

# Empowering the Self Through Ego-State Therapy

An E-Book by Maggie Phillips and Claire Frederick

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## Creative Strategies for Recognizing, Eliciting, and Building Alliances with Ego States

### Chapter One

Most therapists and increasing numbers of lay people are familiar with the concept of “ego states.” The term *ego state* was popularized by Eric Berne, creator of the therapeutic model of Transactional Analysis, and author of the widely read book, *I’m OK—You’re OK*. Fewer people have heard of Paul Federn, who actually coined the term *ego state* and the idea that individual personalities are composed of multiple ego states that constitute a family of self, in contrast to Berne’s model of “parent,” “adult,” and “child.” Berne and Federn were both colleagues of Freud, and built on Freud’s personality model of ego, id, and superego, though their theories have taken ego state therapy in somewhat different directions.

Others like Jack and Helen Watkins (1997), who have been our teachers, have further developed the theory of personality multiplicity utilizing hypnosis as a primary way of eliciting and providing treatment to the ego state system. Although there is now common understanding and acceptance of our multi-faceted nature, divergence remains about how best to work with multiple aspects of self.

This chapter presents creative strategies for identifying, activating, and building alliances with personality states, drawing primarily from the Federn-Watkins lineage, while acknowledging that more recent theories such as structural dissociation and internal family systems, also have contributed a great deal to the evolution of ego state therapy, as have more traditional theories of gestalt therapy, psychosynthesis, and other “parts” models.

### Understanding Ego States

An “ego state” is one of a group of personality states that is relatively stable across time. It is distinguished by a specific role, emotion, behavioral, memory, and/or cognitive function. Ego states exist as a normal aspect of personality development. Every individual has a number of different ego states, each of which is designed to assist the personality in important ways.

Ego states evolve as creative ways of coping with the demands of external environments, allowing us to master developmental challenges such as distinguishing between acceptable responses in social, home, and school situations. An example of this occurs as young children start school and learn to adapt to rules and expectations unique to that environment such as raising their hands for permission to ask questions

or leave the classroom. As this set of responses is repeated over time, it may evolve into an ego state that is compliant, polite, or even placating in response to the requests of others.

A second type of ego state emerges as we internalize various personality energies of our parents and other important life figures that serve as important sources of positive, negative, and ambivalent responses to developing personality patterns. These introjected ego states are similar to Eric Berne's delineation of the "parent" ego state, though within the Watkins' model, introjected ego states may manifest through a wide spectrum of ages, diverse verbal and nonverbal presentations, and complex interactions within the personality structure.

For example, an adult client may have a two year old ego state who introjected father, mother, or siblings as they were at the time the client was age 2. Another introject state may represent the same family figure as they exist in current life (Emmerson, 2003). Still another type of introject may represent a family figure across significant experiences within an emotional category, such as criticism, praise, or neglect.

Ego states can also be created in response to traumatic events such as injuries, accidents, illness, natural disasters, or childhood abuse. An example of a trauma-related ego state might include one that helps a child dissociate from physical or sexual abuse. Over the span of several years of continued abuse, this dissociative state might take the form of a somatic signal, such as a stomach ache, that warns of impending danger when mother or father's drinking escalates beyond a certain point based on a number of familiar cues such as slurring of words, facial expression, emotional communication, verbal phrases, and voice tone, behaviors which the child has learned may precede violent behavior.

This emerging somatic state may later be triggered in interactions with other individuals who exhibit certain alcohol-related behaviors, so that the adolescent or adult can escape potentially threatening situations by withdrawing to cope with digestive problems. Eventually, this somatic state may contribute to debilitating illness such as ulcerative colitis or Crone's disease, while the state's original protective function and connection to specific early childhood experiences may remain unconscious.

### Conscious and Less Conscious States

Ego states are separated from each other by varying degrees of dissociation. Within a given individual, there are "surface" states that are known to the core self. This type of ego state most frequently assumes "executive" roles in typical personality functioning. Conscious or surface states are relatively consciously connected to each other, communicate with each other, and tend to work in a cooperative fashion. There are few conflicts or other barriers between these states and shared memory function among

them is relatively intact. Examples of more conscious states include those related to daily roles such as parenting, working, cooking, and conducting relationships.

Less conscious, more unconscious, or “underlying” ego states demonstrate more dissociative distance from other states. The range of communication and connection varies widely. Some states are so split off from the whole personality that they are virtually unknown. These highly dissociated states tend to take charge of functioning without permission or knowledge of the core self.

An adult with dissociative disorder or complex PTSD may have an ego state that contains the somatic, emotional, cognitive, or behavioral aspects of early attachment trauma. For example, an adult client may develop intense aversions to certain smells connected with past abuse such as sweat or perfume and develop phobic responses such as excessive hand washing or environmental allergies. The dissociated state may be the only one with knowledge of the original traumatic experiences linked to the smells and may orchestrate the avoidant behaviors in unpredictable ways to protect the personality from “dangerous knowledge” that, from its limited experience, might provoke an even more dysfunctional breakdown.

These states usually cannot be accessed without hypnosis or other approaches like EMDR or imagery that permit guided access to the unconscious world. Ego states that are closer to the “surface” may interact with more conscious states, while more deeply unconscious states may rarely connect with daily experiences and the parts that play executive roles in them.

## **Evaluating the Need and Appropriateness of Ego-State Therapy**

Aside from obvious signs of dissociative disorder, which includes Dissociative Identity Disorder, there are many clinical problems that may be related in more subtle ways to ego state conflicts. Examples of these include simple phobias, depression (particularly atypical depression), panic attacks and anxiety disorder, obsessive compulsive disorder, PTSD, eating disorders, sexuality disorders, pain and health problems, and interpersonal difficulties.

It is usually helpful to obtain a thorough history as well as a medical clearance, if this is relevant to the client’s presenting problems. Evaluation for ego-state therapy always follows the basic assessment indicated for any practitioner’s licensing or certification parameters.

Important elements of ego state evaluation (Frederick, 2005) include:

1. Inquiring about “ego dystonia” or the extent to which clients are uncomfortable about their symptoms. “This just isn’t like me at all most of the time” or similar phrases can be a common indicator that a client is in conflict with other states about targeted difficulties.
2. Unusual or unexplained emotional patterns, such as mood swings or bipolar presentation.
3. Unusual or chronic somatic experience, such as intractable migrating pain, that is unresponsive to usual diagnoses or treatments.
4. Unusual elements of fantasy, including recurring images that provoke intense anxiety and become “mystifying signals” (Frederick & Phillips, 1996).
5. The “language of parts” indicating ongoing conflict or struggle or a sense of self-division.
6. Inappropriately persistent “self-talk” where the client hears internal voices that distract from a functional daily life.
7. A fear of “going crazy” in non psychotic clients can indicate ego state conflict.
8. Observed atypical or unusual behaviors such as tics, voice shifts, fluctuating facial expressions, or wildly inconsistent behavioral patterns can indicate ego state “switching.”
9. Unresponsiveness to all other treatment remains one of the most common indicators of ego state difficulties. Treatment failure occurs usually because key ego states are not participating or because inner struggles override the client’s desire for change.
10. Inner ego state exploration (by any of the methods described below) that reveals the presence of self parts in ways that resonate with the client. Exploration should not be conducted solely to determine ego-state difficulty, but rather to find out what is going on with the client at deeper, less conscious levels of awareness related to targeted difficulties.

## Identifying and Accessing Ego States

There are many ways to find and activate ego states successfully. It’s important to remember that regardless of the method used, the primary focus when first activating ego states with any client is ego strengthening. This can include formal uses of hypnosis, indirect or Ericksonian hypnotic technique, and nonhypnotic methods that suggest the expansion of both observing and experiencing ego capacities. Examples include the activation of *inner strength* (Frederick & McNeal, 1998), a powerful inner resource believed to be “something like an ego state” and connected to the survival instinct.

Ego-State Therapy is conducted in several stages that we have called the SARI model (Phillips & Frederick, 1995). During stage one, the “S” stage, treatment activities focus on strengthening and stabilization, and ego states are used primarily to promote ego strengthening. Stage 2 “A” phase follows with a dual focus on activating the sources of

self-division difficulties while activating inner resources that can reduce dissociation and provide reconnection. During stage 3, the “R” stage, ego states help to reconnect with dissociated elements of traumatic experiences including trauma-related ego states and to resolve posttraumatic symptoms. In the final fourth “I” stage, the client is helped to integrate work initiated in earlier stages as well as to move toward personality integration. Throughout the use of the SARI model, the practitioner must organize therapeutic experiences in alignment with the goals of each stage.

Since this ebook primarily builds on Jack and Helen Watkins’ model of ego-state therapy, the section that follows begins with hypnotic methods and concludes with a review of nonhypnotic methods.

## Hypnotic Approaches

As Gordon Emmerson (2003) points out, hypnosis and ego-state therapy share an important symbiotic relationship. Without hypnosis, ego-state therapy provides theory and technique but does not provide access to the full range of states and possibilities for healing. Ego-state therapy also provides an excellent platform for using hypnosis in many complex and effective ways. For more general information about hypnosis, how to introduce hypnosis to clients, and how to use various inductions, please see Phillips and Frederick (1995), Frederick & McNeal (1998), and Phillips (2000).

*(1) Ideomotor signals* can be used to elicit information about ego states related to a particular problem or even to communicate with ego states that are non-verbal or preverbal as well as those that can interact verbally. This method involves linking different fingers to represent “yes,” “no,” and “I don’t know” or “I don’t want to tell you.” No formal hypnotic induction is really necessary. It is helpful to explain to clients, however, when asking them to allow the unconscious to identify the signals, that although the finger movements in response to various questions may seem “chosen” consciously, the impulse to identify a particular finger remains unconscious.

This method can prove invaluable when communicating with ego states that manifest somatically or symbolically. An example of this benefit occurred with Mary, age 42, who exhibited a series of musculoskeletal symptoms including neck and shoulder pain that did not respond to chiropractic, acupuncture, relaxation or other appropriate treatments and disrupted her sleep. When we explored the source of these symptoms using ideomotor signals, Mary’s finger responses indicated the presence of a state named “Protector” who believed he had to put on armor to protect the core of the body from being violated, as he had learned to do during childhood when Mary had been sexually abused by her next door neighbor.

During several sessions, Protector was helped to see that his “armoring” was no longer needed since the danger had stopped long ago. With encouragement, Protector

adopted a new way of protecting the body by voicing concern when he feared Mary was in a situation where her boundaries were not being respected. This more mature communication allowed Mary to evaluate potential threats and make more effective decisions about dating and participating in social settings. Gradually, Protector shifted from nonverbal somatic fear responses to verbal interactions with the therapist and with other internal states. As this shift occurred, all of Mary's physical symptoms resolved.

(2). *Imagery and Hypnotic Suggestion.* Imagery is usually an effective method for finding and working with ego states. Most clients are familiar with imagery and feel relatively safe using it. Occasionally, clients with key ego states who are young child parts, however, appear to resist suggestions related to imagery. Usually these reactions are related to concrete thinking stages of development. Ego states that evolved during these developmental windows may actually be unable to understand imaginal suggestions. It is also important to note that more common forms of resistance may include self-protection from exploring dissociated trauma experience, which might be outside the client's window of tolerance.

Kevin, a client with severe attachment disorder, was interested in hypnosis to help him with a series of failed relationships with women. When we discussed the use of hypnotic ego-state therapy, Kevin was eager to try this method. "I've tried many forms of 'talk' therapy, and none of them really helped me. I'm hoping this will because I have a constant battle going on inside myself."

We agreed that we would begin with an inner journey to find the ego state(s) that might provide support and confidence before we sought those that were related to the panic he felt whenever a woman moved to close to him physically and emotionally. After a session or two completing his history with a special focus on early and latency attachment experiences with family members and introducing him to hypnosis, Kevin felt ready to begin inner work.

As part of the hypnotic induction, Kevin was asked to imagine himself on his favorite running trail. There was a long pause, and then an unmistakably young voice said, "I don't know how to do that and I might get lost." Follow-up questioning revealed that one or more parts were feeling confused and scared. Subsequent dialogue continued:

Th: "I'm glad you can tell me how lost you are feeling. Can you tell me how old you are?"

K: "I'm about 5 years old. I don't understand how I can be here with you and at the same time be outside running."

Th: "I'll bet you're very good at playing pretend games. Do you know how to play pretend?"

