Single-Session Manualized Ego State Therapy (EST) for Combat Stress Injury, PTSD, and ASD, Part 1: The Theory

Arreeed F. Barabasz a, Marianne Barabasz a & John G. Watkins b

a Washington State University, Pullman, USA
b University of Montana, Missoula, USA

Available online: 25 Aug 2011


To link to this article: http://dx.doi.org/10.1080/00207144.2011.595349

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SINGLE-SESSION MANUALIZED EGO STATE THERAPY (EST) FOR COMBAT STRESS INJURY, PTSD, AND ASD, PART 1: The Theory

ARREED F. BARABASZ AND MARIANNE BARABASZ
Washington State University, Pullman, USA

JOHN G. WATKINS
University of Montana, Missoula, USA

Abstract: Ego state therapy (EST) evolved from a psychodynamic understanding of personality as a product of an individual’s ego states to a conceptualization of how ego-energized and object-energized elements are bound together to cope with a traumatic event. Neurobiological studies now substantiate Watkins’s war neuroses conceptualizations. Because of their severity, trauma memories are encoded in the subcortical-subconscious brain regions that are accessed by the single-session manualized EST procedure but not by the popular cognitive-behavioral management therapies. The imprint of the trauma is not accessible or resolvable by such top-down verbal understanding or reframing; EST is a bottom-up therapy. Abreactive hypnosis facilitates ego state expression at physiologically and psychologically intense levels sufficient to activate subcortical processes to release affect in the presence of the therapist, who adds ego strength to the patient. This is followed by interpretation and reintegration. The result is a reconstructed personality that is adaptive and resilient.

Patients with combat stress injury (Figley & Nash, 2007), Posttraumatic stress disorder (PTSD), or acute stress disorder (ASD) have been exposed to events beyond normal human experience, such as major accidents, assault, combat, natural disasters, rape, sexual abuse, or torture. These experiences may serve as a catalyst for recurrent flashbacks of the trauma. Dissociative symptom expression includes avoidance, anxiety, depression, hypervigilance/hyperarousal,
recurring flashbacks, emotional numbness (Litz, 1992), difficulty remembering, concentrating, and sleeping, nightmares, and survivor guilt. The resulting social and functional impairments are the same sort of problems we encounter when dealing with the repressed conflicts of deep-seated disorders.

Combat stress injury, PTSD, and ASD require an external stressor as a diagnostic criterion. This highlights the complex interplay between external trauma factors and the inherent biological, psychological, and social factors (Connor & Butterfield, 2003; Keuroghlian, Butler, Neri, & Spiegel, 2010). For individuals who have a trauma disorder, on any given day at any time, a variety of emotionally charged reactions triggered by an external stimulus may be experienced. This can leave them dysfunctional.

**NEUROBIOLOGICAL BASES OF EGO STATE THEORY**

Van der Kolk (1994) elucidated a bottom-up explanation of the neurobiological underpinnings of traumatic reactions. He states that traumatic memories stay “stuck” in the brain in the nonverbal, nonconscious, subcortical region (hippocampus) where they are not accessible to the frontal lobes—the understanding, thinking, and reasoning part of the brain. Van der Kolk focused on the neurobiological underpinnings of traumatic reactions and explained how trauma disrupts stress-related hormones and activates subcortical-subconscious brain processes. Individuals are unable to sufficiently process or to integrate trauma memories into conscious mental frameworks. Subconsciously encoded trauma memories can be triggered by reminders such as sounds, odors, visual stimuli, etc. These regions are simply not accessible to the thinking and reasoning frontal, executive-processing parts of the brain, which are the only areas available to top-down cognitive therapies. The popular cognitive-behavioral reframing therapies are limited, because they operate from the executive structures on down.

