キーワード：精神分析、舌症候、対象関係論

Key words: psychoanalysis, burning mouth syndrome, object-relations theory

Introduction

The fact that psychological factors can affect the human body and cause illness has been discussed for a long time, although it was not until recently that the importance of the relationship between body and mind was widely accepted in public. Freud was one of the people who contributed to the progress of psychosomatic medicine. He placed a special emphasis on the unconscious mind’s effect on the human body, and began the argument about the connection between psychoanalysis and somatic symptoms. He had been studying somatoform disorder and focused on the association of symptoms and early development. It is generally said that most illness would have psychosomatic components. Most diseases have multiple causes, including psychological causes, and it is very difficult to distinguish which diseases are caused by only psycho-
logical causes. However, there are some diseases in which psychological factors play a great role of causation.

In fact, there are many patients suffering from somatoform disorder whose exact cause doctors cannot account for. In the field of dentistry, we also have opportunities to see patients suffering from the disorder in their oral region. Dentists usually come to be annoyed by their persistent complaints, and do not know how to treat them. Only few attempts have so far been made at the psychoanalytic interpretation of psychosomatic symptoms in dentistry, therefore this paper is intended to discuss psychoanalytically the causes of psychogenic and psychosomatic orofacial pain and discomfort.

The oral zone plays an important role from the beginning of life. Although the mouth has several purposes, its main purpose is to take nourishment for self-preservation. Freud explained the oral stage and its characteristics, which plays an important role in the development of the structure of the psyche \(^3\). Also Abraham examined the oral stage more closely and expanded Freud’s theory, constructing his theory of oral character formation \(^4\). This may give some explanations of why patients in psychosomatic dentistry have problems in the oral region. Considering the possibility that the oral region has some symbolic meanings for them, an investigation of the oral stage is inevitable in this research.

The patients who complain about orofacial pain and neurotic anxiety in the oral region often have obsessive symptoms. They frequently check their teeth or tongue to confirm that there is nothing wrong, however, they believe that there should be something wrong in their mouths. Their concentration on the symptoms in their mouths shows that the mouth has important meanings for them in their unconscious mind. I would postulate that the patients have been struggling with ambivalent feelings, aggressive impulses and affectionate feelings towards people close to them, since they experienced the fear of object loss. Freud comments that the compulsive act is ‘a representation of a conflict between two opposing impulses of approximately equal strength’ \(^5\), and this notion could also be applied to those patients with orofacial pain. The mouth can express our ambivalent desires in primitive ways, so that the symptoms could be the result of oral conflict which the patient cannot cope with any more. Moreover, the symptoms could also have a meaning of punishment or inhibition of the intense aggressive desire.

In this research, I focused on patients with burning mouth syndrome (BMS, glossodynia), which is relatively common disease in psychosomatic dentistry \(^6\). The condition is symptomized by a burning or tingling sensation on the oral mucosa, tongue, palate, lips and pharynx. There are no visual signs on the parts where pain is felt. The medical report says the syndrome includes chronic anxiety or depression in addition to possible bodily conditions, such as nutritional deficiencies and changes in salivary function \(^7\). It is considered that BMS has multiple causes including psychological distress, and some patients are sufficiently responsive to antidepressants and benzodiazepines. However, there are other patients suffering from BMS whose symptoms are not affected only by medication. Houdenhove and Joostens suggest the possibility of the success of psychotherapeutic treatment for those patients \(^8\).

Therefore the purpose of this paper is to apply the psychoanalytic theories to our patients with BMS at the Department of Head and Neck Psychosomatic Medicine at the Hospital affiliated with Tokyo Medical and Dental University in Japan, and analyze their psychological, especially etiological factors. I will present three cases where psychopathological factors should be considered important to understand the etiology and examine the usefulness of psychoanalytic approach to those patients.