K: "Yes, I used to play all the time with my sister. Is this a pretend game?"

Th: "That's right, it is! Can you pretend that you are running as you do every morning?"

K: "Sure, that's easy. I'm at the first curve now."

After this exchange, Kevin had no difficulty responding to suggestions that as he continued to run, he would feel more and more relaxed and safe inside. The session continued with ways of communicating with "the runner," who liked to be in his body feeling strong and solid. For the rest of therapy, imagery approaches were good resources in therapy and allowed him to find several important ego states that helped to improve his current attachment experience.

One imagery technique that is especially helpful in ego-state therapy is the dissociative table technique. This method was developed by George Fraser (1991), The first step is to create with the client's input an inner place which contains a table around which various parts of the personality will gather. Settings may vary, ranging from a deck overlooking the ocean to a secured inner room.

After the client describes the table and the number of surrounding chairs. Suggestions for safety are given first followed by the approach of various states within the self who want or need to be included in the "meeting." Sometimes the client responds immediately to the invitation for parts of the self to come to the table and can describe each part distinctly. For other clients, help is needed with detailed inquiry of the client's awareness and encouragement of the process of coming together. It is not uncommon for ego states to demonstrate varying degrees of participation, with some parts claiming places at the table while others linger in the background or state that they are not ready to participate directly.

Usually, it is a good idea to clarify rules of engagement, including the identity of an inner leader for table discussions and interactions. I find it helpful to rotate leaders once a basic table protocol has evolved, which often promotes integration and collaboration. Also important is the structure of how to determine which ego state will speak at a given time. Such techniques as passing a microphone or talking stick, using go-betweens to talk for parts who are not able or willing to speak directly, or shining a spotlight on the speaker can be helpful.

The agenda for any particular meeting needs to be set with the therapist's participation and support. Periodic interaction with the ego state leading the meeting gives the therapist understanding of what is transpiring, how and what various parts contribute to agreed upon tasks, and an opportunity to make sure the meeting concludes with clear understanding of how agreements reached will be carried on outside of sessions. As inner cooperation become more automatic and complete, the practitioner can become



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less directly involved during sessions, and clients can be invited to conduct unsupervised table sessions on their own.

For more information, please visit [www.empty-memories.nl/dis\\_91/Fraser.pdf](http://www.empty-memories.nl/dis_91/Fraser.pdf), <http://www.informaworld.com/smpp/content~db=all~content=a903929956~tab=citations>, or <http://linkinghub.elsevier.com/retrieve/pii/S0193953X05000985>.

**3) *Hypnotic Age Regression or Age Progression.*** If you are trained in hypnosis, you are well aware of these two time oriented methods to explore past history as well as to orient to future possibilities.

Regression techniques used to elicit and work with ego states are too numerous to specify in this format. Some of these include visual techniques of looking through the pages of a photograph album, watching a home movie, following the rope of time, or riding the train “of time” back to prescribed events or time periods.

Since not all clients respond to these strategies, it is important that the professional be acquainted with additional techniques. One important method is the affect/content/somatic/resistance bridge technique. The affect bridge was developed by Jack Watkins (1971), which was later modified to include somatic bridging.

The **affect bridge approach** requests that the client bridge from an unwanted emotion of unknown origin such as fear or rage back to an event or time period that can provide understanding of how the intense affect began to develop. Suggestions can be quite simple. Following a basic hypnotic induction (Phillips & Frederick, 1995) and exploration of the emotional state in current time, the client is asked to let his/her mind drift back to a time when similar feelings were “first experienced” or to an earlier time with significance for the client’s current concerns. Ideomotor signaling or imagery, as well as age regression techniques can be used to deepen and expand client focus.

**The somatic bridge approach** is very similar, placing the focus on bridging from an unwanted somatic experience in the present time, such as pain, tinnitus, or vertigo, to a past event or time period that can provide further information about the origins of the symptom and ways of resolving it. The practitioner might say, once the client has created a comfortable state of hypnosis, “Just take me back in time with you to a time or place where you had the same or similar sensations in your body.”

**The content bridge technique** operates similarly, with focus placed on bridging from an experience that is activating or distressing in present time to an event in the past that provoked similar reactions.

Gordon Emmerson (2001) has created a similar technique, which he calls the **resistance deepening technique**. This is used when the client cannot seem to create

a hypnotic technique due to some unknown resistance or barrier. Rather than trying to avoid the resistance, another possibility is to explore the resistance as a way to deepen the hypnotic experience.

Beginning with an induction that is comfortable the client, the client is then asked to explore the state of any resistance and its cognitive, somatic, emotional and symbolic components. A recommended question is “tell me *exactly* what you are experiencing right now.” If no “resistance” is indicated, a follow-up question might be, “It’s good that you are feeling comfortable right now. I wonder if you are also aware of anything keeping you from letting go more completely. If so, can you tell me what your sense of that barrier might be?” Another effective question is, “Where in your body is the least relaxed part?”

Depending on how the client responds, the treating professional can help the client search further using a body scan or similar technique, or continue on with the planned hypnotic focus for that session if the client responds that no barrier is present. Continuing to track the client’s inner experience will usually lead to another moment of resistance, which can then be more easily explored.

When the client is able to identify a sense of resistance, the next step is to invite the client to go deeper into whatever reaction seems to be linked to the feeling of resistance. For example, if the client reports tightness in the abdomen, it’s possible to explore the tightness first as the client currently experiences it. Then, the client can be invited to “go into the tightness that is inside the tightness” or asked, “Is there any way that you can turn up that sensation even higher so that you can really feel what is happening right now?”

Sometimes the client will indicate indirectly that there is an ego state issue, stating for example, that some part inside is having trouble letting go of control. At that point, it may be a good opportunity to ask to speak to that part, asking the client to signal when that part seems ready to communicate.

The use of age progression to help the client orient to positive future possibilities is extremely useful with clients who demonstrate significant fragmentation or ego-state conflicts related to trauma and either have very negative views of the future or cannot think of the future at all. It is extremely important to plant the idea that a positive view of the future can be developed over time. Often, clients helped to do so will comment, “I never expected to be alive this long and now I am creating a life that makes me want to live as long as possible.”

Techniques for age progression include structured hypnotic methods such as Erickson’s “crystal ball” technique where the client is invited to imagine a crystal ball and to look in that ball to discover something about what will be different when their treatment is completed. A similar example is suggesting that the client can imagine riding a train that

is traveling into the future, looking out the windows to identify the new surroundings that may surround them, as well as nonhypnotic ways of inquiring, “How do you imagine the next phase of your life when the problems we are struggling with now will be more fully resolved?”

We have written elsewhere (Phillips & Frederick, 1992) about how the client’s negative views of the future can offer prognostic indications about what level of ego-strengthening is needed, or about adjustments that can further strengthen the therapy alliance or the treatment framework. Similarly, the client’s ongoing use of positive age progressions can be viewed as an indicator of more adequate ego strength.

#### *4) Indirect, Naturalistic, or Conversational Hypnosis.*

Indirect approaches, popularized by Milton Erickson, are used when there are important cautions about the use of more formal hypnotic approaches. Common concerns include the possibility that a fragile or deeply depressed client may become further destabilized, that clients with poor internal boundaries might become flooded with too much undefended internal experience as hypnosis brings down internal barriers, or that highly anxious clients become obsessed about how hypnosis will work or has performance issues about “doing it right.” In the latter case, psychoeducation can help the client better understand what to expect and so demystify the hypnotic process.

If the professional encounters these or other concerns, indirect hypnosis can be used effectively provided that the practitioner is trained in this approach as well as in ego-state therapy. The advantage of indirect methods is that they can help introduce the client more gradually to hypnotic principles and prepare them for more formal techniques.

Metaphor and storytelling can be introduced in a nonthreatening way to facilitate rapport, deepen internal communication, and permit clients to respond comfortably at their own pace. Metaphors can also be used to “seed” an idea that might be threatening or challenging, implemented by an associational bridge that is more closely related to the client’s problem, offering strategy for resolution, and then reinforced with more direct communication (Phillips, 2001).

One such metaphor is a story that develops the imaginal experience of a tree with deep, strong roots. No matter how hard the winds shake its branches or storms threaten its stability, the roots hold the tree securely as it moves through seasons that present different challenges. To deepen this beginning stage of hypnosis, suggestions can indicate that although each tree has different roots, appropriate for its needs, the roots for all trees work in the same basic ways. An associational bridge can then imply that even though the client does not currently feel a sense of inner safety and security, his/her own creative mind can serve as the roots of the tree, providing invisible, deep

possibilities for support during times of turmoil. If the client responds well to these kinds of metaphorical suggestions, more direct suggestion can then be used to evoke inner safety (Phillips, 2001).

Another Ericksonian technique used with clients who demonstrate divided self difficulties is the principle of utilization, which requires the professional to accept all the symptoms, reactions, behaviors, and attitudes of the client, no matter how dysfunctional or negative they might seem, as potential assets and resources in the treatment process. Rather than requiring the *client* to make immediate change, it is the treating practitioner that must change his/her style, technique, or expectations to meet the client more fully.

For example, many clients are overwhelmed with somatosensory flashbacks related to childhood sexual abuse that make it difficult for them to have positive intimacy experiences. Some approaches might immediately focus on eliminating these symptoms or on analyzing their origins. An Ericksonian approach, however, would help the client utilize these symptoms in order to help stabilize functioning. Suggestions might include ones that encourage the client to utilize the onset of flashbacks to modify their expectations of their activity level, as cues that they need to create different somatosensory experience through exercise, yoga, or other more neutral or positive experience.

For additional information about appropriate Ericksonian methods that can be used in ego-state therapy, please see Emmerson (2003), Hartman (1995), Phillips (2000), Phillips (2001), Phillips & Frederick (1995), and Frederick & McNeal (1998).

## Nonhypnotic Methods for Activating Ego States

Recently, ego state therapy has evolved into a multi-modal model of change as other schools of psychotherapy have explored ways of eliciting and working with ego states. Although we will revisit this issue more thoroughly in chapter 4, this section features two nonhypnotic methods to augment our current discussion.

*EMDR Ego-State Therapy* offers one creative way of approaching work with ego state conflicts and problems. It is important to note that this method is designed for professionals well-trained in treating trauma and dissociation, in ego-state therapy, as well as in *EMDR (Eye Movement Desensitization and Reprogramming)*.

After introducing ego-state therapy and EMDR with bilateral stimulation (BLS also known as Dual Attention Stimuli—DAS), it is important to begin with targets for ego-strengthening, such as creating an inner sanctuary or safe place. When appropriate to begin accessing ego states, this process can be introduced in a very simple way to

allow the client to connect with conflict-free ego states that can help the therapeutic process (Phillips, 2007):

Th: “We’ve talked about how you believe that your anxiety difficulties emerge from a terrible struggle inside. As a way of getting started, let’s find and connect with a part of you inside that can help you find some of the resources you need to solve this problem. Can you identify one of the resources that might help you resolve some of your anxiety symptoms?”

Cl: “I think I need to find a part of me that feels more confident.”

Th: “That’s an excellent idea. Can you recall a recent time when you felt confident?”

Cl: “Yes, at that big meeting at work last week, I felt really prepared when I gave my presentation. I received lots of positive feedback and that felt really good.”

Th: “OK, so just focus on that scene and the feelings and sensations that go with it and let’s ask that a part of you inside, that is connected with that feeling of confidence, come forward during the next set of bilateral stimulation and let us know how he can help.”

In later stages of work, similar approaches can be used to explore past traumatic events related to the client’s problems, to create corrective healing experiences, and to promote personality integration. For comprehensive information about this approach, please see *Healing the Heart of Trauma and Dissociation with EMDR and Ego State Therapy*, edited by Carol Forgash and Margaret Copeley.

*The Empowerment Dynamic* is an updated version of the Karpman triangle, developed by Dr. Stephen Karpman, who suggested that the roles/ego states of victim, rescuer, and persecutor help to explain addiction to the drama of trauma. David Emerald has transformed these three roles into creator, coach, and challenger to demonstrate how individuals entrenched in the role of victim can focus on creating the lives they want vs. fixating on what they do not want, how “rescuers” can learn to coach others by helping them to focus on their strengths rather than maintaining powerlessness, and how perpetrators can become challengers instead of abusers.

