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INDIRECT EGO-STRENGTHENING IN TREATING PTSD IN IMMIGRANTS FROM CENTRAL AMERICA

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Abstract

As a result of civil war in El Salvador and Guatemala, hundreds of thousands of refugees fled to the USA during the 1980s. Many of these refugees experienced torture and other abuse, and current adaptation is complicated by post-traumatic stress disorder (PTSD). The scope of the problem is examined along with cultural factors in mental health treatment and the limitations of conventional exposure therapy. The authors describe two indirect, hypnotic ego-strengthening techniques that are useful in treating PTSD in this refugee population.

Key words: ego-strengthening, exposure therapy, hypnosis, metaphor, PTSD, self-efficacy

Introduction

Torture is one of the most appalling violations of human rights. It is strictly condemned by international law and by the United Nations Convention against torture. According to Amnesty International, torture continues to occur in 79 countries, some of which have signed the Convention. It is estimated that 40% of immigrants to western Europe were victims of torture, which usually includes physical violence from kicks, fists, rifles, iron rods and electricity; mutilation from knives, suspension by arms or legs; and being pushed from heights. Survivors of torture are in urgent need of medical care, physiotherapy and psychological care (Prip, Tived and Holten, 1995).

Civil war in El Salvador and Guatemala

Torture, a major contributor to post-traumatic stress disorder (PTSD), often occurs within the context of civil war. In the central American country of El Salvador alone an estimated one to two million people fled to the USA in the 1980s, with the majority settling in southern California. In Tucson, Arizona, some 600 families are followed by the Task Force on Central America. A major role of the Task Force is co-ordinating legal, medical and mental health care to these people. The present paper discusses the scope on the problem, reviews the use of hypnosis and behavioural treatments with PTSD and focuses of specific indirect hypnotic techniques that are useful with these clients.

As a part of a counter-insurgency movement during Guatamala's 30-year civil war, the government employed a systematic campaign of terror against the indigenous Mayan population. Between 1981 and 1983, the Guatamalan army — by its own estimates — destroyed over 400 rural villages and killed between 50 000 and 100 000 villagers (Melville and Lykes, 1992; 535). Within this campaign, the military invaded villages and randomly tortured, mutilated and kidnapped people of all ages, while the survivors were left with emotional sequelae, including not knowing the fate of disappeared family members.

During roughly the same period, El Salvador was also engaged in civil war. Between the hardline military and guerilla forces, roughly 40 000 civilians were murdered. This number rose to 60 000 by 1987 (Crittenden, 1988; 17). University students, reform leaders, unionists, members of the Roman Catholic clergy and anyone else labelled 'subversive' were subjected to torture and disappearances. This resulted in a massive exodus to the USA.

Peace accords in both El Salavador and Guatemala in the 1990s have caused a slowing of forced immigration to the USA. High rates of unemployment and crime in the cities has caused the exodus to continue, although at a slower pace than in the 1980s. Recent immmigrants report continued practices such as the army's seizing young girls from villages for the purposes of rape and forced labour.

Mental health problems among refugees

Mental health problems are common among both refugees and those people who remain in these countries. PTSD symptoms in this population range from 50% to 100% (Cervantes, Salgado de Snyder and Padilla, 1989; Bowen, Carscadden, Beighle and Fleming, 1992). Sexual violence is common is torture victims, as well as the infliction of physical and psychological pain. Symptoms of psychological distress are not limited to adults. In a survey by Quirk and Casco (1994), 69% of children who had experienced a disappearance within the family showed symptoms of stress which included poor scholastic performance, enuresis, pronounced fear, anger outbursts and developmental delays. Studies suggest that the incidence of PTSD is high in the general Salvadoran population as well as in refugees (Bowen et al., 1992). Head injury is a common sequela of torture, with neuropsychiatric symptoms including memory loss, headache and other problems (Goldfield, Mollica, Pesavento and Faraone, 1988).