Neuroimaging studies using script-driven, trauma-imagery symptom-provocation paradigms (Hull, 2002; Lanius et al., 2001; Lindauer et al., 2004; Van der Kolk, 2007) provided physiological data supporting the bottom-up conceptualization of accessing brain areas where trauma is encoded. Consistent findings revealed neurobiological shifts that were specifically associated with the focused attention and heightened arousal of reliving the trauma. The findings showed that participants who were exposed to traumatic reminders (triggers) displayed increased cerebral blood flow in the right medial orbitofrontal cortex, insula, amygdala, and anterior temporal pole. However, in the left anterior prefrontal cortex coincident relative deactivation was noted. The deactivation was especially dramatic in Broca’s area. This
expressive speech center of the brain is essential to communicate thoughts and feelings. Subsequent research showed that when a previous personal trauma is triggered, regions of the brain that experience intense emotions are activated. The activity of brain structures involved in the control of emotions and the translation of experience into communicable language is simultaneously decreased (Hull, 2002; Lanius et al., 2001; Lindauer et al., 2004; Van der Kolk, 2007).

A trauma patient may display inappropriate emotions, bizarre reactions, and/or “freeze up” when confronted with seemingly normal challenges. Furthermore, since Broca’s area of the brain shuts down, these individuals become extremely limited in their ability to communicate what it is they are feeling. In an attempt to cope with these events, the traumatized individual seems to regress to primary process thinking (Barabasz & Christensen, 2006; Christensen, Barabasz, & Barabasz, 2009), responding to reminders of the past by automatically engaging in thinking and actions that were once appropriate and adaptive at a primary level but are now maladaptive in response to the current presenting stimuli. These findings are consistent with Jackson’s explanation (1958) that conceptualized the brain as hierarchically organized from the bottom up.

J. G. Watkins and Barabasz (2008) recognized that the imprint of trauma is not accessible via the verbal, intellectual, defensive, or executive parts of the brain but is deeply entrenched in the subcortical-subconscious (amygdala, hippocampus), which are at best only peripherally affected by thinking and cognition. J. Watkins’s (1949) original conceptualization, now supported by data, foreshadowed precisely how patients process trauma first from the bottom, primitive subcortical regions then upward and finally to the executive conscious levels. To do effective therapy, we focus on changing the way people regulate these core functions. Processing should not be limited to talking about trauma or cognitive reframing at the purely conscious level but instead activate the primary-process regions to an intense reliving of the actual events (Barabasz, Barabasz, & Watkins, in press).

Despite the neurophysiological data and complexities involved in these deeply encoded trauma disorders, the most widely used treatments today are top-down talk interventions such as critical incident stress management (Everly & Mitchell, 1999), emphasizing exploration of the traumatic experience by initial mental health responders. Cognitive (cognitive-behavioral) therapies as used in U.S. Veterans Administration hospitals are the most frequently used therapies. However, J. Watkins (1942, 1949, 1951) observed that the vast majority of these patients, especially those with combat stress injury, are unable or reluctant to talk about the stress-inducing events (J. Watkins & Barabasz, 2008, p. 201) but responded well to hypnotically induced intense abreactive “reliving” of the trauma. Recent neuroimaging data support J. Watkins’s discoveries in his treatment of combat survivors.
(J. Watkins, 1949, 1951) and later a range of civilian cases. J. Watkins developed ego state therapy (J. Watkins & Barabasz, 2008; J. Watkins & Watkins, 1997) from his work with these patient groups, which guided the structure and development of the manualized single-session procedure (Barabasz, Barabasz & Watkins, in press; Barabasz, Christensen, Barabasz, & Watkins, 2011).

Our view is that the cognitive-behavioral therapies are, at best, superficial. As JGW explains (J. Watkins & Barabasz, 2008, p. 235): cognitive-behavioral therapy/cognitive processing therapy (CPT; Monson et al., 2006) or anxiety desensitization by prolonged exposure therapy (PE; Foa, Hembree, & Rothbaum, 2007) attempts to paste a coping skill on the surface of an injured person. Thus, further removing that person emotionally from the “self.” The apparent positive therapeutic results from these top-down therapies have been achieved at the cost of ignoring conditions and behaviors, which are mediated through unconscious processes. Patients are taught only to reframe their intrusive thoughts to “manage” their painful trauma symptoms. There is no resolution of the trauma. The patient remains troubled and is ripe for retraumatization. The apparent functioning is superficial.

