International Journal of Clinical and Experimental Hypnosis

Publication details, including instructions for authors and subscription information:
http://www.tandfonline.com/loi/nhyp20

Selected Topics in Ego State Therapy
Claire Frederick

Tufts University School of Medicine, Boston, MA, USA
Published online: 18 Aug 2006.

To cite this article: Claire Frederick (2005) Selected Topics in Ego State Therapy, International Journal of Clinical and Experimental Hypnosis, 53:4, 339-429, DOI: 10.1080/00207140591007518

To link to this article: http://dx.doi.org/10.1080/00207140591007518

PLEASE SCROLL DOWN FOR ARTICLE

Taylor & Francis makes every effort to ensure the accuracy of all the information (the “Content”) contained in the publications on our platform. However, Taylor & Francis, our agents, and our licensors make no representations or warranties whatsoever as to the accuracy, completeness, or suitability for any purpose of the Content. Any opinions and views expressed in this publication are the opinions and views of the authors, and are not the views of or endorsed by Taylor & Francis. The accuracy of the Content should not be relied upon and should be independently verified with primary sources of information. Taylor and Francis shall not be liable for any losses, actions, claims, proceedings, demands, costs, expenses, damages, and other liabilities whatsoever or howsoever caused arising directly or indirectly in connection with, in relation to or arising out of the use of the Content.

This article may be used for research, teaching, and private study purposes. Any substantial or systematic reproduction, redistribution, reselling, loan, sub-licensing, systematic supply, or distribution in any form to anyone is expressly
SELECTED TOPICS IN EGO STATE THERAPY

CLAIRE FREDERICK

Tufts University School of Medicine, Boston, MA, USA

PREFACE

Since its creation, Ego State Therapy has achieved considerable recognition among clinicians who practice hypnotically facilitated psychotherapy. This is particularly true in Europe. The First World Congress of Ego State Therapy took place in Bad Orb, Germany, March 20–23, 2003. This conference was heavily attended and featured concurrent workshops and scientific paper presentations on Ego State Therapy. The next World Congress will be held in Pretoria, South Africa, in 2006.

After its creation (J. G. Watkins, 1978a; Watkins & Watkins, 1979, 1979–1980, 1981, 1982, 1988, 1990, 1991) Ego State Therapy was somewhat sparsely represented in the scientific literature in the 1970s and 1980s. Much ego state work was done with Dissociative Identity Disorder (DID) patients, and very little was published about its applicability in such areas as pain management, the anxiety disorders, depression, and performance enhancement. There are several reasons why the practice of Ego State Therapy and the published literature in that field expanded dramatically in the 1990s. One is that its cocreators conducted an ever increasing number of instructional workshops (Steckler, 1989) in the field. The other, often less recognized, is that Helen Watkins did intensive (weekend or “marathon work”) (Watkins & Watkins, 1997, p. 141–154) Ego State Therapy, frequently with psychotherapists who utilized hypnosis in their own clinical work and teaching. The impact of her psychotherapeutic efforts on the expansion of Ego State Therapy should not be underestimated. The author has spoken with many professionals who have confided that their intensive work with Helen Watkins produced substantive changes in their lives.

Yet another reason for the expansion is that several clinicians were able to publish material that showed not only an extension of its applications, but also the deep connections between Ego State Therapy and other aspects of psychotherapy such as the therapeutic alliance, transference/countertransference, ego strengthening, phase-oriented treatment, developmental repair, Ericksonian approaches, and so forth.

Manuscript submitted July 9, 2004; final revision received September 11, 2004.

Address correspondence to Claire Frederick, M.D., Heritage Building, 15 Columbia Street, Suite 401, Bangor, ME, 04401, USA. E-mail: montamat@mindspring.com
This constituted an apposition and association of fundamentals that brought Ego State Therapy further into the mainstreams of hypnosis, psychotherapy, trauma treatment, work with neurotic patients, and work with seriously disturbed patients.

The selected topics presented here constitute an introduction of Ego State Therapy to the readership of the *International Journal of Clinical and Experimental Hypnosis*. In many ways they have as much to say about personality theory and the techniques of psychodynamic psychotherapy as they do of Ego State Therapy. This monograph presents a view of Ego State Therapy that is extremely limited because of the necessary page number restraints essential to its production. It is the hope of the author that some of the material presented may stimulate further interest in the field. Chapters One through Four offer an overview of Ego State Therapy, its similarities and differences from Internal Family Systems Therapy (Schwartz, 1995), and other forms of polypsychism, the nature and formation of ego states, the character of Center Core phenomena, the diagnosis of ego state pathology, and the necessary elements of treatment utilizing this modality. Chapters Five and Six present basic material about the therapeutic alliance and the transference/countertransference field as background for some information about how they can be used in Ego State Therapy. Chapter Seven is devoted to a consideration of the creation and modification of ego states, as well as the significance of positive ego states in psychotherapy and pedagogy.

**CHAPTER I
POLYPSYCHISM AND EGO STATE THERAPY**

It has been said that the world can be divided into Platonists and Aristotelians. Although not inept at the kind of formal logic used by Aristotelians, Platonists tend to favor another kind of logic, one that processes information via metaphor and analogy. As illustrated by the potent mixture of thought and feeling in the Symposium (Hamilton & Cairns, 1966), they often consider affective input as a valuable source of knowledge. Aristotelians, on the other hand, use the strict yardstick of formal logic as a governor to their understandings of what may be true. Psychotherapists can be more Aristotelian, or more Platonic. Psychotherapies that are aimed at cognitive and behavioral changes could be viewed as falling more into the Aristotelian mold, whereas those more directed toward subjective self-understanding, affective exchange, and the therapeutic relationship tend to be more Platonic.
The current thrust of acceptable medical and psychological science in psychotherapy is definitely Aristotelian. Its emphasis on efficacy studies as necessary to justify any therapeutic procedure adheres to the paradigm of Aristotelian logic. Although such studies are conducted with psychodynamic therapies, more is done with the more easily measurable behavioral and cognitive-behavioral work. Regardless of orientation, the need for theory cannot be ignored. Without theory, the therapist may well become a “wild” therapist (Freud, 1912/1961b), one who steers the course of therapy without compass or chart.

Ego State Therapy (Watkins & Watkins, 1997), one of the Twentieth Century’s creative contributions to hypnoanalysis, is an approach that is allied to the interactive, uncovering, and developmentally reparative psychodynamic psychotherapies. The theory upon which it is based is couched in the language of metaphor and analogy. It is because it can be such an effective therapeutic method that it has grown in scope and practice since its creation. It is probably better evaluated with effectiveness measures than with efficacy studies.

Of the theoretical structure of Ego State Therapy, its creators said, “We recognize that in a short time our views may be out of date” (Watkins & Watkins, 1997, p. xiii). Their theories, like all theories, are frameworks upon which we can distribute and examine our data in some useful way. By their nature, theories are meant to be useful, neither true nor false, and like all theory, temporary. Similarly, they “should generate research hypothesis while suggesting new and as yet unobserved relations . . . (and) make prior assumptions explicit” (Watkins & Watkins, 1997, p. 2). Barabasz and J. G. Watkins (2005) amplify this:

Theories are, by their nature, oversimplifications. In a sense, the more simplified a theory can be elucidated, the more useful (and perhaps more likely to be used) it becomes as a decision guide to practioner-scientists and research scientists. Both groups can draw upon a stated theory to conceptualize their clinical treatment plans or experience, and then test them for effects. Psychotherapists are better equipped in their work when they recognize that all clinical interventions are, in essence, mini experiments. As a basis for an intervention, a theory, if useful, predicts the outcome with responsible reliability. A theory is not necessarily true or false. The usefulness of a theory then depends on whether or not its predictions are borne out and whether or not treatment outcomes can be controlled when it is applied. Theory that most succinctly provides an explanation of a phenomenon, which can also be applied to real life treatments for our patients, therefore, becomes the best science can offer practice. (p. 54)

New theories and different data, as well as changing paradigms, are filling our most cherished theoretical constructs with unsuspected fragilities. Nevertheless, Ego State Therapy deserves to be understood as a coherent and significant form of hypnotically facilitated psychotherapy
in our time. It offers a unique and practical way of accessing human experience therapeutically. It is quite remarkable in that it is able to bridge paradigms and to coexist with and utilize many other theoretical frameworks.

**POLYPYCHISM AND PERSONIFICATION**

Ego State Therapy is based on the premise that the human personality is polypsychic. Historically, primitive science (as opposed to the arts that have always recognized polypsychism) originally viewed the individual personality as unitary. The New Testament description of Jesus casting out devils from an afflicted individual portrays one of the views of polypsychism entertained by the science of his day. In the Christian tradition, the soul could also be inhabited by the Holy Spirit as well as by angels. In Greek and Roman mythology, one could become a host for positive energies such as the muses or the spirits of gods. Parts of the self such as the soul could also be lost or stolen with resultant pathology. Throughout the ages, and in every culture, examples of polypsychism abound.

Formal definitions of dipsychism and polypsychism did not appear until the Nineteenth Century, and they were an outgrowth of studies of multiple personalities. Ellenberger (1970) believed that the term "polypsychism" was coined by Durand (de Gros), a magnetizer. Both Freud and Jung found it necessary to adopt some form of polypsychism in their theories. Freud used a tripartite model of personality that had an Id, an Ego, and a Superego, and Jung conceptualized personality as an outgrowth of a number of archetypes and complexes. Many other clinicians and theorists have viewed the mind as a confederacy of parts or subselves. These include Janet (1919/1976), James (1890/1983), Prince (1905/1978), Alexander (1930), Kernberg (1976), Kohut (1977), and even Erickson (Erickson, unpublished manuscript, 1940s/1980; Erickson & Kubie, 1939/1980). Polypsychism is a feature of Gestalt Therapy (Perls, 1973) as well as Psychosynthesis (Assagioli, 1965), and Transactional Analysis (Berne, 1961).

**THE “HIDDEN OBSERVER” AND NEO-DISSOCIATION THEORY**

There are other kinds of observations and findings that complement the orientation that the mind is multiple in its composition. The first of these comes from hypnosis research conducted by Hilgard (1977, 1984). In a series of experiments with normal subjects he identified a "hidden observer," an aspect of personality out of conscious awareness. Hilgard proposed the neo-dissociation theory (1977, 1991) as a way of understanding this and related phenomena. He thought that the mind was divided into compartments that observe and regulate it
within their own separate realms. According to Hilgard these compartmentalized mental energies communicate with one another and with something like a core or central personality that he called the “executive personality.” When compartments (informational or energy systems) of the mind are not able to communicate with the core or executive personality, they may carry on their functions without regard to what is going on around them. Hypnosis is one situation that alters the relationship of the compartmentalized functions with the executive personality. Hilgard’s findings and his neo-dissociation theory are interpretable from several theoretical paradigms, including the cognitive-behavioral position (Kihlstrom, 1984) and socio-psychological conceptualizations (Lynn, Marc, Kvaal, Segal, & Sivec, 1994). J. G. Watkins & H. H. Watkins (1997) reported findings within individuals whom they had previously treated that were similar to those of Hilgard. Although their study could have been better designed, they felt it reinforced their belief that “hidden observer” material supported their own psychoanalytically oriented theory of ego states.

NEUROPHYSIOLOGY AND THE HIDDEN OBSERVER

There may be connections between psychological explanations and brain development. The correct questions to ask in investigating such connections are still a matter of discussion (Woody & McConkey, 2003). Nevertheless, neuroscience may have something to contribute to the Watkins’ viewpoint. It is now known that the developmental sculpturing of the structure of the brain grows as a result of the interaction between the developing brain and its environment, including its interpersonal environment (Cozolino, 2002; Schore, 1991, 1994, 1997, 2000; Siegel, 1996, 1999). This means that our childhood experiences have neuroanatomical and neurophysiological consequences. Siegel (1999) states that there are several sources of information that suggest the hidden observer is present “outside the state of hypnosis” (p. 325). He cites findings from neuroscience (Siegel, 1996, 1999), child development studies (Harter, 1988; Harter, Bresnick, Bouchey, & Whitsell, 1997), memory studies (O’Donohue, 1997), and clinical material with patients with a variety of psychological disorders including dissociative patients (Chamberlain, 1995). Siegel believes that there is sufficient evidence to indicate 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. (p. 231)
According to Siegel (1999) the brain is faced with the task of organizing the activation of “billions of neurons with trillions of interconnections. . . into the organized patterns that create mind” (p. 208). It does this through “states of mind” that permit the brain to function in an integrated manner. “A state of mind can be defined as the total pattern of activations in the brain at a given time” (Siegel, 1999, p. 208). These states of mind consist of “functionally synergistic processes that allow the mind as a whole to form a cohesive state” (p. 209). Siegel believes the evidence suggests that there are basic processing modules. Once a state of mind (Horowitz, 1987) has occurred, it can be recalled. Repeated activation of a state makes for a greater likelihood that it will be activated in the future. “Particular states of mind may develop cohesion through their repeated activation, as well as the functional benefits of their internal linkages” (Siegel, 1999, p. 211). States of mind with perceptual bias affect memory processes, internal mental models, and behavior responses can develop enduring clusters. Such clusters can become the “dominant information-processing mode” at any given time. States of mind are both organizing and self-reinforcing, and they are very sensitive to context.

Siegel uses the theory of nonlinear dynamics of complex systems (a collection of 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; they are nonlinear; and they develop emerging patterns, which have periodically or continually recurring characteristics.

As the brain develops, states of mind become “attractor states” within the system, influenced by both history and context. As the system becomes more complex, it also becomes more stable. Additionally, it is nonlinear. A relatively minor dysfunction at one level of the system could produce major dysfunction in other parts of the system and/or of the entire system. Because of their recursive properties, clusters become increasingly specialized.

Siegel (1999) notes that the clustering of modules of affect and information (easily detected with clinical pathologies connected with early life trauma or attachment difficulties) are also present in normally developing children. He concludes:

We have multiple and varied “selves” which are needed to carry out the 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, 1998, pp.229–230)
Other neuroscientists have focused attention on studies of the brain that suggest a substrate for such mental organization (Gazzaniga, 1989, 1995; Ornstein, 1987). Ornstein (1987) believes that there is a neurobiological basis for believing that we all have “multiminds.” Neuroimaging studies of patients with Dissociative Identity Disorder (DID) (Reinders et al. 2003; Saxe, Vasile, Hill, Bloomingdale, & Van der Kolk, 1992; Tsai, Condie, Wu, & Chang, 1999) appear to support the polysychic orientation. However, since they have been done with clinically ill patients, the applicability of their findings to the ordinary human cannot necessarily be inferred. These studies do point in the direction of a path that requires further exploration.

The search for further and more specific evidence of neuroscience underpinnings will involve a variety of methods and devices for exploration. Neuroscience explorations within the field of hypnosis are proceeding in several directions (Barabasz, 2000; Barabasz et al. 1999; Rainville, Carrier, Hofbauer et al. 1999; Rainville, Hofbauer, Bushnell, Duncan, & Price, 2002; Spiegel, 2000).

**THE EGO STATE MODEL AS AN ENERGY MODEL OF PERSONALITY**

Ego State Therapy is a psychotherapy that views the human personality as being composed of a number of parts, or subselves, that constitute something like an internal family. It is a combination of individual, group, and family therapy techniques. Ego State Therapy was created by John and Helen Watkins (J. G. Watkins, 1978a; Watkins & Watkins, 1976, 1979, 1979–1980, 1981, 1982, 1988, 1991, 1997) as a form of hypnoanalysis. Although there are indirect, non-hypnotic forms of Ego State Therapy, it is most often conducted when patients are in formal trance. Ego State Therapy is based on several concepts of Paul Federn (1928, 1952), one of Freud’s earliest associates. Although a detailed classic psychoanalytic explanation for Federn’s theories will not be offered here (the reader is referred to J. G. Watkins (1991) and J. G. Watkins & H. H. Watkins (1997), a brief explanation is required.

The idea that energy plays an important role in mental processes was of primary importance to Freud (Ellenberger, 1970). Freud’s own energy theory of personality was based on the interaction between a positive life-energy, the libido, which is pleasure seeking, and (a later development) thanatos, the “death instinct” that is concerned with aggression and that must be neutralized.