**Subjects and Methods**

I have completed Master degree schemes at the Centre for Psychoanalytic Studies at the University of Essex in the UK in 2006 where I took survey courses in psychoanalytic theory and methodology in both clinical and non-clinical areas (Table 1, 2). The scheme at the Centre provided courses of psychoanalytic theory, especially the British School of psychoanalysis, which is based on the object-relations theory. I have not been trained as a clinical psychoanalyst, so the aim of this
research is to apply the psychoanalytic ideas to my clinical cases and assess their validity and reliability. I examined three of my patients whose chief complaint was burning pain in the mouth yet who had diagnosed that there were no visible signs of disease. Psychoanalytic study of patients with BMS could help clarify its psychological aetiology. During the interviews I chose to focus on the following; patients’ life experiences, family histories, current state of close relationships. Zakrzewska suggests that patients with BMS may have had a difficult childhood, inadequate parenting, marital and financial irregularities. In terms of object-relations theory, it is worthwhile to consider the idea that the patients might have had a difficult phase in ego-developing. The psychoanalysts of the British School developed Freud’s theory and constructed the theory that objects have significant influence on the child’s development of ego. My attempt here is to determine if the theory can be applied to our clinical patients with BMS.

In this study, I reported that their onset of BMS was related to their uncontrolled suppressed anger and tendency of dependence, and suggested their vulnerability may have originated in their oral conflict in their childhood. We had more than five sessions individually and each session lasted for about 30-40 minutes on average.

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Results

Three of my clinical cases provide the effectiveness of psychoanalytic interpretation and treatment. I will show each of them specifically and explore its further possibility.

Case 1: Mr. W was a 69-year-old man whose chief complaint was a burning pain on his tongue. He had visited several clinics and been prescribed tricyclic antidepressant and benzodiazepines and vitamins. Yet his distress was not alleviated, but rather his anxiety and irritation deepened. He was very talkative and pleasant and said he was trying to be sociable and took part in several clubs after he retired. He was living with his wife who was still working, and their children had left home and were independent. When he was younger, he founded a company and succeeded in building it into a medium-sized company. However, four years previously, he had handed over the practical management of his company to his trusted subordinate who was also his best friend (I will call him A for convenience), and he sometimes went to the office just to check how the management went on and helped him occasionally. Yet soon after the takeover, the relationship between them deteriorated rapidly, and he felt very uncomfortable going to the office, as he felt harassed by his former subordinate A. Then he decided to stop visiting the office, and retired completely. A while after that, he began to suffer the burning pain on the tongue, and at the same time his tongue’s sense of taste also changed. Everything he ate always tasted more salty than before, so that he could no longer enjoy eating. It was his most annoying situation because he was proud of being a gourmet, and used to go out to dine in popular restaurants frequently. He lost his appetite, and often felt anxious for no apparent reason. In addition, he could not sleep soundly, and became nervous about his pain, so that he was always moving his tongue to touch the palate or the upper front teeth. His mind was completely occupied with the discomfort in his mouth.

It was not until in the 7th session that he began to talk about what happened to his company and the rupture with A. He had tried to ignore his negative feeling towards A subconsciously, however, after he admitted that he had suppressed his hostility since then, he gained ability to cope with his symptom and felt better. As six months passed, his symptom did not annoy him as much as before.

Case 2: Mrs. T was a 52-year-old housewife whose hobby was recitation of Chinese poems. She was a very talkative, animated woman whose chief complaint was chronic pain in her mouth. She claimed that her pain had worsened when she felt a sense of irritation vis-à-vis her husband. She initially displayed reluctance to talk about her anger and complaints against her husband, however, she spoke negatively about him when asked to talk about her family. She said she had been annoyed by his thoughtless behaviour and managed to pay off his debts he accumulated behind her back. When she talked about her husband, I saw her difficulty of controlling her aggression although she tried to suppress it. In spite of her hatred, she refused to think about divorce from him. She mentioned his good points as well, such as his kindness and sincerity. She had contradictory emotions towards him yet she did not seem to realize her difficulty in controlling it. She said she would never hope to divorce because her parents got divorce when she was a child. The relationship between her and her mother was not quite good. During our second session, I found her stronger emotion against her mother. She did not talk much but mentioned her vehement hatred towards her mother. She seemed to have difficulty to deal with her unresolved anger which was associated with her neurotic uncomfortable sensation in her mouth. I encouraged her to talk about her complex emotions and suggested that they might affect her symptoms. After four sessions (two months later), she said she began to feel less uncomfortable and gained ability to tolerate the pain which she had been always suffered.