In contrast to top-down talk about the trauma reframing approaches such as CPT, or anxiety desensitizing by PE, EST is bottom up. EST accesses the ego states harboring the trauma, frustration, anger, and depression then facilitates their expression and repeated release at psychologicaLly and physiologically intense levels sufficient to activate subconscious-primary processes. Our manualized EST procedure is theorized to change the way patients respond to and process stimuli at subcortical-subconscious levels. Drawing from the psychoanalytic tradition, EST reconstructs the patient’s personality by resolving underlying conflicts while fostering communication and empowerment among the patient’s ego states (Barabasz, Barabasz, & Watkins, in press; Barabasz et al., 2011; J. Watkins & Barabasz, 2008, p. 235; J. Watkins & Watkins, 1997).

Unlike time-consuming traditional psychoanalytic interventions, where one awaits the transference to be activated by the subconscious, the manualized bottom-up EST procedure rapidly demystifies subconscious processes making them accessible and understandable by the patient. The therapist’s ego strength is incorporated into the intense release procedures that target traumatized ego states. Abreactive repetition not only exhausts the bound-up physiological and psychological reactions but also serves to quickly overcome the trauma and to restructure the patient’s personality. The various parts of the patient’s personality that were previously unable to express themselves learn to communicate. The patient becomes empowered to release trauma memories with the associated fear, anxiety, and depression.
(Emmerson, 2003; Frederick, 2005) and resolve the issues. Maladaptive and unwanted symptoms no longer manifest themselves from unresolved states that developed in response to the traumatic experience(s). The patient emerges from EST with the ability to be adaptive, assertive, giving, strong, and logical as well as fully able to express anger appropriately yet be sensitive and caring with family and others. The previous inner turmoil, where the ego states made the patient dysfunctional, is permanently changed by EST to the pretrauma-event level of functioning but with new strength and resilience to retraumatization. The person emerges with improved psychological and physical health and the capacity for a richer experience of living. EST does not change the event; EST is focused on emotions and is effective because the emotional reactions about the past are changed. Attitudes about the event are then freed to change adaptively without reframing interventions. EST works because it is emotion focused and because it activates subcortical emotion structures (amygdala, hippocampus).

Ego State Therapy Fundamentals

The human personality is not unity; although it is usually experienced as such. Our personalities are separated into various segments. Unique entities (ego states) serve different purposes. We refer to the ego state that is overt and conscious at a particular time as the executive state. States that are not executive may or may not be aware of what is going on at a conscious level. Conflicts among states can take up so much energy, that the individual is forced into withdrawn, defensive postures. Those with combat stress injury, PTSD, or ASD will not be “at peace” until the conflicts are resolved and inner strength is reconstructed (Watkins & Barabasz, 2008, p. 236).

Ego states start as defensive coping mechanisms. When repeated they develop into compartmentalized sections of the personality (Emmerson, 2003 p. 3). They may also be created by a single incident of trauma such as an auto accident, combat, rape, tornado, etc. A person’s ego states are separated from each other by boundaries that are “more or less permeable” (J. Watkins & Watkins, 1997, p. 25). Each state is distinguished by a particular role, mood, and mental function, which when conscious (executive) assumes the person’s identity.

Ego states maintain their own memories and communicate with other ego states to a greater or lesser degree. Traumatized ego states may be entirely subconscious or when brought to consciousness have great difficulty expressing themselves. Single-session manualized EST brings these ego states to full expression through the intense reliving brought about by hypnotically induced abractions, which when properly carried out activate primary processes and the relevant subcortical
regions at the emotional processing level. Unlike multiple personalities in dissociative identity disorder, ego states are a part of normal personalities.

