Special Article

Psychoeducation in Patients with Atypical Facial Pain: A review

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Abstract
Background: Atypical syndromic facial pain refers to a group of conditions that include various forms of facial pain. Many times, these pains are related to the psychological sphere of the patients. **Objective** :Psychoeducation is both an educational and psychotherapeutic approach that considers the patient holistically and helps them improve the quality of life for themselves and their family. An appropriate multidisciplinary approach to the patient aims to help them explore the thoughts and feelings associated with pain and anxiety and develop skills to manage them.
Aim: The purpose of the research is to collect data from existing scientific research and studies that have been carried out so far, on the subject: the effect of psychoeducation on patients with atypical syndromic facial pain in the management of anxiety and pain. The literature search was conducted on the online platforms: PubMed, Scopus & Google Scholar. The data were processed in their entirety and categorized through content analysis. The keywords used for the literature search were: (1) Psychoeducation, (2) Patients with facial pain, (3) Stress Management, (4) Pain Management, (5) Painful Myofascial Syndrome, (5) Social Pedagogy, (6) Social Neuroscience.
Results: Psychoeducation is shown to be effective in improving patients' quality of life by providing them with the tools to manage both pain and the emotional impact of anxiety. Furthermore, the importance of an interdisciplinary approach is substantial, as professionals from various fields (physicians, psychologists, social pedagogues) collaborate to address patients' needs holistically.
Conclusion: Psychoeducation contributes positively to the management of anxiety and pain, helping patients develop self-management skills and explore the thoughts and emotions associated with their pain

Keywords: Pain, Dentistry, Facial Pain, Psychoeducation, Stress, Psychiatry

Introduction

Atypical syndromic facial pain, also referred to as idiopathic facial pain, is a persistent daily pain localized in the face, varying in intensity, distribution, and type, and typically occurring on one side of the face often in the nasolabial fold or the chin area. It may radiate to the upper or lower jaw as well as to broader regions of the face and neck. The pain may be triggered by a surgical procedure in the anatomical area or by trauma to the face, teeth, or gums; however, it may also occur

without a clear etiology, as it can be attributed to psychological factors (Agostoni et al., 2005). Accurate diagnosis is essential for successful treatment and for preventing potentially serious consequences (Benoliel & Gaul, 2017).

The recommended diagnostic and therapeutic approaches for atypical syndromic facial pain should be based on a holistic psychosomatic management of the patient. This management requires a multifactorial collaboration across different scientific disciplines and should include pharmacotherapy, patient education, relaxation techniques, psychological interventions, and physiotherapy. The combined application of Psychoeducation and physiotherapy has been shown to produce positive outcomes in the management of pain and anxiety, whereas physiotherapy or Psychoeducation alone yields limited results in addressing chronic pain (Vanhaudenhuyse et al., 2018; Adam et al., 2006).

Understanding and accepting the factors that may contribute to the onset of facial pain, stress, and muscle tension or spasm in the facial area is a fundamental step for the patient to be able to manage the symptoms they experience. Through Psychoeducation, patients can be trained and acquire self-management skills, as well as adapt to the appropriate treatment designed to address their condition and the symptomatology they present (Vanhaudenhuyse et al., 2018).

The present study presents the results regarding the impact of Psychoeducation on patients experiencing atypical syndromic facial pain. Research and studies from around the world were selected—already published and accessible through the online platforms PubMed, Scopus, and Google Scholar. Additionally, the content of this work was enriched with scientific textbooks related to the topic. All data were processed in their entirety and categorized through content analysis. Psychoeducation is a therapeutic process aimed at providing accurate information about an illness, teaching strategies for its effective management, and supporting the individual. Its core components include information provision, skills training, and psychosocial support (Swaminath, 2009). More specifically, psychoeducation is specialized training that encompasses educational efforts and interventions applied to patients and their families, aiming to prevent relapse among individuals with mental disorders and to support the restoration of their health (Atri & Sharma, 2007).