Case 3: Mrs. K was a 75-year-old housewife suffering from BMS for about 2 years. Her pain began soon after she had dental treatment and then she noticed that she was clenching her teeth while sleeping. She had experienced the loss of people close to her. Her father passed away when she was 4-year-old, and her mother became incapacitated as a result of an injury caused by the fall at downstairs in the earthquake when K was 32-year-old. Her mother died of the injury ten years later. Her husband also died suddenly when she
Psychoanalytic Study of Psychosomatic Dental Problems

was 46-year-old. Her two brothers passed away some years ago and her sister was suffering from Parkinson’s disease. Mrs. K felt a strong anxiety about her sister’s condition. Moreover, she talked about her loneliness as her friends could not go out with her as often as before due to poor health. Thus she had been in anxiety about losses having experienced some profound traumas of losing her close people. Her pain worsened following a big earthquake in her hometown. Then she had come to realize that her pain could be related to the past trauma of losing her mother in an earthquake. She had focused exclusively on her symptoms and did not consider her psychological pain, so establishing the connection between her symptoms and her past experiences represented a significant mental shift. When asked whether she was experiencing ongoing difficulties in interpersonal relations, Mrs. K admitted to be irritated by her friend, whose behaviour she perceived as selfish. When speaking negatively about her friend, Mrs. K appeared contrite. When suggested that she had no obligation to continue meeting her friend, Mrs. K agreed, and her pain receded when she realized how much she suppressed her hatred towards her and tolerated her attitude. She began to accept that her suppressed feeling which she tried to ignore and her anxiety originated in her sad experiences of losing people. Her symptom improved three months after our first meeting.

Discussion

Now I will focus on the psychoanalytic explanation of the reason why they have psychogenic symptoms in the oral region. There are two important components of the oral cavity: Teeth and tongue. They play an important role for almost every function of the mouth, and the mouth is regarded as an entrance to interior of the body, to incorporate external matter.

Freud defined the oral function as the first stage of pregenital organization. He pointed out the sexual aspect which the mouth has in childhood, and called it oral or cannibalistic pregenital organization. He writes about the phase as follows:

Here sexual activity has not yet been separated from the ingestion of food; nor are opposite currents within the activity differentiated. The object of both activities is the same; the sexual aim consists in the incorporation of the object—the prototype of a process which, in the form of identification, is later to play such an important psychological part).

He emphasized the original form of identification in terms of sexual aim. To eat and to be eaten would represent identification of the object. This is a very primitive and savage form of activity to unite with objects. Yet the impulse to eat and incorporate objects could also cause the fear of being by the object. There are some myths and folktales about being eaten which mirror the anxiety of being eaten in the world, such as Little Red Riding Hood, the Old Father God Kronos devouring his sons in Greek mythology. Thus eating often indicates both the wish to unify with the loved person and the unconscious fear and anxiety of being eaten by that person. We could say that the desire to incorporate objects through the mouth is based on the notion of identification. Freud explained narcissistic identification represented by regression as the cause of melancholia as follows.

... identification is a preliminary stage of object-choice, that it is the first way—and one that is expressed in an ambivalent fashion—in which the ego picks out an object. The ego wants to incorporate this object into itself, and, in accordance with the oral or cannibalistic phase of libidinal development in which it is, it wants to do so by devouring it.

He says regression to the oral phase is characteristic of melancholia. I would assume the psychogenic symptoms developed in the oral region are associated with the regressed oral cannibalistic stage more closely than melancholia. They express their unconscious desires of identification in simpler ways than patients with other psychosomatic symptoms. Freud emphasized ambivalent phases of identification, namely love and hostility. He says;

It behaves like a derivative of the first, oral phase of the organization of the libido, in which the object
that we long for and prize is assimilated by eating and is in that way annihilated as such. The cannibal, as we know, has remained at this standpoint; he has a devouring affection for his enemies and only devours people of whom he is fond.

