American Journal of Clinical Hypnosis
49:3, January 2007

Treating Postpartum Depression with Hypnosis: Addressing Specific Symptoms Presented by the Client

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Abstract

Postpartum Depression is experienced by 10-15% of women who give birth (Bloch, Rolenberg, Koren, & Klein, 2006). This disorder causes maternal distress and has been significantly associated with infant and child developmental problems (Carter, Garrity-Rokous, Chazan-Cohen, Little, & Briggs-Gowan, 2001). Once believed to be contraindicated (Crasilneck & Hall, 1985), hypnosis for depressive disorders has been advocated as an effective intervention strategy (Yapko, 2001). Addressing specific symptoms and skill development has been promoted as an effectual hypnotic strategy for depression (Yapko, 2001); however, little empirical evidence of the efficacy of hypnotherapy for postpartum depression or effective hypnotic strategies exists. The present article is a report of a single case in which hypnotherapy was successfully utilized in the treatment of Postpartum Depression by attending to the specific problems presented by the client and developing client skills to resolve existing problems and prevent their recurrence.

Key Words: Postpartum, Depression, Hypnosis, Treatment

Treating Postpartum Depression with Hypnosis: Addressing Specific Symptoms

The past two decades have seen an increased interest in postpartum depression (PPD). The Baby Blues, those mood swings, crying spells, and irritability that may occur just after childbirth are relatively mild and usually disappear within a few days. The National Institute of Mental Health [NIMH] (2005) estimates that up to 80% of new mothers experience some degree of these transitory symptoms. However, postpartum depression (PPD) is a more serious problem that is estimated to affect 10-15 % of new mothers (Bloch, Rolenberg, Koren, & Klein, 2006; O'Hara & Swain, 1996).

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In addition to the suffering and economic losses associated with depression, numerous studies have found maternal depression to be negatively correlated with optimal infant and child development (e.g., Carter, Garrity-Rokous, Chazan-Cohen, Little, & Briggs-Gowan, 2001; Feldman, Weller, Leckman, & Kuint, 1999).

The identifying characteristics of PDD can parallel cognitive and physical symptoms of other types of depression; additionally, PPD may include disturbing thoughts or images of harming the infant (Epperson, 1999). Mothers with postpartum depression often feel guilty and ashamed of their thoughts and feelings, a phenomenon that increases the intensity of their depression (NIMH, 2005).

Prior history of mental illness, difficult pregnancies, and stressful events preceding or concurrent with the pregnancy have been identified as correlates of PPD (Campbell & Cohn, 1991; Paykel, Emms, Fletcher, & Rassaby, 1980). Research of the relationship between preexisting depression and PPD has been mixed. Some studies have found a history of major depression to be associated with PDD (e.g., Nielsen-Forman, Videbech, Hedegaard, Dalby-Salving, & Secher, 2000) whereas others have found no correlation between pre-pregnancy depression and the development of depressive symptoms postpartum (e.g., Henshaw, 2003). In a study of 1800 women in a hospital maternity ward Block, Rolenberg, Koren, and Klein (2006) did find that the presence of depressive or anxious mood during pregnancy was a significant predictor of PPD. A possible explanation for the disparity of findings in prior research about the relationship between historical depression and PPD may include an analysis of events with potential to precipitate depression that occur just prior to, during, or soon after pregnancy. Preoccupation with pregnancy may interfere with resolution of disturbing events that then become overwhelming after the birth of the child. Additionally, negative emotion from disturbing or traumatic events in childhood may be triggered by maternal-infant interactions that parallel the mother's childhood memory even when the mother did not have an identified depressive episode.

According to NIMH (2005), effective treatments for PPD include antidepressant medication and talk therapy. For much of the last century hypnosis was considered to be contraindicated for depression primarily because of the increased risk of suicide with depressed clients (e.g., Crasilneck & Hall, 1985). More recently, however, hypnosis for the treatment of depression has received more positive attention. Although there is a paucity of research on treating depression with hypnosis, the literature supports the reduction of depressive symptoms when hypnosis has been used to treat other disorders such as anxiety (e.g., Crawford & Barabasz, 1993) and chronic pain (e.g., Lynch, 1999). Additionally, hypnosis has received empirical support for the treatment of specific symptoms associated with depression like insomnia (e.g., Anbar & Savedoff, 2005; Younus, Simpson, Collins, & Wang, 2003) and low self-esteem (e.g., Torem, 1992; Valente, 1990). Yapko (2001) proposed that hypnosis can be effectively used in treatment of depression when interventions are directed toward specific depressive symptoms and risk factors like cognitive distortions and maladaptive interpersonal patterns.

The following case study reports the process and outcome of an initial interview and two interventions using hypnosis in the treatment of PPD. The purpose of the article is to document a case in which brief hypnotherapy was the exclusive intervention in a successful treatment of postpartum depression.

Case Report

A twenty-seven-year-old mother of five-month-old twins presented for treatment for PPD that had been resistant to psychopharmacological treatment for depression and

anxiety. In the initial interview, the client reported that she had been married for seven years, had a stable, supportive marital relationship, and had taken fertility drugs after failing to become pregnant for five years. The twins were the couple's first children. The client chose not to involve her husband in the therapeutic process.