Cultural factors

Many of these clients are agrarian people with little education. For some Indians from Guatemala, Spanish is but a second language. Some refugees may be unfamiliar with things such as telephones and indoor plumbing. They find themselves suddenly cut off from their culture and community, and must adapt to an alien culture centred on the use of electricity. In fact, when crossing a city street in Tucson, some displayed unfamiliarity with traffic lights, thinking that they were leftover Christmas decorations. The concept of time, for some refugees, is different from ours in that they mark time by events, such as Christmas or the harvest, rather than by the clock. Nevertheless, despite these obstacles, as well as psychological problems, most refugees we have treated appear quite resourceful. Many strive to learn English and they value their children's education in American public schools. Refugees in this

country typically find employment in restaurants, as landscapers and as maids in hotels.

It is common for Central Americans to experience additional trauma *en route* to the USA, for example robbery or rape in Mexico. Some refugee clients may fear hospitals or clinics, which in their own country may have been agents of persecution. As people in exile may avoid discussing unpleasant events of the past, trauma may remain hidden as they concentrate on survival in the present. PTSD symptoms are often masked by somatic complaints, which is invariably a good place for interviewers to begin their enquiry. The legal status of some refugees may preclude meaningful employment, as they may stay hidden, fearing arrest and deportation. They sometimes live in conditions that are more crowded and impoverished than they experienced in their own country.

Some refugee clients hold superstititous beliefs. For example, if they have a dream, they believe the dream will come true. Some may also believe that hypnosis is magic; however, they may also view psychotherapy, or even conventional medical treatment, in a similar light. Curse, along with religious guilt, is seen more commonly in Arizona in Mexicans and American citizens of Mexican origin. For example, these clients may attribute an episode of anxiety or fear to a curse laid by a witch (Gafner and Duckett, 1992). Also, Central Americans appear to rely less on alternative medical care, such as herbs or the treatment provided by traditional healers in Hispanic neighbourhoods.

Refugee clients in mental health treatment may grant trust warily, and it is important for therapists to provide a setting where clients can begin to experience trust, and where anxiety and fear can be contained (Fischman, 1991; 181). One woman from El Salvador reported that she had awakened in a pool of blood and that her husband and children were lying around her, all slain. She was brought to the clinic every week for over a year and each time, before she could be seen, she fled from the waiting room. Finally, she stayed long enough to be interviewed and was eventually treated successfully.

Helping clients to differentiate between past and present can build trust and put a label on the origin of client fears. Psychoeducation about depression and PTSD often does little good. When showing clients picture books that explain the genesis of PTSD, some refuse to believe that trauma is the source of their symptoms, suggesting instead, for example, 'I feel this way because of the pill they gave me in Guatemala' or 'Because I used to drink heavily — that's why I'm this way'. Some clients may feel that they are going crazy and they need to know that they are experiencing a normal psychological reaction to an abnormally stressful situation. Clients' losses usually include loss of nuclear family, home, culture, friends and loss of legal status.

Facing such overwhelming losses and the horrifying experiences of the clients can affect therapists who may have reactions ranging from obsessive interest to phobic avoidance. As a result, processing feelings and reactions in supervision is recommended (Fischman, 1991; Pope and Garcia-Peltoniemi, 1991). It is important for clinicians to try to understand loss from the client's perspective. For example, one woman showed little distress at the kidnapping and killing of her husband. Perhaps such apathy or disinterest makes sense in a place where civil war and cruelty span generations.

The *testimonio*

Refugee populations and, more specifically, torture victims may require treatment methods that diverge from the standard fare. One such useful method is the *testimonio*

(Cienfuegos and Monelli, 1983). The *testimonio* helps to empower clients by allowing them to speak out as witnesses to horrific experiences. With this method, clients are asked to write or speak into a tape recorder detailing injustices they have suffered. Accordingly, they are 'standing up' for their right to dignity and respect. The *testimonio* may be public, as in the case of the mothers of disappeared children at the Plaza de Mayo in Argentina in the 1980s (Aron, 1992). From the therapist's perspective, clients are beginning to actively process the traumatic experience. Similar active processing occurs in the legal arena when they prepare their applications for asylum. With the help of an attorney, clients provide a detailed account of historical events and their effect on the individual as justification for remaining in the USA. Sometimes, claims for political asylum are denied despite seemingly compelling evidence, such as gunshot wounds, torture scars and the death of family members.