According to Freud, ‘identification is the original form of emotional tie with an object’, and ‘in a regressive way it becomes a substitute for a libidinal object-tie […] by means of introjection of the object in the ego’, and ‘it may arise with any new perception of a common quality shared with some other person who is not an object of the sexual instinct’ 12). Namely, identification through introjection is originated in the early relationship with objects and may be applied to later situations in adulthood according to the quality of the relationship with the object. Following Freud, Melanie Klein discussed introjection in terms of the early relationship between infant and mother. The ego introjects good and bad objects and they are identified with the ego by way of introjective identification. Introjective identification helps to form and develop ego, and the first introjected part to the infant’s inner world is the mother’s breast 13). Klein emphasized the infant’s sadistic impulse when s/he feels frustrated, and the infant’s phantasy of devouring the body of the mother 14). The sadistic impulse is a significant factor for devouring the object in the oral phase, and it is directly connected with the role of the mouth.

In fact, infants begin to practice biting when the first teeth erupt. As the oral activity slowly changes from sucking to biting, we can see their sadistic aspects in terms of biting. This sadistic impulse is considered closely by Abraham in his further development of Freud’s concept of the oral phase of pregenital sexual organization. Abraham elaborated the peculiarity of the oral phase and character formation in his paper, which shows his idea of two phases of the oral stage. He pointed out that the oral sadistic impulse arises after the eruption of teeth, and it is differentiated from the sucking period 15). He states the sadistic phase in depressed patients can be explained as ‘regression to the most primitive stage’, in other words, ‘the oral or cannibalistic stage, as they hide their tendency to devour and demolish their object’ unconsciously 16). He says that the unconscious wish of the melancholic is to destroy his love-object by eating it up 17). He emphasized the regressed oral sadistic impulse in melancholia, which is also discussed by Freud in 1917. In the paper of Mourning and Melancholia, Freud says that the melancholic has ‘a satisfaction of trends of sadism and hate which relates to an object, and which have been turned round upon the subject’s own self’ 18). We can say that it is the sadistic impulse which is connected with the oral phase that causes melancholia. This oral sadistic desire is also based on the wish to identify with the object.

According to Abraham, there are two different characters at the oral stage 19). The early oral stage is sucking, and its trait is savouring and indulging pleasure, which might form optimism and impatience, or envy and hostility. The latter is biting, and we can observe the infant’s sadistic impulse at this period without difficulty. These phases could affect the way of speaking in adulthood. Some of them gain oral gratification by much speaking instead of sucking or biting. The mouth can obtain gratification and also express hostility to the object. In the later oral stage, namely after the eruption of teeth, the ambivalent tendencies are seen more clearly. This idea of character formation based on the oral stage may have an influence on the choice of psychosomatic and neurotic symptoms. The ambivalence is characteristic in the oral stage, which is shown as oral conflict. The infant comes to know how to obtain pleasure and gratification, and at the same time, displeasure and anger through the oral phase. Glover defines some oral characters—omnipotence, impatience, envy and apprehension, following Abraham. The neurosis related to the mouth zone, which he calls ‘neurotic mouth character’ is mainly ‘an exaggeration of normal mouth characteristics’ 20). He also points out that the attitude of that kind of patient was likely to be dependent on the parents 21).

The oral stage is a very important period in the development of the infant’s object relationship. The infant needs to be dependent on the mother, however, as the ego develops, the infant comes to realize the need to change the dependent relation to a more individual one. However, if the infant had some difficult situation in the oral stage, the possibility to regress to that
stage and having problems related to the oral zone could be raised. They may have great difficulty of individualization, as they feel anxiety about being separated and afraid of losing their loved object in addition to their tendency for dependency.

Now let us examine the clinical examples I have stated earlier. We can assume from above three cases that they harboured hidden hostility against their close people although they wished to be indifferent to them. Freeman presented a case of a patient of hers with BMS and suggested the hypothesis that the sensation of BMS could be ‘experiencing rage or sexual excitement’ 22). She referred to previous studies of BMS which suggested that BMS was related to ‘the loss of a loved one as well as repressed aggressive wishes and sexual phantasies’, and supported the theory that the nature of BMS has elements of aggressive and sexual wishes 22). Behind their aggression, we could see their hidden wish to control their close people.