Paul Federn (1952), a close associate of Sigmund Freud, was the first to apply the concept of ego states to provide a psychodynamic understanding of multiplicity. He hypothesized that whether a physical or mental process was experienced as a part of the self (I or Me) or as an object (he, she, or it) was determined by the nature of the energy (ego or object) that activated it. He also recognized that personality is the product of an individual’s multiplicities, which he termed ego states. Ego states can be created by trauma or through identification with significant figures in one’s life. For example, if I introject my mother, an object representation of her will be formed around my perceptions of her. That object representation may be changed into an indentifact (identification) through its investment with ego energy (cathexis). Then a mother ego state will have been created within me. When that ego state becomes activated (executive), I will experience and behave toward the world like my mother or at least as I have encoded my perception of her.

Federn’s disciple Eduardo Weiss (1960) translated his papers and extended many of their implications. But neither Federn nor Weiss ever seemed to fully recognize the significance of ego states in their treatment procedures, nor did they understand that a different theoretical formulation was needed to comprehend its potential as a new sophisticated form of hypnoanalysis (J. Watkins & Barabasz, 2008, pp. 236–237).

Although Federn was likely the first to view a person’s personality as the product of his or her ego states, he considered only elements that were ego-cathected (energized) as belonging to an ego state. John G. Watkins was the first to recognize this limitation, noting that experience consists of both ego and object representations interacting within a cohering pattern. Ego states were redefined more broadly:

An ego state is an organized system of behaviors and experiences whose elements are bound together by some common principle and separated from other such entities by a boundary which is more or less permeable. Ego states may be large, encompassing broad areas of behavior and experience or small where they include only very specific and limited reactions. (J. Watkins & Barabasz, 2008, p. 236)

J. Watkins modified and extended Federn’s conceptualizations and developed the basics of ego state theory with Helen Huth Watkins. Ego state theory includes ego-energized and object-energized elements. Thus, when they have become organized together in a coherent pattern the ego state may represent an age of a relationship in the individual’s life, which may have been developed to cope with certain
situations including traumatic events (H. Watkins, 1978; J. Watkins & Watkins, 1979, 1982, 1986, 1997). In my (AB) opinion, this became one of John G. Watkins’s greatest contributions to the science and practice of psychotherapy. Ego state therapy is now better understood at the neurobiological level and its most powerful and focused therapeutic features condensed for the single-session manualized intervention for trauma disorders.

Assume for a moment that your patient was traumatized by physical abuse as a 5-year-old. Becoming quiet, saying little, and withdrawing passive-aggressively was a way of handling the situation and calming the patient’s father. Such coping patterns seemed to also work in later life. So now when in trouble with an authority figure, the adult finds the 5-year-old ego state returning no matter how short-sighted, present-oriented, and ultimately self-defeating it may be. As Hunter (2008, p. 88) points out, those with borderline personality disorder “still cope the way they did when they were 5 years old.” This may account for the observation that those with borderline personality disorder often function well in most areas of life, becoming successful doctors, lawyers, officers, etc., yet, given the appropriate trauma trigger, a child ego state is activated and their behaviors become removed from the reality of the situation. Situationally inappropriate fear and dysfunctional behavior is precipitated.

An ego state is activated by a trigger that invests it with a substantial quantity of ego energy, so it becomes the “self in the here and now.” We say that it is executive and it experiences the other states, if it is aware of them, as he, she, or it, since they are primarily invested with object energy. 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 because of the severity of the memory that is encoded in the subconscious. Even without a traumatized ego state, we can react to another person in surprising ways, surprising even to ourselves. Those with ASD, PTSD, or combat stress injury respond pathologically when faced with what they construe as a trip-wire reminder of previous traumatic stress. Unresolved trauma will produce unwanted symptoms and inappropriate behavior.