Exposure therapies and PTSD

There is a long tradition of treating anxiety disorders with various exposure therapies that include systematic desensitization, flooding, prolonged exposure and implosive therapy (Levis, 1980; Rachman, 1980; Barlow, 1988). Exposure therapy is effective in treating combat-related PTSD in single-subject design studies (Black and Keane, 1981; Fairbank and Keane, 1982), as well as in randomized clinical trials for war-related PTSD (Keane, 1989) and rape-induced PTSD (Foa, Rothbaum and Riggs, 1991). In 1999, Foa, Davidson and Francis published their poll of clinicians who treat PTSD. In this consensus of experts, anxiety management, cognitive therapy and exposure therapy were rated as highly effective, whereas hypnosis was rated low along with psychodynamic therapy and eye movement desensitization and reprocessing (EMDR). Exposure therapies so dominate research grants and the literature that methods such as hypnosis may be summarily dismissed by many practitioners.

However, on closer examination, exposure therapies may have some serious drawbacks. Pitman, Orr, Altman, Longpre, Poine, Macklin, Michaels and Steketee (1991) found that exposure techniques may exacerbate depression, panic and alcohol consumption, whereas Allen and Bloom (1994) noted that exposure therapy was contraindicated in clients with marked psychological dysfunction, personality disorder, suicidality, impulsivity, substance abuse or resistance. The problem was underscored in a study of prominent behaviour therapists who treat PTSD. The study showed that exposure techniques were used in little more than half of their cases (Litz and Blake, 1990). Within our own practice, many clients fit most of the conditions listed above. Additionally, those clients, like refugees with PTSD, often find exposure therapy too aversive. They simply do not wish to re-open old wounds. Clearly, other treatment options must be considered.

Hypnosis and PTSD treatment

In the late 1880s, 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 (Van der Hart, Brown, Van der Kolk, 1989). Kingsbury (1988) noted that pathological symptoms such as dissociation, present in PTSD, are also common phenomena in hypnosis. Because of this natural 'fit' Kingsbury (1988) called hypnosis an isomorphic intervention for PTSD. Spiegel (1997) also underscored the similarities between hypnotic phenomena and PTSD symptomatology. Specifically, with the

traumatization, clients are accustomed to experiencing dissociation, amnesia and emotional numbing. In therapy, these experiences can be linked to hypnotic dissociation, amnesia and physical numbing as a way to create a safe abreaction and to ratify trance. When PTSD clients are in the midst of flashbacks, they experience time distortion. This dissociated awareness is akin to age regression. Similarly, intrusive re-experiencing of symptoms is a form of absorption of attention, whereas stimulus sensitivity is like hypnotic suggestibility. Because of their previous experiences, PTSD clients are likely to have high hypnotizability, according to Spiegel and Cardeña (1990), who also discuss how hypnosis can help them restructure traumatic memories positively. In therapy, we may explain to clients that hypnosis helps them because it builds on their skill at 'spacing out' and going back in time.

Facilitating abreaction can be important in the use of hypnosis with trauma victims. We believe that Hammond's (1990) technique involving age regression, abreaction and reframing, to be among the very best. This technique employs a careful age regression to the time of the trauma, followed by a directed abreaction of anger, guilt, sadness and any other abreacted feelings. This is followed by a reframing of the experience, which reinforces the client's strength and resources for coping, for example 'In the past, you did the best you could coping with this horrible experience, and now, having expressed all these important feelings, and with a new perspective, you can do better in the future'. However, it is also important to process the hypnotic experience at the conscious level as well once the client is brought out of trance. In our experience, Hammond's (1990) technique works best with clients who have experienced a single trauma. However, for some clients, even this technique is too directive and reminiscent of traditional exposure therapy.

To date there has been only one published study involving controlled, randomized methodology for hypnosis as a treatment for PTSD. In this study, Brom, Kleber and Defares (1989) demonstrated that hypnosis was equal to psychodynamic therapy and anxiety management, but more effective than wait list controls. Various authors have described the utility of directive hypnosis in treating the sequelae of trauma in populations such as Holocaust survivors (Somer, 1994).

Indirect hypnosis

Some therapists, for example Dolan (1991) and Phillips (1993), rely on indirect or metaphorical hypnotic techniques when treating the sequelae of childhood molestation and sexual assault. These workers note that reframing of symptoms assists both cognitive restructuring and affective relief. Of course, these highly individualized Ericksonian techniques do not lend themselves to standardized research protocols.

