Weden A, J Altern Complement Integr Med 2022, 8: 268
DOI: 10.24966/ACIM-7562/100268

HSOA Journal of
Alternative, Complementary & Integrative Medicine

Short Review

A Short Commentary on Physiotherapeutic Management of Temporomandibular Disorders in the United Kingdom: A Call to Holism and Compassion

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The Size & Nature Of The Problem Of Temporomandibular Disorders in the UK

Epidemiological data demonstrated that Temporomandibular Disorders (TMDs) blight the quality of lives of profound numbers of people throughout the world [1,2]. Reflective of the global burden TMDs are the second most common source of orofacial pain and in the United Kingdom (UK) [3]. Those with a TMD not only have to live with painful and mechanical symptoms derived from the masticatory myofascia and temporomandibular joint, but in reality epidemiological data demonstrates that the majority of patients with a TMD also experience primary headaches [4], neck pain [5] and otological complaints [6].

The 'journey' for such patients to find suitable care can be protracted thereby compounding the patients suffering and likely contributing to the embedment of the condition for the patient [7]. The provision of care for patients with a TMD within the UK can also be disparate leading to inconsistencies in care nationally creating a 'post-code lottery' and national inequity for patients seeking a solution or management of their TMD [7].

There is Hope

Suffering from a TMD, even if it is chronic, is not a life sentence. Numerous studies and systematic reviews demonstrate that TMD's are amenable to a variety of treatment approaches. These systematic reviews have demonstrated common and traditional physiotherapeutic techniques such as exercises therapy [8], manual therapy to the masticatory system [9], combined manual and exercise therapy to the cervical spine [10] and acupuncture [11] attenuate TMD symptomology. Recently we have illustrated that physiotherapy delivered by suitably trained physiotherapist in the UK can mirror the international research indicating that even those with chronic TMDs can benefit from physiotherapy [12]. Reassuringly also physiotherapeutic modalities can also attenuate headaches [13], neck pain [14] and the otological complaints that afflict most TMD sufferers [15].

Albeit the aforementioned physical therapies have demonstrated efficacy in improving TMDs and the constellation of symptoms that accompany TMDs, it should be noted that the effect size of such therapies in isolation can vary [16]. Despite the census that TMDs are a musculoskeletal disorder [17], psychological therapies alone can also contribute to the reduction of TMD symptoms [18]. This should be of no great surprise as the pathophysiology of TMDs is widely accepted as multifactorial and bio-psychosocial [19] and numerous musculoskeletal pain conditions can experience pain attenuation from psychological therapies [20].

Integrated Physical and Psychological Therapies… What is the State of the Art?

Numerous studies have now explored whether blending physical therapies with psychological therapies delivered by physiotherapists augments the effect of physiotherapy. A systematic review of such studies has demonstrated that in essence patients' outcomes from these integrated approaches are superior to physical therapies on their own [21]. The effect size of this blended approach however was disappointing low despite its laudable a priori logic and at the time there was no studies looking at such a model with patients suffering from a TMD.

However, what must be noted from this systematic review was the lack of options available to the patients of which psychological modality was integrated into the physiotherapeutic treatment. Patients did not undergo the process of psychological formulation to find the optimum psychological modality that would meet their unique needs. Not everyone with lower back pain or headache needs Cognitive Behavioural Therapy (CBT) or biofeedback approaches for example. Some patients respond better to Mindfulness Based Interventions delivered in a group context or some patients with the same pain condition will have a better response to the psychological therapy with one-to-one interpersonal counselling. As is the case with physical therapies, psychological therapies need to be personalised to the unique individual. Only when this happens in studies will we get a true sense of the potential effect size of integrated bio-psychological therapies.

The Challenges, Opportunities and scope of Practice Concerns for Physiotherapists

Cognisant of the need for many patients experiencing a TMD to undergo a care package that delivers pain attenuation via physical

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Citation: Weden A (2022) A Short Commentary on Physiotherapeutic Management of Temporomandibular Disorders in the United Kingdom: A Call to Holism and Compassion. J Altern Complement Integr Med 8: 268.