Individuals for whom other forms of ego-state therapy may not be appropriate can easily explore this model in a self-paced fashion. The empowerment dynamic (also known as the power of TED) can be applied through reading, journaling and/or discussion of *The Power of TED* book, by working with the TED workbook or ebook, and by visiting the website to view excellent explanatory videos and podcasts. For more information, visit <http://www.powerofted.com/index.html>.

Letter Writing and Journaling can be invaluable aids to ego-state therapy. Many clients who do not respond to hypnosis or other methods, can be helped to activate key ego states by writing a letter from the adult self to the self part that is connected to specific symptoms, to ego states connected to general helplessness, fear, anger, or despair, or to aspects of self during a particular time period of the client's life. This letter is written outside of sessions, shared with the practitioner and can serve as springboard to more formal ego-state work. Once the first letter is completed, a second letter might be written by the ego state back to the adult, sharing feelings and other information, and requesting specific forms of support.

## Guidelines for Forming Therapeutic Alliances with Ego States

Claire Frederick (2005) has identified several general principles that can facilitate forming, maintaining, and strengthening effective alliances with ego states. These include:

- 1) Therapist persistence in communication efforts that express flexibility, empathy, energy, and create a safe holding environment that can repair attachment and developmental deficits.
- 2) Resonance with the client's whole personality and with individual ego states by attuning to and feeling with the client. Therapists who do this work need to be mindful of the danger of compassion fatigue and burnout and to obtain adequate professional consultation and support as well as providing for good balance in their personal lives.
- 3) Interactive trance that allows the professional to tune into his/her unconscious participation in the relational field and to allow his/her own ego states to interact in healthy ways with those of the client. Successful management of transference and countertransference issues allows the practitioner to experience, identify, and meet the multi-dimensional needs of the client's ego states. This can create a positive "countertransference trance" (Phillips, 1994).
- 4) Remembering that alliances with the client's whole personality, and with ego states provide models for alliances that can develop among ego states and move them toward integration. Relational experiences need to include empathic and transitional elements, renurturing, and interactions that clarify and strengthen boundaries.
- 5) Offering support for deep emotional connection with the treating professional that includes mirroring which accepts the client absolutely and unconditionally and allows for idealizing of the therapist and even emotional twinship, while also fostering independence and autonomy.

## Summary

Ego-state therapy can help to widen the window of therapeutic possibility for clients who have severe trauma in their backgrounds as well as by individuals who have more minor unresolved trauma and seek the resolution of troubling symptoms. The flexibility, comprehensiveness, and depth of ego-state therapy allows many individuals who might not otherwise be able to make good use of treatment, to achieve permanent change.

This chapter is best used by adding the rich resources included in the text and in the bibliography at the end of this e-book.

## Designing Symptom Resolution and Corrective Experiences That Utilize Neuroplasticity and Facilitate Integration:

### Chapter 2

#### The Neuroplastic Brain and Ego State Therapy

Ego State Therapy offers great potential for healing the mind, the body, and the spirit. We think about its healing effects on the body with concepts such as “the transformation of ego states,” “integration,” “modified reactions to stress”, “the reduction/elimination of pain”, and “recovery from a host of mind-body based physical illnesses”. One of its most momentous effects, however, is the production of profound changes in our brains. We are living in the era of “the brain.” Neuroscientists of the 1960’s and 70’s and beyond have shown that our multiminds are encoded within our central nervous systems and that the brain is more plastic and malleable than we ever guessed .

The development of the brain is “use-dependent” (Cozolino 2002; Perry, 1997; Siegel, 1999; Schore,. 2003). This takes us to the very heart of how ego states are formed. Patterns of affects, somatic sensations, cognitions, and behaviors become encoded in our brains as ego states because what is fired together (neurons) eventually becomes wired together (Cozolino, 2002; Doidge, 2007; Siegel, 1999).

There is abundant evidence from the application of non-linear child development studies and neurophysiologic studies that ego states have a neurologic presence in the brain. They are not “just metaphors.” They are aspects of our selves that are physically and biochemically established in our brains as well as our minds:

“Siegel uses the theory of non-linear dynamics of complex systems (a collection mathematically derived principles that govern the behavior of various physiochemical systems such as aggregates of molecules, etc.) (Boldrini, Placidi,

& Marazziti, 1998) to understand “parallel distributed processing” and “connectionism” as they apply to states of mind. Systems viewed from the standpoint of complexity theory have three basic characteristics: They are self-organizational, non-linear, and they develop emerging patterns which have periodically or continually recurring characteristics” (Frederick, 2005, p. 244).

Our concepts of what we do with Ego State Therapy have expanded. We live in an era in which we are becoming increasingly aware that psychotherapy changes the brain itself:

“ Neuroplasticity is the concept that the brain can change itself through thinking, behaviors, and learning as well as exercise, attention, novelty, and surprise. All of these activities have the ability to turn genes on and off, thus shaping the anatomical configurations of the brain, but also human behavior, our emotions and cognitions, and at times our motor and sensory abilities” (Frederick, 2009a).

Since the 1990’s there have been increasing numbers of reports that therapy can produce changes in the brain. These include a variety of neurophysiological studies such as regional cerebral blood flow (Yamanishi, Nakaaki, et al., 2009), cerebral glucose metabolic rate (Schwartz, Stoeddel, et al., 1996), electroencephalographic (EEG) studies (Thase, Simons, & Reynolds III, 1996) and neuroimaging (Baxter, 1992). Studies have also shown that medication changes brain physiology in similar ways (Schwartz, Stoessel et al., 1996). Additionally, Reinder, Nijenhuis et al., (1997) were able to find different brain imaging patterns with different alters of a person with Dissociative Identity Disorder (DID). Neurophysiologic studies about the impact of psychotherapy and medication on individual ego states still need to be done. However, currently we have many reasons to believe that when we use Ego State Therapy, we are changing the brain itself. Indeed, it has now been demonstrated that our interventions actually allow genes to turn on and off and express themselves in ways that permit the neuroplastic changes to take place ([www.ernestrossi.com](http://www.ernestrossi.com)). The Rossi’s have created the Psychosocial Genomic Research Group ([www.ernestrossi.com](http://www.ernestrossi.com)) which is dedicated to the ongoing pursuit of evidence about the genomic – neuroplasticity-psychotherapy connection.

### **Integration as the Alpha and the Omega of Treatment**

Integration is neither something that just happens out of the blue, nor is it a miraculous coalescence of the elements of the BASK Model (Braun, 1988 ) that we only need address as we are in the last phases of a phase-oriented treatment model such as the SARI model (Phillips & Frederick, 1995). Integration is both a process and a normal human function and not a single event that is going to happen one day in a therapy session (although it may be conceptualized to be that way by some of our patients). The SARI Model is a dynamic one, and actually encourages work toward integration from



the very beginning of therapy. Integration is the goal toward which therapy must be directed from its very beginning. Several principles need to be in place:

- **Initial Work:** The therapist introduces the concept of integration very early in treatment. We use the Cooperation Principle (Gilligan, 1987) to discover and individualize the metaphors we may draw on to help the patient understand what integration is. For example, the idea of an orchestra playing in harmony might be helpful for a patient who is musical; a working Internal United Nations, for someone with interests in government and political affairs, etc. However, it is not sufficient to introduce the concept. The process of ego state work needs in some way to be explained as well.
- **Ongoing Work:** The presentation of models of integration and how the process works to the patient is not a one-time event. Like good teachers, we remind our patients about the model and the process, and, when relevant, even help create additional models. Within the framework of the therapeutic alliance the therapist is also able to model integrating work with the parts and to encourage the patient to work with his/her internal family on an ongoing basis every day. Traumatic transferences and developmental issues often distort or negate the model with certain ego states. Some parts need to be ego-strengthened, worked with developmentally, and/or have certain trauma material resolved before they can even comprehend how to move to certain essential parts of the model such as communication, cooperation, and empathy.

## Clinical Example

Judy, age 26, was preparing to do graduate studies in marine biology, had had untreated symptoms for seven years. She had had many hospitalizations, arrest, inpatient rehab programs, and psychotropic medications. She reported memory difficulties, losing time, depersonalization, derealization, identity confusion, and identity alteration and was relieved by the diagnosis of Dissociative Identity Disorder. She was terrified of the part of her that sought alcohol and acted out.

When she told the therapist she wanted that part destroyed, Judy was told that every part was important and deserved our care and attention. Integration did not entail destroying any part of her. The therapist described integration and talked through to this part. Judy was able to access that part. She learned to her surprise that this powerful part, "I'm the Greatest," wanted to help her. As she had been sober for several months, the part realized for the first time that alcohol was not needed for them to have contact.

The therapist worked with this part and the presenting part so that within the safety of the therapeutic alliance they were able to make some agreements about access to one another and the need for safety and appropriateness when "I'm the Greatest" was

executive. This pathway to integration was explained to both parts. As they communicated more with one another, they would eventually understand one another more and more. Their relationship would deepen as they worked like a team. Eventually they would simply “know” what was going on with the other and would be able to carry out projects in seamless harmony.

This brief therapeutic honeymoon was interrupted when the therapist reminded them of the reality that there were other parts there that neither of them liked that need to be brought into the team as well. “You don’t mean those children? I hate them!” They both exclaimed similarly. The explanations about the integrative process resumed. “I didn’t say it wouldn’t be work,” the therapist said at the end of the session. “It will be, but you can do it, and I will help you.”

## **Symptom Resolution**

### **The Importance of Symptom Resolution**

Integration and the general success of treatment are also connected with the presence of transtheoretical effectiveness factors in treatment (Amundson, Aladdin & Gill, 2003). Early symptom relief is a powerful effectiveness factor. Norcross (2002) discovered that empirical data about the psychotherapy relationship revealed certain effective features that play important role is the success of all psychological treatments. They include:

- the therapeutic alliance,
- cohesion in group therapy,
- empathy,
- goal consensus, and
- collaboration.

Additionally, “Promising and probably effective features include; 1) positive regard, 2) congruence/genuineness, 3) feedback, 4) repair of alliance ruptures, 5) self-disclosure, 6) management of countertransference, and 7) the quality of relational interpretations. Adapting or tailoring the therapy relationship to specific patient needs and characteristics (in addition to diagnosis) enhances the effectiveness of treatment” (Oster, 2003, p. 8). It is vital that the therapist model as well as encourage these themes and standards in the relationship of ego states with one another as well as in the psychotherapeutic relationship.

Helping patients with symptom resolution brings vitality to therapy, improves the therapeutic relationship, and has the potential for changing the belief systems of the ego states. It also amplifies the expectation that treatment will be successful. The increased mastery patients experience becomes exponential when we teach them how to use some of the variety of techniques now available to us (self-hypnosis, somatic

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experiencing, sensorimotor techniques, EMDR, energy therapies etc.) to help themselves during the courses of their lives outside of therapy.

### **Symptom Resolution with Ego States and the Greater Personality**

Some of the symptoms that need to be addressed early on are:

- **Flashbacks, Hyperarousal/Freeze Responses, and Anxiety**
- **Sleep Disturbances**
- **Depression**
- **Pain and Fatigue**

A variety of techniques can be enlisted to relieve these symptoms (Phillips & Frederick, 1995; Frederick & McNeal, 1999). They include self-hypnosis, and meditation techniques (particularly mindfulness), energy therapies, EMDR, sensorimotor techniques, somatic experiencing, Qui Gong, Yoga, and physical exercise. Additionally, patients can be encouraged to get physical exercise, eat a good diet, and use available ancillary resources such as appropriate medical care, evaluation for appropriate psychotropic medications, acupuncture, chiropractic, and massage.

Ego-strengthening should be used with every patient (Frederick & McNeal, 1999; Phillips & Frederick, 1995). Among the most powerful ego-strengthening techniques is the activation of Center Core phenomena that come from the conflict-free sphere of the ego (Frederick, 2009; Frederick & McNeal, 1999; Phillips & Frederick, 1995). We recommend that they be employed frequently. These will be the major topic of discussion in Chapter Three of this book.

**Hyperarousal/Freeze Responses, and Anxiety:** Flashbacks and hyperarousal/freeze responses are symptoms that need to be addressed without delay. They are trauma reactions and communications about the current state of the patient's mind-body. Individuals in trauma reactions are functioning at subcortical levels (the blood supply to the cortex is diminished), and have difficulty with cognitive processing. The therapist helps the patient to identify and "label" what is happening with the mind-body. This followed with early interventions for relief of these symptoms. This kind of early symptom relief also strengthens the therapeutic alliance. The next goal is to help patients learn to control their symptoms: The therapist teaches the patient how to remove or mitigate the symptoms in the session and encourages their use as a continued form of self-care in their everyday lives. From a long term perspective we are helping patients eliminate these symptoms permanently through gradual changes in the neuroplastic brain which is learning new ways to react.