Like Freud, Federn also had a dual drive theory, but in his case the drives had to do with whether the mind focused its energies on “self” or on an “object” that was not-self. The kind of energy that allows for a sense of self, or subjective experience, or “me-ness,” he termed “ego cathexis,” that which resulted in a perception of otherness, or an
object, or “not-me-ness,” he called “object cathexis.” Federn (1952, p. 62) thought that the feeling of the self was the pure energy of ego cathexis and that, could it be freed of all ideation, it would be the pure essence of the self.

When, for example, I experience “my memory,” “my knee,” these can be thought of as having ego cathexis. When I discover, but fail to immediately recognize, something I have forgotten I had written in a diary many years ago, or a drawing I produced, I may not have the same sense of self. I may think “What an interesting teenager,” or “What a kid this must have been.” The ego cathexes have become quite attenuated and need to be reactivated. If my knee is anesthetized for some medical reason, I may know it is my knee because I see it, but it may really feel like “the knee” instead of “my knee.” In other words, the anesthetized knee will have become invested with object energy instead of ego energy because I have become neurophysiologically dissociated from it and am not experiencing it subjectively.

Another of Federn’s many contributions was the concept that the human ego is comprised of a number of “ego states,” each of which is formed in childhood, and all of which exist in some dynamic relationship with one another. Ego states, like the greater personality, should have senses of “me” and “not-me,” and could also become invested with ego energy (“I am Sally”) or object energy (“He is Richard”). Ego states are in dynamic relationship with one another. This interaction allows the individual ego states to experience ego cathexis and object cathexis and to be able to sense the self and the other. Ego states possess both kinds of energies in a dynamism that keeps them separate yet together.

Federn thought that ego states were only formed in early childhood. Growing information about ego state formation in traumatic situations (Putnam, 1989; Ross, 1989), material about the creation of helpful ego states (Frederick & Kim, 1993; Frederick & Sheltren, 2000; Frederick, Sheltren, & Toothman, 2000; Gainer, 1993, 1997; Ginandes, 2004), and other clinical data suggest greater personality plasticity than envisioned by Federn. They also evoke speculation concerning the possibility of ego state formation for specific reasons at later times in life.

It is important to note that Federn considered the issue of boundaries among ego states to be important. These personality energies are separated from one another by something analogized as a membrane that J. G. Watkins and H. H. Watkins (1997) have described as “…more or less permeable” (p. 26). The management of these boundaries and of energy investments results in how the self is experienced. The ego state with the most energy in the system is experienced by the greater personality as “the self.” J. G. Watkins and H. H. Watkins (1997) call such an ego state the “executive ego state” (p. 26). The executive ego
state experiences “I-ness,” and regards the other ego states as the “other (he, she, it).” Federn’s model is only one possible model for polypsychic energies. Although J. G. Watkins and H. H. Watkins (1997) utilize it, they are aware of its limitations.

We do not hold that Federn’s two-energy theory is the explanation for subject-object and other psychological processes, nor is a belief in it essential for the practice of ego state therapy. Indeed, the very existence of ego and object cathexes awaits future biophysiological research for any confirmation as to their reality. However, among the various personality theories with which we are acquainted, this theory seems to offer the best rationale at the present to account for what happens during psychodynamic transformations. (p. 235)

Federn’s theories were further explained and somewhat expanded by Eduardo Weiss (1960a&b, 1966). However, neither Federn nor Weiss fully understood their therapeutic possibilities. It remained for J. G. Watkins and H. H. Watkins (1997), psychoanalytically oriented psychotherapists who often used hypnosis to facilitate psychotherapy, to create a more comprehensive framework and a treatment modality that addressed ego states specifically.

**EGO STATE THERAPY: A COMPREHENSIVE POLYPYSCHIC TREATMENT MODALITY**

*Ego State Therapy Methodology Development*

Ego State Therapy has been described as a hypnoanalytic technique in many publications (Frederick & McNeal, 1999; Phillips & Frederick, 1995; J. G. Watkins, 1978a, 1992, 2003; J. G. Watkins & H. H. Watkins, 1976, 1979, 1979-1980, 1981, 1982, 1988, 1990, 1991, 1997). This is probably an outgrowth of its originating in close connection with formal trance and hypnoanalytic techniques, as well as its early emphasis on abreaction as a healing agent. However, Ego State Therapy can be viewed more accurately as a treatment modality. J. G. Watkins (2003) describes the development of this theoretical and clinical system in the following way:

Based on the psychoanalytic theories of Paul Federn, John and Helen Watkins and their associates (Frederick, Phillips, Hartman, McNeal, Morton and others) have published many papers and several books detailing Ego State Therapy techniques. Other investigators (such as Kluft, Torem, Fraser and Hunter) have further advanced the use of Ego State Therapy in their treatment of dissociation. (p. vi)

Ego State Therapy as a treatment modality never stands completely alone. It is the most accommodating of psychotherapies in that it creates an arena in which any technique or therapeutic approach that a
therapist may use with an individual patient can be synthesized into use with any of the ego states. These include but are not limited to cognitive-behavioral interventions, psychodynamic exploration, ego-strengthening, and trauma work with individual ego states. In addition to work with the individual ego states, internal group therapy or family therapy is also conducted.

In his Foreword to Emmerson (2003) J. G. Watkins (2003) reminds us that Ego State Therapy has several unique advantages as a psychotherapeutic modality, since it can deal with deep unconscious structure. He notes that Emmerson (2003) has categorized ego states into “surface states” whose activities are usually within conscious awareness, and “underlying states” that operate at a deep unconscious level and usually require hypnotic activation for therapeutic interventions. The “cognitive therapies,” by their very natures, are only able to be directed to surface states. While successful with many, such therapies may not only lack depth, but may increase self-alienation in certain patients in whom the problem symptoms are produced by underlying states. Such patients may be unresponsive to numerous therapeutic techniques that are addressed to surface states.

... to paste a coping skill on the surface of an injured personality is to further remove that person emotionally from the “Self” (J. G. Watkins, 2003, p. vii)

A second advantage to Ego State Therapy is that it appears to have the capacity to produce deep changes in personality structure in considerably less time than psychoanalysis or other psychodynamic psychotherapies. Although they may come about more rapidly, these changes are believed to be long-lasting. Whether this be the case continues to be the subject of disagreement.

Effectiveness of Ego State Therapy

The claims for success as a modality of treatment and of permanent structural change put forth by Ego State Therapists do not have the same kind of research buttressing as do, for example, those of cognitive therapists (Beck & Emery, 1989). In this sense, but to a far greater degree, Ego State Therapy shares the research problems of many psychodynamically oriented psychotherapies (Miller, Luborsky, Barber, & Docherty, 1993) as well as those that arise when hypnosis is part of the picture (Fromm & Nash, 1992).

Neither the efficacy nor the effectiveness of Ego State Therapy has been established. J. G. Watkins and H. H. Watkins (1997) reported their findings with 42 of their own patients. A significant number reported that they experienced Ego State Therapy as being more helpful to them than their previous therapies. However, this study has significant problems. Lynn (2001a) raised questions about the design:
These anecdotal reports of patients apparently contacted by their therapist, sometimes years after the treatment, are highly suspect and likely to be compromised by any number of self-report and self-selection biases. There are many reasons why therapists have ‘satisfied customers,’ independent of actual changes in their patients’ lives. Whereas ego state therapy may well be effective, controlled research using psychometrically sound assessment instruments, administered by researchers independent of the treating therapist would be far more useful than anecdotal reports. (p. 317)

Frischholz (2001) also believed the Watkins’ research to have failed to validate their theses. There are indeed problems with the Watkins’ (J. G. Watkins & H. H. Watkins, 1997) interesting retrospective, anecdotal study. As Lynn noted, it lacked standard “blinding,” a separation of treating professionals from researchers whom the patients did not know. It is additionally vulnerable to criticism for other design problems. In another piece of research on the efficacy of Ego State Therapy, Emmerson and Farmer (1996) discovered Ego State Therapy to be efficacious in the treatment of women with menstrual migraine headaches. Ego State Therapy lacks the body of efficacy studies that many consider to be the gold standard today. Nevertheless, it has grown as a modality because it is perceived by the clinicians who use it to work on a practical, clinical level.

**Efficacy Research Versus Effectiveness Research in Ego State Therapy**

Efficacy studies come with their own generic problems:

Since the 1960’s, increasingly focused, controlled, and exacting standards have been applied to evaluations of psychotherapeutic methods (Chambless & Hollon, 1998). Clinical trials have as their purpose what researchers refer to as determination of “efficacy” — evidence that a particular treatment works. This particular scientific approach arises from the “medical model.” (Wampole, 2001, pp. 8–18) (Amundson, Aladin, & Gill, 2003, p. 12)

Amundson et al. (2003) perceive this emphasis as arising from several sources. One is the need for sound scientific underpinnings to psychotherapeutic procedures. This has the potential for removing them from the domains of passionate, but unfounded, partisanship (Beutler, Williams, & Entwhistle, 1995; Talley, Strupp, & Butler, 1994; Garb, 1998). Another motive springs from the emergence of third party payers and is monetary. Most efficacy-based therapies are cognitive-behavioral. They are easy to quantify and measure and usually are relatively brief. Unlike long-term, psychodynamic psychotherapies, they are also easier to teach, practice, and prorogate. Hence, they have become a major focus in graduate training (Peterson, 1991; Dobson, 2002; Amundson et al., 2003, p. 12).
In their analysis of the application of efficacy-based research to hypnosis, Amundson et al. (2003) question its applicability to therapeutic hypnosis and express their concern that to force hypnosis upon such a Procrustean bed might imperil its survival as a therapeutic modality. Their disquiet about the relationship between efficacy studies and clinical practice was echoed in Frederick’s (2003b) editorial comments on their article.

Although efficacy studies have been termed the “gold standard” for clinical care, it is perhaps the better part of wisdom to wonder if all that glitters is truly gold. (p. 1)

Frederick (2003b) pointed to Gabbard’s (2000) unease with efficacy studies. Gabbard (2000) described an increasing backlash “...against tightly controlled efficacy studies that were being conducted in academic settings” (p. 1). Among the objections were the exclusion of 80% to 90% of available subjects, the possible effects of advertising about the research upon the experimental population, and the absence of patients with comorbidities from studies. Gabbard (2000) also wondered to what extent generalizability from research findings could be applied “to the real world in which our patients live” (Frederick, 2003b). To this can be added the somewhat disconcerting fact that Luborsky et al. (1997) were able to demonstrate that identical treatment applications (manualized and strictly controlled) can yield results that vary strongly. Gabbard suggested that it is neurophysiology research that may eventually be a proper path for investigating the results of treatment.

There are many reasons why efficacy studies may not be the best way of measuring whether Ego State Therapy can be helpful to patients. Among them (as with therapeutic hypnosis and other hypnotically facilitated psychodynamic psychotherapies) are design problems, population selection, the issue of comorbidity, and the fact that Ego State Therapy is often combined with other forms of psychotherapy, as well as the difficulties inherent in making measurements in complex systems. Fortunately, there is another available way of measuring whether therapies are helpful.

The National Institute of Mental Health has asked for more effectiveness (as opposed to efficacy) research (Markowitz & Street, 1999). Effectiveness studies attempt to research process as opposed to content and to locate those common, transtheoretical elements that make therapies useful to patients. In his review of the effectiveness literature, Oster (2003) referred to Norcross’s (2002) examination of available empirical data about the psychotherapy relationship.

Demonstrably effective features include; 1) the therapeutic alliance, 2) cohesion in group therapy, 3) empathy, 4) goal consensus, 5) collaboration. 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. Additionally, 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)

The missing link for Ego State Therapy at this point is that it has not undergone the scrutiny of rigorously controlled research. Ego State Therapy may well be where psychoanalysis was nearly a hundred years ago. Many case descriptions or reports exist. However, the next phase of objective evaluation is now required. Clearly, both efficacy and effectiveness studies are desirable. One way for research to begin is for individual clinicians to use individual case design (Borkhardt & Nash, 2002; Fonagy, & Moran, 1993).

The individual case design requires that the causal process study, as well as its effect, be documented with objective records, and wherever possible, operationalized and measured. The degree of control we decided to exercise over the causal process determines whether an individual case study is experimental or naturalistic. (Fonagy & Moran, 1993, p. 64)

Several well-recognized conceptual frameworks in psychology have been based on the analyses of individual cases. These include the psychological theories of Piaget (1952) and Allport (1961). Single case studies may be qualitative or quantitative. Qualitative studies usually precede the quantitative. Qualitative studies may include “replication by segmentation” and “time series analysis.” Eventually, they can be extended to “patient series” or quasi-experimental designs. The possibility for true experimental design also exists. Single case studies can also be quantitative.

The future of Ego State Therapy, like that of many hypnotically facilitated interventions, may well rest on its becoming the object of several different types of research (neurophysiologic, individual case studies, traditional group studies) that will examine both efficacy and effectiveness issues. How much of the needed research will be done may depend on the emergence of individuals within the field of Ego State Therapy who will organize a much-needed research focus for it.

The following chapters yield some fundamental information about the theory of Ego State Therapy and how ego states form and interact.
Ego states are personality energies that are born of interaction with the environment and often arise from the need to solve problems or meet conflicts. They are the creative formations of both the brain and the personality as the human organism strives to navigate the world in which it finds itself. Each ego state has its own relatively enduring affects, body sensations, thoughts, memories, fantasies, and behaviors. Each ego state has its own wishes, dreams, and needs. Ego states relate to one another much as family members would. Although they are separated from one another, they engage in the transmission of information, ongoing communication, role assignments (including leadership roles), cooperative ventures, and the sharing of goals and purposes. As in families, there may be subgroupings and alliances as well as hostilities and conflict. The relationships of ego states to one another can best be understood from a family therapy perspective (Bowen, 1960, 1978; Jackson, 1957; Satir 1983), or a more general systems model (Schwartz, 1995).

EGO STATES IN THE NORMAL PERSONALITY

In the normal personality, ego states relate almost seamlessly. Their relationships with one another are harmonious. The normal personality does have the capacity, however (via different ego states within it assuming the executive position), for a great deal of variation. A single individual may think, act, feel and behave quite differently from one time to another as a function of which personality part has the most energy. Frederick & McNeal (1999) have offered the following illustration of this:

For example, Dr. Jenkins is a renowned psychoanalytic theoretician. When she lectures, she wears well-styled business suits or attire of a similar fashion. Her hair is contained in a carefully coiffed French roll, and she usually adorns her blouse or sweater with a single strand of pearls. Her vocabulary is sophisticated and superb, and her bearing is dignified. It would come as quite a shock to her students to behold her behavior at most faculty parties. There she literally lets down her abundant hair, wears gypsy earrings and short skirts, and is known for her outrageous jokes and pranks, as well as her frank and earthy speech. When the party is over for Dr. Jenkins, it is over. Both her lecture persona and her party persona are aspects of a self who is quite aware of them and actually has quite a bit of choice about her behavior. When she sings the classics with her choral group, as she sometimes does, another persona—the soprano who exults in this type of activity—becomes visible. Were Dr. Jenkins to sing arias in her classrooms, lecture at parties, or party in the middle of a choral performance, we would be concerned about her. As it is, we can know simply that she is a complex person with several well-functioning ego states. (pp. 76–77)

However, ordinary human beings usually encounter internal conflicts in their lives. They may feel in conflict about decisions, great or
small. Some are as minor as which movie to see, while others are as major as which profession to enter or which individual to marry.

THE FORMATION OF EGO STATES

Perhaps the most important feature of Ego State Therapy is that its orientation is positive and adaptive. There are a few dicta in Ego State Therapy that, if remembered, can keep Ego State Therapy on track, and one of them is that: “Every ego state has come to help.” This belief is tightly embedded in conceptualizations about how ego states are formed.