Several advantages of a metaphorical approach include allowing therapists to:

- Bypass reflexive objections of clients.
- Test clients' responses to ideas without calling attention to them.
- Build a careful foundation before being direct.

The approach encourages clients' active mental search in order to develop access to stored or imagined resources, or to stimulate new associative pathways (Combs and Freedman, 1990). Accordingly, clients (even relatively concrete or unsophisticated clients) may experience a greater sense of creativity in and responsibility for the therapy process.

Milton H Erickson (Rossi, 1980) referred to the unconscious mind as a vast storehouse of information and resources that people develop unwittingly 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 clients freedom to tailor the message within the story to the most helpful and personalized therapeutic form. Because clients have drawn their own conclusion, they have created their own interventions from raw material, drawing upon previous self-learnings and placing this old knowledge into an expanded format. Resistance is avoided and independence nurtured.

Refugee clinic in Tucson, Arizona

This clinic is run by the Task Force on Central America that grew out of the 'underground railroad' or sanctuary movement of the 1980s. The clinic is a rotation for medical students and interns in the Department of Family and Community Medicine at the University of Arizona. Its services range from pre-natal care to geriatrics. For the refugees, the clinic is a place of safety, security and trust. Treatment for trauma and related problems is provided by *pro bono* mental health practitioners and includes individual, group and family therapy, as well as medication. Hypnosis is employed regularly and sometimes in conjunction with a type of bodywork called zero balancing provided by physiotherapists. The goal of zero balancing is to balance the body's energy and involves a gentle lifting and tugging of various parts of the patient's body.

Our non-directive hypnosis with these clients makes ample use of metaphors and stories. When we began working with refugees we used an iceberg as a metaphor for the unconscious mind. We soon realized, however, that most of them did not know what an iceberg is. We then learned to employ metaphors from the experience of these mainly agrarian people — birds, flowers, rivers and other things familiar to them. Like people of all cultures, they especially appreciate stories. These stories eventually became an integral part of ego-strengthening in our hypnotic work.

Ego-strengthening

Hartland (1971) was one of the first to advocate ego-strengthening within hypnosis. He proposed directive suggestions such as 'you *will* lose weight'. Less directive is the approach of Stanton (1993) for whom ego-strengthening is a cornerstone of therapy. Proponents advocate ego-strengthening early in therapy, recognizing that many clients may not let go of their symptoms until they feel strong enough to do so. We may give clients a medical analogy to help them to understand the rationale. Just as physicians need patients to be as healthy and strong as possible before surgery, we try to build up, or strengthen the ego, before going on to deeper work. Clients with chronic PTSD have usually experienced years of depression and dissatisfaction with life. They seem readily to understand our rationale of 'mental strengthening'.

Self-efficacy

Improved self-efficacy may be defined as clients' believing that their behaviour will lead to successful outcomes. Bandura (1997), a long-time proponent of building self-efficacy, believes that the greatest benefits bestowed by psychological interventions

are not specific remedies for particular problems, but rather helping clients to acquire the socio-cognitive tools necessary to deal with situations that arise in life. Ironically, this approach of the eminent socio-cognitive academician is very much in line with the staunchly atheoretical Milton Erickson, who similarly strove to strengthen individual clients by accessing unconscious resources and amplifying these strengths for improved psychological well-being.

Bandura (1997) contends that among the mechanisms of human agency, none is more central or pervasive than beliefs of personal efficacy. Personal enablement through mastery experiences is the most powerful way to instil a strong and resilient sense of personal efficacy (Bandura, 1997). Bandura (1997) does not address unconscious process *per se*, except to note that vicarious experience is less likely than guided enactive mastery to produce strong and generalized efficacy beliefs. He adds that people exhibit some generality in their sense of personal efficacy across different activities, especially for tasks for which they already possess requisite competencies, and that modelling with cognitive rehearsal builds stronger self-efficacy than modelling alone (Bandura, 1997).