## **Flashbacks**

Many of our traumatized patients who have flashbacks have ego states that may already be in a negative trance state that is negative. At such time de-hypnotization is called for and can lead to both symptom relief and a mastery experience for the patient.

### **Clinical Example**

“Alice, Alice **[the therapist may have to repeat and speak more loudly in order to pull the patient’s attention away from the trauma focus]**. . . Alice, tell me five things you see **[the patient begins to focus away from the trauma material in order to identify the five things and tell the therapist about them]** **When the patient has completed the task, the therapist then speaks again,** “ Good, you’re doing great. Now tell me five things you hear...**[ the patient next reports on five things he/she feels. This is repeated with requests that the patient report four, then three, then two things seen, heard, and felt.]**  
Should the negative trance not be completely broken, such maneuvers as shaking the arms, legs, fingers and toes can be useful, as can deep knee bend and jumping jacks.

**Depression:** Depression is frequently associated with post-traumatic and dissociative symptoms. Its elimination is highly desirable because depression constricts cognitive abilities and reduces our capacities as problem solvers. Cognitive Behavioral techniques (Aladdin, 2007), ego-strengthening techniques (Frederick & McNeal, 1999; Phillips & Frederick, 1995), other techniques involving the body such as energy and various eye movement techniques, and medication all have the potential to change the neuroplastic brain and improve energy and cognitive abilities.

**Sleep Disturbances:** Like depression, sleep disorders are common in the post-trauma population. However, we should not assume that all sleep disorders are psychological. Ongoing or “treatment resistant” insomnia and/or disturbed sleep merits medical investigation to determine whether any physical causes such as sleep apnea are at play. Focused attention on helping the patient select which techniques work best is another important part of the symptom relief pattern. Quite frequently we discover that insomnia is the result of the activity of one or more ego states that are literally afraid to close their eyes.

**Pain and Fatigue:** While the maximum elimination/mitigation of pain and/or the restoration of energy might be goals in therapy that will require time to achieve, a number of early interventions, sometimes, “braided together” (Phillips, 2000), can bring relief, changes in belief systems, and help motivate patients to take further therapeutic steps. The detailed and creative use use of a sophisticated array of clinical applications including utilization techniques and Ego State Therapy with patients who suffer from

pain and fatigue can be found in Phillips (2000, 2007) comprehensive treatments of the subject.

It may be helpful to address refractory pain, fatigue, and many other mind-body problems through the lens of an Extended Strategic Model (Ginandes, 2002). Ginandes proposes that the first phase of treatment be devoted to cognitive, behavioral, and hypno-behavioral work (including utilization techniques). This will be useful to in symptom resolution with many patients. In the face of refractoriness or resistance to treatment, Ego State Therapy in an extended treatment framework becomes essential.

**Clinical Example:** Andrew, a 60-year-old mathematician sought help because he feared the pain of hip replacement surgery which was scheduled to take place in two weeks. He also had chronic pain from osteoarthritis which he had had for a number of years. An intelligent and educated man, he felt great shame at being such a “wus.” Andrew’s mother had been mousy and retiring; his father, a constantly complaining tyrant who never seemed to find anything Andrew did to be good enough. His father (deceased for a number of years) had walked with a limp and used a cane because of injuries sustained in a boating accident before Andrew was born. Assessment revealed that Andrew had both physical difficulties (arthritis) and signs and symptoms of a somewhat covert dissociative disorder, which placed a psychological overlay on issues related to his body, especially his skeletal system and musculature. Child parts had become frightened of not being able to carry the burdens of aging and panicked. In a single session Andrew was able to establish a healing dialogue with his deceased father. The “Father” ego state was affected by the interaction and made positive changes. “He’s jogging! He doesn’t have a cane.” Because of some previous experiences with direct, suggestive hypnosis for smoking cessation, a second session was devoted to direct suggestion and imagery approaches designed to prepare Andrew for surgery.

Andrew went through surgery and rehabilitation with stellar speed. He was amazed at what he had been able to do. However, eight months later, he returned to therapy complaining of difficulty managing the symptoms of osteoarthritis. As for preparation for surgery, he wanted his symptoms to vanish rapidly and permanently with direct suggestive hypnosis. When I explained to him again that learning to manage such symptoms adequately was a process with which I would be more than willing to engage with him in working out and would involve a certain amount of exploration, self-observation and self-care, he expressed disappointment. Andrew is considering his possibilities at this time. To resolve his difficulties, he will need to make a choice do some “heavy lifting” in therapy.

Most therapists have seen patients like Andrew. Symptom relief alone may be sufficiently helpful for a number of our patients. Yet for many “Andrews” the therapy

must deepen. Ginandes (2006) has described six ego states that seem to be present in treatment-resistant ego-state driven mind-body problems. They are:

1. **The Illness Ego State** is that part which presents as the symptom
2. **The Stone Walling Somatic Ego State** embodies deep unconscious resistance change. The reasons for the resistance involve such issues as protecting younger, frightened ego states and defending trauma material, as well as the gratification of secondary gain.
3. **The Inner Monitor Ego State**, a conflict-free part of the self that monitors the psychophysiological homeostasis of the body.
4. **The “Death-Longing Ego State”** is a part of the self yearns for release from the illness through death no matter how hard the patient may be working to sustain and improve life. It is frequently covert. Although observing and working with this part can be important when working with terminally ill patients, it is recommended that we not activate it. In some instances. However, it may appear spontaneously. When this happens we can work with it successfully. It is not malevolent.
5. **The Empowered Healing Guide” Ego State** knows what is needed for restoration of health. It has deep knowledge and is related to other archetypal self objects such as Inner Wisdom and Inner Strength (Frederick & McNeal, 1999; McNeal & Frederick, 1993).
6. **The “Therapist as Healer” Ego State** resides within the therapist. It often mirrors or is activated by the Empowered Healing Ego State. It usually emerges during a mutual healing trance state in which both patient and therapist are involved (Gilligan, 1987).

### **Corrective Experiences in Ego State Therapy**

The term “corrective emotional experiences” was created by the psychoanalyst, Franz Alexander (1930) for experiences, other than insight, that were needed to catalyze healing. There is no way to separate corrective experiences from the entire fabric of therapy: the therapeutic alliance provides corrective experiences, ego-strengthening often a corrective experience, and symptom relief itself can provide correction because it may change the patient’s internal structure and internal self-perspectives (Frederick & Phillips, 1999); Watkins, 1992).

We can, however, look at corrective experience through several lenses, each of which has the potential to be helpful in our focus on the patient's needs. They may blend with one another to some extent. They are:

1. The Discovery and Utilization of Resources
2. Corrective Developmental Experiences
3. Correction of Special Problems (for example, such as those presented by silent or hostile ego states), and
4. Other corrective experiences such as uncovering trauma, expressing strong emotion, abreaction, creativity, spirituality, energy therapies, Somatic Experiencing, and so forth.

Corrective Developmental Experiences and Special Problems will be considered in Chapter Three. In this chapter we will reflect on several kinds of corrective emotional experiences that do not easily fall into the other categories.

**The Discovery and Utilization of Resources.** Although resource identification and utilization can be considered within the greater category of "Ego-Strengthening," the discovery of previously unknown resources within oneself (Frederick & McNeal, 1999; Erickson, 1980; Gilligan, 1987; Phillips & Frederick, 1995; Phillips, 2007), particularly when properly framed by the therapist, can alter profoundly the patient's view of his/her own capabilities to deal with life.

### **Clinical Case Example**

Ned, an astrophysicist, had a chaotic employment history and was having difficulty getting a job. Although he had self-diagnosed himself as having a Borderline Personality Disorder, he describes sporadic occurrences of very regressed behavior on the job. His presentation in the office was one of extreme discomfort, vigilance, suspicion, and sadness. He did not seem able to be able to make himself comfortable. Ned and I worked together to see what he might be able to do for himself to gain greater comfort.

The therapist invited Ned to simply close his eyes and recall a time when he had been very successful. She suggested that he might want to revisit his college graduation (summa cum laude and a Phi Beta Kappa key), or the time he had been awarded a prestigious fellowship. Ned's posture began to relax, and a smile appeared on his face." After observing that Ned appeared to be comfortable, Ned was told that this was always part of him to which he could turn when he experienced distress. It was a part of him no one could ever take away from him." When Ned opened his eyes and returned to an outer focus, he described feeling quite different. He was relaxed and no longer sad. We

discussed this experience as now belonging to a repertoire of activities Ned was collecting for the purpose of calming and strengthening himself. Ned agreed to take the time to get in touch with this and other significant experiences of success in life.

The resource Ned had discovered was the positive past. The use of the resources of the past, the present, and the future, can be corrective in patient's beliefs about how helpless they really are, whether they have any power, and whether they can manage outside the therapy session (Frederick, 2005; Frederick & Phillips, 1992; Frederick & McNeal, 1999; Phillips & Frederick, 1992, 1995; Phillips, 2007).

### **Abreaction**

“Abreaction has played an important role in the history of Ego State Therapy (Watkins & Barabasz, 2008; Watkins & Watkins, 1997, 2000) as well as in the history of the treatment of trauma and dissociation. It remains a controversial topic for some. There are two very different perspectives: One is featured in Watkins (1992) and Watkins and Barabasz (2008). It continues the Watkins' view (1997, 2000) that abreaction is essential for recovery in Ego State Therapy when trauma issues are present.

The other, espoused by Kluff (1982, 1989), Gold (2000), Phillips and Frederick, Frederick and McNeal, and many others, is that “full bore” abreactions are frequently undesirable and can be retraumatizing. They have the possibility of destabilizing the patient. Some think they should be avoided whenever possible and replaced with trauma material access that allows the patient to metabolize it without destabilization or ‘trauma addiction.’

The Watkins (1992) model is connected with classical Freudian psychoanalysis of the 1960's and earlier and is based on a therapy model that uses Helmholtzian energy concepts to explain both how the human personality is constructed, as well as how changes in therapy take place. Contemporary psychoanalytic models offer different explanations about the structure of the personality and what therapy accomplishes. The Guidelines of the International Society for the Study of Trauma and Dissociation (International Society for the Study of Trauma and Dissociation (2005) echo Phillips and Frederick's (1995) insistence on careful planning of abreactions, emphasis of using different levels of affect, and attenuating abreaction material through fractionation as well as their concern about destabilization.

Perhaps more importantly, the fields of trauma and dissociation have shifted emphasis from trauma alone as the causation of ego-state problems to more contextual (Gold, 2000) and relational perspectives (Courtois & Ford, 2009). Attachment dynamics as well as other psychosocial elements are considered to be as important, and often more important, than trauma alone as causative and or contributing agents in ego state pathology” (Frederick, 2009 d).



Nevertheless, accessing trauma material can be a path for corrective experiences. What is new in the experience is that both parts that have carried the trauma and frightened standers by, as well as stronger adult parts, can be helped by the therapist to negotiate trauma material in different ways.

These include such corrective internal activities as internal confrontation of abusers by the stronger parts, arrest of abusers by an internal police force, bringing in Center Core phenomena that are not frightened by the traumatizer, or even removing traumatized parts from the scene to a place of safety. Some therapists lend themselves to help in these inner imagery scenarios. From a behavioral standpoint, these carefully planned and limited visits to trauma material permit the patient to become desensitized to it.

**The silent abreaction** (Watkins, H. H., 1990) was created to give patients a path for expressing the kind of pent up rage that is often released in classic abreactions. In this technique, the patient is guided by the therapist to travel to a remote rock formation, ascend to a place where there are many rocks, and to use a sledgehammer to smash the rocks. As this happens, the patient is encouraged to internally shout, utter expletives and so forth: to vent emotion within).

The therapist acts as a cheerleader. When the patient reaches a point of exhaustion, the therapist asks him/her to think of one good thing. This is essential. It helps the patient leave negative and potentially destabilizing emotions, contain them, and leave them. In Watkins' (1990) script, she then invites the patient to take a walk with her into a calming and peaceful scene. To be able to access strong negative emotion, express it in a controlled way, and put it back in its place is a major achievement. The silent abreaction is a powerful corrective experience. With it patients can learn through practice to master affect expression, affect containment, and discover that they are able to move into positive feelings when they choose.