Normal Adaptation and Differentiation

One reason for ego state formation is that certain ego states are needed for the individual to be able to function in one’s culture, life roles, work, and play. These are ego states that are needed for normal differentiation and functioning in the world. They enable the individual to move from work to play; from daydreaming to the implementation of various skills. Children may even use different language styles when in different ego states. For example, a child may come to use “perfect grammar” quite naturally at his/her academically demanding school, while at home or in their neighborhood his/her speech may with equal naturalness be vastly different. So, may manners and general import vary. Students from military academies and institutions such as West Point develop certain ego states associated with military bearing and behavior that are often unmistakable for the rest of their lives. One reason to think that ego states can be formed later on in life is that such adaptive ego states can develop to carry on the activities of a trade or profession. One of the purposes of apprenticeship systems may be the development of such ego states.

Introjection of Significant Life Figures

Imitation and subsequent identification (Orlinsky & Geller, 1993) are essential parts of human development. Such figures are seen as having love, power, knowledge and skills, and/or other attributes that are needed by the child to negotiate life in their family and in the world. In a very real sense many of the important figures in our lives as both children and adults have been the source of ego state formation within us. How many of us can hear our mother and father’s voices in our minds and see their gestures? While most of this is attributed to memory, the presence of introjects cannot be overlooked. Caretaker ego states may also carry with them problems of competition, aggression, depression, greed, envy, somatization, and so forth. It is also possible for a child to develop ego states that are introjects of the drama of an entire event. In adult life introject ego state formation may also
occur in extraordinary circumstances. For example, a torture victim might form an introject ego state based on the torturer.

**Trauma**

There are many kinds of traumatic experiences. In the lingua franca of traumatology, traumata are often divided into “Big T” trauma and “Little t” trauma (Schwartz, 2002). Because Ego State Therapy was developed out of work with severely traumatized patients (Watkins & Watkins, 1997), it may be associated with major trauma in the minds of many. However, smaller events and cumulative trauma (the repeated failure of the care-giving parent to meet the developmental needs of the growing child (Khan, 1963) can also structuralize the mind-body into ego states as well.

**Clinical Case Example**

Annie is having difficulty in the dating scene. Although she meets men easily and experiences her first dates as successful and fun, something happens when men begin to declare interest in her of the kind that could lead to a committed relationship. At that point, she feels “frozen,” and she starts withdrawing from the man in question.

When Annie was six years old, her father frequently told her what a wonderful little girl she was and how special she was to him. Annie’s mother, who was quite narcissistic, developed a clinical depression and began to have difficulty with her husband’s normal interest in his daughter: “Don’t tell her things like that! They will only make it impossible for her to get along with people!”

Annie developed an ego state that caused her to withdraw from her father when he praised or complimented her. In this way, she was protecting her mother from blows to her self-esteem. In her adult life this ego state became activated when her dates focused their attention on her seriously. Later in therapy, Annie realized that the state also became activated (but to a much lesser degree) when her supervisor complimented her for her work performance. At those times she would lower her head, “freeze” her posture, and be momentarily incapable of speech.

The connection between trauma and subsequent psychopathology remain a topic of debate (Brown, Scheflin, & Hammond, 1997). All trauma does not necessarily produce psychopathology. There are important life elements such as context, family structure, and the presence or absence of significant family pathology. It is the presence or absence of restorative experiences that determine whether the child will develop a pathologic response to trauma (Brown, Scheflin, & Hammond, 1997; Kluft & Mulcahy, 1985; Tillman, Nash, & Lerner, 1994; Waites, 1997). However, J. G. Watkins and H. H. Watkins (1997)
believe that when trauma becomes truly overwhelming, children have only a limited number of options. According to J. G. Watkins and H. H. Watkins (1997), children may become psychotic in its face, may commit suicide, or may create a new personality energy to deal with it (one or more ego states).

From the standpoint of brain development it can be supposed that factors such as restorative experiences (Kluft & Mulcahy, 1985) and a supportive family structure (Tillman et al., 1994) could interrupt post-traumatic replay before it became entrenched into structuralization within the brain (Cozolino, 2002; Siegel, 1999), and such experiences might well make the establishment of an enduring trauma-based ego state less likely.

Attachment Problems

The Watkins have not specifically included attachment pathology as a source of ego state formation. Such a category of causation is required. We are primarily members of a group, and even the most solitary of us exists in relation to an internalized group, our Internal Family of selves. Another way of looking at attachment is that it

... is an inborn system of the brain that evolves in ways that influence and organize motivational, emotional, and memory processes with respect to significant caregiving figures. (Siegel, 1999, p. 67)

Attachment has high survival value at the most basic evolutionary level. At the mental level attachment is the foundation for interpersonal relationships. When secure attachments are present, the parent responds with emotional sensitivity to the signals of the child. This gives the child a sense of well-being and positive emotion.

Repeated experiences become encoded in implicit memory as expectations and then as mental models or schemata of attachment, which serve to help the child feel an internal sense of what John Bowlby called a ‘secure base in the world.’ (Siegel, 1999, p. 67)

Ainsworth (1967, 1989), Ainsworth, Blehar, Waters, and Wall (1978), and Bowlby (1979, 1980, 1988) have provided evidence for the fundamental role that attachment, one of the affectional ties in mammals, plays in human development. Bowlby called attention to Harlow’s (1960) work with affectional ties in primates, as well as his own work with children who had severe attachment disorders. His application of attachment theory to grief and bereavement (later popularized by Kubler-Ross in 1969) includes perspectives that are both developmental and relational.

All affectional bonds—whether those of infancy, of romantic love, of transference, or of countertransference—follow the same specific rules (Ainsworth, 1967, 1989; Ainsworth et al., 1978; Bowlby, 1979,
1980, 1988). They have been summarized by Frederick (2003a): (a) Sub-
stitutions are not allowed. They always involve a specific individual
for whom there is absolutely no substitute (b) they are always persist-
ent (c) the relationship is emotionally significant (d) proximity or con-
tact is always desired with the person (e) there is always distress at
involuntary separation (Cassidy, 1999), and (f) the additional criterion
required for attachment is that felt security and comfort is sought by
one individual from the other as a primary goal of the relationship
(Ainsworth, 1989).

Attachment is one of several innate psychobiological emotional sys-
tems that direct animal and human behavior. Security and comfort are
sought as primary goals of a relationship by one individual from the
other (Ainsworth, 1989). Attachment patterns are established early in life
and manifest themselves in the transference. Among attachment patterns
are secure, anxious-ambivalent, anxious-avoidant, and disorganized-
disoriented attachments. Attachment styles may vary from ego state to
ego state, so that the transference-countertransference field when
viewed from an ego state perspective, may reflect great variation and
add to the appearance of spiraling or cycling during treatment.

**EGO STATES AND ATTACHMENT**

Many individuals develop personality energies whose purpose is to
fill in gaps, to substitute for losses, to counter the terrors of separation
as well as inadequate presence (e.g., a caretaking parent who is physi-
cally “there,” but emotionally and empathically absent), and to offer
some version of transitional experiences, nurturing, constancy, and
companionship. These creations may not be introjects per se. Fre-
frequently, they are the work of the imagination for example, idealized
parents, playmates, siblings, and heroes who have no counterpart in
the real world.

However, there are multiple issues concerning ego states and
attachment. Many ego states that are not formed in response to attach-
ment deficiencies per se have attachment problems nonetheless. This is
particularly true of ego states that were formed as a response to
trauma. Trauma disrupts healthy senses of attachment. The develop-
mental deficiencies that follow it (Fine, 1990) may lead to significant
attachment problems. Whenever child ego states are encountered, the
attachment paradigm must be kept in mind.

At times ego states that have been formed to deal with attachment
disruptions or absences may engage in reassuring transitional experi-
ences (Fink, 1993). According to Fink, some of them can become actual
fetishes (Greenacre, 1971), entrenched ego states with specialized self-
soothing activities (not infrequently associated with sado-masochistic
fantasies). Frederick and McNeal (1999) have noted that such ego
EGO STATE THERAPY

states are “... frequently engaged in pathological transitional behaviors such as compulsive autoeroticism and other forms of sexual behavior, eating disorders (especially bulimia), addictions to drugs and alcohol, and addictions to fantasies, objects, and people” (p. 165).

The therapeutic alliance is the primary medium for the restoration, or in some cases, the establishment of secure attachments in ego states. Other maneuvers for developmental repair may also be necessary. The development of secure attachments among all the ego states within a greater personality is one of the tasks of Ego State Therapy, and it is essential for integration.

THE CENTER CORE OF THE PERSONALITY

As we consider ego states, we may wonder whether there is also a center or a core of self that conveys a sense of wholeness to the individual. J. G. Watkins and H. H. Watkins (1997) have postulated the presence of a core ego that:

... contains a number of behavioral and experiential items that are more or less constant in the normal individual and which present to the individual and to the world a fairly consistent determination of the way he and others perceive his 'self.' ... During active periods the core ego is expanded, extending ego cathexes over more mental structures and processes. (p.26)

Torem and Gainer (1995) also proposed a concept of Center Core. They noted that the Inner Advisor techniques (Comstock, 1991) recommended by Hammond (1990) were commonly used in the treatment of patients with a variety of dissociative disorders. Torem and Gainer (1995) thought the purpose of Inner Advisor techniques to be the promotion of the patient’s objective and self-reflected thinking. They defined the Center Core as:

... the resources experienced by the patient while in this ego state reflect an aspect of the patients own “core” personality or innermost, central self. ... The Center Core can elucidate hidden agendas that affect therapy through subtle or covert influences of conflicting ego states. In this ego state the patient also can learn to foresee and better avert crises. (Torem & Gainer, 1995, P. 260)

Torem and Gainer (1995) subsequently amplified their view of the Center Core of the personality. They substituted the term Center Core for Inner Advisor, and they seemed to have regarded it as a sphere of the ego that represented the individual’s many strengths and was somehow separate from the conflict of the parts. They referred to one of these as “inner strength,” but they did not connect it with McNeal and Frederick’s (1993) Inner Strength. They conceptualized the Center Core dually as both an ego state that has an awareness of the “... experience
of unity and wholeness” (Torem & Gainer, 1995, p. 127) that promotes within the personality and “... a representation of the patient’s own inner strengths and resources (Torem & Gainer, 1995, p.128).

Torem and Gainer’s Center Core has much in common with Comstock’s (1991) Inner Advisor, J. G. Watkins and H. H. Watkins’s (1997) Observer Ego State, and Rossman’s (1987) Inner Wisdom in that these aspects of the personality emphasize what is rational and logical in the experience of the family of selves and do not appear to be directly involved in conflict. The precise nature of the Inner Advisor/Center Core is complex. However, it can be viewed as sharing certain elements of the Self as described in Internal Family Systems Therapy (Schwartz, 1995):

The purpose of the Inner Advisor is to provide the patient with a “transcendent” perspective of reason and objectivity. The Inner Adviser can be interpreted as a symbolic representation of the patient’s own, though perhaps dissociated, ego-strengths. The Inner Advisor also can be interpreted as an introject of the therapist that occurs within the context of the therapeutic relationship. In the dissociative disorders, particularly in multiple personality disorder, the Inner-Adviser is experienced as a distinct ego state, the function of which is to preserve logical, rational, mature and objective thinking. We used the designation of “Center Core” to identify its role. The term “Center Core” denotes that the resources experienced by the patient while in this ego state reflect an aspect of his/her own “core” personality or innermost, central self. Such positive framing encourages the experience of mastery and discourages disowning or externalization of therapeutic gains. . . . The Center Core can be understood as serving a deeper, existential function. As a natural accomplishment of integrated living, individuals achieve a sense of unity or wholeness of the self. We postulate that this experience of the unified self is a perceptual achievement that becomes acutely impaired in the experience of trauma. (Torem & Gainer, 1995, p. 126-127)

According to Torem and Gainer, the Center Core is activated with hypnosis and the suggestion that the patient has within an aspect of self that thinks rationally and logically. The Center Core can be experienced as an energy field or as an object or personification. Torem and Gainer (1995) recommend that therapists personify the Center Core in the therapeutic process, enter into dialogue with it and teach patients how to access this aspect of personality for valid information. They believe that therapists are able to depend on the Center Core for significant information and help as long as the therapeutic alliance is working. The more dissociated patients are able to use the Center Core, the greater becomes their sense of the self as a unified whole.

While they understand that there is a possibility that Center Core phenomena could be iatrogenically created ego states, they noted that the increased ego-strength that follows interactions with the Center
Core is unlikely due to the therapist. Ultimately, they are uncertain as to the precise nature of the Center Core, however, inasmuch as it could be something that is innate within the patient, a metaphoric visualization of resources or an iatrogenically created ego state.

McNeal and Frederick (1993) and Frederick and McNeal (1993, 1999) became interested in the activation of powerful conflict-free aspects of personality whose manifestations could include, but were not necessarily limited to, affective experiences of power and strength as well as cognitive, rational information and rationally understood behaviors. They developed the concept that there were conflict-free resource energies deep within the personality that, when activated, could have profound experiential effects on ego states as well as on the greater personality.

Although most explanations for the mechanisms or dynamics of ego-strengthening had been based on cognitive-behavioral theory, McNeal and Frederick (1993) and Frederick and McNeal (1993) had turned to the ego psychology of Heinz Hartman (1961, 1965). Hartmann believed that the ego developed separately from the Id and that it had a number of autonomous functions that were not affected by personality conflict. Among these were such things as memory, perception, and motility. These functions did not develop out of frustration of the drives or spring from conflict but were always present from the time the individual was born. He theorized that the ego contains both defenses and adaptations. Hartman (1961, 1965) placed those ego functions that exist separate from conflict and frustration as belonging to the conflict-free ego sphere.

McNeal and Frederick (1993) described the hypnotic activation of Inner Strength, a conflict-free aspect of the ego that was concerned with one’s deepest survival. Inner Strength was fearless and was incredibly strong. In an examination of the effect of Inner Strength activation upon ego states, Frederick and McNeal (1993) concluded that the Inner Strength technique “... accesses internal survival mechanisms so that insight becomes translated into action. This technique activates helpful ego states which then become integrating mechanisms in therapy” (p. 251). They believed that Inner Strength was one of many internal resources that could be therapeutically evoked from the unconscious (Erickson & Rossi, 1976). Although McNeal and Frederick (1993) defined Inner Strength as “... an ego state that has always been there from the moment of birth” (p. 172), they clarified this by adding that it was “... something like an ego state” (p. 177). They did not feel it was identical in nature or function with other ego states. Subsequently, Frederick (1996b) categorized helping ego states into “conflict-laden” ego states and “conflict-free ego states.”

Later, Frederick and McNeal (1999) incorporated into their thinking Jung’s (1969) conceptualizations of the archetypes, patterns of instinctual
behavior that resided in the collective unconscious. Within the conflict-free sphere of the ego Frederick and McNeal (1999) identified a number of powerful archetypal self-objects (Gregory, 1996) such as Inner Strength, Inner Wisdom, Inner Love, and Inner Advisors. To this group should be added “Higher Self” (Watkins & Watkins, 1997) and “Life Energy” (H. Watkins, 1990), Observer Ego States (Watkins & Watkins, 1997), and the Inner Healer (Ginandes, 2002). Ginandes (2004) also emphasizes the role of the therapist’s own pro-active conflict-free ego state, the “Therapist as Healer,” in her work with mind-body cases.

Frederick and McNeal (1999) adopted Hartmann’s (1961, 1965) term, conflict-free sphere of the ego, for what is often called the Center Core of the personality. They thought that it held both archetypal and enduring aspects of personality as well as unique and highly personal conflict-free aspects. They reported positive, strengthening, and healing effects when conflict-laden ego states were able to experience the archetypal self-objects. The power of the archetypal self-object, Inner Strength, to ego-strengthen immature ego states (Frederick & McNeal, 1993, 1999) and to help them grow developmentally is now recognized widely throughout the Ego State Therapy literature (Emmerson, 2003; Phillips & Frederick, 1995; Watkins & Watkins, 1997). The profound effect of its activation in the normal personality is eloquently described in Morton’s (2003) narrative of her use of Inner Strength in alpine mountain climbing.

Conflict-free energies can impart strength, information, instruction, the sense of being loved, reports on other ego states, and other helpful gifts in Ego State Therapy. They play an even more powerful role in Internal Family Systems Therapy (Schwartz, 1995) where the self is completely central.

