with the highest prevalence observed in women aged 35-55 years. A few patients (approximately 3%) experience complete and spontaneous remission of symptoms. In 50% of patients, spontaneous remission occurs within 6-7 years.

Forms and types of burning mouth syndrome [2]:

- “Primary” (idiopathic), which is characterized by an unknown local or systemic cause and involvement of central and peripheral neuropathic pathways
- “Secondary”, which is caused by “local” systemic or psychological factors
- Type I, which is characterized by a burning sensation in the mouth and tongue during the day and is not associated with mental disorders (condition);
- Type II, which is characterized by constant pain throughout the day and is associated with mental disorders, especially chronic anxiety
- Type III, which is characterized by periodic pain with atypical localization, for example, in the area of the mucous membrane of the cheek or tongue root, associated contact stomatitis, reactions to dietary supplements and the involvement of unspecified mental disorders.

After examining this group of patients for three years, we observed pronounced symptoms of an anxiety spectrum of conditions (excessive cognitive/somatic hypermobility) and depression in them. The following early cognitive patterns are observed on the YSQ scale: "vulnerability", "undeveloped identity", "rigid standards", "submission/self-sacrifice" and "seeking approval".

From the emotional regulation side, using the BDHI scale for examination, we noted the presence of physical, indirect aggression, resentment, and a high hostility index. The patients themselves note that forcibly they agree with everything and do not show that they are angry, "they feel the thermometer hot inside", they are convinced that they need to be "comfortable, pliable, helpful". There is a fear of "powerful" people ("I'm like a little one").

Flaming mouth syndrome can be considered as a "mask" of depression. The symptom is an expression of narcissistic wound, narcissistic fragility (examination on the PNI scale). The absence of an internal value compass where to move in life leads to a feeling of "vital sadness", "psychomotor stop", "confusion", which may be completely or partially hidden by somatic symptoms.

Patients have a lack of autonomy. There is an inability to realize depression and separation (the work of loss).

Burning in the mouth is a symptom that arises as a result of complex dynamics, from hysterical conversion to inability to realize separation (divorce, loss of relationships, children becoming adults) and the error of "failure" in the narcissistic core (sense of identity, "What's mine", "who am I?") [4].

According to the SCL-90-R scale, these patients have pronounced indicators of somatization, obsessive-compulsive disorder, depression, anxiety, hostility, phobic anxiety, psychoticism. In this regard, we can say that the flaming mouth syndrome is a somatoform disorder, a form of bodily distress because:
Stressful life events precede the syndrome.
Most patients have mental disorders or a history of psychiatric treatment prior to the onset of the syndrome

- Manifests itself in older women (65+) due to specific biological and/or psychological factors
- 79% of patients have alexithymia (according to the examination using the TAS-20 scale,difficulties in identifying and describing feelings) [4]
- Violation of the regulation of negative affect
- Violation of symbolic thinking, limited fantasy life
- Externally oriented cognitive style
- Difficulties in distinguishing feelings from bodily sensations, as well as violations of intuition and empathy.

Women have higher T-scores on the SCL-90-R scale for somatization, obsessive-compulsive and paranoid ideas.
Psychological factors:

- Compliance mode (I want to prove, explain, change)
- Obstacles ("I can't do...")
- Work loss (loss of mother, lack of father)
- "Super emotional", "phallic mother" (I don't want to be the same)
- Phallic narcissism
- Striving for exhaustion (doing something mode, "driving myself like a horse")
- Privilege. Fighting injustice
- Changes in professional identity
- Breakdowns on the child with self-accusation ("my tongue is my enemy")
- A tendency to form phobias. For example, a strong anxiety about a tumor of the salivary gland is a hypochondriac idea.

Only recently, integrative approaches of psychoeducation + psychotherapy + psychopharmacotherapy have been applied in foreign practice [1,3]. Recently, studies of the psychodynamic approach and interpersonal therapy have begun Showing a significant improvement in symptoms after specialized protocols. CBT. A review of the treatment tactics of patients successfully treated with the combination of CBT + sertraline was published. The effects of CBT alone, alpha-lipoic acid alone, and combination therapy (CBT+ alpha-lipoic acid [1]) were compared. Combination therapy was more effective than individual treatment methods [3-4].

**References**

1. YT, Chen LY, Lee HC (2015) Psychosomatic consideration to the burning mouth syndrome. Psychiatry Clin Neurosci 69: 125-126.
2. Alsabbagha R (2022) Aviv Ouanounou Burning Mouth Syndrome: Etiology, clinical presentations, and treatment alternatives. Dentistry Review 1: 21-37.
3. Milani Alessandra-Maria-Ceolin (2018) A successful approach to conrol burning mouth syndrome using matricaria recutita and cognitive therapy En. Journal of Clinical and Experimental Dentistry 10: 499-506.
4. Tu T, Watanabe M, Suga T, Hong C, Takao C, et al. (2021) Personality Traits in Burning Mouth Syndrome Patients with and Without a History of Depression. Front Psychiatry 29: 6-19.

**Copyright:** ©2023 Melehin AI. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.