The physical pain experienced by a patient is a subjective experience and is often linked to psychological factors. For example, pain may decrease when the individual is distracted and does not focus on it. The placebo phenomenon demonstrates that a person's psychological state can have a therapeutic effect, as the individual may feel not only that the intensity of pain is reduced, but also that they have been cured. Somatoform disorders include somatization tendency, conversion disorder, body dysmorphic disorder, hypochondriasis, factitious disorder, and malingering. In one study, neuroimaging results obtained through magnetic resonance imaging provided useful information about somatised anxiety and how it affects and creates problems in the gastrointestinal and stomatognathic systems. The main purpose of the study was to describe a Psychoeducation program applied to patients with atypical facial pain combined with temporomandibular joint dysfunction and to provide information regarding the impact of somatised anxiety–stress on these conditions. The results showed that by educating patients and introducing appropriate methodological techniques, they are able to manage their anxiety, gain better control over their emotional state, and clearly improve their pain symptoms (Biegańska & Pihut, 2014).

Another study evaluated the contribution of Psychoeducation in individuals with autism, with the aim of improving their management and cooperation during dental treatment. By implementing an intervention program that utilized psychoeducational techniques and strategies, patients with special needs demonstrated improvements in their quality of life, as did their families. Quality of life is related to the individual's subjective perception and depends on health, psychological condition, and environmental relationships. Certain dimensions of quality of life include emotional and physical well-being, which involve the reduction of chronic stress and access to preventive and specialized healthcare. Therefore,

Psychoeducation played a significant role in facilitating dental intervention and supporting effective collaboration between the dentist and the patient with autism (Orellana, Martínez-Sanchis, & Silvestre, 2014).

Through a psychoeducational and physiotherapeutic intervention, changes were examined in the symptomatology of patients with myofascial pain before and three months after the restoration of stomatognathic function with the assistance of a dental prosthetic intervention. Cognitive functioning included processes related to memory, learning of new information, auditory and verbal memory, perceptual and attentional processes, executive functions, and problem-solving ability (Biegańska-Banaś et al., 2018).

Anxiety directly and indirectly affects the symptoms of painful myofascial dysfunctional syndrome. As with other disorders, habits in the oral region and jaw joint symptoms triggered by anxiety may lead to long-term problems if not addressed promptly. Therefore, individuals should attempt to reduce their stress in a way that suits their personal needs in order to maintain the health of their stomatognathic system (Hong, 2014).

Several Psychoeducation programs have been implemented for the management of temporomandibular joint disorders (TMJD) and other orofacial pain conditions. Another example is a recently evaluated pilot Psychoeducation program that included relaxation exercises, training in pain self-management, and information regarding the nature and management of the disorder. Patients participating in this program reported positive outcomes regarding pain reduction and improved functionality, although improvements were moderate, and further research is needed to confirm the effectiveness of these approaches (Cohen et al., 2007). However, research also indicates that although clinicians and patients acknowledge the role of psychological factors in the development and maintenance of chronic orofacial pain, general practitioners and dentists often feel inadequately equipped to manage it. There is a need for academic, interdisciplinary training that fosters creative convergence and collaboration between the humanities, social sciences, and medical sciences, always with the aim of deeper understanding and enhanced patient satisfaction (Dowd et al., 2015).