**Internal Family Systems Therapy**

*Predecessors of Ego State Therapy*

Transactional Analysis (Berne, 1961) differs greatly from Ego State Therapy (Emmerson, 2003a; Phillips & Frederick, 1995) although they share the term “ego state.” Both of these systems were developed from Federn’s (1952) theory of ego states. Berne’s Transactional Analysis works with five fixed ego states only. Psychosynthesis (Assagioli, 1965) also deals with parts. It categorizes them into Sensation, Emotion-Feeling-Impulse, Desire, Imagination, Thought, Intuition, Will, and Central Point (the personal self). Voice Dialogue (Stone & Winkelman, 1985) also tends to categorize subselves into roles. Gestalt Therapy (Perls, 1973) also has an idea of the usefulness of “parts work.” In this respect Perls leans heavily on the externalization techniques of psychodrama (Moreno, 1946). Although it uses certain “parts” approaches such as “top dog” and “underdog,” it lacks a comprehensive system or theory of parts. Like Phillips and
Frederick (1995) and Frederick and McNeal (1999), Emmerson (2003) is clear that none of the superficially similar systems has a vision of many unique ego states, each with a personal history, narrative, thoughts, feelings, desires, behaviors, and body connections.

Internal Family Systems Therapy

There is one contemporary version of polypsychic therapeutics that is remarkably like Ego State Therapy in many ways despite very genuine theoretical differences. Internal Family Systems Therapy (Schwartz, 1995) shares many conceptualizations and treatment approaches with Ego State Therapy. One of its major differences from Ego State Therapy is the role of the Center Core personality in the composition of the greater self, as well as in the treatment process. Schwartz, who is a family therapist, developed a view of the human personality as composed of subselves that existed in a system and were subject to the same rules that govern all systems, be they internal families, families of origins, boards of directors, or baseball teams. Schwartz views ego states, or parts, as unique and particular and as being adaptive in the sense that they come to help the greater personality. It respects all of the parts and fosters the creation of therapeutic alliances with them.

Schwartz (1995) realized that the same systems dynamics observed in groups appeared to exist within the individual personality’s own aggregate of subselves. Schwartz’s (1995) definitions of parts, or subselves, is remarkably similar to J. G. Watkins and H. H. Watkins (1997) definition of ego states. Their concepts of a differentiation-dissociation spectrum are also remarkably parallel.

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. (pp. 34–35)

Schwartz (1995) is clear about how his model differs from others: (a) Its focus is on the networks of parts of the individual and not just on the individual parts: (b) it emphasizes connections between the internal family system and the individual’s external family system, and it works with both of these and (c) it differs in what it assumes about the qualities and roles of the Self.

The parts (ego states in the Ego State Therapy framework) are divided by Schwartz (1995) into categories that describe their functions without subsuming their unique individuality. These categories help
therapists understand the strategic functions of parts. Schwartz classifies parts into a three-group system of exiles, managers, and firefighters.

Exile parts are the most fragile and sensitive within the system. They carry the psychic injury, the pain and fear. They usually hold the trauma memory material for the system and are frequently flooded with shame and guilt. They are usually child parts. These parts are shoved into the background by the system. The manager parts have as their roles the tasks involved in keeping the exiles protected away from the rest of the internal system and out of consciousness. These manager parts fear the disruptive escape of the exiles into consciousness. They arrange patterns of memory, affect, behavior, and sensation to protect the exiles from anything that will produce reaction and stimulate them into overt expression. Exiles signal their presences in a number of ways such as flashbacks and other post-traumatic symptoms, somatizations, and dreams. All the while, the managers are attempting to contain them. They do this through life patterns, symptom clusters, and other defenses such as avoidance, denial, and flight, etc.

When even the best efforts of the managerial parts are unable to keep the exiles locked up, the third category of parts, the firefighter parts, become activated to “put out the fire,” to extinguish whatever memory material, affect, imagery, or other mental content may activate the exile states. Firefighting activities are frequently therapy-interfering. They include such things as suicide attempts, substance abuse, sexual acting out, depersonalization, flight, and rage attacks.

According to Schwartz (1995), the parts exist in order to protect a core personality, which Schwartz calls the Self. They have as their function (especially in trauma) the separation of the Self from the body via dissociation. Parts that have had to be so protective of the Self eventually lose confidence in the ability of the Self to be able to take the leadership role. Schwartz (1995) sees the separation of the Self from the body and from its leadership role as constitutive of internal dysfunction. The Self itself is conflict free:

\[ \ldots \] whenever the Self is not functioning effectively, it is not because the self is defective, immature, or inadequate, as some other approaches assume. Instead, the Self has all the necessary qualities for effective leadership, but it is constrained by parts that are afraid to differentiate fully from it. This is a difficult assumption for many therapist to accept. (p. 39)

The task of Internal Family Systems Therapy is to reconnect the parts with the Self and to restore the leadership of the Self, or Central Core of the personality. Schwartz (1995) calls the Self “The I’ in the Storm” (p. 37) and sees it as being identical with Csíkszentmihalyi’s flow state (1990). Whenever parts are able to be reunited with the Self, they are healed.
Schwartz (1995) believes that the Self can be felt as a wave, or energy, as in a sense of connection with the universe, or as a particle, as in the experience of a personal self. He has used Beahrs (1982) metaphor of the conductor and the symphony orchestra to describe the relationship of the Self to the parts (ego states). “One major goal of the model, then, is to help each client differentiate the Self as quickly as possible so that it can regain its leadership role” (Schwartz, 1995, p. 40).

Concepts of a powerful conflict-free Center Core or Self are present in both Ego State Therapy and Internal Family Systems Therapy. Ego State Therapy emphasizes the development of high functioning ego states and the integration of ego states with one another. It sees archetypal self-objects, or Center Core activity, as often being crucial to this process. For Internal Family Systems Therapy the restoration of trust in the Self and the reclamation of leadership, not by mature ego states but by the Self itself, is the goal. Internal Family Systems Therapy does not claim to use formal hypnosis or to employ hypnotic interventions. This is probably not entirely the case. The intense focus on the internal material produces spontaneous trance states.

Ego State Therapists generally hold great respect for Internal Family Systems Therapy, and many Ego State Therapists find certain Internal Family Systems Therapy ideas to be helpful to themselves and to patients. The behaviors of ego states can sometimes be better understood when the therapist speculates whether they are behaving like managers, firefighters, or exiles (Sowada, 2003). Internal Family Systems Therapy also brings to polypsychic approaches a greater understanding and application of systems theory. It appears to lack the comprehensive approach to developmental repair of child parts that can be found in Ego State Therapy (Frederick & McNeal, 1999; Phillips & Frederick, 1995).

The following chapter describes the ego state spectrum, how to diagnosis of ego state pathology, and the use of personification in the language of Ego State Therapy.

CHAPTER III
EGO STATE PATHOLOGY

THE EGO STATE SPECTRUM

Ego states can be thought of as existing on some kind of spectrum in terms of their relationships (separateness vs. closeness) with other ego states. J. G. Watkins and H. H. Watkins (1997) have called this the Differentiation-Dissociation Continuum, and Phillips & Frederick (1995) describe it as the Ego State Spectrum. At one end of this
spectrum are ego states that have very thin boundaries and are not very separate from one another. An individual with a predominance of this kind of ego state might present as somewhat a colorless personality. As we have seen, normal differentiation provides for greater separation of the ego states from one another. These normal separations afford complexity, but at times, they could also be a source of some internal conflict that would be reflected intrapsychically or interpersonally. As one proceeds along the Ego State Spectrum, it can be noted that ego states with boundaries somewhat thicker than “normal” may be associated with clinical symptoms. When such ego states become executive, individuals may experience the symptoms of such difficulties as Post-Traumatic Stress Disorder, depressions, obsessions, compulsions, panic attacks, sexual compulsions, sexual identity problems, anti-social behaviors, somatic difficulties, intractable pain, eating disorders, resistance to psychotherapy, and so forth. These ego states are more dissociated than differentiated.

Yet further on the continuum or spectrum are the full-blown dissociative disorders. Such clinical syndromes as Conversion Disorder, amnesias, and Somatization Disorder can be found here. At the extreme end of the spectrum from integrated ego states are those that are severely separated and dissociated. They manifest themselves as the alters of Dissociative Identity Disorder (DID). When separation among ego states is quite extreme and the ego states are self-activated (take over the executive role in the personality in the absence of hypnotic activation), are not under the control of the greater personality, and come out spontaneously, DID exists. Here the ego states are given the special name of alters. In this disorder, ego states activate themselves, often in a chaotic and troublesome fashion.

DISRUPTIONS IN THE DYNAMICS OF THE INTERNAL FAMILY

Ego state pathology is always the result of disharmony within the internal family of selves. There are several reasons for a failure in harmonious relationships among the internal energies.

1. Ego states relationships are greatly affected by the nature of each ego state’s boundaries—certain ego states may have boundaries that are “too thick.” Such ego states do not communicate with, or cooperate with, other ego states because they are not in positive energetic relationships with them. When the boundaries are too dense, some ego states may not even be aware of the presence of other ego states within the greater personality.

2. Certain ego states may be too immature to be able to relate to the other ego states. Their immaturity may be of such a nature as to be disruptive. All of us need childlike personality energies for play and creativity. However, certain child energies that have arisen to deal with trauma
may have severe developmental deficits and may not be able to manage boundaries, contain or modulate affect, or control some behaviors. Additionally, their thinking may be primitive and contain many cognitive errors. Their immaturity is often an operationally “too-thick” boundary for an immature ego state.

3. Yet, other ego states, often called malevolent or destructive ego states, may be “protector states” that in addition to having overly thick boundaries separating them from the others may engage in destructive activities and produce disruption within the system in misguided efforts to safeguard other parts and/or the greater personality.

INTEGRATION IN EGO STATE THERAPY

When the ego states energies of the internal family are in a state of communication, cooperation, and an ongoing ability to share consciousness, integration is said to be present. When ego states are integrated, they can be activated with hypnosis, but they do not become fully activated with “ego cathexis” or “I-energy” on their own. The opera singer, for example, who is in her Diva ego state, does not become only that energy. Should another singer develop an acute medical condition on stage and collapse, the opera singer would seamlessly move into a personality energy that knew about dealing with emergencies.

DIAGNOSING EGO STATE PATHOLOGY

Personification in Diagnosis and Treatment

Ego states are not little people running around inside one’s head. They are coherent aggregates of personality energies with structural neurophysiological substrata. However, effective Ego State Therapists do not work with energies. They work with personifications, important tools of the imagination. Perhaps one of the less valued and least understood aspects of psychodynamic psychotherapy is the intrinsic role of imagination. Hillman (1976) reminds us that Jung believed that “Image is psyche” (p.23).

When the Ego State Therapist works with ego states, he/she calls them by name, relates to them therapeutically, works hard to establish a therapeutic alliance with the ego states and strives to help the ego state resolve its own difficulties as well as those it may have with the internal family of selves. In so doing, the therapist moves into another dimension of psychological reality—the world and the story, or narrative, of the psychic energy engaged. This is not a world of historical veridicality, but of a kind of narrative truth (Siegel, 1999; Spence, 1982) and “meaning making” (Horowitz, 1973). This is a world and a therapy that is understood better by psychodynamicists than by behaviorists simply because it utilizes a specific paradigm.
Currently, the idea that restricts subjectivity to a person (as opposed to an ego state or a Jungian archetype or complex) has descended to us from Christian views that only a person with a body and soul deserves Divine regard and from Cartesian viewpoints that separate the world into perceiving subjects that are alive and many objects that are dead, with nothing in between (Hillman, 1976). This Western scientific perspective is held by some degree of necessity to some extent by all members of the scientific community. From the standpoint of the actual practice of conducting psychodynamic psychotherapies, it is however, highly restrictive and does not allow for the mythological, the metaphorical, or the indefinite or uncertain that are part and parcel of such therapy. It disparages anthropomorphism and the mythical and depotentiates personifications and mythologies through allegorism.

In fact, psychologists in general denigrate personifying, labeling it a defensive mode of perception, a projection, a ‘pathetic fallacy,’ a regression to delusional, hallucinatory or illusory modes of adaptation. (Hillman, 1976, p. 2)

Yet, to . . . give subjectivity and intentionality to a noun means more than moving into a special kind of language game; it means we actually enter into another psychological dimension. (Hillman, 1976, p. 1)

The use of personification, like the use of hypnosis to retrieve memory material or repressed material, or to otherwise work with a patient is decried by some (Lynn, 2001a, 2001b) who do not utilize personification as do Jungians, Gestalt Therapists, Internal Family Systems Therapists, and Ego State Therapists. Lynn (2001a, 2001b) stated his belief that Ego State Therapists should obtain Informed Consents from their patients in which it is acknowledged in some detail that all reference to ego states is metaphorical. This appears to be an attempt to fit together two paradigms that are in this respect incompatible. Cavanaugh (1991) reminds us the term “bridging paradigms” can be read in two ways. One is bridging paradigms; the other is “bridging paradigms.”

Taking the second meaning. . . If we mean Kuhnian paradigms, then how do we go about bridging different paradigms that may be mutually exclusive (in a strict Pepperian sense)? (Cavanaugh, 1991, p. 2)

Kluft (2001) also noted that scientific paradigm incompatibility (Kuhn, 1970) could result in a lack of agreement about how to proceed clinically. While Ego State Therapy can and does accommodate many paradigms that can be useful when applied practically to therapeutics, it cannot be combined with a paradigm that heuristically excludes personification.

From a practical standpoint, one cannot form a therapeutic alliance or enter into a deep intersubjective relationship with a metaphor.
this sense Ego State Therapy can truly be compared, and in the best and most vital sense, with fiction. Like psychodynamic psychotherapies, fiction manipulates words, metaphors, and subjectivity in order to give an experience that is deep, leads the reader into a different reality, contains some special wisdom for the reader and imparts some universal truth.

A novel is not an allegory. . . It is the sensual experience of another world. If you don’t enter that world, hold your breath with the characters and become involved in their destiny, you won’t be able to empathize, and empathy is at the heart of the novel. This is how you read a novel: you inhale the experience. So start breathing. (Nafisi, 2004, p. 110)

As we shall see, it is necessary to have deep emotional involvement when engaging in Ego State Therapy and essential to achieve the strong feelings that allow empathy for ego states to develop. This is the kind of imaginal reality in which Ego State Therapy takes place. Although it is not a literal reality, it is nonetheless, a therapeutic reality. General discussion with patients about the role of imagination in therapy with adequate reference to the imagined psychic structures used by Freud, Jung, and others can be helpful, as can dialogues about how theory gets translated into therapeutic practice, but they should not override or subsume the therapy itself. Were they to do so, they would devitalize it.

**EGO STATE PROBLEMS: MAKING THE DIAGNOSIS**

How does the clinician know whether Ego State Therapy is indicated, or will even be useful, for a given patient? Aside from the extremes of personality dissociation found in Dissociative Identity Disorder (DID) in which ego states (alters) often present with identifying pathologies that can be as clear as international road signs, there are many who enter consultation rooms with ego state problems that may be less easily detected. Among these are variations of the common problems of individuals who do not have a major mental illness. These may include patients with such things as simple phobias (Malcolm, 1996), depression, particularly atypical depression (Frederick, 1993a; Newey, 1986; Torem, 1987a), panic attacks with or without agoraphobia (Frederick, 1993a), Obsessive Compulsive Disorder (OCD) (Frederick, 1990, 2002), post-traumatic stress disorder (Phillips, 1993a), somatization difficulties (Phillips, 1993b), fertility problems (Morton, 2001), compulsive sexuality (Sowada, 2003), morbid obesity (Frederick & Johnston, 2002), anorexia nervosa (Torem, 1987b), and pain control problems (Gainer, 1993, 1997). Patients may also come to therapy for help with their interpersonal relations. They may describe behaviors that are counterproductive or actually sabotaging. Frederick (1990, 1993b) and subsequently, Phillips and
Frederick (1995), described several indications of possible ego state pathology. Ego state exploration is not intended to preempt the ordinary and complete evaluation of the patient. It is always “in addition to” other items such as history and a mental status examination. Patients with complaints that sound like ego state problems could have organic illness such as temporal lobe epilepsy, brain lesions, metabolic difficulties, or a host of other medical issues. Patients may also have dual diagnoses. Medical clearance is recommended for all patients who report signs or symptoms suggestive of ego state pathology. An ego state diagnostic examination cannot stand alone. It must always be embedded within sound medical and psychological practice.