The array of corrective experiences is vast, but its continued exploration is an important element in therapist growth and development. It is always helpful for Ego State Therapist to learn to use other therapeutic modalities such as energy therapies, eye movement therapies, somatic approaches, and other approaches. These are often used within Ego State Therapy to provide corrective experiences.

In the following chapter we will look at developmental repair, how to deal with the special problems we face with malevolent ego states, the role of attachment in ego-strengthening, and how to expand the powerful Center Core phenomena that strengthen patients, give them wisdom, guide them, move them toward healing, and help them make the developmental advances so necessary for integration.

## **Developmental Issues: Maturation, Malevolent Alters, Attachment, and Expanding the Core Self Through Developmental Repair**

### **Chapter 3**

Integration cannot take place when parts are psychotic, silent and uncooperative, destructive, or developmentally incapable of appropriate relationship. A great deal of our therapeutic work with ego states provides corrective emotional experiences for them: Attachment problems are healed within the safety of the therapeutic alliance, through the alliance itself, alliances with other parts, and profound Center Core experiences. Mastery and control over trauma symptoms (including traumatic transferences) emerges, and healthy self-esteems develop. Parts learn to communicate with one another, to work together, and to develop empathy for one another. However, certain developmental issues often require specific identification and interventions: Trauma produces developmental arrests and cognitive deficits and cognitive errors.

Therapists must always assess the developmental levels of ego states. Are they verbal or preverbal, latency, adolescent, or adult? Look first at the behaviors the ego states display—then ask other parts about them in order to obtain an even clearer picture. Clues about the level of development are present in the speech tonality, sentence structure, content and interests, body postures, and the relationships of parts with the therapist and with one another. Child ego states present differently from adolescent ego states, and they have different goals as well as therapeutic needs. Certain developmental deficiencies require repair in order for certain ego states to be able to relate successfully with other parts and to resolve dependency issues with the therapist. Certain universal developmental needs frequently require specific interventions:

Object Permanence (Piaget, 1954) is a developmental milestone. When it is present an individual can be identified as the same person over time and within different settings and presentations. Ego states that do not have object permanence may act confused or disoriented about who the therapist really is from session to session. Clues about this can be found in how the ego state perceives the therapist. Statements such as “Who are you?” within the context of the therapist having met the part earlier suggest object permanence difficulties. When parts ask “are you there?” therapists frequently interpret this as a sign of insecurity or dependency. Careful questioning is called for in order to determine whether it may a sign of object permanence problems. There are specific hypnosis exercises that can foster the development of object permanence (Baker, 1984), which are described and explained in great detail both in Frederick and McNeal (1999) and Fromm and Nash (1997).

Object Constancy when achieved allows the individual to perceive both desirable qualities and undesirable qualities as being contained within the same person. Ego states that have not accomplished this developmental task are frequently identifiable

when they manifest this deficiency by splitting the transference. The therapist is at times seen as an all-giving saint (over-idealizing) and at other times as a devil incarnate (degradation). Ego states with this developmental deficiency may often seek dual therapists. They are at risk for dropping out of therapy when they are only able to see the therapist as bad. Baker's (1984) hypnotic exercises are also helpful with this developmental task.

Attachment issues can be complex, are frequently intertwined with other developmental deficiencies, and often present as dependency in the therapy (Steele, van der Hart, & Nijenhuis, 2001). Attachment is one of the relational bonds in animals (Ainsworth et al., 1987; Bowlby 1979, 1988) that help us survive. Not only does it foster physical care for the newborn; it also is the path for the right brain development that is needed for affect development and regulation (Bowlby, 1988; Schore, 1993a, 1993b). Frederick (2005) adapted Steele, van der Hart, and Nijenhuis (2001) to summarize some rules about attachments in human relationships:

1. The object of attachment cannot be substituted. Once the bond is formed, replacements do not work.
2. Attachment bonds are enduring.
3. The relationship is always a significant one.
4. There is always a desire to be physically close to the attachment figure.
5. Involuntary separation causes distress
6. The primary goal of the relationship is to receive security and comfort from the object of attachment

Individual ego states within the same greater personality can have very different attachment patterns or styles. They inevitably manifest themselves in the transference and are reflected in therapist countertransference responses as well.

### **Patterns of Attachment in Clinical Practice**

- **Secure attachment:** The child is confident about the parent's responsiveness and availability/ knows the parent will be comforting and protective.
- **Anxious-ambivalent attachment:** The child is uncertain about availability and responsiveness as well as whether the parent will be comforting and protective. Patients with this kind of attachment style may be clinging, very much distressed by separation, and they are frequently frightened of their environments.
- **Anxious-avoidant attachment:** This patient expects to be ignored. He/she has no confidence that there are responsive people to be relied on for comfort and protection. This patient expects to be ignored or rebuffed and often attempts to live a life without love.

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- Disorganized-disoriented attachment: This attachment style is often seen in those who have been abused and/or neglected in childhood. Their behavior is confusing and erratic and they may give opposing messages to therapists simultaneously. We commonly see such patterns in patients with Dissociative Identity Disorder (DID)

The most powerful tool for healing attachment problems is the reliable, containing, nurturing therapeutic alliance (Frederick, 2005).

### **Cognitive Distortions and Deficiencies**

Therapists must always assess the realm of cognitive function with every part. Trauma can interfere with cognitive development and abilities (Fine 1990). Many cognitive distortions manifested by ego states are functions of failure to develop. They arise from the narcissistic level of development and from magical thinking as well as from the failures in abstract thinking. Further, Ego states may also entertain false beliefs that are instilled into them by traumatizers. These include (but are far from limited to) such beliefs as:

1. I really want to be abused.
2. I really like being abused.
3. I deserve to be abused.
4. If I tell about this I will be killed (or my family, friends, or pets).
5. I am bad.
6. Nobody else will love me (except the traumatizer).
7. Because of the abuse, I will never have a happy life

### **Special Ego State Problems**

#### **Silent Ego States**

Ego states can be silent (Frederick, 1994; Phillips & Frederick, 1995). This may be because the ego state has chosen not to speak, not to reveal its presence, and/or not to participate in therapy. Some silent ego states, however, are preverbal and lack the ability to communicate through speech. At times therapists become aware of silent ego states only because other ego states report their presence. Other evidence for their presence can be found in:

- Flashbacks
- Dreams

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- Hypnotic dreams
- Repeated patterns of behavior
- Unexplained feeling states
- Somatic symptoms

Silent ego states often express themselves affectively and/or somatically. Some silent ego states also manifest as symbolic, mysterious, and elusive ego states (Frederick & Phillips, 1996; Phillips & Frederick, 1995). These states are always ambivalent about whether they will make themselves know and communicate. The “mysterious” imagery is a communication from this kind of ego state and a signal that it wants its presence known to some degree.

The therapist can often capitalize on this ambivalence with “talking through (indirect Ego State Therapy), ideomotor signals, and to the many probable transference fears such states frequently entertain. Transference fears held by many silent ego states include (Frederick, 2005, 2008; Phillips & Frederick, 1995):

- Fear of being killed off by the therapist
- Fear of abandonment by the therapist
- Fear of retraumatization by the therapist
- Fear of consequences of facing trauma material
- Fear of fusion with or absorption by the therapist or other ego states.
- Fear that they cannot escape their abusers or escape sadistic ego states that are present within the internal family (Frederick, 2008). Silent ego states may be internally involved in a reenactment of the traumatic memory material, and sadistic, abuser ego states may also be warning them to be silent.
- Fear that the traumatizer will retaliate for revelations made by the ego state. Therapists must often exercise tremendous patience and persistence (Frederick, 1994, 2008; Frederick & Phillips, 1996; Phillips & Frederick, 1995) before frightened silent or symbolic ego states are willing to communicate with them more directly. An interactive approach in which the therapist gives feedback about noticeable changes in body reactions, changes in affect, or communication style can also be helpful (Frederick, 2008). Active psychoeducation about “how frightened children think and what they fear” is invaluable.

Dreams, programmed dreams, hypnotic dreams, automatic writing, graphic art, soft sculpture, hand puppets, and sand tray are other pathways for communication with silent ego states. Some of these techniques require special training and supervision.

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Once communication has been established, then the establishment of a therapeutic alliance is the highest priority. Many silent ego states eventually achieve verbal communication. A good number of pre-verbal states are fragments and their energy becomes naturally assimilated by the internal system.

## **Malevolent Ego States**

The special problem that exists for malevolent ego states is one that must always be addressed whenever they are present. These ego states are also called destructive states, hostile ego states, and protectors. They produce a number of physical and psychological difficulties for the patient. These include such symptoms and behaviors as self-mutilation, unsafe sexual practices, suicidal behavior, aggression to others, somatic manifestations including physical illness. It is of the utmost importance that therapists be aware of the potential for dangerousness to the patient and to themselves.

We can only work safely with malevolent ego states if we are fully aware of their potential for physical and psychological harm to both the patient and the therapist (Frederick, Phillips & Frederick, 1995; Watkins & Watkins, 1988). Malevolent ego states are aspects of the personality that are repositories of the primitive rage that is held and contained for the entire internal system (Watkins & Watkins, 1988)" (Frederick, 2005).

Malevolent ego states are all protector states. Each one is trying to help the greater personality in some way. From the standpoint of Internal Family Systems Therapy (Schwartz, 1995) they can be either Manager states or Fire Fighter states (Frederick, 2005).

## **The Management of Malevolent Ego States**

Malevolent ego states must always be validated by the therapist. These ego states are usually very powerful and have great significance within the internal family. If their power and importance is not acknowledged by the therapist, these parts will have no respect for the therapist's reality testing or for the therapist's ability to understand them. Therapists always validate malevolent ego states and then work diligently to keep them in ongoing communication. Within the framework of their communication, the therapist must find a way to establish a therapeutic alliance. The alliance can sometimes begin when at least one common goal is shared by the therapist and the ego state. The common goal offers the possibility of extending the therapeutic alliance. Work with malevolent ego states often can be done more effectively if we are able to know more about how they tend to function. We can usually identify them as fitting into one of three categories (Frederick, 1996, 2005; Phillips & Frederick, 1995).

- **Functionaries.** These are malevolent ego states that believe themselves to be part of the greater personality (Frederick, 1996, 2005; Phillips & Frederick, 1995). They are like members of a dysfunctional family whose roles are to carry the family's rage, to rule the roost, and to be the enforcer of punishments.
- **Jannisseries.** These ego states are convinced that they do not belong to the greater personality. They frequently believe that they belong to an abuser or a group of abusers. These aspects of personality need a great deal of help in accepting their connection with the both internal family and the body itself (Frederick, 1996; Phillips & Frederick, 1995; Frederick, 2005). The first task with these parts is to help them see that they do, indeed, belong to the patient. This can be quite difficult. Frederick (1996) and Phillips and Frederick (1995) recommend that helping these parts to realize that they do possess characteristics of the body of the greater personality such as fingerprints and DNA is helpful. If it is known that abuse has taken place, comments about the use of lies and other tactics by abusers may also be useful. Certain hypnotic deprogramming approaches that are designed to changed beliefs instilled by abusers can also be used (Frederick, 1996; Phillips & Frederick, 1995).
- **Daemons.** Daemon ego states are psychotic. Their behaviors and reasoning often do not make sense. They frequently do not recall why they behave as they do, nor why they originally arrived on the scene. They are regularly bullies, and the other parts are terrified of them. Their loneliness can be an opportunity for the therapist to coax them into experiments in relationship with other parts (Frederick, 1996; Phillips & Frederick, 1995; Frederick, 2005).

## **Clinical Example**

“A malevolent ego state who called herself Touretta (because she felt she could tantrum better than anyone with Tourette's Syndrome) was activated. Touretta was enraged, controlling, and volatile. She didn't really care whether she got Jewel into trouble. Although she stated emphatically that she had not produced the accident, she appeared to have no serious regrets that it had happened.

With the passage of time, therapeutic work with Touretta that validated both her anger and her desire to protect other ego states was able to mitigate her tendency to impulsive behavior. She became more aware of her feelings, matured developmentally and was able to develop empathy for the other parts of the Internal Family. Eventually, she became a helper and a co-therapist. The quality of the alliance changed to reflect her increasing ability to act as a reasoning, organizing, and integrating force with the remainder of the internal family. Eventually, Touretta called upon me to understand that her judgment was now better than that of the presenting patient. The presenting patient (host ego state) and I validated Touretta's excellent judgment and expressed pleasure

that she could now be of such great help to the members of the Internal Family. Touretta became a de facto co- therapist” (Frederick, 2005, p. 393).