Cognitive Psychotherapy in Pain Management

Psychological reactions that may arise from pain include: anger, aggression, sadness, despair, sleep disturbances, eating disturbances, depression, and personality changes. These changes often distress not only the patient but also affect their surrounding environment. Appropriate psychological support and guidance play a decisive role in pain management. Depending on the needs and clinical course of each patient, psychotherapy may be applied in combination with other treatments (Malfliet et al., 2024)

Cognitive Behavioral Therapy (CBT)

Its fundamental hypothesis is that it is not only the nature and severity of symptoms (pain) that cause an individual to suffer, but also the way they perceive these symptoms. Therapeutic efforts focus on modifying the individual's perceptions/thoughts ("cognitions") regarding the problem, adopting alternative perspectives, and altering the behaviors that perpetuate it. Treatment is individualized according to the patient's needs (Vitiello et al., 2013; Adolphs, 2009). CBT is used for treating children and adolescents with chronic pain conditions, which are quite common in this age group. Frequently applied techniques include relaxation training, parent behavior strategies, and biofeedback. Some studies also included cognitive techniques (Palermo et al.,2016). Meta-analyses examining the effectiveness of psychosocial treatments in reducing pain in children have largely focused on pediatric headache populations. One meta-analysis of psychological therapies found that, compared to untreated control groups, CBT-based interventions resulted in clinically significant (50%) improvement in pain treatment, with improvements generally maintained three months after therapy. However, across studies, no significant improvement was found in variables related to pain-associated disability or adolescents' emotional functioning. CBT-based treatments have strong appeal for older adults because they are

safe in comparison to the adverse effects of other treatments (minimal risks compared to documented risks of pain medications and anti-inflammatory drugs) and because they emphasize self-management skills (Veehof et al., 2011). Furthermore, CBT skills that enhance pain management ability and reduce emotional distress may benefit common comorbid conditions such as diabetes and cardiovascular disease. One meta-analysis identified only 12 such studies, five of which lacked a control group (Lunde, Nordhus, & Pallesen, 2009). This review concluded that CBT was effective for pain, with effect sizes comparable to those reported in other CBT meta-analyses for pain. A small effect was found for physical functioning, and there were no statistically significant effects on depressive symptoms or medication use (Lunde et al., 2009). Lunde et al. (2009) raised methodological concerns regarding research quality, measurement, treatment-component heterogeneity, and inadequate reporting of procedures and treatment content across studies. A recent study found that a CBT-based self-management program for outpatients aged 65 and older with chronic pain provided significant benefits (Nicholas et al., 2013). The program outperformed the control group in the following variables: post-treatment disability, pain-related stress, depressive symptoms, fear-avoidance, catastrophizing, and self-efficacy. Most of these benefits were maintained one month later. Importantly, twice as many participants in the pain self-management group (44%) compared to the exercise control group (22%) and the waitlist group (20%) achieved clinically significant improvement in pain-related disability. Such programs are typically delivered in group format and include relaxation training, cognitive restructuring, problem-solving techniques, and communication skills (Ersek et al., 2008).

Other innovations in therapy delivery include nurse- or psychologist-led group self-management interventions conducted in participants' homes or in nursing homes where they resided. However, no differences were found between these groups and the control group, which received a self-help pain book during the study. Another study examined a CBT-based pain intervention for older adults delivered either in participants' homes or nursing homes and showed that CBT was comparable to the waitlist condition in improving pain but superior in increasing the use of relaxation skills and reducing maladaptive pain-related thoughts (Green et al., 2009).

In the absence of serious pathology, if pain is bothersome but not threatening, individuals often show a brief reduction in pain-inducing activity but eventually return to previous activity levels. However, if pain is perceived as catastrophic, it can trigger phobic reactions, increased self-monitoring, and avoidance behaviors. This body of chronic pain research closely aligns with Beck's approach and the anxiety model. Avoidance and catastrophizing appear to form the basis of dysfunctional behaviors in individuals with chronic pain. The therapeutic approach therefore derives from the fear-avoidance model, with graded exposure to previously avoided activities as a primary strategy. Through behavioral experiments, patients are encouraged to challenge dysfunctional beliefs and expectations related to injury or pain (Sturgeon, 2014). Exposure begins after a hierarchy of feared situations is created, starting from the least anxiety-provoking condition. Another research described CBT for chronic pain as an integrated set of techniques whose emphasis, structure, and dosage vary depending on the target population, availability, and expertise. The goal is always to improve dysfunctional thoughts, emotions, and behaviors rather than to eliminate pain itself (Lin et al., 2014)