This is pertinent to indirect hypnotic ego-strengthening in that clients who self-reference metaphors — for example, a story whose meta-meaning connotes survival and strength — often appear to gain more control over their symptoms. This then sets the stage for further therapy, which could include further hypnosis, conventional exposure therapy or 'talk' therapy in which generality and skill acquisition are encouraged. Also, we believe that interactive hypnosis, for example verification through finger signals of imagined mastery in age progression, approximates an *in vivo* mastery experience and sets the stage for actual behavioural change.

Two types of hypnotic ego-strengthening

It is always most curious to us how all clients, including refugees with PTSD, appear to self-reference metaphors in their own particular fashion. We employ two general ego-strengthening techniques in hypnosis. One involves a story, which we call 'metaphorical ego-strengthening', whereas the other is what we term 'short-burst ego-strengthening'. Both are typically employed following any variety of inductions and deepenings.

In metaphorical ego-strengthening, the story may *be* the therapy portion of hypnosis or additional suggestions may follow the story. We usually ask for unconscious acceptance of the metaphor and use finger signals to verify the acceptance, rejection or 'I don't know' response. We may tailor stories to a client's particular needs, but we also have many standard stories about things such as a tree in a forest that survives drought, lightning strikes and other adversity, or a person who prevails and prospers amidst tribulation and hardship. Many of these are described in the *Handbook of Hypnotic Inductions* (Gafner and Benson, 2000). As many clients with PTSD do not wish to close their eyes, we often absorb refugees' attention in the flame of a candle while they count aloud backwards, slowly, from 100 to one. As they are counting we tell them a story about a greenhouse (Wallas, 1985) and intersperse suggestions for dissociation, amnesia, time distortion and other phenomena. We never interpret a story for clients, even if they ask its meaning. This signals implicitly that they have the resources to derive the important meaning from the story by themselves. We may also use restraint, holding them back from change, explaining that the symptom has had a protective function and deserves respect.

Although metaphorical ego-strengthening does not usually involve confusion, short-burst ego-strengthening relies exclusively on a confusion technique. This technique employs a short confusional statement, or *non sequitur,* followed by a suggestion such as 'You can go deep'. For example, a *non sequitur* such as 'The wind sometimes blows from east to west' followed by a suggestion 'You can be in control'.

According to Gilligan (1987), when a client hears an out-of-context statement such as a *non sequitur* an unconscious search begins as he or she seeks a way out of the confusion. We provide a way out, by way of suggestion in the desired direction. We prefer bland and neutral *non sequiturs* that are devoid of meaning or negativity. At the same time, we do not want the *non sequitur* to be purposeful or didactic. So, for example, we would use 'I wonder why, in supermarkets, those shopping carts always seems to stick together' instead of 'She bent to her task with maniacal relish'. Or, we would use 'He could hear a silence between the leaves' as opposed to 'She saw cobwebs in the garden that was overgrown with weeds'. We wish to do as little as possible to achieve the desired effect. So, following induction and deepening, the therapy component would consist of no more than three or four *non sequiturs*, each followed by a suggestion such as 'You can be strong'.

With both techniques, we explain to clients beforehand what we are doing, for example, 'We may be saying some things that don't quite make sense, and all this is done to help you'. Clients appreciate that our efforts are designed to build them up or make them stronger. Not explaining what will occur may be viewed by clients as disrespect. Showing respect with refugees is obviously important, just as important as recognizing their values and world view.

Of course, we also employ other means to build self-efficacy, such as encouraging skill acquisition and expanding social contacts. In this regard, we employ role rehearsal and similar traditional means. To measure change we use scales such as the PENN PTSD scale and the Beck depression and anxiety inventories. One of the authors of the present paper speaks Spanish, which greatly facilitates treatment of central Americans. Both techniques have also been successfully employed with refugees with PTSD from Africa and the Balkans; however, we have found all means of psychotherapy more difficult when we have to work through an interpreter.

Conclusion

In summary, indirect ego-strengthening techniques have proved eminently useful in treating PTSD in refugees, but have been used equally successfully with the anxiety and depression of other populations (Gafner, 1997; Gafner and Young, 1998). With this non-threatening approach, resistance is bypassed and as clients feel stronger they can tolerate more directive techniques. In many cases, indirect ego-strengthening techniques by themselves effect both reframing and affective relief.

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