Abstract

Ego State Therapy (EST) has emerged from a psychoanalytic understanding of personality as a product of an individual’s multiplicity of ego states, to a conceptualization of how ego-energized and object-emerged elements are bound together to cope with a traumatic event. Neurobiological studies reveal that around 1949, Barabasz and Watkins' theories were developed. Barabasz’ (1994) work reveals the conceptualization of biological trauma memories encoded in the subcortical (subconscious) brain regions which are of their severity, trauma memories are encoded in the brain. Neurobiological studies now substantiate who adds ego strength to the patient. This is followed by conceptualization of how ego-energized and object-energized reactions, triggered by an external stimulus, may be considered. The human personality is not a unit, although it is usually experienced as such. Our personalities are separated into various elements—ego states—which serve different purposes. Conflicts among states can take up too much energy that the individual is faced with. Frozen ego states, which have formed in the brain, are handled in the non-conceptual (subconscious, unconscious) regions of the brain.

Introduction

Patients with combat stress injury (CSI), post traumatic stress disorder (PTSD), or ASD have been exposed to events beyond normal human experience such as major accidents, avatar, combat-related violence, sexual abuse, or torture. These experiences can serve as a catalyst that can create recurrent hallucinations of the traumatic event. Descorative imagery of the event may lead to avoidance, depression, hypervigilance/hypohyphusness, nightmares, emotional numbing, or violent impulses. It is difficult to remember, concentrating, and sleeping. The result is social withdrawal and avoidance of the sorts of problems we encounter when dealing with the repressed conflicts of deep-seated disorders.

Combat Stress Injury, PTSD, and ASD require an external stimulus as a diagnostic criterion. In the memory of the event, the interplay between external trauma and the inherent biological, psychological, and social factors (Connor & Butterfield, 2003; Kreeghall, Batzer, Neill, & Spiegel, 2010). For individuals who have a trauma disorder, on any given day, at any time, a variety of emotionally charged triggers, triggered by an external stimulus, may be experienced. This can leave them dysfunctional in a variety of ways.

Neurobiological Basis

Neuro-imaging studies have revealed that patients with CSI, PTSD, or ASD, when exposed to trauma “triggers,” demonstrate increased levels of stress-related hormones and blood flow in certain areas of the brain (e.g., hypothalamus, orbitofrontal cortex, insula, amygdala, and anterior temporal lobe). However, as the prefrontal cortex deactivation was noted, the deactivation was especially dramatic in the prefrontal cortex speech center of the brain essential to communicating what one is thinking and feeling. The activity of brain structures involved in the control of emotions and the translation of experience into communicable language is simultaneously decreased (P. K.,. 2005).

Walking & Barabasz (2008) recognized that a person cannot access the impact of trauma via the verbal, intellectual, defensive, and unconscious brain areas of the brain because the trauma is entrenched in the non-verbal, non-conscious (subconscious) subcortical areas (amygdala, hippocampus) that are, at best, only peripherally affected by thinking and cognition. Individuals with CSI, PTSD, and ASD process trauma and engage in the prefrontal “bottom” subcortical regions, and then upward toward the executive conscious regions.

When the traumatized individual is triggered by reminders of the past circumstance, the prefrontal cortex deactivates and the brain responds to the trauma as if it were the first time it occurred (Barabasz & Christensen, 2006). The Broca’s area of the brain then down and down in an automatic engagement in thoughts and actions that are maladaptive responses to the current presenting stimuli.

The effective therapist will attempt to change the way patients regulate these core functions from the “bottom up” by accessing and “working through” ego states (Barabasz, Barabasz, & Watkins, 2012).

Cognitive-behavioral processing therapies, such as anger management, attempt to guide a coping skill on the surface of an injured person, ignoring behavior mediated by unconscious processes. Traumatized persons are taught to “reframe” their instinctual thoughts to help “manage” their painful symptoms. Apparent resolution of functioning is superficial. There is no resolution of the trauma. The patient is placing a band aid on a bleeding cancerous tumor.

In contrast to “bottom up” therapies, abreactive EST is “bottom up.” It accesses the ego states harboring the trauma, fluctuation, anger, and defenses, and facilitates the expression and resolution released. When carried out properly, the expertise of the patient’s psychological and physiological reactions activate subcortical primary processes which allow the reactions bound up in the non-conscious subcortical (subconscious) regions of the brain.

