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Reply to Dr. Owen's comments

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Dear Editor,

As Dr. Owen correctly notes, the results of our study are at odds with what he states is the 'extremely common view held by health professionals that there is something a little different about these patients.' Although TMJPD patients were slightly more depressed and hypochondriacal than pain-free controls, so too were individuals suffering from pain due to knee and shoulder injuries, whiplash, back pain and other acute disorders. These small elevations were not clinically meaningful and disappeared in response to a positive treatment outcome. Similarly, Eversole et al. [1] report significant differences between groups which, nonetheless, fall within the normal range. Merskey et al. [6] suggest that TMJPD patients may even have a lower rate of psychological illness than other chronic pain patients.

In partial support for his suggestion that there are distinct differences between TMJPD patients and other individuals, Dr. Owen draws our attention to a paper by Marbach and colleagues [2] in which they found lower natality rates among TMJPD patients compared to healthy, matched controls. This did not seem to be related to interrupted pregnancy, contraceptive use, or frequency of sexual relations. Dr. Owen's inference that this 'reduced fertility might indeed relate to reduced orgasmic function in these patients' seems to be an unwarranted extension of these findings.

The explanation for the difference in number of children (particularly the tendency for those without pain to more often have three or more children and for those with pain to more often have none) may have nothing to do with 'orgasmic function.' It may simply reflect an incompatibility between having a painful disorder and desiring a large family.

Dr. Owen suggests that we might be more likely to find differences between TMJPD patients and controls if we considered changes in eating, drinking and sexual behaviour. Again, it would not be surprising to find such differences, as these activities are likely to be adversely affected by painful conditions.

Dr. Owen further suggests that it might prove fruitful if we shift our focus from examination of disorders of mood ('higher psychological functioning' or 'neocortical functioning') to alterations in somatosensory input from the trigeminal area. He posits that there may be some disturbance in the processing of somatosensory information from the trigeminal area in these patients which makes them susceptible to this disorder. Evidence related to this hypothesis is lacking.

Even if this were a factor, it would not address Dr. Owen's claim that TMJPD patients are somehow different from other patients. In the paper [2] that Dr. Owen cites, Marbach et al. conclude that TMJPD patients and controls were 'similar on most measures of personality characteristics.' Other papers by Marbach and associates [3–5] also support the finding that TMJPD patients do not seem to differ that much from other pain patients. As noted in our paper, perhaps clinicians are quick to psychopathologize these patients because they do not readily respond to their interventions.

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