The client denied prior mental illness or depressive symptoms even through several years of infertility and fertility treatment. The woman reported that during pregnancy she had experienced the deaths of two people important in her life and another death one month after the birth of the twins. She waved her hand in a dismissive way when discussing the deaths while simultaneously beginning to cry. Symptoms of depression had begun five days postpartum and included sadness, crying spells, feelings of guilt and worthlessness, hopelessness, and periodic thoughts of harm to the infants. Vegetative symptoms and suicidal ideation were denied.

Thoughts of harm were most prevalent and intense when one or both twins were crying and the mother was alone with them. Thoughts of harm to her children were not only distressing but confusing to the mother; her confusion about her feelings was reiterated several times during the interview. She denied ever harming or attempting to harm the children. At the conclusion of the interview, the client was given information about hypnotherapy. She agreed to hypnotherapy provided it could commence immediately as she perceived her situation to be critical.

The hypnotic interventions were completed in two separate sessions. The first hypnosis was conducted immediately after the initial interview; the second session occurred two weeks later. Both inductions employed eye fixation and hand levitation; the language was permissive in nature. Stages of trance included an induction phase, deepening, intervention, and termination.

Because confusion and the nature of her reaction to her children's crying appeared to be causing the greatest distress to the mother, the purpose of the first hypnosis was to increase client insight and provide alternative emotional responses to infant crying. The induction included suggestions that beliefs and patterns of reactions originate in youth and a suggestion that clarity would emerge during trance. The intervention phase began when the client's breathing became regular and slow, facial and shoulder muscles relaxed, and blinking and swallowing reflexes slowed—phenomena that indicated to the therapist that the client was receptive to hypnotic suggestions. The intervention consisted of four parts: 1) retrieval of positive affect associated with safety, connectedness, and confidence, 2) exploration of past experiences with emotions that paralleled the client's affective response to infant distress; 3) self-parenting suggestions for resolution and the creation of alternative responses; and 4) transference of altered responses to future experiences. Termination contained a post-hypnotic suggestion for automatic retrieval of positive affect and adaptive response when her children cried. After trance, the client reported that she understood her reaction to her crying infants, and then believed that she had not been angry with them nor had she really wanted to harm them. Instead, the client believed that her feelings had been "mixed up" and that she was re-experiencing a distressing event in her childhood in which she had felt abandoned by her father in favor of a sister. When one twin cried in distress, the client "felt his feelings" and responded emotionally much as she reported having done in the original event from her childhood. The new cognitive frame was not critical of her maternal characteristics, did not elicit guilt, and encouraged an adaptive response to her children when they cried.

In the subsequent session, the client reported that she had been able to care for her

children without assistance. Although she felt normal frustration of caring for two infants who sometimes had needs that one person alone could not simultaneously satisfy, she had experienced no thoughts of harm to the infants in the interim between the two therapy sessions.

In the second session, trance induction and deepening was similar to the first hypnosis. The client's incongruent behaviors during the interview indicated that unresolved grief might be a factor in her depression. The second intervention consisted of three metaphors of grief that were employed for the following purposes: 1) to provide a stage-based normalized grief process, 2) to provide adaptive ways of honoring deceased loved ones, and 3) to alleviate guilt of surviving loved ones. Termination included a reference to the first trance interventions with a suggestion for continued adaptive response. During trance, the client cried at various points; following trance, she reported feeling relief.

A third session was scheduled for two weeks later; however the client called to cancel the appointment due to a time conflict. She did not reschedule. In a subsequent telephone call six weeks after the first intervention, the client reported that she had been symptom-free since the second hypnotherapy session. She no longer experienced any thoughts of harm to her infants. Additionally, questions about her losses indicated that she had navigated the grief process to resolution: neither avoiding nor obsessing about the deaths. A telephone interview five months post-therapy confirmed that therapeutic gains remained intact and that maternal-infant relationships were normal.

Discussion

A number of limitations to the outcome of this case exist. The present article is based on a single case and until additional cases replicate the outcome, findings cannot be generalized beyond the boundaries of the reported case. Additionally, no objective measures of depression were used; reported initial and final affective states were the subjective self-report of the client. Extrapolation of this outcome is further limited by the client's reported high level of functioning prior to onset of her depression. Historical Major Depressive Disorder, Bipolar Disorder, and psychotic disorders have been associated with a greater incidence of PPD and an exacerbation of symptoms when PPD occurs (e.g., Campbell & Cohn, 1991; NIMH, 2005; Paykel, Emms, Fletcher, & Rassaby, 1980). Therefore, clients who have experienced episodes of mental illness prior to their pregnancies may not have the same type of response to hypnosis as was demonstrated in this case report.

Despite limitations, the case is congruent with existing literature. The process and outcome of this case is consistent with Yapko's (2001) assertion that effective treatment of depression with hypnosis consists of interventions directed at specific symptoms. Details of the client's presentation were used to guide the intervention. Whereas physiological symptoms of appetite or sleep disturbance are present in many presentations of PPD, this mother identified cognitive symptoms of confusion, guilt, negative thoughts about herself and intrusive ideation of harming her children. The interventions were designed to address the maladaptive response to her infants' distress and unresolved grief. The interventions encouraged cognitive changes about herself, her children, and their future together. Additionally, the interventions supported the development of skills to resolve grief and implement adaptive cognitive and behavioral responses to infant distress and grief in present and future occurrences.

The client's rapid response to brief hypnotic therapy and her extended recovery support the efficacy of hypnosis in the treatment of PPD when specific cognitive and

behavioral symptoms are addressed. Future research examining the efficacy of hypnosis in the treatment of PPD in a wider range of client presentations has potential to enlighten and guide clinical practice in this area.

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