A CBT-based therapeutic program includes psychoeducation, skills training, relaxation techniques, social skills, and physical exercise. Similar to anxiety treatment programs, behavioral experiments are incorporated so that new skills can be applied in daily life, along with relapse prevention and management. The effectiveness of CBT has been examined in numerous studies to date. In another the authors examined CBT effectiveness in chronic pain in adults (excluding migraines). The review included 24 meta-analyses published before 2008, encompassing a total of 4,781 chronic pain patients. The aim was to compare CBT and behavioral therapy with passive control conditions (waitlist or usual care) or active control treatments (structured treatments

including patient commitment, support groups, pharmacotherapy, etc.) regarding pain, mood, and disability post-treatment and at follow-ups. Of the six comparative studies evaluating CBT versus passive treatment, two demonstrated significant advantages for CBT in chronic pain reduction, mood, and follow-up outcomes. Similarly, of the six studies comparing CBT with active treatments, four showed significant differences favoring CBT, particularly regarding disability both post-treatment and at follow-up (Eccleston et al., 2009). Another study provided more recent results, including research up to 2011. Findings were similar to those from 2009, with improved methodological parameters. CBT appeared to have the advantage of maintaining improvements in pain and mood for a longer duration compared to other active treatments. Additionally, in comparison with passive treatment conditions, CBT results were notably more stable (Williams, 2012).

The relationship between mind and body is bidirectional and multifaceted. In the field of literature, this relationship has long been described as "psychosomatic," whereby physical factors, combined with psychosocial factors, influence the development of psychological problems and illnesses, whether this influence is direct or indirect (Orzechowska et al., 2021).

Through Psychoeducation, the value and importance of emotional support and enhanced coping in all forms of serious illness are reinforced. Psychoeducational interventions are flexible and can effectively address certain risks. They have been successfully implemented either as a primary treatment method or as an adjunct, and they are also included in prevention programs or used as educational tools experienced by patients and their families in various settings (Lukens & McFarlane, 2004).

Facial Pain

Patients with facial pain often seek help from physicians of various specialties for the pain they experience in the facial region. Facial pain is frequently associated with dental problems such as pulpitis (inflammation of the tooth with intense pain), periapical periodontitis (inflammation of the gums and surrounding tissues), odontogenic infections, and occasionally with neoplastic or systemic diseases of the oral mucosa, the salivary glands, or the paranasal sinuses. Many facial neuralgias may either mimic idiopathic trigeminal neuralgia or present as atypical facial pain or neuralgias directly related to dental pathology, as previously described (Roberts et al., 1984; Bush et al., 1993).

Facial pain that represents symptoms of a specific pathological entity is typically classified as secondary or symptomatic neuralgia. Persistent orofacial pain is very common and arises from a group of conditions affecting the face, head, and mouth. The disorders responsible for this type of pain include temporomandibular disorders, burning mouth syndrome, persistent dental pain, trigeminal neuralgia, and atypical syndromic facial pain (Breckons, et al., 2018). Chronic orofacial pain affects every aspect of patients' lives, causing both physical and psychosocial distress (Aggarwal, et al., 2021). Cognitive Behavioral Psychotherapy is a form of treatment that seeks to address the needs of patients presenting with somatic disorders of multifaceted nature. Based on numerous positive reports, Cognitive Behavioral Therapy is considered the most effective treatment for patients with somatised disorders (Bleichhardt et al., 2004).

Physical disturbances observed in the body are often forms of "expression" of abnormalities in the patient's psychological sphere. Psychosomatic and functional disorders, due to their uncertain nature and the lack of effective treatment, often pose clinical challenges for healthcare professionals (Sirri, Fava, 2013).

