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TOUCHING TRAUMA: COMBINING HYPNOTIC EGO STRENGTHENING AND ZERO BALANCING

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Abstract

Reports in the literature cite a variety of somatic and psychological treatment modalities that address the physical and behavioural sequelae of torture (Prip, Tived and Holten, 1995; Amris and Prip, 2000; Jefferson, 2000). In this brief paper, we would like to highlight a combined treatment method that we have found useful in our work with refugees.

Key words: ego strengthening, exposure therapy, hypnosis, ptsd, torture, zero balancing

The setting

A refugee clinic in Tucson, Arizona is a programme of the Department of Family and Community Medicine of the University of Arizona, and the Center for the Prevention and Resolution of Violence, a programme of the Hopi Foundation (the Hopi Nation is a Native American Indian tribe in northern Arizona). The clinic, which meets one evening a week, is a rotation for medical students and interns, who provide services ranging from paediatric care to geriatric medicine. The clinic is also staffed by volunteer mental health practitioners and physical therapists.

The refugee clinic is an outgrowth of the Task Force on Central America in Tucson, whose 'underground railroad' provided sanctuary in the 1980s to refugees fleeing political strife in EI Salvador and Guatemala. Since then, the clinic regularly sees refugees from the Balkans, Africa, and countries in the Middle East, although Central Americans continue to comprise the majority of our patients.

The typical torture patient in our clinic evinces symptoms of depression and chronic post-traumatic stress disorder (PTSD). By the time we begin our combined treatment approach, many of these patients may be receiving ongoing medical treatment for the sequelae oftorture, along with psychotropic and other medications.

Combining treatment modalities

Since the early 1990s, we have provided both standard physical therapy and conventional psychological treatment, both independent of each other. During this time, the first author began providing a specialized form of bodywork called 'zero balancing' to traumatized torture survivors, while the second author continued to treat patients with standard talk therapy (exposure), hypnosis, and Eye Movement Desensitization and Reprocessing (EMDR). As aspects of these diverse somatic and psychological methods appeared to

complement each other, we decided to try some of them together. Because many patients have shown dramatic improvement, for example, improved sleep, diminished nightmares, faster healing of physical symptoms and brighter mood, with this combined approach, our first-line treatment is now the simultaneous provision of zero balancing and hypnotic ego strengthening.

Zero balancing

Zero balancing is a gentle, hands-on bodywork system whose goal is to balance the structural body and the energy body through touch. It was developed in the 1970s by Fritz Smith MD, an osteopath and acupuncturist who strove to integrate Western concepts of anatomy and osteopathic medicine with the Eastern principles of energy and healing in the treatment of chronic pain (Hamwee, 1999). Designed to enhance physical and emotional well-being, zero balancing focuses on the relationship of energy and structure in the body. Structure refers to the musculo-skeletal system, specifically bone and key joints in the body, while energy refers to something understood and worked with in oriental medicine. It comes closest in western medicine to what we understand as electromagnetic fields. The 'energy body' is not visible, but is palpable and perceptible as temperature changes, tissue softening or movement of tissue beneath the physiotherapist's fingers. A parallel example would be electricity. We cannot see electrical energy, but we see its effects. The same is true with body energy: we cannot see it, but we see and feel its movement, or non-movement in the density of the tissue (Smith, 1987; Oschman, 2000). A rise or shift in emotions, or breathing pattern changes, may also indicate a change in the energy of the body. Structure is that which is static and material in the body, and energy is that which moves and changes.

As an integrative therapy that works with body and mind, zero balancing first focuses on bone and specific foundation joints. According to a basic concept of oriental medicine, it is in bone that energy and structure can be accessed and touched together. Bone is the core of the skeletal, or structural, body and touching bone can have a grounding effect, or stimulate the recall of a traumatic experience.

A second principle of zero balancing, which grows out of the first, is the concept of 'tissue memory'. This has both a structural component and an energetic, or vibrational, component. A traumatic event often leaves a vibrational scar, so to speak, in the tissue. Physically, the tissue may have healed, but the vibration of the trauma is believed to be still present. Using a respectful and specific kind of touch, practitioners can access trauma at the level of bone, the core of the body (Weill, 1983; Ballentine, 1999). It is .also believed that at this core a person is well, and when this core is touched, or comes forward, people with physical symptoms will often experience their essential well-being. Healing occurs when people have a body-felt experience of a change, or a shift, which objectively is seen as relief or a release. During this release, a patient's objective response is hypnoidal, or trance-like, in that a mild dissociation is observed. Subjectively, at this same point, patients may report a pleasantness or relaxation, along with a feeling of well-being.

