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A CASE STUDY ILLUSTRATING TRAPS, PITFALLS AND CONCERNS FOR THE HYPNODONTIST

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Abstract

This case study is about hypnosis for intractable pain in the case of a patient who had trigeminal neuralgia, which through medical intervention had become anaesthesia dolorosa. The study will address the demand characteristics set up by the patient. Inherent in the demands were pitfalls and traps that ultimately resulted in a pyrrhic victory. This case illustrates the need to know the limits for the hypnodontist: of their jurisdictionally permitted scope of practice; their own abilities; whose goals are being met by the intervention; and what outcomes define success for the patient and the hypnodontist.

Key words: anaesthesia dolorosa, hypnodontist, patient expectations, scope of practice, trigeminal neuralgia

Introduction

Hypnosis has a long history in relieving pain and suffering. Its future also shows great promise (Chaves, 1997; Elkins, Jensen and Patterson, 2007; Abrahamsen, Baad–Hansen and Svensson, 2008; Liossi, Santarcangelo and Jensen, 2009). This case report examines a situation in which hypnosis was chosen to relieve the chronic pain of anaesthesia dolorosa. There is little in the literature for the relief of anaesthesia dolorosa or its antecedent trigeminal neuralgia with hypnosis, the most recent found in a PubMed search being Gurian (1985). In and of itself, this is not particularly noteworthy – many case reports may be read detailing hypnotic interventions for chronic pain relief such as trigeminal neuralgia and anaesthesia dolorosa. They all have something instructive to offer to the hypnodontist. What makes this case study of interest are the demand characteristics of the case, not the hypnotic interventions. On first gloss, the hypnotic interventions were failures.

Hypnosis is the last resort for some patients when all other treatments fail to offer relief. For this particular patient, hypnosis was the last treatment in a series of interventions that had failed. The merits of this case for the hypnodontist are that it offers many potential pitfalls and confronts the issue of to what extent dentists should be therapists.

Trigeminal neuralgia and anaesthesia dolorosa

Prasad (2009: p1, L46) defines trigeminal neuralgia as:

> a syndrome of paroxysmal excruciating, lancinating unilateral facial pain. The trigeminal nerve is the fifth cranial nerve, and through its three branches is responsible for the sensory

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> innervations of the orofacial complex. There is convincing evidence that the idiopathic form develops from focal demyelination at the trigeminal root entry zone with subsequent ephaptic cross-talk between axons. Vascular compression of the nerve root causes this demyelination in most patients.

Treatment consists initially of medical management using anticonvulsant therapy and other agents. For those cases that are not manageable pharmacologically surgical interventions may be the treatments of choice. Microvascular decompression of the trigeminal nerve is the most common; however, glycerol rhizotomy has also been frequently used. Gamma knife therapy is emerging as an alternative treatment for the elderly patient and those with co-morbidities. Both rhizotomy and gamma knife are considered minimally invasive treatments.

Glycerol rhizotomy has numerous side effects. They are generally mild and manageable. The risk of the procedure leading to anaesthesia dolorosa is 0.8% (Blomstedt and Bergenheim, 2002; Sindou and Tatli, 2009). Stedman's (1972) dictionary defines it as severe spontaneous pain occurring in an anaesthetic zone. This condition is extremely difficult to manage.

The patient

The patient, a middle-aged female, was referred to the author for assistance with anaesthesia dolorosa. This was subsequent to tic douloureux or trigeminal neuralgia. Her general medical history was uneventful.

History of the presenting condition

Her trigeminal neuralgia was on the right side of her face and had started in 1993. She had daily episodes of pain. In 1994 a glycerol rhizotomy was performed that was unsuccessful and led to anaesthesia dolorosa. At the time of her presenting for care, the pain was localized not only in V_3 but also in V_1. She had experienced two attacks in the previous six weeks, where one lasted 8 hours and the other was 12 hours in duration.

She was experiencing daily episodes of pain for which she was taking oral Topamax® (topiramate), an antiepileptic; Percocet® (oxycodone and acetaminophen compound); and dilaudid as required. A neurology consultation had determined that she now had a severe lesion with permanent damage.

Dental history

Since the pain on the right made eating unbearable, she was now chewing only on the left side of her mouth. This unilateral mastication on the left resulted in the loss of an implant supported crown.

Family history

The patient's husband is a dentist with some familiarity of hypnosis. Her dentist is a cousin who performs her general dentistry.