It is undeniable that headaches and facial pain are frequently associated with emotional burdens experienced by each individual, and the primary cause should always be sought and identified, along with any additional or contributing factors. Wolff (1963) argued that the emotional strain of a patient can be a cause of painful symptoms in stomatognathic disorders, where the facial muscles become tender and painful upon palpation and highly vulnerable even to minor dental interventions (Woolf ,2011).

Atypical Syndromic Facial Pain

Many patients who visit a physician with facial pain as their primary symptom describe

atypical symptoms that may be associated with a disease or disorder. Naturally, the physician must carefully examine the patient both clinically and through laboratory tests in order to rule out all possible conditions that could be responsible for these atypical symptoms before concluding that the patient is suffering from depression or neurotic symptoms projecting an internal psychological problem in the form of facial pain or atypical neuralgia (Lascelles, 1966). Even if this is eventually confirmed, clinical monitoring of such patients is essential, as these symptoms may represent the first indication of an underlying pathological entity or disease.

The term *"atypical"* was first used in 1924 and was applied to patients with facial pain who failed to respond to neurosurgical treatment. The etiology and definition of atypical syndromic facial pain remain controversial, leading some authors and researchers to even reject the validity of this diagnostic category. Atypical syndromic facial pain refers to a group of conditions involving various forms of facial pain—such as headaches, preauricular pain, submandibular pain, neck pain, infraorbital pain behind the globe, etc.—without an anatomical or pathophysiological cause that can explain the pain. The intensity of facial pain may range from mild to moderate or severe, significantly impacting quality of life and disrupting the patient's daily functioning (Do et., 2021).

Pain in the face and temporomandibular joints may be directly related to dysfunction of the stomatognathic system caused by poor dental occlusion due to tooth loss, or maladaptive functional habits of the patient combined with somatised anxiety, leading to muscular spasm of the masticatory and facial muscles. Muscle pain is directly associated with a series of neurophysiological changes that are closely linked to psych emotional and cognitive alterations (Gerwin, 2019). Pain may also arise following surgery or trauma to the face, teeth, or gums, but may also occur in the absence of a local cause. Atypical facial pain, to some extent, includes presentations of pain not associated with a specific abnormality. Studying the neurophysiology of muscle hyperactivity or facial muscle spasm reveals a synergy between the central nervous system and the contracting muscles (Mitsikostas, 1998).

Through Psychoeducation, the patient can receive information and positive reinforcement enabling them to break free from the intense states of the "vicious cycle" of muscle spasm – pain – muscle spasm. However, treatment must be individualized to achieve the best possible outcomes. Therefore, psychological intervention can contribute effectively to restoring quality of life and modifying behaviour in the management of chronic orofacial pain not associated with stomatognathic pathology (Yamaguchi et al., 2022).

The diagnosis, evaluation, and treatment of patients with atypical syndromic facial pain is one of the most challenging clinical issues, as these patients present with diverse signs and symptoms. According to multifactorial clinical studies, many patients with psychosomatic disorders also have traumatic psychological experiences from their past (Mottaghi, et al., 2011).

Empathy – Communication Skills – Person-Centred Approach

Reason and emotion are deeply interconnected, and the absence of emotional response significantly affects the decision-making process (Brosch,2013). The treatment of patients is strongly influenced by the psychological component that concerns them as individuals, and since the era of Hippocratic Medicine, the vital and therapeutic importance of physician–patient communication has been emphasized. In the study the authors examined interpersonal relationships and appropriate communication skills of physicians constituted an important factor for effective treatment and patient satisfaction. Physicians carried out their duties with complete acceptance, empathy, equality, support, and a positive attitude towards all patients (Ryan, 2022).

In another study empathy, understanding, kindness, and respect demonstrated by healthcare personnel are essential aspects of effective patient care. More specifically, communication skills among physicians and caregivers can contribute positively to establishing a relationship with the patient that facilitates risk identification, the

provision of preventive advice, early detection of problems, referral to other specialist physicians or therapists, as well as the continued support and guidance of the patient. The emphasis of the person-centered approach focuses almost exclusively on the relational dimension of care and on how healthcare professionals treat the patient (Mills, 2018).