### **Working with Other Members of the Internal Family**

Our therapeutic work with malevolent ego states cannot be limited to only working with them. Most of them are frightening to other members of the internal family. This is especially true of child ego states. As we form alliances with malevolent states, we encourage them to begin to communicate in different ways with other internal family members. The usual way this can happen is through our preparing the other ego states for this new kind of activity and relationship. We must often help them with their fearfulness by such maneuvers as offering support, creating agreements, and making a plan for them to remove themselves to a Safe Place should they be too overwhelmed.

### **Expanding the Core Self**

The concept of the “self” is one that sparks many opinions and various debates. Some theorists believe that there is a fully formed and powerful Self in each of us which is the instrument of healing (Schwartz, 1995). Others (van der Hart, Nijenhuis, & Steele, 2006) think that there is an original self whose reaction to trauma results in the emergence of various energized personae and ego states. Although the Watkins (1997) stated that there was a central “self” that became more egotized, or energized, when ego states achieved greater integration, they never elaborated on this idea and it is not clear what the implications of their concept might be.

The idea that there is a consistent “self” that is not a product of our minds acting to fill in many gaps and perceiving unity where there actually is multiplicity does not appear to be borne out by modern science (Howell, 2008). One useful way of thinking about the self is that the self we perceive consists of two kinds of energies: the internal family of selves (the ego states) and the conflict-free Center Core of the personality.

### **The Center Core**

Concepts of Center Core phenomena have existed within the trauma and hypnosis communities for many years. Allison (1974) reported the presence of Internal Self Helpers (ISH) in his work with Dissociative Identity Disorder (DID) (formerly known as Multiple Personality Disorder). These Internal Self Helpers (ISH) were free of both conflict and feelings. Frederick (2009) compared them with Mr. Spock in Star Trek: unemotional, but brilliant and terrific problem solvers. The therapist received information from them and gave them work assignments that directed their efforts within the internal family.



Torem and Gainer (1993) and Gainer and Torem (1995) proposed a complex conceptualization of a Center Core. Their Center Core contained the safe space, internal self helpers, and a variety of inner strengths. Their Center Core shares certain features with Comstock's (1991) Inner Advisor; Watkins and Watkins (1997) "center core"; Rossman's (1987) Inner Advisor; Schwartz's (1995) Self; Ginandes' (2006) Empowered Healing Guide; Feinstein and Krippner's (2002) Inner Shaman; Flint's (2006) "unconscious"; and Krakauer's *inner wisdom*. Some of these personality energies can bring reason and logic, but more importantly, others of them promote wisdom, empathy, love, strength, and healing within the internal system.

McNeal (1989) and McNeal and Frederick (1993) described Inner Strength, a center core phenomenon connected with the individual's deepest survival instincts. This energy can be experienced multimodally and often brings new experiences and cognitions. Phillips and Frederick (1995) categorized Inner Strength as a form of ego strengthening that is protective-evocative, a resource state (Erickson, 1980) from the unconscious that the therapist can help the patient learn to activate.

Frederick and McNeal (1999) believe that Center Core phenomena such as Inner Strength, Inner Love, and Inner Wisdom belong to the conflict-free sphere of the ego identified and extensively described by Hartmann (1961, 1965). They also connected them with Jung's archetypes. Gregory (1996) contributed the idea that these archetypal, conflict-free energies can be used by individuals therapeutically as selfobjects (Kohut, 1971). She created the term "archetypal selfobject" for them.

### **Gifts from the Center Core**

There is little experimental evidence to support the use of Center Core energies. However, they are widely used by therapists who work with trauma patients as well as non-traumatized patients who can utilize these energies with a variety of issues such as performance anxiety, phobias, self-esteem issues. One reason they are used so extensively is that they are so helpful with stabilization and strengthening as well as moving the patient into greater self-care. Patients who learn to bring these resources such as Inner Wisdom or Inner Strength to their ego states can move more rapidly and more confidently through the therapeutic process. Krakauer (2006) and many others notice that patients who use these techniques use more rational thinking and are able to progress into more adult behaviors.

Frederick (2009) wrote a commentary on Krakauer's Two Part film Technique. Krakauer's (2006) Two Part-Film Technique (TPF) is an autohypnotic two screen technique that helps the patient to explore how to deal with conflicts. In the first screen the patient sees conflicts, situations, reenactments, relationships and so forth played out in ways that are based on familiar defensive responses. In the second screen, the patient's own internal conflict-free resource of wisdom, *inner wisdom*, helps the patient

see how to deal with the issue in a different and wiser way. The patient is free to choose which direction he/she will take.

Krakauer (2001, 2006) explains the effectiveness of her Two-Part Film Technique (TPF) as springing from the actions of positive, wise, and caring unconscious internal resources that belong to an aspect of the personality she calls *inner wisdom* as well as the “collective heart.” With this technique the role of the therapist is minimized because the patient uses self-hypnosis, in which he/she is well-trained by the therapist, and accesses self-generated multimodal imagery. There is reliance on the active participation of an inner resource state — *inner wisdom* — for the clarification of cognitive distortions and the mitigation/change of undesirable behaviors. Krakauer differentiates her technique from those in which the therapist actively directs resource states to perform specific activities” (Frederick, 2009).

Frederick (2009) reflected further in the forthcoming International Society for the Study of Trauma and Dissociation (ISSTD) Clinical Corner Expert Commentary about the ways in which Center Core phenomena are helpful:

“ It may be useful to wonder more about the mechanisms of action of these conflict-free energies. I suggest that they give to patients an additional internal version of what we do with good therapeutic alliances. When therapists reinforce the use of Center Core phenomena as an integral part of treatment with the consistency and faithfulness of Krakauer (2006), we add a powerful co-therapist to the treatment team, one who is there 24 hours a day.”

### **When Center Core energies are used in therapy:**

- They are liminal. Center Core activity not only produces changes within the patient in the short term; it also places the patient at the threshold of a number of significant internal interactions that lead to new thoughts and experiences.
- They are in and of themselves transitional experiences (Winnicott, 1953; Frederick & McNeal, 1999). Transitional experiences are essential for growth and development, separation and individuation. Unfortunately, many patients cling to a limited range of pathological transitional experiences such as substance abuse, gambling, or compulsive sexuality. The developmental narcissism of many ego states may limit their ability to participate sufficiently in external transitional spaces with the therapist; however, everyone has within an intrapsychic transitional space (Morton & Frederick, 1997). Each time a patient accesses *inner wisdom*, he/she has transitional experiences that are initially liminal to the extension of internal transitional spaces and experiences. These contribute to internal self-soothing, the ability to tolerate separation, and increased creativity.

In time, and with repeated access, the Center Core activities and the other aspects of the internal transitional space merge.

- They provide containment. Just as the deeply intersubjective therapeutic alliance acts as a container for the patient's uncontrolled affect, behaviors, perceptions, somatizations, and so forth, so also can the Center Core. The psychological embrace of Transitional Archetypal Selfobjects often is experienced as an internal holding environment.
- Center Core phenomena have nurturing qualities. Although emphasis is often placed on the rational or organizing properties of the Center Core, one of its most amazing characteristics, when accessed, is the often subliminal sense within the patient that he/she is being cared for with such things as clarity, understanding, courage, direction, or the ability to see the larger picture. These are things that parents help their children to achieve through a series of interactions in the external world. It is no accident that an Ideal Mother (Brown & Fromm, 1986) or a fully-realized persona of someone who has died (Frederick, 2003) can become activated from the Center Core. The caring parenting energies are already there. They emerge whenever any Center Core process is evoked.
- There is an internal neutralization of shame. Our trauma patients carry heavy burdens of shame (Nathanson, 1992). Freeing the patient from shame is a vital part of treatment. The conflict-free, understanding, strengthening, healing Center Core never shames the patient. Instead, the complete and unconditional acceptance, as well as the many forms of help that are given freely by the Center Core, wipe away shame, a bit at a time.
- Center Core phenomena assist with secure attachments. The entire process of therapy with our patients is one in which attachment patterns are repaired. We tend to emphasize the work we must do in an ongoing fashion to facilitate this change. There seems to be little room to question that constant, powerful, helpful, organizing, and healing internal conflict-free energies can also play an authoritative role, achieving internally (and sometimes better and more powerfully) what the therapist also does in the alliance.
- They promote both integration and healthy conscious-unconscious complementarity (Morton & Frederick, 1999). Jung (1939) was concerned about the need for the conscious mind to communicate with the vast knowledge held by the unconscious. He called the activity that allows this to happen the *transcendent function*, and he created the technique, *active imagination*, to facilitate the process. Erickson (1948/1980) believed that therapists who failed to help patients carry out this form of integration could be well compared with surgeons who did appendectomies but failed to sew up the incision. Gilligan (1987) noted that one of the principal problems in integration occurred when

boundaries between the conscious and unconscious were too “opaque.” Recurrent interaction with the Center Core can become a prime factor in developing the healthy conscious-unconscious complementarity that is needed for integration.

- Neuraplastic changes take place in the brain creating greater communication and integration of the left and right hemispheres of the brain (Doidge, 2007; Schore, 2003; Siegel, 1999). Hebb’s (1949) principle can be useful in understanding what takes place in psychotherapy: “Neurons that fire together, wire together.” In other words, the plastic brain forms stronger and more numerous neuronal connections in new areas as personalities reconfigure. This is not to say that there is current evidence that the conflict-free sphere of the ego resides in one or another of the hemispheres solely. It does mean, however, that the facilitation of BASK (behavior, affect, sensation, and knowledge; Braun, 1988) components and other forms of integration is modeled and strengthened with the use of the Center Core. Recently, a patient commented: “Do you remember the inner place of core strength to which you led me? I had been visiting that as needed since our work. . . Well, now I do not have to go to another place within me to find that energy. It is now swirling around my ‘older wiser woman’ like the wind.”

## **A Few Guidelines**

All conflict-free manifestations are not the same and should not receive identical responses from the therapist. Our differential approach has divided them into two types.

*Positive Functionaries.* Krakauer’s (2001, 2006) recommendations do not particularly apply to this category. Sometimes chatty Observer States and other ISH’s, who at times seem to want to have a dialogue with the therapist and be part of a treatment team, are specific kinds of manifestations of the conflict-free core and may not be present in every patient. They behave most often like members of the staff of an enlightened management firm, nannies, or even technicians. They engage in a great deal of “left-brain activity,” and they need to be dealt with much as one would deal with conflict-laden ego states: Establish a therapeutic alliance; discuss and define how therapist and ISH will work together; help other parts establish good and useful alliances with such “parts”; request information, assign tasks and appeal for other kinds of help as is appropriate; and work with the patient and/or ego states to determine how much direct conscious access to these conflict-free parts would be good for the patient to have when not in therapy sessions.

*Transcendent Archetypal Selfobjects.* The other category within the Center Core functions very differently. *Inner wisdom*, Inner Strength, Inner Love, Inner Shaman, Empowered Healing Guide, etc. are working in different, deep, and more powerful ways that we associate with “right-brain activity.” Unlike Positive Functionaries they can be assumed to be present in everyone. The term “transcendent” does not imply that these

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are spiritual energies (although some believe they are), but rather relates to Jung's (1939) "transcendent function." The nature of both patient's and therapist's transactions with these potent internal forces must be very different from those of the Positive Functionaries. It must always be remembered that Center Core energies are often at play without any specific summoning by the therapist or the patient.

Much can be generalized from Krakauer's excellent suggestions for the therapist's and patient's relationship with this kind of energy. These conflict-free energies manifest themselves in unique ways. McNeal and Frederick's *Inner Strength* (1993), for example, unlike Krakauer's *inner wisdom* experience, has no agenda. It is simply to be experienced. Patients, however, usually need therapist guidance to evoke Transcendent Archetypal selfobjects within themselves initially, and therapists also can make direct and indirect invitations to appropriate ego states to participate in the experience. Beyond guidance toward activation of Transcendent Archetypal Selfobjects, I recommend that the therapist minimize his/her own input into the situation and not clutter it with his/her own expectations.