The Role of Hypnosis

Hypnosis has an important role in single-session EST. Those with PTSD and ASD have higher hypnotizability than the general population (Yard, DuHamel, & Galynker, 2008). The hypnotic state is characterized by the patient’s ability to sustain a state of attention and receptive and intense focal concentration. Hypnosis is also a
dissociative process (Barabasz & Christensen, 2010; Hilgard, 1986; Hinterberger, Schöner, & Halsband, 2011; D. Spiegel, 2007; H. Spiegel & Spiegel, 2004; Tobis & Kihlstrom, 2010). Hypnosis makes it possible to focus on one segment of the personality while we simultaneously ablate (dissociate) away the other parts. Hypnosis, as employed in ego state therapy (Barabasz, 2008a, 2008b; Vermetten & Christensen, 2010; J. Watkins & Barabasz, 2008; J. Watkins & Watkins, 1997) targets the fullest expression of the traumatized ego state. We activate and exhaust the patient’s symptomatic expressions while providing the needed resources, by adding the therapist’s ego strength, to respond to the threatening agent(s), to resolve the trauma, and to reconstruct the personality.

Once resolved by EST, the trauma symptoms disappear because they are no longer driven by the underlying ego state maladaptation that carried the trauma (Barabasz, 2008b). The patient has overcome the fear and can rapidly return to normal-range functioning—adaptive, strong, at ease, and empowered. Although hypnosis, per se, is not a requirement for some applications of EST when carried out over a series of sessions (see Emmerson, 2003, 2006), it is generally regarded as the most efficient and reliable method of activating regressive processes to release affect and to reconstruct and resolve traumatic events (Abramowitz & Lichtenberg, 2010; Barabasz & Christensen, 2006; Christensen, Barabasz, & Barabasz, 2009; Patterson, Jensen, Wiechman, & Sharar, 2010; J. Watkins & Watkins, 1997). Lynn and Cardeña (2007) and D. Spiegel (1992) view hypnosis as a key in the treatment of combat stress injury, PTSD, and ASD.

We regard abreactive hypnosis as essential for successful outcomes of our 5- to 6-hour, single-session manualized procedure (Barabasz, Barabasz, & Watkins, in press). Thus far, two evidence-based placebo-controlled studies with 40 and 30 patients, respectively (Barabasz, Barabasz, Christensen, Hasse, & Bruna, in press; Christensen, Barabasz, & Barabasz, in press) also indicate that hypnosis is essential to long-term maintenance of symptom-free functioning.

Single-session manualized ego state therapy is a comprehensive and integrated approach that has been shown to be effective and long lasting for the treatment of those who suffer from the effects of trauma. It uses hypnosis to reconstruct the personality and to create an internal status quo of cooperating units. Previous to the new single session procedure, EST was conducted over a period of days or weeks albeit often in lengthy sessions. The traditional procedures, although well accepted because of numerous case-study trials (J. Watkins & Watkins, 1997, pp. 162–194), have not been subjected to placebo-controlled efficacy tests that meet World Health Organization (Cochane evidence-based) criteria.
Our manualized approach was inspired by our own work with patients, evidence presented by J. Watkins and Watkins (1997) and from unpublished clinical trials attempting resolution of trauma in a mere 4 hours. It was learned that 5 to 6 hours were required for the procedure, which was then subjected to efficacy testing meeting evidence-based criteria in two studies (Barabasz et al., in press; Christensen et al., in press).

Consistent with EST procedures carried out over days or weeks, the single-session approach deals with unresolved ego states that lie in the unconscious and precipitate the expression of emotional reactions. Maladaptive reactions are conceptualized as related to a lack of cooperation among ego states that have been inadequately expressed and are unresolved. Single-session EST assumes that there can be no inner peace or adaptive functioning unless hypnotically facilitated release, resolution, and cooperation are achieved.