Collaboration across different specialties and the integration of multiple scientific approaches contribute to improved outcomes. The provision of emotional support by the care team is equally important as the performance of surgical procedures (Dimovska et al.,2016).

Temporomandibular disorders (TMD) - Studies

Temporomandibular disorders (TMD) have statistically increased in recent years and are considered one of the most widespread pain-related problems in Dental Medicine, while also constituting a significant social issue. According to research and studies, approximately 40–60% of the global population presents at least one symptom of dysfunction within the stomatognathic system (Urbański et al., 2021). TMD often present with a range of orofacial conditions that create dysfunction in the hard and soft tissues of the masticatory system (LeResche, 1997). Diagnosis is largely descriptive, based on the symptoms and painful signs reported by patients (Huggins, et al., 2002; Schnurr, Brooke', & Rollman, 1990). It has been observed that temporomandibular joint pain is frequently accompanied by psychological distress—primarily depression and somatization of anxiety—and may also be associated with psychosocial disability (Schnurr, et al., 1990).

Various approaches and therapies have been proposed for the treatment of TMD. More specifically, treatments provided by a General Dentist or a specialized clinician such as a Gnathologist, Prosthodontist, or Oral and Maxillofacial Surgeon focus on the predominant painful symptom of the disorder. Such treatments include administration of anti-inflammatory drugs, analgesics, and antidepressants, the use of intraoral occlusal splints, physiotherapy, occlusal adjustment or dental arch reconstruction, surgical intervention of the affected joint, or arthroscopy. However, symptoms may also be addressed through biopsychosocial treatments based on self-management or through education and Cognitive-Behavioral Therapy (Dworkin et al., 2002).

In one study, a combined treatment was implemented in 21 patients—nineteen women and two men—who suffered from odontogenic pain. This type of pain was localized within the dentoalveolar region and was not associated with any clinical disease; it is presumed to arise from neuropathic and pathophysiological mechanisms, which are extremely difficult to understand, explain, and assess (Makino et al., 2018). The treatment consisted of jaw exercises—kinesiotherapy—and Psychoeducation (Makino et al., 2018).

In another study conducted in the Department of Oral Medicine at the School of Dentistry, University of Washington, pain and symptomatology in patients presenting with temporomandibular disorders (TMD) were evaluated. To be included in the study, patients were required to meet specific criteria, such as reports of facial pain or pain in the masticatory muscles, ear pain, difficulty opening the mandible, discomfort, and symptoms of pain in the orofacial region. Patients ranged in age from 18 to 70 years, and all participants were categorized by the attending clinical researcher regardless of pain level or intensity. The clinical study lasted one year, and data from the questionnaires and clinical examinations were evaluated at baseline, after therapeutic intervention at three months, and at the end of the intervention at twelve months (Mottaghi et al., 2011).

Mandibular Dysfunction

The activities of the masticatory muscles may be either normal or abnormal, and they are categorized as functional, such as chewing, swallowing, and speaking, or non-functional, such as tooth grinding, dysfunction of mandibular movement, etc. (Rao, Bhat, & David, 2011). Physiotherapy aims at passive and active jaw mobility, stretching exercises, as well as the application of heat or cold stimuli for pain relief. Additionally, the treatment involves patient's education regarding parafunctional oral behaviors, diet,

the nature of the disorder, and the treatment plan and goals (Williams et al., 2012).