Zero balancing has been used in many countries by massage therapists, physical therapists, osteopaths, nurses, acupuncturists, emergency department physicians, and other practitioners. A variety of patients have been treated with zero balancing, including those in both acute and chronic states of imbalance or disease, as well as with patients who are physically well, but in emotional states of transition, stress, or post-trauma. Just as imbalances in bone can have widespread effects, positive touch to these same areas can produce profoundly positive effects (Lauterstein, 1994).

Hypnosis and PTSD treatment

In the late 18808, Pierre Janet recognized the utility of hypnosis in treating trauma. He was the first to create a systematic, phase-oriented treatment for what we now know as PTSD.Kingsbury (1988) noted that pathological symptoms, such as dissociation, present in PTSD, are also common 'phenomena in hypnosis. Because of this natural 'fit", Kingsbury called hypnosis an isomorphic intervention for PTSD. In the literature, there is only one randomized, controlled study involving hypnosis and PTSD. This study (Brom, Kleber and Defares, 1989) found hypnosis was equal to psychodynamic therapy and anxiety management, but more effective than wait list controls.

Hypnosis may be used to restructure or transform traumatic memories, as well as to abreact previously unexpressed feelings of sadness, rage, guilt, and so on. Hammond (1990) advocates such highly directive techniques for PTSD patients. Similarly, Hartland (1971) discusses a highly directive method of ego strengthening, for example, inducing trance and then suggesting, 'You can be strong'. However, in the vast majority of cases, we find that a patient's sense of self-control is enhanced if we address traumatic symptoms more gently and indirectly, appealing to the patient's unconscious mind (Gafner and Benson, 2001). In fact, these indirect methods may be useful with military veterans coping with the problems of old age (Gafner, 1997)~chronic paranoid schizophrenia (Gafner and Young, 1998), and a general mental health clinic population (Gafner and Benson, 2003).

Milton H. Erickson referred to the unconscious mind as a vast storehouse of information and resources that people develop unwittingiy and of whose functioning they are unaware. He believed that a trance state allows accessing of unconscious understanding of metaphors, such as ego-strengthening stories. Trance allows patients freedom to tailor the message within the story to the most helpful and personalized conclusion. Because patients have drawn their own conclusion, they have created their own interventions from raw material, drawing upon previous self-learnings and placing this knowledge into an expanded format. Resistance is avoided and independence is nurtured (Erickson, Rossi and Rossi, 1976).

Indirect hypnosis

Phillips (1993) and Dolan (1991) rely on indirect or metaphorical techniques in treating the sequelae of childhood molestation and sexual assault. Several advantages of a metaphorical approach include allowing therapists:

- to bypass reflexive objections of patients,
- to test patients' responses to ideas without calling attention to them, and
- to build a careful foundation before being direct.

The approachencourages patients' active mental search in order to develop access to stored or imagined resources, or to stimulate new associative pathways (Combs and Freedman, 1990).

Combining zero balancing and indirect ego strengthening

In a typical session, the physical therapist and psychotherapist speak with patients about their progress to date and how they are feeling. Patients then lie down on their backs and

the physical therapist begins by applying gentle lifting, or curved pulls, to key areas of the body, holding each area for a few seconds. These are 'fulcrums' or points of balance around which the physical and energetic body reorganizes and often becomes very relaxed and quiet. A feeling of trust and safety is established with this kind of touch. The fulcrum is based on the zero balancing premise that if something can be balanced to neutral without judgment or comparison by holding it in its own space, it will naturally move to its highest possible potential.

Concurrently, the psychotherapist begins a conversational hypnotic induction and deepening, offering suggestions for slowing down both the mind and body. It is at this point in the process that patients often experience past trauma, and feelings surface that may have been repressed for many years. With the guidance of the psychotherapist, and the safe touch of the physiotherapist, patients continue to verbally release more of their story and attendant emotions.

The psychotherapist then begins metaphorical ego strengthening, that is, an ego-strengthening story, perhaps about someone else who survived and prevailed in the face of adversity, or about a tree in the forest that suffers drought and strikes by lightning, and then survives, continuing its life in the forest among other trees. We have a dozen 'stock' stories that are employed in this manner. Patients almost universally seem to self-reference these metaphors, thus incorporating them and adapting them to their own situations.