In regard to the case of Mr. W, his experience of object loss (the company and the trusted subordinate) must have caused anxiety and aggression, which could arouse his regressed sadistic impulse which Abraham advanced. It could be also appropriate here to apply Freud’s concept of melancholia to this case. His unconscious wish to attack and incorporate the lost loved object in order to become omnipotent again led him to regress to the oral stage. However, this sadistic impulse should be repressed, and it turns to the patient himself. Freud says; ‘we perceive that the self-reproaches are reproaches against a loved object which have been shifted away from it on to the patient’s own ego’ 23). His super-ego punished him for his oral sadistic desire towards the loved-object, which was expressed in the form of BMS. The second case, Mrs. T’s suppressed anger was more obvious. Yet she needed to stay with her husband although she felt hatred for him. Her need was to control him as she wished because she could not tolerate her anxiety for the loss and separation, which could be rooted in her experience of being ignored by her mother in her childhood.

Her strong preferences for smoking, singing, chatting show her fixation to her oral gratification which she still longed for. In the case of Mrs. K, we can see that her anxiety was related to her experiences of losses of her close people. Her vulnerability of the psychogenic pain was caused by her sad experiences of sudden losses. Also, she had a difficulty to maintain a friendship with her old friend. Although she harboured hatred against her, she could not break a relationship with her.

It is conceivable that the patients’ desire to maintain close relationships incorporates an element of immature dependency, including a subconscious wish to control. Taylor summarized the development phase of early childhood, from symbiosis to individuation, reviewing Mahler’s differentiation subphase of separation-individuation. According to him, the early mother-infant relationship during the symbiotic phase structures the basis for the following object relationship 24). There are sub-phases of separation-individuation, and if the infant goes through these phases adequately, individuation can be completed and the infant can permit sufficient functioning when s/he confronts the absence of another person (Figure 1.). Taylor also explains the case of the failure of separation-individuation, which can lead to the infant’s psychosomatic illness 24). He states the reason for the failure referring to the study of Masterson and Rinsley as follows; when a mother is struggling

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*Psychoanalytic Study of Psychosomatic Dental Problems*

**Fig. 1. The movement from fusion through to separation**
*(Fairbairn’s psychology of dynamic structure)* 31)
with intense symbiotic needs herself she may discourage separation-individuation in her child by withdrawing her supplies as the child tries to separate, so that she made a strong tie with her child which rendered unable the child to be independent. This tie may harm the child’s correct development of relationship with the object. The child feels anger and irritation over his/her dependency on the mother and harbours a murderous desire towards her for depriving him/her of ‘autonomy and identity’, yet at the same time the child has the wish to ‘fuse with her in order to avoid the total abandonment he fears’. This symbiotic relationship also affects the relationship with others in later life, and can be the onset of disease. When the separation of the symbiotic partner happens, the fear and anxiety of abandonment occur and it is experienced as ‘losing part of the self’, and ‘the associated “giving up” affects may be accompanied by the onset or exacerbation of disease’. From this point of view, people who could not succeed in separating from the primary object have a tendency to suffer psychological disorder. This pathological aspect of the relationship may influence the person’s later life in terms of close association with other people. I would postulate that the people with psychogenic symptoms related to the oral zone would have this pathological relationship more or less in their childhood and are likely to have a similar relationship with people close to them. Their choice of symptoms could explain this aspect; their fixation on their oral function is obvious and it is associated with the unconscious desire to incorporate and introject the object. Their primitive wish to ‘fuse’ with the object should organize from this failure of individuation. They feel considerable anxiety, fear and anger when they experience separation. The separation is so intolerable and is perceived as if a part of themselves is detached that they express their helplessness in the form of illness. They do not know how to endure the absence of the object, because ‘their ability to form symbols and to think abstractly is limited, and they frequently report an absence of transitional objects in their childhood histories’. They still remain at ‘a stage of infantile dependence (corresponding to Abraham’s ‘oral phase’)’ in Fairbairn’s theory in adult life. As Fairbairn claims that depression is related to ‘disturbances of development during the stage of infantile dependence’ and to difficulties arising in object-relationship over biting, I would say neurotic symptoms in the oral region also indicate some problems in that stage. The pathogenic mother-infant relationship mars the infant’s ability to cope with separation, and makes it difficult to live without someone even in later life, so that they express their agony by symptoms when they experience the fear of separation. Their neurotic concentration on symptoms in the mouth expresses directly their need to cling to someone as well as to attack someone, their ambivalent emotion towards them—love and hate. They have an unconscious desire to bite and incorporate them, not to be separated from them.