Social history

The patient is a psychologist who lives and practises in a city several hours drive from the author's office.

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Incidental information, observations and impressions

The patient arranged for her appointment to take advantage of her practice downtime. She requested *one session* for her care. She was planning to drive from her home to attend the appointment. She was offered a 2 hour time period and the session fee was explained to her. This is significant in that the fee was an out-of-pocket expense for her. The fact that she did not balk at the request for payment at the time of the appointment or its sum was indicative of her need. In the local milieu, most patients are third party reimbursement driven and are willing to forego needed treatment if there is limited or no coverage for it.

Her husband telephoned approximately one week before the patient's scheduled appointment. Ostensibly, his purpose for calling was to inquire about the author's training in hypnosis, specifically by whom and where this took place. He was also interested in the author's experience in dealing with trigeminal neuralgia. The author's credentials were explained and he was reassured that the author had indeed treated patients with trigeminal neuralgia in the past. Her husband also proposed being present during the session. Since this would hamper the doctor–patient relationship, he was dissuaded from attending.

On the appointed day, the patient arrived and was ushered through our usual intake process. This involves the collection of demographic information, an anamnestic medical and dental history, and a hypnosis questionnaire. Once the administrative procedures were completed, the author reviewed the information with the patient. At that time she was observed to have Dr Wayne Dyer's book, *The Power of Intention* in her possession.

The patient's intake questionnaire (her answers are in italics):

1. How did you find out about our hypnosis service and the office? *'referral'*
2. How do you think our service will help you? *'ameliorate dental problems that have resulted from not chewing on my right side of my mouth'*
3. What results do you expect from your treatment with us*?* *'excellent'*
4. How will this anticipated result change your life? *'hopefully I will be able to resume chewing on the right side of my mouth'*
5. What do you know about hypnosis*?* *'I am certified in hypnosis'*
6. Have you ever been hypnotized before, why and with what results*?* *'yes. Poor results'*
7. Hypnosis is not done to you, but done with you. **All hypnosis is self-hypnosis!** Are you willing to actively participate in your treatment*?* If you answered 'No' please explain below. *'yes'*

As can be seen in the above our hypnosis intake questionnaire asks about patients' knowledge pertaining to hypnosis, their expectations and the circumstances and outcomes of any previous hypnotic experiences. Question 7 may be construed as a therapeutic contract. The patient had had a basic introductory hypnosis workshop at which the author had been leading a dental training track. In this way, she knew of him beyond the referral source. She considered herself 'certified'after this introductory course.

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During the practical exercises of the workshop, she contended that she was, 'never under'; 'was fully aware, fully conscious'; 'never in deep trance' and thus was not hypnotizable. The inductions she experienced included an 'elevator descent' and 'staircase descent' and suggested glove anaesthesia. She knew what she should be feeling, but never experienced it. Thus she was not truly expecting success from our session. Question 3 asks about expectations for hypnosis. She wrote 'excellent' – a formidable challenge!

Our usual treatment format

To ensure that the information provided is accurate, the intake questionnaire is reviewed with the patient. Additional information is generally elicited, which is then incorporated into the mutually developed treatment plan. Once this has been accomplished, three different inductions are carried out with conscious discussion between inductions. Ego strengthening and general suggestions alluding to the specific problem are given during each of the inductions. The rationale is to provide sufficiently different methods for trance to ensure that the patient's tool box has more than just a hammer. There is also the utilization of fractionation in the process. A fourth induction technique is generally utilized during a second appointment after a week of prescribed practice. It is in this second session that the problem is addressed with specific strategies from information gleaned in the first session. To aid practice a recording is made for the patients. Subsequent sessions may be employed based on the patient's responses to a further week of prescribed practice. In this particular situation all of this was compressed into one 2 hour session.

Treatment and results

Initially, the three inductions employed with this patient were a modified form of Wark's alert induction; Humphrey's bouncing rubber ball; and an arm catalepsy visualization technique that the author has synthesized. These inductions generally are successful with most people. The alert induction works nicely with anxious patients and does not require the stereotypic 'sleep' experience. It allays their mistrust and employs their hyper vigilance.

Humphrey's bouncing ball induction has a damped harmonic motion imagery that everyone is familiar with – whether from their own childhoods playing with a ball or through observation of others. As a focus of attention the damping harmonic motion nicely deactivates sympathetic nervous system excitation and leads to a pleasant parasympathetic enhanced state.

