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CASE REPORTS

Post-traumatic stress disorder managed successfully with hypnosis and the rewind technique: two cases in obstetric patients

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ABSTRACT
Two obstetric patients presenting with post-traumatic stress disorder in the antenatal period are discussed. The first patient had previously had an unexpected stillborn delivered by emergency caesarean section under general anaesthesia. She developed post-traumatic stress disorder and presented for repeat caesarean section in her subsequent pregnancy, suffering flashbacks and severe anxiety. Following antenatal preparation with hypnosis and a psychological method called the rewind technique, she had a repeat caesarean section under spinal anaesthesia, successfully managing her anxiety. The second patient suffered post-traumatic stress disorder symptoms after developing puerperal psychosis during the birth of her first child. Before the birth of her second child, she was taught self-hypnosis, which she used during labour in which she had an uneventful water birth. These cases illustrate the potential value of hypnosis and alternative psychological approaches in managing women with severe antenatal anxiety.

Keywords: Post-traumatic stress disorder; Hypnosis; Rewind technique; Obstetrics

Introduction

Post-traumatic stress disorder (PTSD) is a severe anxiety condition characterised by symptoms of re-experiencing a traumatic event.[1] Symptoms include flashbacks, nightmares and distressing thoughts together with mood disturbances, poor sleep and avoidance of precipitating stimuli.[1] The American Psychiatric Association has specified diagnostic criteria for PTSD.[2] A diagnosis requires a history of exposure to a traumatic event with symptoms from each of four symptom clusters defined as: intrusion, avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity. Symptoms should have been present for at least one month, cause functional impairment to the individual and not be caused by medication or other illness. The incidence of PTSD following childbirth has been estimated at 1–2% with the most important risk factors being subjective distress in labour, obstetric emergencies, trait anxiety and a history of psychological problems.[3] Importantly, severe anxiety disorders such as PTSD are a risk factor for the development of depressive and other psychiatric disorders.[4] It is estimated that around 10% of new mothers develop a depressive illness and around two per thousand suffer from puerperal psychosis.[5] Unfortunately, suicide remains a leading cause of maternal death and the identification and management of risk factors was strongly recommended in the Centre for Maternal and Child Enquiries (CMACE) document, Saving Mothers' Lives published in 2011.[5]

Hypnosis is a procedure where a therapist suggests that a subject experience changes in sensations, perceptions, thoughts or behaviour.[6] It has been used extensively in the treatment of anxiety and depression and recent evidence suggests it may be useful in helping treat PTSD.[7] The rewind technique was first described in 1991 as a specific treatment for PTSD,[8] and is often used in combination with hypnosis. It aims to reduce the emotional arousal associated with a previous traumatic event by viewing the event in a dissociated or indirect manner. The patient is asked to rapidly fast-forward and rewind the images associated with the event to allow it to be reframed as non-threatening. Theoretically, memories of the past trauma should no longer produce intense negative emotional feelings.[9] Currently, there are no reports in the medical literature regarding the use of the rewind technique.

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Case 1

A patient in her second pregnancy was referred to the antenatal anaesthetic clinic for discussion of anaesthesia before caesarean section. Two years previously, she had undergone emergency caesarean section whilst in labour following concerns about fetal wellbeing. The fetus was unexpectedly stillborn and the patient remembered being informed of this by her mother immediately on arousal from general anaesthesia.

Whilst recalling the events of her first pregnancy, the patient became visibly distressed and tearful. She confessed to having troublesome flashbacks related to the event, including remembering pressure around her airway before the general anaesthetic and the distress of being told of the stillbirth on waking from anaesthesia. These flashbacks had become more frequent as her second pregnancy progressed and she also reported having poor sleep and regular feelings of severe anxiety. The patient was keen to avoid general anaesthesia for repeat caesarean section but was very worried about her ability to cope with the whole experience under spinal anaesthesia.

The patient was initially taught self-hypnosis using the Elman induction technique,[10] followed by progressive muscle relaxation and special place imagery, with the aim of reducing her daily anxiety. Despite achieving mild anxiety reduction she still experienced regular severe flashbacks. On her fourth visit, the patient agreed to experience the rewind technique. Under hypnosis, the patient imagined observing herself watching a video recording of the previous traumatic incident. The patient then imagined fast-forwarding and rewinding the video six times to allow the traumatic event to be reframed as a non-threatening memory.

A few weeks later, the patient attended for elective caesarean section. Although still anxious, she said her emotions were now ''neutral'' when she revisited her previous traumatic experience. The caesarean section was carried out uneventfully under spinal anaesthesia. Hypnosis was used whilst the anaesthetic was sited and for the short period before the baby was born to help alleviate anxiety. A healthy baby was delivered, and a few weeks later the patient reported that the ''neutral'' feelings related to her previous experience persisted.

Case 2

A patient pregnant with her second child was referred to the antenatal anaesthetic clinic for discussion of analgesia options for labour. Her first labour, three years previously, had been a distressing experience. The patient had an epidural sited for labour which was ineffective and a repeat technique using a combined spinal-epidural had also failed to provide adequate analgesia. She reported feeling in constant distress and in continuous pain with periods of memory loss. Around the time of delivery, she experienced distressing hallucinations, for example, feelings of ants crawling on her skin and imagining that her partner was a character from a cartoon. These episodes continued into the puerperium, when she also experienced regular negative flashbacks to her labour comprising visions of being tortured and shouted at by the medical staff. Her postpartum mood was very low with disturbed sleep and regular panic attacks, leading her to be prescribed antidepressants.

Before her first anaesthetic consultation in the current pregnancy, it was established that the patient had experienced puerperal psychosis and PTSD resulting from her first labour. She had undergone several months of cognitive behavioural therapy (CBT), which included a course of eye movement desensitisation reprocessing (EMDR). This had been partially successful but severe anxiety about her upcoming labour persisted, with occasional flashbacks and panic attacks. She was particularly anxious that she might have a similar experience during her second delivery.

On closer questioning, the patient reported previous failure of local anaesthesia for dental procedures in addition to the failed neuraxial blocks for her first labour. She had a history of lower back pain and had hypermobile joints in the hands and wrists. This raised the possibility of Ehlers-Danlos syndrome type 3 which has an association with local anaesthesia resistance.[11] The suggestion was made that opioid drugs given during her first labour may have contributed to her peripartum psychological problems. The patient was keen to avoid opioid drugs and it was decided to plan for delivery without opioids or neuraxial analgesia.

In the middle of the third trimester, hypnosis was offered to the patient as an adjunct to analgesia for labour and as a way of alleviating anxiety in the weeks before labour. A light hypnotic trance was induced following the Spiegel induction method.[12] The patient demonstrated a high capacity for hypnosis and agreed to practice self-hypnosis regularly at home before her labour. She was worried about losing control of her surroundings as she became profoundly relaxed under hypnosis; however, she was reassured that she would always be able to respond to situations requiring her immediate attention even under deeper levels of hypnosis.

The patient went into spontaneous labour at term and used self-hypnosis and trans-cutaneous electrical nerve stimulation (TENS) in the early stages of labour. A community midwife was called who found the cervix was 5 cm dilated, at which stage the patient was admitted to the labour ward. Labour continued to progress well. The patient used self-hypnosis for analgesia in combination with inhaled Entonox and three hours after entering hospital, a healthy infant was delivered in the birthing pool. Although she remained anxious after