In another study patients, through psychoeducation, understood the importance of their participation for the rapid and effective treatment of symptoms. More specifically, patients recognized the significance of identifying the oral parafunctional activities (OPAs) they exhibited, the frequency with which these occurred throughout the day, and the type of pain experienced. Furthermore, patients were trained to relax their tongue, masticatory muscles, and jaw. The clinical interventions and treatments, combined with Psychoeducation, aim to provide patients with behavioral skills that will enable them to effectively manage the stress and pain associated with their condition. They seek to modify self-destructive patterns of thinking to improve psychological functioning. They also aim to enhance feelings of self-efficacy by promoting the belief that patients are capable of successfully managing the disorders they experience in the facial region. Finally, according to studies, psychological variables tailored to the unique needs of each patient are more directly related to treatment outcomes than physiological variables (Lavigne et al., 2008).

Anxiety

Factors such as psychological stress, anxiety, and depression, in combination with parafunctional oral habits and behaviors, can induce chronic pain in the context of somatized stress, which is classified among the subgroups of temporomandibular disorders (Rugh, et al., 1993). Hyperactivity of the masticatory muscles, clinically manifested as tooth grinding, constitutes a significant concern for dentists due to its consequences, which include severe abrasion or even destruction of the teeth (such as tooth fractures), difficulties in dental restoration, the risk of temporomandibular joint damage due to strong masticatory forces with the potential onset of temporalis muscle tension headaches, as well as the sounds produced by tooth grinding or disc displacement, all of which may affect the quality of life and daily functioning of both patients and their immediate environment (Gatchel et al., 2007; Khoury et al., 2015).

Pain

Pain is a complex and multidimensional experience that involves sensory, emotional, and cognitive components. According to the International Association for the Study of Pain (IASP, 2020), pain is defined as “an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage” (Raja et al., 2020). Pain is a multifaceted experience arising from the dynamic interaction of the patient’s physiological state, thoughts, emotions, behaviors, and sociocultural influences (Roditi & Robinson, 2011a). Although patients often understand that they must change their lifestyle in order to manage or cope with pain, this does not necessarily mean that they are prepared or willing to implement such changes (Valieva et al ., 2025).

In a study by Jochum et al, on patients with chronic jaw pain and facial pain, the psychosomatic causes were investigated, as well as the ways in which the psychoeducational and physiotherapeutic interventions applied over six months influenced the course of pain perception and their quality of life. To treat restricted mobility and jaw pain, posture during work was evaluated, possibly harmful habits and stress-inducing situations in daily life were analyzed, and chewing behavior was examined. After these examinations and discussions were conducted, patients underwent psychoeducation with specialized psychologists aimed at behavioral therapy. The direct link between stress and chronic pain was extensively explained, and individual stress-inducing situations experienced daily by the patients were addressed through detailed discussions. Indeed, the impact of stress was evident in the tense and altered masticatory muscles as well as in tooth bruxism. Based on cognitive-behavioral therapy interventions, patients, through changes in their own behavior, began to intervene positively in the processes related to pain and the symptoms they exhibited. The results of the study demonstrated that the combination of Psychoeducation and specialized physiotherapeutic intervention can significantly reduce pain in patients with chronic jaw and facial pain. Furthermore, quality of life improved, and jaw dysfunction

was almost completely eliminated (Jochum et al., 2015).

According to various studies, treatments involving exercise therapy, cognitive-behavioral therapy, and intensive interdisciplinary rehabilitation show moderate effectiveness for chronic pain. However, chronic pain may be relieved immediately, and Psychoeducation is required for treatment Psychoeducational programs with a cognitive-behavioral approach may serve as tools for more effective chronic pain management (Salvetti et al., 2012).

The benefits of incorporating psychological therapy into multidisciplinary approaches to pain management include, but are not limited to, improved capacity for pain self-management, enhanced coping resources, reduced pain-related disability, and decreased emotional distress. These improvements are achieved through various effective psychological, behavioral, and cognitive techniques. Through these changes, psychologists can help patients feel more autonomous in managing their pain and able to live a normal life despite it. Additionally, the skills acquired through psychological interventions empower patients and enable them to become active participants in managing their condition while gaining valuable abilities that can be applied in the future (Roditi et al, 2009).