The visualization/arm catalepsy uses the non-dominant arm and the imagery of the patient watching their favourite TV programme. Glove anaesthesia follows quite easily after catalepsy is achieved. Inherently it is a directed, yet very permissive and a non-intrusive method.

The patient demonstrated all the analog signs of trance including good catalepsy, *but* consciously did not accept any of the trance validations! We persevered for an hour. At this juncture, further hypnotic work was abandoned and a discussion was undertaken. She was posed with the following question: 'What was she afraid of to not want to give up her suffering?' As it turned out, the patient was in therapy addressing this very question and other of her issues. Sadly, she had conveniently neglected to mention this during the initial conversations and history taking.

As a final tactic, the book she was reading, *The Power of Intention,* was utilized as an entrée to give her a method of self care. Intention is suggestive of meditation and

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eastern concepts. Thus, a chakra induction was used. The colours associated with the higher chakra centres, namely blue, purple, violet and ultimately white, were used and trance was induced. It was suggested to her to go back to a period before the neuralgia. Once there, she was to visualize herself and she was to meld with that pain-free self. For future practice the mantra 'AUM' was suggested and her intention was to be meditating on a cure. Consciously, it was also suggested to the patient to meditate daily to receive an answer to the posed question.

Follow up

One month later, telephone follow up revealed that the patient was satisfied with her experience. Meditating had elicited some positive effects, but not the original symptom reduction that was requested. She was, however coping better.

Discussion

In dentistry, there is the story about the little old lady that arrives in the office needing a new set of dentures. She invariably states that she's heard great things about the doctor's abilities to make great dentures. She then pulls out a bag full of dentures made by 'incompetents'. Who would guess that she's not really a little old lady, but a trophy hunter! This case is reminiscent of the little old lady.

Dental hypnosis is complicated by several factors when encountering complex cases such as this one. First and foremost is the issue of scope of practice. Jurisdictions vary, but in our province, dentistry does not formally include therapy as part of its scope. Secondly, most dentists are either not trained to handle complex psychological issues such as this case or do not wish to handle them. In utilizing hypnodontics, dentists work around issues, rather than deal with them directly. We have no qualms about hypnotic physiological interventions, but eschew psychological ones. Thirdly, even if one did not shy away from psychological interventions, the financial realities of dental overheads would make it generally untenable for the patient. Protracted treatment over several sessions would be impossible and brief therapy of one or two sessions may not be sufficient.

This case presents several demand characteristics for the experienced hypnodontist and ego crushing ones for the novice. It is obvious that the patient, willing to harbour in the port of last call, has an unrealistic view and perception of hypnosis, in spite of being 'certified' to coin her term. This is particularly noteworthy in the light of her profession.

Her request for a single session is also remarkable. One would wonder how many clients she helps respond appropriately in only one session. The time constraints are related to taking a round trip of several hundred kilometres between cities for the sessions. It is understandable that she wished to limit the number of sessions. Limiting the number is one thing; unrealistically constraining it to one is another. However, in this circumstance, a mental health professional should have insight enough to query the single session request.

The patient's spousal involvement is also interesting. On the surface, it may appear to be protective of his wife. It is not unreasonable for one knowledgeable professional to consult with an unknown out of town colleague on the behalf of his wife. Yet, his interrogation over the phone of the author's credentials and his insistence on being present suggest more is involved. Generally, when one is given a referral to a consultant by a trusted source, one does not interrogate them, nor make requests that are bound to inhibit

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the doctor–patient relationship. The referral source was a mutual acquaintance of the author, the patient's husband and a colleague of the patient's in her home town.

Expectation of 'excellence' as an outcome is thought provoking. Most professionals strive to provide exemplary care to each patient. Yet the provision of excellence is a rare feat in a mode of care that requires the patient's volitional involvement. Should there be secondary gain issues lurking, as the author suspects there are in this case, the expectation is unrealistic and self-deluding. This demand characteristic is again incongruent in light of her profession.

In conclusion, the author was aware of the challenging constraints that were presented from the outset. He accepted that from the hypnodontist's perspective, this might be considered a pyrrhic victory – fraught with issues, most outside the scope of the hypnodontist. Ultimately, the patient did find benefit from the session she had. The benefits were on her terms, in her time, and in a form that best met her real needs.

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