A second method of indirect ego strengthening that we employ, also combined with zero balancing, is what we term short-burst (Geary, 1999)/ego strengthening. Following hypnotic induction and deepening, the therapist employs a short confusional statement, or non sequitur, followed by a suggestion such as 'You can go deep' or 'You can overcome this'. According to Gilligan (1987), when a patient hears an out of context statement (a non sequitur), for example, 'They sold Mexican blankets along the road for only three dollars', an unconscious search begins, as patients seek a way out of the confusion. The therapist provides a way out, and in the direction of desired change.

With both the metaphorical and short-burst techniques, we explain to patients ahead of time what we are doing, for example, 'We may be saying some things that don't quite make sense, and all this is being done to help you'. Both techniques are presented to patients in terms of 'mental strengthening", which torture survivors with years of discouragement readily understand.

We also employ nonhypnotic means of ego strengthening, such as role play of difficult social situations, or encouraging skill acquisition so that patients will feel more confident and better about themselves.

Such combined treatment oftentimes serves to stabilize acute symptoms and allows the therapists to proceed with other phases of treatment, i.e. resolution of traumatic memories and memory integration (Brown, Sheflin and Hammond, 1998). As patients feel secure enough to process their trauma - and as .'talk therapy' predominates - we maintain the stimulus control, with the patient sitting or lying on the physiotherapist table, both therapists present, etc.

Case example A

Graciela is a middle-aged woman who fled EI Salvador (a country in Central America) in the 1980s because of threats on her life. In the small Central American country, Graciela's husband was affiliated with a trade union, and accordingly she, too, was regarded as a

subversive. She was arrested and detained for 90 days, during which time she was interrogated, beaten, raped and burned by cigarette butts. En route to the US through Mexico, she was robbed by thieves, and raped by policemen.

Since being in the US, she has shown a host of symptoms characteristic of PTSD, as well as headaches, depression, suicide attempts, and total body pain. She slowly lies down on the physical therapist's table, her body tight and tense. When the first author touches her, tears well up in her eyes. With the introduction of hypnotic relaxation and indirect ego strengthening by the second author, she allows her breath to go deeper, and she shows increased movement and softness in her structure. After five weekly sessions of combined treatment, Graciela feels less physical pain, and she begins to speak freely about her sadness and anger. Several months later, her mood is consistently bright and she is successfully managing her life for the first time in many years. Graciela continues to be seen every two months for a booster session.

Case example B

Pilar is a woman in her 50s from the Central American country of Guatemala, from where she fled after being arrested by both the guerrillas and Government soldiers. Both factions accused her of collaboration with the enemy. Although the guerrillas released her after a short period of essentially benign treatment, the Government's secret police interrogated her and tortured her with electric shock, and she was gang raped. Adjustment in the US has been difficult for her and her children. A year before she was seen in our clinic, she sustained an ankle injury that required surgery. At the time, her ankle had not healed well, and she could not actively move it. Pilar walked with difficulty using a cane, and she endured continued swelling, even though she had received long term traditional physical therapy, nonsteroidal anti-inflammatory medication, antidepressant medication, conventional psychotherapy and family therapy.

We began weekly combined treatment, and after the third session she began to actively move her foot, and soon she assumed a near-normal gait and no longer needed a cane. Her family noted a lifting of her depression, and how at home she was noticeably happy and relaxed. As therapy progressed, Pilar, for the first time, spoke about her torture, of finding her murdered husband's corpse, and other vital aspects of her trauma.

This is another example of how touclring the energy body and the structural body together often facilitates the release of emotions that may have been stored for a long time. Thus, after several sessions, torture survivors can show improvement both physically and emotionally, which aids them in their relationships, and in the overall resettlement process.

Conclusion

There is a long tradition of treating anxiety disorders, including PTSD, with various exposure therapies. There is a similar tradition of employing highly directive hypnotic techniques, both in abreacting feelings and transforming traumatic memories, as well as in directly boosting self-efficacy. However, many traumatized patients, especially torture survivors, may remain in treatment and respond more favourably to gentle and indirect techniques, such as indirect ego strengthening within hypnosis.

There is also a long tradition of treating the physical sequelae of torture with standard physical therapy. We believe that zero balancing - though not currently an evidence-based

method - is an especially effective bodywork approach that addresses both the physical and psychological issues of torture survivors. Zero balancing is a gentle, respectful physiotherapeutic approach, as is indirect ego strengthening within hypnosis. We have found that zero balancing and this hypnotic technique complement each other well, and when combined, serve to hasten the progress of torture survivors.

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