Received: July 25, 2022; **Accepted:** August 03, 2022; **Published:** August 10, 2022

therapies as well as behavioural and psychological modalities, experts in the field in the UK have suggested physiotherapists may be well positioned to deliver such an approach [22]. This would not seem an unreasonable suggestion as physiotherapist are taught to deliver all care underpinned by the biopsychosocial model [23] and can deliver psychological therapies with good fidelity [24] with sufficient training. The UK's National Institute of Clinical Excellence (NICE) recently published their guidance on the management of chronic primary and secondary pain which includes orofacial pain [25]. They concluded the following four management options should be offered to such patients:

- Exercise programmes & physical activity
- Psychological modalities (Acceptance & Commitment Therapies and CBT)
- Acupuncture
- Pharmacological management

With extended training physiotherapist can deliver all the included strategies mentioned above including pharmacological therapies. That said, many systematic reviews exploring the utility of pharmacological therapies for TMD don't conclude with convincing advocacy for this approach [26,27]. Indeed, many highlight the potential iatrogenic consequences of the plethora of pharmacotherapies suggested in the literature, often delivered with a 'suck it and see' approach for the patient leading to often questionable compliance to the pharmacological regime.

So if physiotherapists in the UK are going to meet the complex needs of orofacial pain patients by delivering competent and comprehensive bio-psychologically informed care, then the question must be posed: are we technically up to the task with right skill set? If the evidence base was the only place to draw any conclusion to this question, then much work needs to be done. Literature that is nearly 30 years old advocates the application of psychological skills to enhance physiotherapeutic care [22] and yet recent United Kingdom evidence on the topic continues to highlight the unfortunate paucity in training and competence to do this [28,29]. The profession must not just pay lip service to the notion of the importance of bio-psychologically informed physiotherapy but invest in extensive training and delivery of therapists to the workplace as competent bio-psychological clinicians who can respond to the needs of the patients suffering from a multi-factorial bio-psychosocial condition such as TMDs.

Part of the remit of these clinicians should not just be the delivery of psychotherapies or psychologically informed physical therapies, but conversely also we should have a clear sense of boundaries, risks and our scope of practice. Physiotherapist will never replace clinical psychotherapists, clinical psychologists or psychiatrists, but we must and can draw from the skill sets of such specialties and collaborate with them to optimise patient care and mitigate risk.

It's Not Just What, But How….Lessons from the Past for the Future

What was also of note from these recent NICE guidelines was not just the advocacy of what to offer our patients, but also how to go about engaging well with them with the purpose of mitigating barriers to a productive therapeutic alliance. Many of these recommendations are astute, evidence based and allow the best possible plans for patient care to be cultivated.

Outcomes aside, much of what is encouraged is also best encapsulated in (but not described as) the concept of compassion-based care. Notably absent in the physiotherapeutic literature is a narrative encouraging us to commit to and embody compassion towards our patients. Studies have explored compassion fatigue in physiotherapy practice [30] but unlike in nursing literature [31], next to no literature describes and advocates the opportunities afforded within the therapeutic physiotherapeutic relationship of personifying a compassionate therapist. Hopefully this will change as compassion-based therapies are starting to demonstrate empirically supported important therapeutic opportunities for complex pain patients including those with TMDs [32].

Ancient philosophers and gurus such as Plato [33] and Gautama Buddha [34] conceptualised frameworks of health and healing underpinned and personified by holism and compassion over two millennia ago. It feels profoundly right and re-assuring (if not a bit tardy) to see such concepts advocated in modern empirically derived recommendations such as the aforementioned NICE guidelines. The call now for physiotherapists treating the complex needs of patients suffering from complex pain syndromes such as TMDs is not just to know the theoretical importance of integrated bio-psychological compassionate care, but to embody it and deliver it.

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