There are many ways in which patients express difficulties within the Internal Family of ego states. They may appear spontaneously within the history, or specific questions may be required before they are elicited. They include:

1. Ego-Dystonia

   In evaluating the patient for the possibility of ego state pathology the therapist should always inquire about the presence of ego dystonia. It is not uncommon that the patient will refer to a behavior or to a symptom with the phrase “It just isn’t like me at all.” The therapist who hears this kind of material can then ask the patient for more detail: How was it “not like” the patient? This is an opportunity for multimodal investigation.

   Thought- What was the patient thinking at the time? How was this different from usual thought patterns and topics? Were there racing thoughts? Did the ideation vary from customarily held ethical, moral, or social standards? Was the patient thinking like an adult?

   Imagery- Was the patient aware of any specific imagery? Was there intrusive memory material?

   Affect- Was the patient’s affect altered in some way? Were depersonalization or derealization present? Did the patient feel his/her own age, size, or shape?

   Body Sensation- What did the patient feel in his/her body while it was going on? Did the patient feel larger or smaller? Older or younger? Was there a change in shape or configuration, coordination, or agility?

   Behavior- Was any behavior different? If so, was it like behavior from an earlier time, perhaps long ago? Did it remind the patient of anything or anyone?

   Context and Meaning- How did the patient’s experience fit in with the general context of his/her external situation at the time? Did the patient have any sense of what the experience meant?

   There is obvious overlap between some of these questions and the questions from the Dissociative Experience Scale (DES) (Bernstein & Putnam, 1986) and the Structured Clinical Interview for DSM-IV Dissociative Disorders (SCID-D) (Steinberg, 1994). Ego dystonia can be a clue
to significant identity confusion. Patients who describe it could have dissociative difficulties and should be investigated for the presence of dissociative disorders as well as ego state pathology. However, not every patient who describes ego dystonia has a severe dissociative disorder. For example, the patient Joan, whose intermittent ego state driven depressive symptoms were described by Frederick (1993b), said she did not feel like herself when she suddenly experienced sudden circumscribed episodes of sadness and tears. Nevertheless, Joan was well in the normal range for dissociation in general.

2. Unusual or unexplained affect

Another clue to the presence of ego state pathology is unusual, exaggerated, greatly diminished, and/or unexplained affect. Anything unusual in the realm of affect should be the occasion for further inquiry. The diagnostic answers may not always be readily available. The patient with alternating moods of depression and elation could have a mood disorder such as Bipolar Disorder, could have DID or could have isolated ego state pathology. Distinguishing the Bipolar pathology and ego state pathology is one of the most challenging aspects of ego state diagnosis. It must be remembered that the two pathologies can coexist at times.

3. Unusual or unexplained somatic experiences

Patients may describe unusual or unusually persistent body sensations or may present with refractory pain. These complaints may or may not be coupled with unusual behaviors. For example, a patient might display “la belle indifference,” may have intractable pain, may complain of multiple somatic issues.

4. Unusual or unexplained experiences within fantasy life

Some patients may come by unusual fantasy experiences such as repetitive imaginal presentations of horror picture images, or of pictures or designs that are sometimes abstract in nature that are meaningless to them. These “mystifying signals” (Frederick & Phillips, 1996) could be the communications of nonverbal ego states.

5. The language of parts

Patients who experience ego state struggles may use the language of parts and make statements like “a part of many ones to do best-and-so; while another part of me may want to do something completely different.” At times patients may describe feeling as though there is a war or battle going on inside of them.

6. A felt sense of dividedness or of an internal struggle or war

Many patients with ego-state problems have a felt sense of dividedness but are frightened to voice it. To many of them the dividedness is a sign that they are crazy, and they are reluctant to offer this information to the therapist. When such patients are asked, “Does it feel as if there is a war going on inside of you?” They most often respond with relief that the therapist has understood them.

7. Exaggerated “self-talk” or actual internal chatter

Patients with ego state difficulties are often aware of internal chatter or voices. These are not hallucinations. In more severely dissociated patients, the voices of ego states become externalized and are experienced as hallucinations. It is often useful to begin this exploration by asking the
patient if he/she has an “internal critic,” the nagging internal voice that so many of us have that is always telling us that what was just done was wrong. Does this voice tell the patient that he/she is stupid, careless, shortsighted, etc. Many patients describe this as “self-talk,” however, a certain number indicates that there are clear voices within, and they may even be able to describe the genders and/or ages of the speaker or speakers.

8. A feeling of “falling to pieces” or “being crazy”

As the examination becomes increasingly complete, and if the therapist has found no evidence of psychosis, the patient may respond to a question like this: “I know that you are not crazy, and I hope that you also know that, but I am wondering if, at the same time, you sometimes feel as if you are crazy?” This feeling of being crazy in a non-psychotic patient is often present in trauma patients (Van der Kolk, 1996) and may signal ego state involvement.

9. Observed unusual behaviors

Without any awareness or sense of awareness patients may display unusual behaviors such as tics or other bodily movements, interferences with vocal productions, changes in the body’s position and tonality, and unusual facial expressions that could cause the examiner to wonder if another personality energy may be present. These minimal manifestations are not necessarily evidence of the extreme ego state pathology of DID, but could, rather, indicate something less severely dissociated within the Ego State Spectrum.

10. Refractoriness to treatment

Refractoriness to treatment remains one of the common reasons that patients with ego state pathologies continue to seek therapists who can help them. This does not mean that the treatment that they have received is bad. To the contrary in the experience of this author many patients with unresolved ego state problems have had high quality treatment performed by well-trained therapists. The missing element is the ego state orientation. The treatment has not been addressed to the aspects of the personality that hold the problems.

11. Positive diagnostic ego state exploration

Diagnostic ego state exploration should never result in harm. It should strike the sound ethical ground that exists between errors of suggestion or exaggeration of symptoms and signs and errors of omission. The therapist should make it possible for ego states to be able to reveal their presence all the while avoiding the suggestion that the patient must be aware of the presence of parts in order to please the therapist. Ego State Therapists have no interest in implanting the notion of parts experiences when that is simply not where the patient is. This is one of many reasons why ego state therapists must, of necessity, be trained to conduct other kinds of psychotherapies. Ego State Therapists should have no personal investment in whether or not ego state pathology is present but, rather, should only be devoted to discovering what is going on with the patient. Beginning Ego State Therapists may need to be reminded that not all ego state exploration results in the identification of either ego states or ego state pathology. Nevertheless, ego states exploration should always be done when there are indications of possible ego state pathology.
Lynn, Marc, Kvaal, Segal, & Sivec (1994) have presented three research studies and a number of references indicating that hidden observer phenomena “can be shaped by situational demand characteristics” (p. 131). Although Ego State Therapists may meticulously avoid overt demands that the patient experience ego states or identify ego state experiences, there can be no question whatsoever that there are many demand characteristics present in any ego state-oriented diagnostic interview. This is one of the criticisms that can be leveled at Ego State Therapy. However, it is also an issue for every other therapeutic orientation as well.

Lynn et al.’s (1994) work is a significant contribution that should be firmly lodged in the awareness of Ego State Therapists when they are conducting diagnostic examinations. The moment any therapist with any theoretical orientation meets with a patient, demand characteristics invariably enter the scene. This is true whether the therapist is a behaviorist, a Jungian, a primal scream therapist, or a rational emotive therapist. It may not even be possible to keep demand characteristics out of the research situation most of the time. There is no question that our patients may always try to fit their data into our theoretical frameworks as they attempt to please us or to respond to our unspoken suggestions. This is part of the territory of psychotherapy. To know this can be the beginning of wisdom, a reminder that our patients are their own infinite mysteries, and that our work depends on their cooperation, both conscious and unconscious. Hopefully, this will inspire humility and careful objectivity in therapists of every theoretical orientation.

Another matter that Lynn et al.’s work underscores is the power of positive suggestion in therapy. The presence or absence of positive demand characteristics from the therapists for honesty, clarity, and working alliances can make the difference between successful and unsuccessful ego state interventions. Phillips and Frederick (1995) Hartman (1998), and Frederick and McNeal (1999) advocate the Ericksonian utilization of symptom words, figures of speech, and sequences in work with ego states.

Ego state exploration may provide material for therapeutic elaboration. This material, expressed in the language of metaphor and imagination embodies the voices of states of consciousness attempting to express themselves relationally. The therapist’s job is to allow the true voice (or if it be the case, the no-voice) to emerge as an authentic expression of a self-energy that is communicating about itself relationally. If done properly by well-trained Ego State Therapists, ego state diagnostics will never damage or harm the patient.

The next chapter describes treatment frameworks and the goals of Ego State Therapy.
CHAPTER IV
THE TREATMENT FRAMEWORK IN EGO STATE THERAPY

PSYCHOEDUCATION: SHARING THE FRAMEWORK

Sharing the framework for Ego State Therapy with patients allows the patient and the therapist to set out on the same road together.

There are many ways to look at the human personality. One way that I find useful, and I believe that in a very real sense is the way things are, is to think of the human personality as composed of parts and being very much like a family inside. We like to think, and we usually think, of ourselves as being undivided. Yet, if you consider it, you realize that you may be more like a diamond or another jewel that has many facets. Each one reflects something different. Each one is an intrinsic and important part of the jewel. For example, I probably have a different personality energy when I teach from when I am sitting with my patients here in this office, just as you probably experience things very differently when you’re at work from when you’re at a party or visiting your family. Yet, every one of the parts of you is “you.” It's possible that the mind is very much like the body. The body needs differentiation, specialization, and parts. The heart does not do the same thing that the brain does. Yet, we need them both. It's important for you to realize that every personality part has come, to help. Even those that may be connected with symptoms are in some way trying to be helpful. When personality energies or parts, or aspects of the self, don’t get along, when they’re not cooperating and working together, often when one of them goes off all on its own, symptoms can develop. It's possible, not necessarily so at all, but possible, that the problems that brought you here could be part of some difficulty within your own internal family of selves.

It is often helpful to work directly with the personality energies using hypnosis. Although we know that these are energies or aspects of the self, we actually speak with them as though they are personalities, or what the great psychologist Carl Jung called “the little people.” What can be so helpful about this method is that with your use of self-hypnosis you can learn to extend the work of your therapy when you’re not here, learn to know yourself better and learn how to take care of yourself better. The goal of therapy with the internal family is integration. That means that all the parts are working together in harmony, that there is a United States instead of the Civil War. It's also important for you to know that every part is just as important as every other part. Sometimes patients want me to try to “get rid of” parts that they may not like. It doesn’t work that way. We work with parts to help them grow and help them learn to get along with one another.
INFORMED CONSENT

The informed consent for Ego State Therapy (done always outside of trance) is educational and offers alternative therapies and choices. Some of the educational material may be repeated in trance after the patient has had the opportunity to discuss fully and ask questions before hypnosis. If the patient chooses not to participate in Ego State Therapy, other forms of therapy are selected. Particular attention is given to the issue of memory. Memory is plastic and always being created anew and woven into the fabric of the patient’s own story of him/herself (Siegel, 1999). Patients are informed that what is dealt with in trance is never memory, but rather “memory material,” or “memory experiences” (Phillips & Frederick, 1995), and that it is not the role of the therapist to tell them “what really happened” (Frederick, 1994a). Indeed, they may never really know exactly what happened to them and that such knowledge will not be necessary for their recovery.

THE GOALS OF EGO STATE THERAPY

The goals of therapy are the result of collaboration. Nevertheless, there is a subset of therapy goals that must be met when Ego State Therapy is conducted:

1. To establish communication with the ego states
   Communication is the door to the many healing relationships the therapist will have with the ego states. In all activations of ego states the maintenance of a gentle, respectful language of cooperation (Gilligan, 1987) is essential:

   What would you like me to call you?
   How old are you?
   Do you know how old X (the patient) was when you came to help him/her?
   What do you like?
   What do you need?
   Is there anything about me that is frightening to you?
   How do you help X (the patient) these days?
   Do you talk with other parts, or maybe do things with them?
   We, X and I, really want to get to know you and to understand you.
   Do you know anything about (the problem/symptom)?
   Do you need anything from us today?
   Is there anything you want to let us know?
   Thank you

2. To establish with all ego states that every ego state is just as important as every other ego state
It is necessary to form such alliances with each ego state. The Ego State Therapist has to be completely democratic, dealing with all the ego states equally.

3. To help ego states form alliances with one another and to move into healthy family function

Helping ego states develop positive communications with other ego states, encouraging mutual endeavors, and promoting empathy are precursors to integration:

You and I have noticed that it seems to be a good thing for us to communicate with one another. It gives us a chance to learn about one another. I wonder if you would consider spending a little time with the part you call Joe. He’s just a kid, and he seems lonely. I’ll bet he would really appreciate a little attention from you.

I know that you and Sally haven’t always gotten along, but I’m hoping that you will remember that she has experienced a lot of pain and sometimes, I think, that may make her grumpy or snippy. Maybe your understanding how much she hurts will help you reach out to her again. I think she needs a pal.

I think you may agree that it will be really good for all of the parts to get together a number of times before our next session. It will give you a chance to talk together about the material that came up today, and you will probably create some projects you will want to carry out together. It could even turn out to be fun.

4. To ego-strengthen ego states and the Internal Family as a whole and to repair damaged self-esteem, manage fear and anxiety, and feelings of inequality

When patients present with neurotic problems (and most of their ego states have boundaries that are closer to normal), ego-strengthening may primarily focus on the ego state that is connected with the symptom. However, in patients with significant dissociative pathology, as well as those with character disorders (McNeal, 2003a, 2003b, 2004), ego-strengthening must often be done with individual ego states and with the entire internal family as a system or group. Direct, indirect, and projective-evocative ego-strengthening, especially Inner Strength (McNeal & Frederick, 1993; Frederick & McNeal, 1993, 1999) can be instrumental in helping the internal system move closer together.

5. To address separation-individuation and attachment issues in transfers with immature ego states while excessive dependency is avoided

Although interest in attachment issues has undergone a revival (Cassidy, 1999), there is little to be found about them per se in the ego state literature. Steele, van der Hart, and Nijenhuis (2001) have considered the relationship between attachment and dependency in patients who have trauma-based pathology. Attachment patterns become structuralized in the brain (Cozolino, 2002; Siegel, 1999).

6. To use with ego states any technique that can be used with an individual patient when that technique is needed

Ego states may present with problems that require a number of different kinds of psychotherapeutic techniques. Ego State Therapy is a therapy.
that bridges paradigms. Depending on the nature of their problems, ego states may respond to cognitive-behavioral therapy, systematic desensitization, psychodynamic approaches, expressive therapies such as dance, art, music therapies, body work, rational emotive therapy, hypnotic techniques, Eye Movement Desensitization and Reprocessing, power therapies, and so forth.

7. To do necessary developmental repair with certain immature ego states

Developmental repair can, at times, be an essential precursor to integration. Although the basic orientation in Ego State Therapy is to utilize the internal and external resources of the patient (Phillips & Frederick, 1995), there may be times when the patient’s resources are not adequate (Frederick & McNeal, 1999; Phillips & Frederick, 1995). The need for helping patients develop internal resources that are not present is particularly true with patients who have both cognitive and emotional developmental deficits as the result of trauma or extreme neglect as well as deficits in language development (Elmer, 1977; Fine, 1990; Fish-Murray, Koby, & van der Kolk, 1987; McCann & Pearlman, 1990; Toro, 1982; Zeilokovsky & Lynn, 1995). Extremely immature ego states often lack object constancy, object permanence, and adequate boundaries (Baker, 1981, 1985; Brown & Fromm, 1986). To this is frequently added the lack of wholeness and positive feeling about oneself that comes from lack of adequate nurturing (Mahler, 1968; Spitz, 1965, Winnicott, 1960/1965). Hypnotic re-nurturing may also be needed (Murray-Jobsis, 1990a, 1990b; Scagnelli, 1976; Scagnelli-Jobsis, 1982), as well as the establishment of object constancy and object permanence (Baker, 1981, 1985; Brown & Fromm, 1986), transitional experiences that can be catalytic for growth, increased boundary formation in ego states that are precursors to integration (Frederick & McNeal, 1999), affect containment and modulation (Frederick & McNeal, 1999), and so forth.