These internal experiences are profound, highly personal, and not entirely, if at all, translatable into words. Therapists should never interfere with the experience unless the patient is having obvious trouble such as interference from a malevolent ego state (an extremely rare occurrence). Soliciting feedback during the experience may dilute the process for the patient. If therapist guidance to move to the next step is needed, feedback can be limited to signals that the patient has initiated or completed the experience or specific stages of the experience.

The patient will need time to continue the experience out of hypnosis, if hypnosis is used, once the trance has been formally ended. Formal dehypnotization (Kroger, 1977) may be necessary even if the patient enters trance via self-hypnosis. Patients' trance states may become quite deepened in these encounters with core energies, and patients should always be carefully taught how to dehypnotize themselves when not in therapy sessions. If the interaction with the archetypal selfobject occurs in the therapy session, it needs to be processed. The material can always be used to advance the process of therapy.

It is generally helpful to the treatment of our patients to foster the patient's access to these archetypal selfobjects outside the therapy session as well as within. Accessing Transcendent Archetypal selfobject energies is one of the most vital and stabilizing means of self-care for our patients. Psychoeducation about the reciprocal dynamics of mastery can help motivate the patient: When the patient accesses the archetypal selfobject, he/she is choosing to seek help from within. This can be extremely important to patients who seek external solutions for internal problems. By the same token, the therapist can also remind the patient that every time he/she accesses these realms of consciousness, he/she becomes stronger, more competent, more centered, and more capable of mastery.

Finally, the therapist needs to check to see if patients are remembering to use these experiences out of therapy for strengthening, internal self-soothing, centering, and containment as well as problem solving when not in therapy sessions. Positive, non-punitive therapist reinforcement and encouragement for this form of self-care is always helpful. . . . (W)hen the therapist makes the use of Center Core phenomena a central part of treatment, the patient invariably achieves greater mastery, a higher level of self-care, and progress toward developmental repair” Frederick (2009).

## Special Topics in Ego-State Therapy

### Chapter 4

The current “state of the art” in psychotherapy draws attention to the need for multi-modal approaches. Not only are there increasing numbers of promising interventions that have proven effective in ego state work, but advances in the neurosciences have contributed diverse findings to the study of the human personality and personality states. This chapter will detail some of the multi-modal approaches to ego-state therapy, including those related to explorations in neurophysiology, internal family systems, structural dissociation, and trauma methodology such as EMDR and Energy Psychology.

#### Neurophysiology and Ego States

Daniel Siegel, author of several landmark volumes on neurobiology, has suggested evidence that:

“...basic states of mind are clustered into specialized selves, which are enduring states of mind that have a repeated pattern of activity across time. These specialized selves or self-states each have relatively specialized and relatively independent modes of processing information and achieving goals. Each person has many such interdependent and yet distinct processes which exist over time with a sense of continuity that creates the experiences of mind” (1999, p. 231).

His position is that these states of mind are integrative, consisting of “functionally synergistic processes that allow the mind as a whole to form a cohesive state” (Siegel, 1999, p. 209). They “develop cohesion through their repeated activation, as well as the functional benefits of their internal linkages” (p. 211). Siegel further describes these states as multiple selves:

“We have multiple and varied ‘selves’ which are needed to carry out the

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diverse activities of our lives . . . As we can see, both developmental studies and cognitive science appear to suggest that we have many selves. Within a specialized “self” or “self-state” as we are now defining it, there is cohesion in the moment and continuity across time” (Siegel, 1999, pp.229–230).

Although ego states were originally conceptualized as evolving only during childhood, more recent information about ego state formation during traumatic situations and about their creation as helper states in adult life suggest greater neuroplasticity than once thought (Frederick, 2005). The fact that any technique that can be used with an individual person can be used with an ego state, further supports the ongoing plasticity of personality formation.

### **The Inner Community**

Bonnie Badenoch (2008), who has trained extensively with Daniel Siegel, has created a model with the help of her colleagues for working with self parts or ego states from a neurobiological perspective, which she calls “The Inner Community.”

Badenoch acknowledges that the science of interpersonal neurobiology provides an important platform for her model. Interactions between mother and child in utero, at birth and post birth initiate neural firing that encodes and strengthens certain states of mind while at the same time resonance circuits embed the presence of mother. Interactions with the therapist or other treating professional help to repair these early patterns:

“The moment-to-moment attunement between patient and therapist helps rewire the internal relational world, while resonance circuits embed the therapist as a comforting member of the inner community. From an attachment perspective, this makes sense, since both wounding and healing occur in the context of relationship.” (Badenoch, 2008, p. 77).

The organization of the Inner Community reflect the layers as related to a conscious-unconscious continuum. Here is a prototype of the Inner Community (Badenoch, 2008, p. 83):

#### **Managing Outer Person**

Conscious: easily available to consciousness

#### **Watcher**

#### **Caring Parent(s)/Nurtured Child**

Deeper mind/less available

**Protector(s):** Defend against incoming pain in order to protect already hurt

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children

**Unempathic Parents/Hurt Children:** Relational parent-child pairs more dissociated/less available to consciousness

**Abandoning Parent(s)/Shamed, Abandoned Children:**  
Relational pairs locked in the deeper mind, experience of the most profound pain

**Original Wholeness/Foundational Family Belief:**  
Original hopes of connection and core family beliefs about the nature of the world and relationships

Although the Inner Community model is similar to Internal Family Systems, one important difference is that the self parts are viewed as existing in pairs and are worked with in this manner. Another difference is that the role of the therapist is seen as a central presence in the patient's inner world, as opposed to acting as guide toward self-leadership, as IFS describes.

According to Badenoach, therapists make several commitments when working with the Inner Family must commit to going into the client's inner world, no matter how painful.

Second, treating professionals must be comfortable providing comfort, which includes being comfortable passing through a period of emotional dependency with the client's inner children. If practitioners lack a sense of their own inner comfort, they may feel drained and detach when comfort is needed, or cling to the client's dependency to protect from their own inner fears of abandonment. As in ego-state therapy, the practitioner must stay aware of his/her own reactions as the therapeutic relationship deepens.

The third commitment is to track the client's internal movements. This endeavor includes the ability to hold a felt sense of brain integration, mind coherence and internal community empathy. The therapist holds this space and invites the client into it for healing. Tracking allows the client to lead the way, rather than reacting to interpretations. A second type of tracking is largely unconscious and involves tracking the right-brain to right-brain, limbic to limbic resonance between professional and client, which is believed essential in rewiring the inner world.

### **Internal Family Systems (IFS)**

Another contemporary model of multi faceted personality, Internal Family Systems (IFS) is more similar to Ego State Therapy. Richard Schwartz (1995), the family therapist who developed IFS, developed a view of the personality as composed of subselves that



existed in a family system and are subject to systemic dynamics.

Similar to ego-state therapy, Schwartz believes ego states are unique and dynamic, and that they are adaptive in coming to help the greater personality in some way. IFS respects all of the parts and creates therapeutic relationships with all of them.

Schwartz' view of self parts is also remarkably similar to the Watkins' view of ego states:

“A part is not just a temporary emotional state of mind or habitual thought pattern. Instead, it is a discrete and autonomous mental system that has an idiosyncratic range of emotion, style of expression, set of abilities, desires, and view of the world. In other words, it is as if we each contain a society of people, each of whom is at different ages and has different interests, talents, and temperaments. . . From this perspective, people diagnosed as having MPD [Multiple Personality Disorder, now known as Dissociative Identity Disorder (DID)] are those who have been so badly hurt that their parts have become polarized to the point of complete isolation from one another (1995, pp. 34–35).

There are several differences between ego-state therapy and IFS: 1) in IFS there is a focus on the network of parts in a given client and not just the individual parts; 2) IFS emphasizes connections between the internal family system and the individual's external family system; 3) IFS differs in its assumptions about the qualities and roles of the Self (Frederick, 2005).

Self-parts in IFS are divided into 3 categories according to function: Exiles, managers, and firefighters. “Exiles” are the most fragile and sensitive parts. They usually carry the pain and fear and typically are child part. The manager parts usually keep the exiles protected from the rest of the inner system (and the inner system protected from them) and outside of consciousness.

The “manager” parts really fear the disruption if exile come into consciousness. Exiles signal their presence through flashbacks and other posttraumatic reaction, dreams, and somatizations. The managers attempt to contain and restrain the exiles and what they carry through life patterns, symptoms, and other defenses such as avoidance, denial, and dissociation.

When the managers are unable to contain the exiles, the third type of parts called the “firefighters” become activated to extinguish whatever aspects of traumatic triggering might be activating the exile states. The firefighters may attempt to distract or interrupt the therapy through suicide attempts, acting out, addiction, or other types of acting out.

From Schwartz' viewpoint, the parts exist to protect a core personality called the “Self.” The Self, which is conflict free, can be separated from the body through dissociation to protect it from the threat of trauma. IFS is designed to reconnect the parts with the Self

in order to be healed and to restore its leadership.

The existence of a powerful conflict-free Center Core or Self is another similarity present in both Ego-State therapy and Internal Family Systems. Using IFS as a lens can sometimes help us understand the behaviors of ego states through its application of systems theory, although IFS appears to lack the depth of developmental repair and other relational interventions that are a part of Ego-State Therapy.

## **Structural Dissociation**

This model, developed by Onno van der Hart, Ellert Neijenhuis, and Kathy Steele (2001) is based on the study of dissociative aspects of personality functioning as originally presented by Pierre Janet, who was one of the first theorists to connect previous life events with current traumatic symptoms and used hypnosis to probe and repair these connections. Janet believed that dissociative symptoms like catalepsy, paralysis, anesthesia and alternative personalities were related to unresolved traumatic memories.

He used hypnosis to activate and work with less conscious parts of the personality, as did many of his contemporaries. Much later, John Watkins and his wife Helen further developed the hypnoanalytic approach to self-division used by Janet, Breuer, Freud and other pioneers into ego-state therapy. Sharing a similar foundation, the structural dissociationists have come on the scene more recently to add another generation to this shared lineage.

Structural dissociation theory holds that the pre-traumatized personality splits into the *apparently normal personality (ANP)* and the *emotional personality (EP)* as a way of coping with trauma. The ANP takes care of daily life such as work, relationships, parenting and play. This part is not focused on trauma, may not even be aware of trauma, and may even be phobic about it.

On the other side of the split, when the EP is activated or “executive,” inner experience consists of the reenactment, emotional and somatic reactions, flashbacks and other traumatic reactions. The ANP experiences the EP as “not me” and defends against the EP and its emotional contents.

Structural dissociationists believe that the major key to understanding the impact of trauma is the nature and degree of dissociation. Similar to ego state theory, the central problem of trauma is viewed as the lack of integration of traumatic experiences which results in dysfunctional personality division and fragmentation (Phillips & Frederick, 1995).

Structural Dissociation theory presents 3 levels of dissociation. In *primary structural*

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*dissociation*, the diagnoses include simple PTSD and Dissociative Disorder with one dominant ANP (apparently normal personality) and one EP (emotional personality).

If there is *secondary structural dissociation*, diagnoses include complex PTSD, DDNOS (Dissociative Disorder not otherwise specified), complex dissociative disorder, and trauma-related borderline personality disorder with one predominant ANP and more than one EP fixated in trauma. The EP's are split into action system that related to either intrusive or numbing functions.

In cases of *tertiary structural dissociation*, the diagnosis is usually DID (Dissociative Identity Disorder) and there are more than one ANP (ex. nurturer and organizer) and more than one EP. These may be equivalent to alternative personalities, which are separated by highly dissociative barriers. They may be unaware of each other, in conflict, or connected through parallel dissociation.

Both Ego-State Therapy and Structural Dissociation emphasize forging a secure relationship with the therapist. Both models also focus on overcoming phobias of attachment and attachment loss of the therapist. An important difference, however, is that Ego-State Therapy also focuses on alliances between the therapist and key ego states, which serve as a model for alliances among ego states.

The main focus of treatment using the SD model is to help synthesize traumatic memories and actions related to them in order to develop more successful action in current daily life. Emphasis is placed on strengthening daily life action systems and regulating the defensive action systems.

ANP's are taught skills such as how to complete daily tasks and regulation of emotional distress. The first stage is to substitute actions, such as diversions or planned distractions when overwhelmed or symptom interruption. EP's receive psychoeducation and also learn skills such as how to separate past from present experience.