Abreactive EST Fundamentals

The human personality is not a unit, although it is usually experienced as such. Our personalities are separated into various elements—ego states—which serve different purposes. Conflicts among states can take up too much energy that the individual is faced with. Frozen ego states, which have formed in the brain, are handled in the non-conceptual (subcognitive, unconscious) regions of the brain.

Traumatized ego states may be entirely subconscious or, when brought to consciousness, have great difficulty expressing themselves. Abreactive EST brings these ego states to full expression through the intense “reliving” brought about by hypnotically-induced abreactions.

Ego State Communication

EST also facilitates communication and empowerment among the patient’s ego states, thus allowing the person to see the person’s personality (Barabasz, Christensen, Barabasz, & Watkins, 2010). This enables the patient to adopt adaptive responses that improve the quality of the core self. EST at knowledge that one cannot change a traumatic event, but can change one’s attitudes toward the event. EST is effective because it targets those emotional reactions to the past by activating the associated subcortical structures to emotional and physiological exhaustion. Rage is expressed and exhausted in the safety of the therapeutic session.

The Role of Hypnosis

The hypnogenic state is characterized by the ability to sustain a state of attention with receptive and intense focal concentration. The role of hypnosis is especially relevant because those with PTSD, ASD, and CSI have been shown to present above-average hypnogenicity (Trautman & Garrett, 1973). The hypnogenic state facilitates the capture segment of the personality and simultaneously abating (or dissociating) the other parts. Hypnosis, as employed in abreactive Ego State Therapy (Barabasz, 1999a), Vermetten & Christensen, 2010), Watkins & Watkins, 1997) targets the fullest expression of the traumatized ego state.

Lynn and Cardieha (2007), and Spiegel (1992) share a view that hypnosis is key in the treatment of CSI, PTSD and ASD. Thus far, two placebo-controlled studies with 40 and 30 patients respectively, Barabasz, Barabasz, Christensen, French, & Watkins, 2013; Christensen, Barabasz, & Barabasz, 2013) show that hypnosis is essential to long-term maintenance of symptom-free functioning.

Conclusion

Ego State Therapy is a prominent therapy worldwide. There have been four large World Ego State Congresses held in the last decade prior to the development of our new single-session procedure. EST was conducted over a period of time (Barabasz & Watkins, 2009). The traditional EST procedure is already internationally well accepted because of numerous case studies that support its efficacy. However, recently it has not been subjected to placebo-controlled efficacy tests meeting the United Nations World Health Organization’s Cochrane evidence-based criteria. To meet this need, two placebo-controlled studies are currently being conducted at Washington State University, Pullman, USA. The results of both provide strong evidence showing that single-session abreactive Ego State Therapy is a comprehensive and integrated approach that is an effective and durable treatment for those who suffer from the effects of trauma (Barabasz et al., 2013, Christensen et al., 2013). [Both will appear in a future issue of the International Journal of Clinical and Experimental Hypnosis, January issue].

Child Abuse Trauma

Imagine a person traumatized by physical abuse as a 5 year old. Becoming quiet and withdrawing passive aggressively was the person’s way of calming his father and trying to handle the situation. Such coping patterns seemed to also work in later life. So when in a “trouble with an authority figure” situation, the person (now an adult) finds his passive aggressive 5-year-old ego state returning, no matter how approachable, present-oriented, and ultimately self-defeating that reaction may be.

For example, those with borderline personality disorder seem to function well in most areas of life, becoming successful doctors, lawyers, teachers. However, when given a trauma trigger, a childhood ego state is activated and their behavior becomes removed from the reality of the situation, precipitating inappropriate behavior. As Hunter (2008, p. 88) points out, those with borderline personality disorder “are still the way they did when they were 5 years old.”

As ego and object energies flow from one state to another, the behaviors and experiences of the individual change. This is especially salient when a traumatized ego state becomes executive. Those with ASD, PTSD, or CSI respond appropriately when faced with a top-down reminder associated with previous traumatic stress. The traumatized ego state becomes executive, producing inappropriate behavior.

The authors currently seek foundation support to carry out a large-scale study to further test this remarkably promising, and new evidence-based, intervention with 1000-3000 persons with PTSD, ASD, or CSI.

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