8. To make the therapeutic alliance interwoven with the transference/countertransference field the intrinsic milieu of therapy

The main drivers in Ego State Therapy are the therapeutic alliance and the transference/countertransference field. The latter topic will be addressed in detail in Chapter VI.

9. To face and resolve trauma issues without retraumatization

The topic of trauma treatment is a large one and will not be addressed per se in this monograph. The use of Ego State Therapy in the treatment of trauma is treated comprehensively in Phillips & Frederick (1995) and Frederick & McNeal (1999). Many who are not Ego State Therapists but work in the fields of trauma and dissociation use principles of Ego State Therapy in their work.

10. To create or restore harmony within the internal family of selves

The ultimate goal of Ego State Therapy is for integration to occur, that is the parts must share continuous coconsciousness.

From the beginning of therapy, integration is the goal of Ego State Therapists. This harmonious and seamless dynamism among ego states is often the result of hard work. It is the job of the therapist to use every opportunity to move the internal system toward integration.
The beginning of Ego State Therapy and all subsequent clinical activities and interactions with ego states also must be done with goals of creating and preserving therapeutic alliances with them (see Chapter V).

Forming therapeutic alliances with ego states is an essential maneuver for the beginning Ego State therapist. As well as for the most advanced. . Although ego states are not real people, they are sensitive, feeling, and judging aspects of the personality, and like individual patients they need respect and empathy if they are to be cooperative in therapeutic work. (Phillips & Frederick, 1995, pp. 65–66)

We begin to communicate indirectly with ego states when we see the patient for the first time. Ego states will be wondering whether they can trust and cooperate, whether the therapist will favor one over the other, and if the therapist will respect them or seek their annihilation. Initial communication attempts must be respectful, gentle, and oriented to safety and stability. Phillips and Frederick (1995) described a number of techniques for accessing ego states:

1. Indirect Talking Through is the first and most preparatory approach to ego state communication to the ego state. This conversational approach (Emmerson, 2003) contains many psycho-educational elements. Phillips and Frederick (1995) suggest that the talking through can also seed hope and embed messages of hope, strength, and capability on an unconscious level.

2. Direct Talking Through is also a conversational approach. It specifically addresses personality issues involving a particular ego state. For example:

“I believe that that part of you that sends you preoccupations and impulses to have S and M sex is trying to help you in some way. You told me that the people who abused you often said that that was the only way you could get love. Remember, they told you that your parents didn’t love you. I wonder if the part that wants you to go out and get that rough and humiliating sex isn’t really looking for love, deep love, the kind that every kid needs.”

3. Calling Out ego states for direct interaction can be done without hypnosis in Dissociative Identity Disorder patients, it is usually done when the patient is in formal hypnotic trance.

The most direct way is to hypnotize the patient and ask if there is a part that feels different from the main personality or that feels an emotion that the therapist knows is counter to what the patient feels in the waking state. . . The therapist can add: ‘If there is such a separate part, just say I’m here.” However, the first time it is done it is important to add a disclaimer as follows: ‘But if there is no such separate part, that’s just
fine...’ The purpose is to avoid producing an artifact. . . (Watkins & Watkins, 1997, p. 108)

Other scripts may be helpful:

I wonder if there is a part of X (the patient) that knows something about (name the symptom). If there is such a part, I would like to have the opportunity to get to know you better. If you wish, you can just speak to me through X’s lips.

or

I am very interested in speaking with a part or parts of X’s personality that may have something to do with the production of (the symptom). We (X AND I) would like to get to know and understand you because you are so very important.

4. Imagery Techniques

Helen Watkins guided hypnotized subjects into creating imaginary rooms into which ego states could enter. A variation of this is the Dissociative Table Technique (Frasier, 1991, 1993). In this author’s modification of this technique, the hypnotized patient is asked to create an accommodation for a group meeting of some kind. Then, the therapist invites the parts of the patient’s personality to come into this space.

After this point I would like to invite the part of X’s (the patient’s) personality to come into the space that he/she has prepared. It’s all right if no parts come in, or if there are no parts to come in. Also, the act of entering the space does not commit the parts to anything, to do anything, or to say anything. We will also understand if there are some parts who have decided to wait before we find out about them. It’s just a way for us to begin to get to know you, and again, it’s okay if no parts come in.

This kind of script is purposely made broad so that artifact creation not be promoted by the therapist. Fundamentally, the therapist is saying that there are probably parts there, but it is alright if there are not. Further, the therapist seeds for an alliance by stating that it is perfectly fine if there are parts that are there but not ready to appear. This signals the patient that the cooperation principle (Gilligan, 1987) is operative, and that the needs of the patient are more important than the needs of the therapist. It is possible with this activation method (as with any) for artifacts to develop, but it is not common. Artifacts per se are not a major problem:

. . . an artifact will not usually last or produce meaningful results, because it will not represent a real and already existent component of the personality. Artifacts are not energized by basic needs within the individual and tend to be transitory unless reinforced by the therapist. (Watkins & Watkins, 1997, p. 108)
The patient’s experience is processed out of trance. Patients describe a variety of experiences. Some parts that appear are widely disparate. At times the parts verbalize. Some patients wonder about the purpose of parts. For example, a patient might say: “There’s an angry Russian teenager in there, and I wonder what he is all about!” Other patients report “At times yes, there were a lot of parts, but they all looked just like me.” Curtis (1996) believes that the material produced by the Dissociative Table Technique can be viewed as a metaphor for the patient’s internal life situations.

5. Ideomotor Exploration

Ideomotor exploration- another exploratory procedure with built-in safeguards is that of ideomotor exploration. Such exploration is best conducted when ideomotor signals have been naturalistically established. Attempts to discover the presence or absence of the ego states that may be connected with the patient’s problems may then take place. A variation on ideomotor access has been described by Accaria (2002). He uses behavioral kinesiology (Diamond, 1979) to discover the presence of covert ego states.

6. Internal Family Systems Therapy

Internal Family Systems Therapy exploration involves respectful, gentle, and direct conversational methods to access what true ego states deserve attention as they provide a safe way to explore for the presence of ego state pathology. Schwartz (1995; personal communication) does not use formal hypnosis. He asks his patients if they are aware of the problem, feelings, or symptoms they came to see him about. He then asks simply if the patient is aware of the part that is causing the difficulty. He also asks what kinds of feelings and thoughts are connected with this part, and he inquires as to whether there are any feelings in the body associated with the activation of this part.

7. Externalization Techniques

Externalization Techniques may activate ego states. Drawing, painting, playdo sculpture, automatic writing, doodling, and the Gestalt chair technique favored by Helen Watkins (Watkins & Watkins, 1997) can be useful.

Working Therapeutically with Ego States

Working Therapeutically with Ego States involves several paradigms. It is of the utmost importance that the patient obtain the therapy that will be best for his/her problem(s). When patients present with obvious, or very easily identified ego state problems, it is often possible to begin Ego State Therapy fairly quickly.
In many of its early presentations Ego State Therapy was often described as either short-term therapy or relatively short-term therapy (Frederick, 1990, 1993b; Newey, 1986; Watkins & Watkins 1981, 1982, 1991). However, J. G. Watkins and H. H. Watkins (1997) have echoed the experience of other ego state therapists: Ego State Therapy can be long-term or short-term.

**Unitary Therapy or Integrated Therapy**

Ginandes (2002) has developed a protocol for “extended strategic therapy” with her “mind-body” patients that deserves careful consideration. There are times when patients may not be ready for long-term therapy and/or the ego state model. Additionally, Ego State Therapy may simply not be indicated for a particular patient or may not be sufficient for the patient. The initial uses of other therapies may both help to clarify whether an ego state diagnosis is merited, whether Ego State Therapy is indicated, and/or whether the patient be a good candidate for it.

Ginandes (2002) noted that despite the emergence of many techniques for rapid therapy, there remain patients who

... both due to temperament and to the nature of their problems, benefit more, or perhaps exclusively, from a course of extensive treatment that integrates more than one modality. Among these may be patients with complex mind/body conditions that have themselves shown to be impervious to medical treatment and adjunctive, straightforward medical hypnosis. (p. 91)

Ginandes (2002) developed her protocol for mind/body cases that were “recalcitrant.” In the case example she intended to be holographic for such situations, she described her work with a “stone-walling” ego state, that is, an ego state that was nonverbal, elusive, uncooperative, deceptive, and dedicated to resisting the changes the therapist offered. The protocol Ginandes (2002, p. 100) has developed from her extensive work with mind/body therapy cases can be extended to many psychotherapy patients with whom Ego State Therapy will eventually be done as part of a comprehensive, integrated psychotherapy approach. The components of her model include: (a) The sequential utilization of hypnobehavioral and hypnoanalytic approaches, (b) the uncovering and integrative developmental work with the somatic ego states associated with the illness condition, (c) the extended treatment time frame required for significant psychodynamic and psycho-physiologic change to occur, and (d) the normative countertransference reactions (exuberance, urgency, frustration, discouragement) evoked by such demanding casework.

Ginandes (2002, p. 92) recommended the “... sequential utilization of an eclectic therapeutic repertoire including hypnobehavioral and
hypnoanalytic approaches.” She began the treatment of the patient in her case example with hypnobehavioral therapy (systematic desensitization) (Jaspers, 1988), hypnotic suggestion strategies, including relaxation imagery (Lankton & Lankton, 1983), and ego-strengthening (Frederick & McNeal, 1999). She also utilized the affect bridge (J. G. Watkins, 1971; Watkins & Watkins, 1997) for the retrieval of positive memory material, resources. It was only after this extensive work that she approached the ego state associated with her patient’s symptoms. Ginandes (2002) model is an integrated phase-oriented treatment model designed for work with mind/body therapy cases. It emphasizes the need to stabilize both the therapist and the patient.

**PHASE-ORIENTED TREATMENT AND EGO STATE THERAPY**

Many patients who present with ego state problems have trauma histories. These traumas may be “big T” traumata, or they may be “little t” traumata (Schwartz, 2002), or cumulative traumata (Khan, 1963). Consequently, Ego State Therapy, often using trauma treatment principles, is always conducted within a phase-oriented treatment model. Such a model allows for a continuation of normal functioning and the establishment or restoration of stability when it is absent. A stable patient can contribute to his/her treatment, become stronger and move into the unknown, make some resolution of his/her difficulties, and achieve integration. Phase-oriented treatment was introduced by Janet (1889; 1919/1976) who used hypnosis to implement each stage (van der Hart, Brown, & Turco, 1990).

Like much of Janet’s work, this phase-oriented treatment model vanished from the scene and was replaced by abreaction models of treatment in World Wars I and II (J. G. Watkins, 1949). In their review of the phase-oriented treatment model, Brown, Schefflin, and Hammond (1997) describe its modern rediscovery by Horowitz (1973, 1976) in his work with trauma victims. Like Janet, Horowitz was less interested in abreaction, or emotional catharsis, than he was in what he called “cognitive completion.” This was “. . . a reduction of the discrepancy between current concepts and enduring schemata” (Horowitz, 1974, p. 771).

Subsequently, many developed phase-oriented treatment models (Brown & Fromm, 1986; Courtois, 1988; Herman, 1992; McCann & Pearlman, 1990; Phillips & Frederick, 1995). Each model has its own defining characteristics and its own particular usefulness. The Phillips and Frederick (1995) SARI model was developed out of this author’s work with hypnotically facilitated treatment, especially Ego State Therapy (SARI is an acronym for the stages of this model.) This model consists of four stages.

Each stage of the SARI model offers an opportunity of both hypnotic and non-hypnotic facilitation of Ego State Therapy. Each stage emphasizes both external and internal resources.
Stage I. Safety and Stabilization.

The alpha and the omega of the SARI Model are safety and stability. A great deal of therapy crashes because the safety of the voyage was never secured from the beginning. Many patients with serious ego state problems are very symptomatic and gravely impaired. In Ego State Therapy the focus in Stage I is on building alliances with emerging ego states and promoting cooperation and internal harmony. Stage I ego-strengthening work with ego states is presented in detail in Frederick & McNeal (1999).

Stage II. Accessing Trauma Material

In this stage, each ego state is helped to achieve some authority over memory material. Although J. G. Watkins and H. H. Watkins (1997, 2000) advocated abreaction and used it successfully, full-blown abreaction is avoided by many therapists today in favor of fractionated visits to trauma material. Cognitive coherence and a sense of wholeness is considered to be more important than large emotional discharges. Stage II work must often be followed by more Stage I work to restabilize the internal system.

Stage III. Reassociation, Reworking

In this stage, the emphasis is on corrective emotional experiences such as controlled affective release, reassociation, developmental work, the correction of cognitive errors, and the development of new external resources. The ego states achieve a greater sense of cohesion, developing stronger and sometimes new internal connections.

Stage IV: Integration

In this stage dissociated material is integrated into the personality, and the ego states move into a seamless state of internal harmony and cooperation and enjoy continuing coconsciousness (Beahrs, 1982).

STARTING THE THERAPY

The conditions of treatment is Stage I work. The patient must have food and shelter and the wherewithal to pay for treatment and any necessary medications. These can be substantative issues with seriously dissociated patients, psychotic patients, and many borderline patients.

A treatment contract is essential. In it the conditions of treatment are established. Such matters as the frequency of sessions, fee, out-of-session contact arrangements, and so forth must be arranged. Frequently issues of self-harm and other therapy-interfering behaviors such as suicide attempts, self-mutilation, substance abuse, and endangering behaviors must be dealt with. Treatment can only proceed
when the patient is stable enough for that to happen. The therapist may have to insist that the patient be evaluated for medication, have a brief hospitalization or attend 12-Step or other relevant substance abuse programs. The safety of the therapist is another primary consideration (Comstock & Vickery, 1993).

Stage I is also a time for reducing symptoms and helping patients learn how to avoid life disruptions. A variety of eclectic hypn behav-
ioral and hypnoanalytic techniques (Ginandes, 2002) are involved in Stage I work. Ego-strengthening is of the utmost importance (Frederick & McNeal, 1999; Phillips & Frederick, 1995). “The most important step in treatment is the establishment of the therapeutic alliance” (Marmer, 1996, p. 196). Marmer’s (1996) recommendations for the psychoanalytic treatment of Dissociative Identity Disorder contain certain elements that have general Ego State Therapy applications. In addition to his regard for the need to work with conflicts and deficiencies (in addition to trauma material) his emphasis on the formation, maintenance, and repair of the therapeutic alliance through the course of therapy affirms a position that is crucial to Ego State Therapy.

Frederick (2001) asserted that the most vital and essential element in all Ego State Therapy is the therapeutic alliance that is created and maintained with every ego state. It is through the therapeutic alliance that the cooperation and the work of therapy is established. Within it grow essential elements such as empathy, trust, self-reflection, and cooperative problem-solving. Therapeutic alliances can be challenging to the Ego State Therapist. The indispensable task of forming therapeutic alliances with ego states can become formidable when further compounded by the presence of nonverbal, immature, and terrified aspects of self. To this can be added the necessity of dealing, at times, with destructive or malevolent parts of the personality. Because the therapeutic alliance can be a vehicle for so much of what occurs in Ego State Therapy, a brief examination of several models of the therapeutic alliance follows. Each model emphasizes something that is valuable and may be used in Ego State Therapy. Chapter V considers important elements of forming, maintaining, and repairing the therapeutic alliance.