Pain management

Given the multidimensional nature of pain, only a comprehensive interdisciplinary model would be ideal for effective pain management. Current approaches recommend the implementation of a multidisciplinary treatment framework that targets not only the pathological aspects of pain but also its cognitive, behavioral, functional, and emotional dimensions. These approaches influence higher-level and long-term subjective and objective outcomes (Morlion et al.,2011).

Self-Care and Therapeutic Guidance for Effective Treatment

One of the most central and fundamental components of the self-care intervention in the study by Huggins et al. (2002) was the development of a personalized self-care plan tailored to each patient. Specifically, through this process, the patient—guided by a specialist—was able to formulate an individualized program targeted to their specific needs. Through structured strategies, the patient aimed to address, correct, and improve particular psychological or emotional factors that contributed negatively to their condition. More analytically, by engaging in regular, repeated behaviors -such as allocating designated relaxation time, performing jaw-stretching exercises, and monitoring symptoms- the patient was able to work toward achieving the desired therapeutic outcome (Brosschot et al., 2006). People may experience functional limitations and a reduced quality of life due to the development and persistence of chronic pain arising from factors that generate psychological stress. The orofacial pain has a significant impact on quality of life, as it affects physical, psychological, and social domains (Aldao et al., 2010). Symptoms related to temporomandibular disorders, such as joint sounds and pain in the temporomandibular joint, occur more frequently in women than in The physiological consequences of stress depend on the intensity and duration of the stressor, as well as on how an organism perceives and reacts to the harmful stimulus (Chrousos, 2009).

According to the interdisciplinary approach, a fundamental and effective tool is the provision of comprehensive information to the patient regarding their clinical condition. Psychoeducational programs encourage participants to use the necessary tools by changing their lifestyle in order to address and improve their physical and mental health (Moons et al., 2010). The contribution of psychology within a multidisciplinary treatment framework is particularly important, as psychological interventions uniquely address the needs of the patient while simultaneously facilitating appropriate management of pain and anxiety (Kolb et al.,2011). Research findings indicate that Psychoeducation has a positive effect on the management of anxiety and pain in patients suffering from atypical facial pain syndromes. Specifically, Psychoeducation helps patients explore the thoughts and emotions associated with pain and anxiety and develop skills to manage these experiences. This approach is shown to be effective when combined with

other treatments, such as physiotherapy, as it enhances outcomes in the management of chronic pain.

Psychotherapeutic techniques, including behavioral approaches and social support, also contribute to improving the emotional state of patients. These techniques help reduce anxiety and pain, enhance patients' self-management, and promote their quality of life.

Moreover, psychoeducational interventions strengthen patients' knowledge of their condition and provide them with essential tools to manage their symptoms more effectively, thereby contributing to their overall well-being. Research findings show that the anxiety and pain experienced by patients with atypical facial pain syndromes are directly related to their condition. Specifically, atypical facial pain syndromes represent a chronic facial pain condition that often lacks a clear organic cause but may arise from psychological factors, such as anxiety. Pain and anxiety are linked to somatized stress, which may exacerbate symptoms. The physical and psychological states of patients interact, and stress management can lead to improvements in pain perception.

Conclusions: According to the research, Psychoeducation appears to have a positive effect on the management of anxiety and pain in patients with atypical facial pain syndromes. Patients participating in psychoeducational programs demonstrated improvements in their emotional state and their ability to manage chronic pain. Psychotherapeutic techniques that combine behavioral therapy and the enhancement of self-esteem contribute to the development of self-management skills, while the combined application of Psychoeducation and other treatments, such as physiotherapy, improves therapeutic outcomes. The results indicate that Psychoeducation has a positive impact on the management of anxiety and pain. Specifically, Psychoeducation helps patients develop self-management skills and explore the thoughts and emotions associated with pain and anxiety, thereby improving their quality of life.

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