Unlike Ego State Therapy, Structural Dissociation does not recognize a Core Self, but suggests that the client "becomes" ANP or EP. In EST (as in IFS) the Core Self is viewed as a central integrative agent, while SD practice suggests integration through a fusion of ANPs with EPs.

## Summary

The Inner Community, Internal Family Systems, Ego-State Therapy, and Structural Dissociation models all emphasize the formation of personality as a multi-faceted system. Although there are important differences between these approaches, they share a focus on trauma as the causation of dissociative splitting and the need for integration of parts to resolve symptoms and promote wholeness and healing.

## **Ego-State Therapy and Other Trauma Methodologies**

In addition to the synthesis of the models explored above, several other models have explored and worked with ego states and self parts effectively although they do not have a central focus on ego state or parts theory. This section reviews two such methods, Eye Movement Desensitization and Reprocessing (EMDR) and Energy Psychology.

### **EMDR/Ego-State Therapy**

EMDR was developed as an information reprocessing model for the treatment of trauma (Shapiro, 2001) providing a structured focus on past experiences that have laid the groundwork for dysfunctional emotions, beliefs, and sensations as well as on current triggers, and positive resources needed to enhance future functioning.

One of the main methods is the use of “dual alternating stimulation” (DAS) (see <http://www.emdr.com/dualatten.htm>), using either bilateral eye movements, audio tones or music, or tapping on knees, thighs or other areas of the body. With help from the treating professional, clients identify targets for EMDR processing, including recent distressing events, triggers, related historical events, and the development of specific skills and responses needed for positive future situations.

During reprocessing, clients attend to elements of past memories, current triggers, or anticipated future experiences while simultaneously focusing on external stimulation provided by sensory paddles, audio tones or music, stimulation of bilateral eye movements, and/or tactile tapping. During the sets of dual stimulation, the client usually experiences emergence of insight and understanding, changes in memory, and new associations, which in turn form the basis of subsequent sets of processing.

After EMDR processing sessions, clients usually find that the emotional or sensory distress related to past memories has been decreased and that they have retained important cognitive awareness. These changes usually result in continued spontaneous changes that can also be enhanced with EMDR procedures.

### **EMDR and Ego-State Therapy**

Recent advances in the use of EMDR include its synthesis with ego-state therapy. EMDR can be used to elicit ego states with simple instructions such as, “During the next set of Dual Stimulation, allow the part of you to come forward inside who knows about the source of this problem.”

EMDR can also be used to work effectively with ego states to promote ego strength and

stabilization (Phillips, 2007). One such approach is the use of conflict free imagery (Phillips, 2000) as an initial focus, finding a time when all of the personality is engaged in an enjoyable experience without any of the symptoms that are the motivation for change. Sets of dual stimulation are then used to strengthen the impact of the image before working with a specific ego state. The first goal is to find an ego state that can serve as a resource in the problem situation, and then EMDR can be used to strengthen that part and to work through any conflicts between ego states related to the difficult that needs to be resolved. After completing necessary trauma reprocessing, EMDR/ego-state therapy can be used to facilitate integration and confidence in future functioning.

### **Clinical Example**

Jeremy (Phillips, 2007), age 35, struggled with multiple symptoms including social and performance anxiety, insomnia, panic attacks, alcohol addiction, and deficits in the areas of attention and concentration related to childhood trauma. In evaluating him initially, we noted that he was aware of inner voices that shared both positive observations, “someday you’ll show everyone how successful you can be” as well as negative ones (“You’ll never figure this out. If you don’t pay attention, you won’t be able to complete this project”). The therapist’s assessment was that Jeremy was a good candidate for ego state work and explained this model to Jeremy.

As we discussed possible specific interventions with his difficulties, the therapist decided to start with a focus on strengthening the whole personality before working with the voices inside. She asked Jeremy to think of a time in his everyday life when he felt and seemed just the way you want to be more of the time, a time when all of him was engaged in a positive manner and he experienced only positive feelings about himself and none of the difficulties he wanted to change.

Jeremy immediate thought of the almost daily experience of reading historical novels in his favorite chair while his cat sat curled up in his lap. This conflict free experience seemed to capture a time of freedom to focus only on relaxation and comfort. As Jeremy further constructed a conflict free image based on this experience, he reported that he felt good about stretching his mind while he was also relaxing his body and feeling connection to the reassuring presence of his cat. This image represented a time of balance and inner harmony, when all was well in his outer and inner worlds.

After testing the image to make sure that it was wholly positive and strong enough to counter the times when he was symptomatic or anxious (Phillips, 2000), we used several sets of DAS with sensory paddles that he held in either hand to further deepen and strengthen his positive response.

Another use of EMDR is to assist in ego-strengthening by helping to activate a positive resource ego state (Phillips, 2001b; Phillips & Frederick, 1995). In Jeremy’s case, we began this task by asking him to recall a time that best represented successful

concentration and organization. We first constructed another conflict free image based on this experience, which involved the successful completion of a work project. Next we used a few brief sets of DAS with the sensory paddles to deepen and strengthen his connection to the image.

When he seemed fully connected to the CF image, the therapist suggested, “During the next set of DAS, I’d like to ask the part of you inside who helped you to complete the project at work and who is very good at concentration and organizing to come forward so that we can get to know him.” Jeremy reported that he saw an image of a young boy who looked like Harry Potter, and who wanted to be called “The Scheduler.” We learned that this ego state was blocked by another part that was scared to look at things.

Our next step was to meet the new part that seemed connected to the targeted problem. We asked the “Harry Potter” part to stand by while we found the second part during a subsequent DAS set. Jeremy reported seeing a “young part” that looked about 6 years old. He told Jeremy, “I don’t want to look at things. I just want to get through them as fast as I can. If I look, it slows me down and then someone might see that I’ve done something wrong. Then they’ll try to help me and it won’t be mine anymore.”

Because it appeared that this 6 year old part seemed to hold the key to resolving Jeremy’s problems of disorganization and inconsistent concentration, we decided to work with him individually (Phillips, 2001a). The first priority was helping him find a safe place inside:

Th: “Would you like to have a place that belongs only to you?”

YP: “You mean no one can find me?”

Th: “That’s right. Only if you invite someone, can they find you.”

YP: “OK... I’m in this room that has a lot of sun and there’s a strong lock on the door.”

We then used several sets of DAS to strengthen the younger state’s connection with his safe place. Subsequently, he identified a series of traumatic memories related to his father raging at him while he was doing his homework. Since this part revealed that he was fearful about exploring past experiences, he was asked what might make him feel more safe. Because he could not identify further resources, the therapist suggested that during sets of DAS using the sensory paddles, he hold the thought “I need something more to feel safe and strong.” Then he could identify a desire for his maternal grandfather, with whom he had always been close, to be present.

After making this connection, the 6-year-old ego state agreed to look at a past scene with his father while his grandfather was beside him. We targeted the cognitions “I’m

stupid” and “I can’t look at this because I’ll be wrong and in trouble,” the image of his grandfather holding his hand, and tension in his body. During several sets of DAS, the young part reported that his grandfather told him that he was smart and could do his homework, and that the problem was that when his father kept interrupting him, he couldn’t focus. With further support, he was able to ask his father to leave the room so he could finish his work and to confront him about his alcoholic anger attacks.

The last step in this sequence was to address future concerns (Phillips & Frederick, 1993). The young part was worried about what would happen if his father interrupted him again. The therapist introduced an interweave, asking the young part, “What would grandfather want you to do if this were to happen again?” The young ego state replied that he would ask his mother’s and grandfather’s help not to let him be alone in the house with his father at night so that he could feel safe. Through several sets of DAS, the young part reported feeling calm and confident and holding the positive cognition, “I can look at this and be OK.”

As a final intervention, the therapist asked the young part if he knew the “Harry Potter” part inside and if he seemed anything like his father. The 6 year old part responded, “He’s just like my father, always wanting me to do something his way.” In several sets of DAS, the young part began to trust that the older part genuinely wanted to help and could help him focus without any anxiety from the past, while the “HP” part learned to be more patient and empathic toward the younger part, and the two of them forged an effective partnership.

During follow-up sessions, Jeremy reported feeling more organized and focused at work, with significantly less anxiety and better sleep. He was appreciative of the rapid changes that were made possible through the synthesis of EMDR and Ego-State Therapy.

### **Energy Psychology and Ego-State Therapy**

Another promising approach since the introduction of EMDR has been the emerging presence of Energy Psychology (EP) in the field of trauma resolution. EP methods have been used to help “thaw” the freeze response, balance fight/flight, assist with self-regulation, enhance relational experience, and resolve symptoms. Techniques have been directed successfully to enhance the meridian system, based on the Chinese acupuncture system, to balance and strengthen the chakra system, based on the Hindu system of *prana*, and to repair and strengthen the biofield surrounding the body.

### **Energy Reversals**

At the heart of resolving inner conflicts is the process of identifying and correcting energy *reversals*. Reversals are defined as energy situations where the outcome is the opposite, or falls far short of, one’s intentions. They can also be evidence of an inner

conflict where the body's energy systems are activated both to initiate as well as to resist change (Feinstein, Eden, & Craig, 2005).

The basic correction is to assume that reversals are present and to correct them using an "affirmation" approach. This is done by rubbing the neurolymphatic points on the left chest 1" below the collarbone and 3" over toward the shoulder while affirming out loud 3 times: "I deeply and completely love and accept myself even with all my problems and limitations." Then this process is repeated with specific conditional reversals such as "I deeply and completely love and accept myself even though I'm not ready to be free of this symptom." After this correction and other preparation steps (Phillips, 2000), specific protocols can be used to treat the targeted problem such as the EFT (Emotional Freedom Technique) 8 point protocol or the TFT (Thought Field Therapy) anxiety protocol.

A more advanced application involves focus on specific reversal conflicts. This is done by energy (muscle) testing, a process much like ideomotor signaling in hypnosis, to determine the presence of specific reversals. For example, the practitioner can test for "I deserve" or "I don't deserve" to be free of this problem.

If the client tests strong for both statements, then the practitioner can do follow-up testing of the statements: "At least one part of me deserves to be free of this problem" and "at least one part of me does not deserve to be free of this problem." If the client tests strong for both statements, that is, if the muscle stays strong in response to both, then this can be considered an ego state conflict. The approach is to continue testing to find out the age, role, beliefs and feelings of the state and to provide appropriate corrective experiences so that the energy reversal is also corrected as verified by further testing.

### **Clinical Example**

Jesse had developed RSI (repetitive stress injury) in his job as a computer graphics expert. He sought help to augment physical therapy and myofascial release therapy, which were helpful but still left his pain levels at high levels more than 5 years after his diagnosis.

After discussing treatment possibilities, we agreed to explore the use of energy psychology since Jesse was intrigued by alternative techniques and had found acupuncture to be helpful with his pain.

Once several steps had been completed, such as testing and correcting for hydration and energy disorganization (Phillips, 2000), we began testing for the presence of reversals. Jesse tested weak for "I want to lower my pain levels" and strong for both statements, "At least one part of me wants to lower my pain levels" and "at least one part of me doesn't want to lower my pain levels."



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Subsequent testing revealed that two parts were involved in the reversals. One part was 16 years old and reported that he had been treated unfairly by a math teacher; the other part was a young 3 year old part who was terrified of his older brother's bullying. The link between these two parts was that each had experienced extreme stress in unfair situations.

More energy testing indicated that these two parts believed that Jesse's pain condition was "unfair" since it prevented him from playing guitar music, which had been a major passion in his life, and because his pain levels remained high despite huge efforts in trying to recover.

In exploring these issues further, we were able to enlist the cooperation of both ego states to contribute to fairness by supporting the greater awareness of fatigue and soreness and prompting Jesse internally to "take a break" from his computer before he felt ready to do so. This intervention helped Jesse reduce his pain levels by 2 points, shifting from a 7 pt. rating (with 10=intolerable pain) to an average of 5 points in less than two weeks. Other work with reversals helped him to lower his pain levels further, allowing greater comfort and productivity at work and the freedom to begin to play his guitar again without fear of relapse.

## **Conclusions**

Recent innovations in ego-state therapy have combined the depth and comprehension of the ego state model with broader theories derived from neurobiology and advances in attachment theory, dissociation, and trauma resolution. Addition of "cutting edge" methods derived from trauma and stress models such as EMDR and Energy Psychology (Phillips, 2002, 2003) increases the effectiveness of ego state work and widens the window of healing possibility for clients with long-standing or intractable problems.

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