CHAPTER V
MODELS OF THE THERAPEUTIC ALLIANCE

CLASSIC PSYCHOANALYTIC MODELS

Contemporary research emphasizes a fact that is well known to good clinicians: that the therapeutic alliance is a most crucial element
in the psychotherapeutic relationship (Barber, Connolly, Crits-Christoph, Gladis, & Siqueland, 2000; Hovarth, Gaston & Luborsky, 1993; Kokotovic & Tracey, 1990; Konzag, Baandemer-Greulich, Bahrke, & Fikentscher, 2004; Lorentzen, Sexton, & Hoglend, 2004; M. C. Miller, 2004; Saunders, Howard & Orlinsky, 1989). In the absence of a vital alliance, therapy will either fail to be launched, make a pretend voyage that is only an empty imitation, or become mired within the swamps of transference and countertransference, enmeshment and repetition. Not only must adequate alliances be formed if successful therapy is to occur (Barber et al., 2000; Frank & Gunderson, 1990; Kokotovic & Tracy, 1990; Lorentzen, Sexton, & Hoglend, 2004; Saunders, Howard, and Orlinsky, 1989), they must also negotiate their own tendencies to deteriorate and fail over the course of therapy (Safran, Crocker, McMain, & Murray, 1990; Luborsky, 1990).

There are currently available several reviews of the development of the concepts of therapeutic alliance (Atwood & Stolerow, 1989; Frederick & McNeal, 1999; Meissner, 1996) as well as therapy outcome research reflective of the alliance (Barber et al., 2000; Hovarth, Gaston & Luborsky, 1993; Hovarth & Greenberg, 1994; Lorentzen, Sexton, & Hoglend, 2004). Until the 1960s the therapeutic alliance was usually conceptualized as a vehicle of interpretation and understanding as it conformed to the therapist’s theoretical models. Thus Freud, (Breuer & Freud, 1893–1895/1961) emphasized the necessity that the patient become a collaborator in therapy. He eventually called this relationship the analytic pact (Freud, 1964/1937). Freud’s colleagues shared his view about the need for an alliance (Bibring, 1937; Fenichel, 1941; Ferenczi, 1950/1916–1917). Freud’s ideas on this matter were further extended in the more elaborate concepts of others, including Sterba (1934), Zetzel (1956), and Greenson (1965, 1967).

Sterba (1934, 1940) described the working alliance as characterized by a “split” in the patient’s ego into experiencing and observing egos. A sine qua non of Sterba’s working alliance was that the patient and the analyst share some goals for the outcome of the therapy. Zetzel (1956, 1985) preferred the term therapeutic alliance for this relationship and activity because her emphasis was more on the nurturing and healing aspects of the alliance. According to Zetzel (1956) the therapeutic alliance was a new and special object relationship developed in a new, significant interaction with another human being. She anticipated the object relations point of view, and she believed the alliance was deeply intertwined with positive transference and was innately nurturing. More mature ego functions were called upon to support the analytic work. Less mature aspects of the patient’s ego that were deeply immersed in the transference experienced the alliance as an arrangement that provided nurturing.
These models of the therapeutic alliance are, for the most part (with the notable exception of Zetzel’s), rather linear and focused on intellectual understandings or insights, cognitive resolutions, and Aristotelian logic. They are based in the mechanical, spatial, and “Helmholtzian” energy metaphors devised by Freud in his attempts to explain mental processes. The therapist and the patient are perceived as very separate entities who are connected, as it were, through cooperation and goodwill and by a few verbal communication lines through which cognitive and affective input and output might flow. In this paradigm the standard of reality is held by the therapist. This reality is construed to be, ultimately, objective in nature and to contain the truth that is central to the healing process. On the unconscious level the mental mechanism of identification allows therapist and patient to develop empathy and understanding for one another.

OBJECT RELATIONS AND SELF PSYCHOLOGY MODELS

Subsequently, additional functions of the alliance have been identified in the light of developing themes in object relations (Kernberg, 1976) and Self Psychology (Kohut, 1971, 1977, 1978). Within the hypnosis community it has been viewed variously as a special kind of interaction (Diamond, 1983, 1984, 1986, 1987), a holding environment (Diamond, 1986), a transitional experience (Baker, 1994), and at times even a fusional relationship (Diamond, 1983, 1987; J. G. Watkins, 1992). Self Psychology’s emphasis is on empathy and the necessity to address empathic failures in order to repair damaged alliances.

INTERSUBJECTIVE MODELS

The intersubjective model provides another paradigm that is quite contemporary. It represents a Copernican revolution within the field of psychotherapy and can be best understood from the perspectives of post-Newtonian physics, the Heisenberg principle, field theory, and quantum mechanics. The reality-grounded wisdom of the therapist is no longer the earth around which the sun and the planets are thought to revolve, for within this model the nature of reality is assumed to be purely subjective (Atwood & Stolerow, 1984; Stolerow & Atwood, 1992; Teicholz, 1999). This perspective is one in which all attributions of objective reality are assumed to be concretizations of subjective truths (Atwood & Stolerow, 1984). The subjective reality of the patient assumes central importance as a relevant and developing process that lies at the very heart of therapy. Within such a paradigm, it is not the patient who must understand and work for the goals of the therapist. Instead, as Kohut (1959, 1971, 1977, 1978) earlier proposed, and Stolerow and Atwood (1992) affirmed:
the foundations of a therapeutic alliance are established by the analyst’s commitment to seek consistently to comprehend the meaning of the patient’s expressions, his affect states, and, most centrally, the impact of the analyst from a perspective within rather than outside the patient’s subjective frame of reference”. (p. 93)

This primary orientation and adaptation to the patient’s inner world and perspective are also distinctly Ericksonian and are addressed in Gilligan’s (1987) formulation of the cooperation principle. The intersubjective orientation extends the dynamic work of the alliance into what Stolerow & Atwood (1992) have conceived of as a medium for illuminating the subjective world of the patient by sharing the very idiosyncratic and totally subjective psychological activities within which the patient organizes his/her experience, as well as the meanings that are encoded within each experience (and for which the experience may stand). Ogden (1994, 1997), in his belief that such a relationship has its own life, has called this field the analytic third. De Quincy (1998) speaks of it as the second perspective. The alliance is also conceived of as a vehicle for transforming body reactions and more primitive affects into identifiable affect and as a mechanism for the modulation of identifiable affect.

Baker (2002) has emphasized the particular applicability of the intersubjective model in hypnosis. Baker explains that “. . . the essence of hypnosis—that which most clearly and critically defined it—is an interaction effect.” (p. 63–64). Baker’s conceptualization of the intersubjective therapeutic field focuses on the interactive process between patient and therapist, the developmental levels involved, and the availability for containment, attunement, and projective identification in “. . . dynamic processes that enlivened the transitional space of hypnotic experience” (p. 65).

**Resonance: A Bridging Theory**

Watkins’ concept of resonance (J. G., Watkins, 1978a, 1992; Watkins & Watkins, 1997) somewhat parallels the intersubjective models of the therapeutic alliance (Ogden, 1994, 1997; Stolerow, Brandschaft, & Atwood, 1983) and most eloquently expresses the affective experiences of the therapist as he/she is engaged in Ego State Therapy. J.G. Watkin’s view of the therapeutic alliance is both intrapersonal and deeply interpersonal. His and the intersubjective models are deeper and much more complete versions of empathy, stronger by furlongs than Nafisi’s (2004) description of the empathy one develops for another reality in fiction, and stronger by leagues than the linear model of the therapeutic alliance held by Freud and the classical psychoanalysts. They reach for the I-Thou (Buber, 1976) relationship. The therapist “becomes” the patient for awhile, as the two personalities
exist in what seems like a single energy field. The therapist co-experiences the patient’s reality both consciously and unconsciously. Because of Watkins’ allegiance to classical psychoanalysis, he has insisted that understanding be one of the goals of resonance. The therapist must pull him/herself out of the unified field and examine and learn from it. Another purpose of this profound interaction is to allow the patient to gain ego strength from the therapist. Watkins describes this as making an “ego-loan” to the patient. This means that during “resonance” the therapeutic alliance may become, at times, a fusional alliance (Diamond, 1983, 1984; J. G. Watkins, 1992). What is crucial in both J. G. Watkins’ resonance and the intersubjective viewpoint (Ogden, 1994, 1997; Stolerow, Brandschaft, & Atwood, 1983) is the role of deep unconscious interaction between the therapist and the patient. These alliances are braided within the transference and counter-transference field in which the unconscious interaction between therapist and patient is the crucial operant (see Chapter VI).

Frederick (2004) has viewed the unfathomable, unconscious, intersubjective patient-therapist interaction in the alliance in Ego State Therapy as one that may additionally have natural growth principles based on the developmental patterns of hidden, primitive ego states when they are present. These seem to exist within a mathematics beyond calculation. Her thought that the unconscious relationships in the alliance may have lives of their own is an intersubjective one.

THE POST-MODERN REVOLUTION

The post-modern perspective, one that followed modern viewpoints, is devoted to shedding the standards, thoughts, feelings, and predispositions of the past. It is prominent in art, architecture, literature, and music. This viewpoint often uses a deconstruction of what has gone before. Currently, quite a few post-modern theorists in psychoanalytic psychotherapy have deconstructed modern theories of both the therapeutic alliance as well as the transference and counter-transference field (Teicholz, 1999). The post-modern perspective frees the clinician to choose which model is most useful to him/her with a particular patient. With some patients the alliance is most valuable as a source of more conscious, cognitive information; with others, the soothing, transitional, and nurturing aspects of the alliance are paramount; while with others, deep, resonating, unconscious bonds that are constructed between the ego states of the therapist and the ego states of the patient assume primacy. The usefulness of postmodern approaches to theoretical models of the therapeutic alliance as well as the transference and countertransference field will be discussed further in Chapter VI.
The often challenging and complex tasks of forming, maintaining, and utilizing therapeutic alliances is further complicated in Ego State Therapy. In the first place, alliances, like transferences (Brown & Fromm, 1986), can be intensified when hypnosis is introduced into the treatment situation (Brown & Fromm, 1986; Frederick & McNeal, 1999). Further, it is necessary to form alliances with each ego state that is involved in treatment. Each ego state has its own subjective world; each has its own history, cognitions, affects, and resistances; each has its own transference reactions to the therapist and to every other ego state. The indispensable task of forming therapeutic alliances with ego states can become formidable when further compounded by the presence of nonverbal, immature, and terrified aspects of self. To this can be added the necessity of dealing, at times, with destructive or malevolent parts of the personality whose avowed goals are often to harm or hurt the patient. As laborious as these tasks are for the therapist, they may be even more difficult for other ego states.

The needs of the ego state as well as their levels of development must be identified and addressed in the formation of alliances. Further therapeutic alliances frequently need to be modified, repaired when necessary and revitalized periodically throughout the course of long-term therapy. The following case examples will attempt to describe ways of forming and working with alliances and various relevant ways of utilizing resonance (J.G. Watkins, 1971) within the intersubjective field (Stolerow & Atwood, 1992), or the analytic third (Ogden, 1994, 1997). They are also intended to address the role of the alliance as a vehicle for ego state growth and development that help move the system toward integration.

**Forming Alliances with Immature Ego States (The Case of Ada).** Ada was an intrepid and successful 50-year-old surgeon who had been raised in a rather unusual fundamentalist religion of which she was still a member, albeit a more enlightened one. Her father, also a surgeon, punished Ada and her brother when they were children by giving them injections with hypodermic needles. He often shouted, “This deserves a great big shot!” Her mother reminded the children that they were sinners.

Ada had both a severe phobia for needles and a pattern of binge eating. Initial attempts to activate the ego state or states that knew about the needle phobia produced images of a little girl of about three years in the patient’s childhood home. She was terrified and extremely wary. “She doesn’t trust anyone,” the more adult Ada, the presenting ego state, told me. “No, she won’t let me hold her or comfort her. What am I supposed to do with her?” Although Ada was quite religious and very active in her church, she cautioned me that there was no use to
her suggesting that the child ego state look to Jesus for help. “This little
girl doesn’t even trust Jesus to be there to help her. He just wasn’t
trustworthy.”

I talked through the adult ego state to the child state, saying that it
was no surprise since the Jesus she had been introduced to by her fam-
ily was such a mean Jesus no one could trust him. Ada understood
this. She asked me for help. “How can I reach her?”

The present author worked indirectly to form an alliance with the
child ego state by resonating with her. Her reason and empathy
allowed her to know that the child could trust no one at this point and
that the Jesus of her childhood was less a loving God than a rottweiler
trained to do her parents’ bidding. She completely accepted and
validated that the child, at this point, could trust no one, and for good
reason. Attempts either to rescue the child ego state or to force it into
premature change would have been futile.

_Helping Ego States to Form Alliances with One Another (The Case of
Ada)._ I encouraged Ada, the presenting adult ego state, to make a con-
certed effort to communicate with the child state during the week
between sessions. She was to tell her, repeatedly, that she understood
that she trusted no one and that there had been no one there to protect
her in the past. Things could be different. She, the adult ego state, was
now available to protect her and to help her, eventually, get out of that
house. She offered her a vision of a future in which she would never be
given an injection as punishment again. Indeed, she would not be fac-
ing any more punishments at all. Ada would understand if she were
not believed or trusted at first.

The following week Ada reported: “She is such a brat! I don’t like
her a bit. She has a tantrum when she doesn’t get her way. Can’t we
just get rid of her?” I explained to her that every ego state is just as
important as every other state. The child was as important as she her-
sell, and the child needed to be nurtured. The adult ego state pro-
tested vigorously that she had not been mothered well, had never
been a mother, didn’t know how to be a mother and had no idea of
what to do. The therapist reminded her that she seemed to be doing
well with both her dog and her cat, not to mention the number of car-
ing and nurturing things she managed to do for her husband. I sug-
gested that she had more to give this childlike aspect of herself than
she realized.

Eventually, Ada was able to temper her attitude and spend time
working with the child ego state. The child became progressively less
fearful. One day Ada became aware of thinking “Why don’t I just go
get those blood tests the doctor wants and get it over with?” Subse-
quently, Ada joined Weight Watchers and took up eating a lot of “legal
food” as a replacement for binge eating practices.
As her treatment progressed, Ada’s more adult ego state learned to look past her negative transference reactions to the child ego state and developed and then increased her empathy, helping her to identify the child’s unquestionable needs for nurturing and to respond to them. The therapist’s contributions were to model empathy for the impoverished, frightened child state, to remind the patient of her resources, and to have as a goal the increasing development of healing alliances among ego states. As the patient grows and changes, the quality of the alliance and its goals may also need to change.

**Developing Alliance Shifts (The Case of Jewel).** Jewel was a high-functioning Master’s level professional with a severe dissociative disorder who came to therapy with recall of having been in an objectively confirmed, prolonged incestuous relationship with her father. She was afraid that in her capacity as a teacher she might have the kind of temper tantrums that had caused her problems in previous jobs. Further, she had a frightening concern that she may have caused a serious auto accident in which she had suffered significant injuries several years earlier because of the activity of an as yet unidentified, destructive ego state. She had no objective evidence for this.

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.

Here the present author was able to shift the nature of her alliance with Touretta. The shift recognized Touretta’s transformation, and the nature of the alliance changed. Touretta, greatly respected for her energy, was being asked to share and to extend the work of the therapist with the internal family. Alliances may also need to take place in
the other direction. Ego states can become destabilized and exhibit regression. In these instances a more developmentally appropriate alliance must be formed.

A post-modern (Teicholz, 1999) approach to the alliance can lead the therapist to use different models of the alliance to meet the changing needs of the treatment situation. The alliance can be a vehicle for many of the tasks of Ego State Therapy. Within its holding environment and deep unconscious interactions, it can provide ego states with an ongoing vehicle for the maturational tasks of containing and transforming primitive affect and body reactions into more identifiable affects that could then be modulated (Stolerow & Atwood, 1992). Such work with seriously disturbed patients is frequently slow and takes place over an extended period of time. One of the present author’s patients (Frederick & McNeal, 1999) who presented as depressed, suicidal, and socially isolated was governed by covert, nonverbal ego state behavior. He had earlier been hospitalized for psychotic (manic) behavior. After seven years of weekly therapy that focused on containing and nurturing aspects of therapeutic alliances as well as the transference and countertransference field, he changed careers, returned to school for graduate work, published several articles in his field, become a presenter at national conferences, taught in a university and gained an advanced degree. He married happily and successfully for the first time when in his late forties.