Also I would like to point out the narcissistic aspects of their persistent complaints of symptoms. Freud discussed the connection between narcissism and pathology in the paper On Narcissism. He explained hypochondria using the libido theory as follows.

The hypochondriac withdraws both interest and libido—the latter specially markedly—from the objects of the external world and concentrates both of them upon the organ that is engaging his attention.

As Freud states, ‘in the case of other neuroses a small amount of hypochondria was regularly formed at the same time as well’, I would postulate that patients with psychogenic oral disorder share the same nature of hypochondria. They concentrate on the oral zone which is symbolized as their important part by which they are able to obtain dependency and at the same time attack and damage the object. Their narcissistic concentration on their mouth is intensified after the oral conflict is displayed in the form of symptoms, and they become obsessed with their symptoms.

Their tendency of dependence may make them regress to the oral phase more easily. According to Fenichel, an oral dependent attitude is likely to be seen in neurotic symptoms. He also pointed out the patients’ narcissistic needs and their demands for compensation.

He states:

In patients who have not learned to master new
Psychoanalytic Study of Psychosomatic Dental Problems

experiences actively, an increase in their oral-dependent attitude, with all its ambivalent features, is a frequent response to the appearance of symptoms. To a certain degree something of this sort happens in every neurosis. All neurotics tend to regress, and whenever one feels miserable and one's own activities are insufficient, the old longing for external help appears.

Neurotic symptoms are 'demands for compensation from the external world', so they need to be taken care of by someone whom they can depend on. Their wishes behind the symptoms have many ambivalent feelings; that is to say, desire to attack the object by biting, to incorporate it, to fuse with it, and to depend on it. These are directly related to the essential role of the mouth. Their unconscious wishes make them concentrate on their oral conditions and they begin to believe there is something wrong in their mouths because they feel anxiety and guilt for their aggression at the same time. The cases of the patients we have examined show that they had both of aggression and guilt, which possibly formed their symptoms.

They used their symptoms as excuses to concentrate on their mouths, in that sense, the pain they felt was their need to resolve their conflicts. This kind of inhibition is mainly contributed by their superegos. Their aggression had to be transformed into the form of symptoms by their superegos, and I would say the choice of the symptoms has its own origin in the patients' unresolved conflicts which can be traced back to their infantile oral stage and early mother-infant relationship.

Conclusion

It should be concluded, from what has been said in the three cases, that their susceptibilities to psychogenic pain disorder are based on their dependency and aggression related to sucking and cannibalistic desire in childhood. Their longing to be identified with and dependent on the object was frustrated when they found they lost their loved objects. The longing was turned into a sadistic desire to incorporate the loved object in a regressed oral cannibalistic way. The conflict between strong aggression using their teeth to attack the objects and the desire to incorporate and unite the objects occurred in their unconscious mind. The pain represents their agony from the ambivalent feelings. Or it could be punishment for their desire to follow their sadistic impulses. We could understand that the patients whose superegos' demands are strict have a predisposition to suffer guilt, so that they use the symptoms as a self-punishment. Thus it seems quite probable that people suffering from psychogenic pain in oral zone have oral conflicts which stem from their early ambivalent oral phases. The present difficult situation or event, which results in anxiety and anger about an uncontrolled loved object, would lead to an evocation of the infantile oral conflict. The patients' unconscious aims are to introject the objects and control them. They often fail to handle their suppressed emotions, and begin to suffer psychosomatic symptoms. It can be very effective to lead them to realize their negative feelings towards their key persons and let them to talk about their suppressed agonies. It is also important for us to see patients' hidden ambivalent feelings behind their persistent complaints.

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References