Single-session EST incorporates (a) hypnotic abreaction to facilitate affect release by repeated direct regression to the traumatic event and/or by use of the affect bridge (Krakauer, 2009) or resistance bridge (Emmerson, 2003). Each hypnotic abreaction is conducted with the addition of the therapist’s ego strength to overcome the stressor. The patient must never be alone when reliving the traumatic event or retraumatization will likely result. Also essential is that (b) the emotional and physiological expression is intense enough to activate bottom-up brain structures (this may, and usually does, involve yelling, crying, beating on pillows, etc.). It is also essential that (c) the hypnotic abreaction is followed by interpretation, resonant reassurance, and calm ego strength support while the participant is still in hypnosis to foster a resilient adaptive restructuring of the personality. When repeated during the 5-to 6-hour single session, the result is a great feeling of relief to the patient and the dramatic disappearance of the patient’s psychopathology related to that experience. Our next article (Part 2; in press) on the single manualized session will elucidate the procedure.

The process is based on the revivification of an emotionally disturbing experience in the presence of the supporting therapist and the release of the affect that has presumably been bound up in that experience followed by interpretation and reintegration. As shown in our placebo-controlled studies (Barabasz et al., in press; Christensen et al., in press) meeting evidence-based criteria, when repeated and properly carried out using the manualized procedure the result is a great feeling of relief to the patient and the dramatic disappearance of the patient’s psychopathology related to that experience. Our next article (in press) on the single manualized session Part 2 will elucidate the procedure.
References


Manual-basierte Ego-State-Therapie (1 Sitzung) für PTSD (Combat-Stress-Injury und ASD), Teil1: Theorie

Arreed F. Barabasz, Marianne Barabasz und John G. Watkins

Ralf Schmaelzle
University of Konstanz, Germany

Thérapie manualisée du moi en une seule séance pour stress à la suite d’une blessure au combat, SSPT et trouble de stress aigu; 1re partie : La théorie

Arreed F. Barabasz, Marianne Barabasz et John G. Watkins
Résumé: La thérapie portant sur l’état du moi (TEM) a évolué depuis une compréhension psychodynamique de la personnalité en tant que produit des états du moi d’un individu vers une conceptualisation de la façon dont des éléments énergisés par le moi et énergisés par l’objet s’unissent pour faire face à un événement traumatique. Des études neurobiologiques fournissent maintenant des preuves à l’appui de la conceptualisation des

Johanne Reynault
C. Tr. (STIBC)

Terapia de estados del yo manualizada de una sola sesión para el estrés por una herida en combate, estrés postraumático, y trastorno de estrés agudo.

Parte 1: La Teoría

Arreed F. Barabasz, Marianne Barabasz, y John G. Watkins

Resumen: La terapia de estados del yo (TEY) evolucionó, de un entendimiento psicodinámico de la personalidad como un producto de los estados del yo de un individuo, a una conceptualización de cómo es que se ligan elementos yoicos energizados y objetales energizados para afrontar un evento traumático. Actualmente existen estudios neurobiológicos que sustentan las conceptualizaciones sobre las neurosis de guerra de Watkins. Dada su severidad, las memorias traumáticas se codifican en las regiones cerebrales subcorticales-subconscientes que son accesadas mediante un procedimiento manualizado de una sola sesión de TEY, pero no mediante las terapias populares cognitivo-conductuales para el manejo de síntomas. Las marcas del trauma no son accesibles o resueltas a través de un entendimiento verbal o reencuadre de arriba hacia abajo; la TEY es una terapia de abajo hacia arriba. La hipnosis abreactiva facilita la expresión de estados del yo a niveles intensos fisiológicos y psicológicos suficientes para activar procesos subcorticales para liberar afecto en presencia del terapeuta, quien le agrega fuerza yoica al paciente. A esto sigue interpretación y reintegración. El resultado es una personalidad reconstruida adaptativa y resiliente.

Omar Sánchez-Armáss Cappello
Autonomous University of San Luis Potosi,
Mexico