EGO STATE CHARACTERISTICS THAT AFFECT THE ALLIANCE

There are certain characteristics of ego states that invariably affect the therapeutic alliance.

1) The Level of Development

The issues for child ego states may be quite different from those of an adolescent or an adult. For example, very immature ego states may lack object permanence and object constancy, and they may be quite deficient in basic trust. The alliance with such ego states will be structured to focus on primitive boundary work, affect containment, transitional experiences, and some form of direct or indirect re-nurturing. On the other hand, alliances with adolescent ego states might capitalize more on the balance between separation-individuation and cooperation, and between appropriate adventurousness and the need to belong to the group.

2) The Nature and Strength of Defensive Functions

Certain ego states, like certain members of a family, may have defensive structures that provide special challenges for the creation and maintenance of therapeutic alliances. An ego state that
uses obsessional defenses requires different relational approaches from one that is freer and more open. The presence of narcissism as a defense was recognized by Janet in his work with the multiple personality Achille (Ellenberger, 1970). One of Achille’s alters was “the Devil.” Janet was able to create a therapeutic alliance with the Devil by appealing to his vanity.

3) Special Problems

Some ego states present with special problems that are manifestations of their defensive styles. Among them are silent or nonverbal ego states. Frederick (1994) described some of the problems that produce silence in ego states and made specific suggestions for establishing communication with them and leading them into speech. Frederick & Phillips (1996) also identified a group of symbolic, mysterious, and elusive ego states that typically present as visualized symbols or as somato-sensory manifestations and described how they had formed therapeutic alliances with such recondite ego states. Johnston (2003) has focused on the anaclitic characteristics of some of these covert, nonverbal ego states that are often unrecognized in more traditional therapies.

Special problems can also exist in forming therapeutic alliances with malevolent ego states. They frequently frighten both the patient and the therapist, may present in highly unusual ways, and they may constitute a danger to either or both of them (Blizzard, 2001; Frederick, 1996a; Watkins & Watkins, 1988, 1997). They are often unable to form alliances unless their presences are identified and their natures and purposes understood. They are always protector states. Identification of which kind of malevolent state is present is often helpful and can often be obtained through ideomotor exploration (Frederick, 1996a).

4) Temperament

The role of biology in governing personality characteristics has been recognized for thousands of years. Hippocrates (460–377) (Ellenberger, 1970) reemphasized the belief of Anaxagoras (500–428 B. C.) that our emotions arise from our brains, thus, fundamentally from our biology. Galen later refined the Hippocratic system to explain how the humors produced the four temperaments: melancholic, sanguine, choleric, and phlegmatic. Psychiatric concern with temperament commanded most of the 19th century perspective (Stone, 1997) until the psychoanalytic movement brought about a de-emphasis of constitutional and other biological influences on personality. Less plastic views of personality based on growing evidence of the biological transmission of traits have reemerged and fueled thought about the influence of temperament on the development of pathology, of hardiness, and even of the ability to utilize psychotherapy.
From the standpoint of developing therapeutic alliances with ego states, the concept of temperament can be extremely useful. The therapist will approach differently a sensitive, creative, artistic ego state from the way he/she would engage an action-driven problem-solver, or a stodgy ego state that must be inspired in some way to develop sensitivity in thought and feeling.

5) Character Styles

Aristotle made the concept of character types popular. Just as they inhabited the plays of Moliere, Aristotelian character types continue to pervade the world of contemporary theater and literature. Within the psychoanalytic and psychodynamic world, formulations about patterns of defense and the formation of specific character types and pathologies are essential. The Ego State Therapist will need to form different kinds of alliances with ego states who are variously obsessive-compulsive personalities, hysterical, avoidant, and so forth.

Therapist Characteristics that Facilitate Alliance Formation

The characteristics of the therapist can also facilitate the development of healing alliances. Diamond (1984) attempted to examine the qualities that were essential to one’s being able to be a good hypnotherapist. Frederick and McNeal (1999) describe them:

The personhood of the therapist is an important key to the degree he may be able to succeed in his endeavors. Diamond (1984) entertained the question of “Why certain hypnotists can produce deeper and more meaningful trance experiences with their subjects than can other hypnotists who may employ the very same operational procedures. (p. 3)

He concluded that the hypnotherapy occurs within the context of an interactional hypnotherapeutic relationship, and that the skill of the therapist is a critical factor. He believes this skill to arise from several factors, the therapist must: (a) have attained a mature level of object relations development and relating to self and others and must be comfortable with deep levels of human interaction, (b) have a capacity for empathy, (c) have both personal and therapeutic trance skills, (d) have healthy levels of integration of his/her own functions such as the receptive and passive, as well as the active and cognitive, and (e) have adequate self-supervisory ability, that is, he/she must be able to identify and deal on some effective level with transference and countertransference issues.

Such a hypnotherapist, according to Diamond (1986) “... creates a special holding environment for the patient. Erickson undoubtedly fulfilled all these criteria and more, hence his special successfulness” (p. 70–71).
For therapists who engage in Ego State Therapy, the following should be added to Diamond’s list: (a) The ability to be in a state of sustained resonance. This goes beyond empathy and into deeply intersubjective, interpersonal trance states; (b) the capacity for tolerating the confusion of a deep intersubjective relationship. The Ego State Therapist engaged in deep intersubjective work may not always experience the same sense of clarity and direction that is present in more cognitively oriented psychotherapies. It may take time for the answers to appear; (c) the ability to relinquish the position of authority. Although some authority must be maintained in order to safeguard the safety of both patient and therapist, the Ego State Therapist has to respond to the felt needs of ego states, to validate them and to make them the center of therapy for a time. The therapist validates but does not indulge destructive needs; (d) willingness to enter and utilize interactive trance. In interactive trance (Gilligan, 1987) the resources of the therapist are available to the patient. This includes the resources of the therapist’s positive ego states; and (e) certain therapist character traits, such as tenacity, patience, courage (but not rashness), a disposition to tenderness and nurturing, and a healthy respect for democracy.

ROADMAP FOR FORMING THERAPEUTIC ALLIANCES WITH EGO STATES

There are a few general principles that can facilitate forming and maintaining resonating alliances with ego states. They include:

1. Communication
   The therapist should be persistent in communication efforts. Although this can demand a great deal of energy, it is important to remember that repetition is frequently necessary with children, and many ego states are immature and childlike. The therapist’s voice and presence, his/her consistent, repeated empathetic engagements contribute to object permanence and object constancy, provide a holding environment and often constitute transitional experiences. Therapists can pay a significant energy price for this exhausting work.

2. Resonance with the ego state
   Therapists must allow themselves to resonate with the ego state. This intensified and comprehensive conscious and unconscious existential participation with the emotional life of the ego states is validating. There is an energy price to pay for this as well. Compassion fatigue and/or other emotional tolls arising from such intense emotional involvement with the ego states may set in (Figley, 2000; Pearlman & Saakvitne, 1995). Such interactions increase therapist need for self-care.

3. Interactive trance
   Therapists should frequently use interactive trance. It allows the therapist to tune into his/her unconscious participation in the transference
and countertransference field as well as resonate more with the patient’s ego states. It increases experiencing, identifying, and meeting the subjective needs of the patient’s ego states.

4. Alliances with ego states
Therapists should remember that his/her alliances with ego states are also essential models for their learning to create alliances with one another. It is not enough to develop therapeutic alliances with ego states. It is necessary to help them develop alliances with one another. Sometimes this can be done directly by assisting ego states with such tasks as learning to communicate and to develop empathy for one another. At other times it can be facilitated by more general statements that remind ego states of the primary importance of the Internal Family. Ego states can become powerful co-therapists.

5. Therapeutic alliances among ego states
Creating and strengthening therapeutic alliances among ego states always moves the Internal Family in the direction of integration. This is that activity that the therapist can encourage with both direct and indirect suggestion.

6. Aspects of the therapeutic alliance
It is important to acknowledge that many aspects of the therapeutic alliance are unconscious, noncognitive, and nonverbal. These include creating a holding environment, providing transitional experiences, renurturing, engaging in spontaneous interactions that strengthen boundaries, and entering into fusional alliances.

In the next chapter the transference and countertransference dynamics in Ego State Therapy will be considered. Their interplay with the therapeutic alliances with ego states, when utilized, bring energy and movement into Ego State Therapy.

CHAPTER VI
THE COUNTERTRANSFERENCE TRANCE

THE HEALING POTENTIALS OF TRANSFERENCE AND COUNTERTRANSFERENCE

Among the kinds of relationships in any therapeutic situation are a real, or reality based relationship. Kohut (1971) called this the realistic bond and considered it to be an essential therapeutic element. It is “an object attachment which is not in the area of transference but which becomes progressively neutralized” (Schowalter, 1976, p. 416). As previously noted, other important relationships in therapy are therapeutic alliances. Yet, another aspect of the relationship between the therapist and the ego states exists within the transference and countertransference field. It is inextricably bound with the therapeutic alliance. Where
transference was once considered to be the alpha and omega of therapy, countertransference appears to have unseated it (Butler, Flasher, & Strupp, 1993).

It is always intriguing to speculate on the nature of the curative forces in psychotherapy. Transference (Breuer & Freud, 1883–1885/1961) and countertransference (Freud, 1910/1964) were originally conceived of as resistances, problems, and blocks to treatment (Breuer & Freud, 1883–1885/1961). One of the valuable operational views of the transference proposed by Self Psychology (Kohut, 1971, 1977, 1978, 1984; Orenstein, 1988; Wolf, 1988) is that: “Empathy in the therapeutic relationship is the primary data gathering tool. . . “ (Seruda, 1997, p. 12). The therapist responds countertransferentially with empathy to the patient’s transference within the field that exists between them. In the corresponding countertransference both greater personalities and ego states are able to have a deep, affective exchange that evoke healing responses from the therapist. Seruda (1997) lists some of the ways this exchange occurs:

1. Mirroring
   The therapist mirrors in the Kohutian sense when he/she accepts the patient absolutely and without qualification. Seruda (1997) cited Goldstein (1990) as stating that mirroring heals because it “ . . . confirms the person’s sense of vigor” (Seruda, 1997, p. 17). This sense of aliveness not only increases self-esteem, it also acts as a structural organizer. Some patients may transferentially seek to merge with the therapist, and this could lead to regressed and symptomatic behavior.

2. Idealizing
   The patient may idealize the therapist as a superlative person who is all kind, completely good, and infinitely caring at all times. “These experiences with one’s caregivers facilitates a person’s pursuing values and ideals as well as enabling the person to feel secure and soothed” (Seruda, 1997, p. 18).

3. Twinship
   In this dynamic, the patient transferentially perceives the therapist as being an identical emotional twin. This provides information about where the patient is developmentally. It also is curative if the therapist manages the transference and countertransference fields because it gives the patient a sense of validation and allows him/her to feel that his/her world is shared with the therapist, not merely observed. At times gentle and caring opposition to the patient’s position can spur growth even further because it helps in the development of courage in speaking and behavior and greater independence.

Each ego state will engage the therapist within the transference and countertransference fields that are specific to it. These fields may often seem to be contradictory. Some ego states may idealize the therapist, while others may denigrate and criticize him/her. Still other ego states may cower in fear of the therapist, as opposed to those who understand what the therapist is doing and have implicit trust in the process.
RELATIONAL VIEWS OF PSYCHOTHERAPY AND THE COUNTERTRANSFERENCE

Historically, countertransference has remained an ambiguous concept concerning there have been numerous disagreements in psychoanalysis and psychoanalytic psychotherapy. Butler, Flasher, and Strupp (1993) state that the disagreements rest on “two pivotal issues” (p. 343). The first issue is whether the term, countertransference, should be expanded or restricted (Kernberg, 1965). The second has to do with whether the drive model or the relational, interpersonal model be selected.


In his classic article Kernberg (1965) identified a more “totalistic” approach that regarded countertransference as embracing “the total emotional reaction to the patient in the treatment situation” (p. 38). Both conscious and unconscious reactions were included. At times it is not clearly separated from the therapeutic alliance, and it becomes even more difficult to separate in Ego State Therapy. Winnicott (1949) had indicated that there might be several kinds of countertransferences operating in the therapeutic situation.

Ogden (1997, 2004) views all psychopathology as diminishing the individual’s “capacity to be fully alive as a human being.” The goal of treatment transcends symptom relief, conflict resolution, insight, and mastery. It is to help the patient find both life and meaning. This goal should be in the mind of every therapist when working with any ego state. Like the greater personality, ego states yearn for meaning, purpose, and vitality. It is in the transference and countertransference fields that the therapist awakens to the needs of individual ego states and the Internal Family. Gilligan (1987) also emphasized the role of unconscious interaction in therapy. He perceived the therapist as someone who had a good amount of conscious-unconscious complementarity (Morton & Frederick, 1999). Such a therapist would use the conscious mind to help the unconscious with its work, and vice versa. Gilligan (1987) believed that the therapist could best utilize his/her countertransference and other unconscious resources by entering into a positive interactive therapeutic trance with the patient.
EMPIRICAL STUDIES OF COUNTERTRANSFERENCE

Butler, Flasher, and Strupp (1993) have presented an informative history of the evolution of concepts concerning countertransference as well as a summary of empirical attempts to scientifically investigate the countertransference. The literature is small. However, paradoxically,

Despite...methodological shortcomings, virtually all the different counter-transference perspectives have received support from the empirical literature....Perhaps most impressive is the recent identification of specific forms of interpersonal relatedness between patient and therapist that are significantly associated with good and poor outcome. (Butler, Flasher, & Strupp, 1993, p. 354)

J. G. Watkins had earlier (1978a) proposed and illustrated a method for measuring resonance in the therapeutic situation. While in no way intended to measure countertransference, it has valuable potential as a research tool that can help identify what is happening in the area of effective empathy.

Dalenberg’s (2000) research in the field of traumatic countertransference underscores the relevance of working within the interactive, affective field. Many patients with ego state problems have traumatic countertransferences.

THE EFFECTS OF HYPNOSIS ON TRANSFERENCE AND COUNTERTRANSFERENCE

It is well known that transference becomes more intense when hypnosis is introduced into the picture (Brown & Fromm, 1986). This should not be surprising. J. G. Watkins (1992) noted that the major theories of hypnosis place emphasis on “interpersonal suggestion, regression, and dissociation” (p. 231), and that these are “essential elements of the transference” (p. 232). Brown and Fromm (1986) have identified four major types of countertransference feelings and attitudes that hypnotherapists experience with their patients. The first is the pregenital countertransference in which Godlike attributes originally connected with the therapist’s parents are transferred to the patient. The second are the oedipal-sexual countertransferences; the third, sibling countertransferences; and the fourth, specific countertransferences that appear when narcissistic, borderline, or psychotic patients are being treated. With this latter group of patients, Brown and Fromm (1992) assume a more totalistic view of transference. As one examines the Self Psychology model (Kohut, 1971, 1977, 1978; Orenstein, 1987; Wolf, 1988) it is possible to see that hypnosis can facilitate the ability of the
therapist to respond therapeutically to the transference projections of the patient. Mirroring can be enhanced and simultaneously contained in trance experiences. Idealizing can be transformed into self-idealization and expanded by hypnotic activation of Core Self resource phenomena such as Inner Strength. In Ego State Therapy the experience of twinship both with the therapist and with other ego states can be enhanced.

COUNTERTRANSFERENCE AND EGO STATE THERAPY

J. G. Watkins and H. H. Watkins (1984, 1997) have cautioned about countertransference hazards to therapists doing Ego State Therapy with patients with Multiple Personality Disorder (Dissociative Identity Disorder). Among these hazards that countertransference problems can promote are continuous communicated fear of malevolent ego states, boundary violations including susceptibility to seduction, physical danger to the therapist, and the fostering of dependency in the patient. They stress the need for the therapist to be heedful that the dissociative defensive structure makes these hazards more likely to be present. These hazards are frequently present when Ego State Therapy is conducted. As J. G. Watkins and H. H. Watkins note (1997, p. 118), “The hazards described are in no way limited to the treatment situation with multiple personalities. They can occur with many types of patients.” Gabbard and Wilkinson (1994) have also cautioned about the danger of boundary violations and other countertransference problems with borderline patients.

Within Schwartz’s (1995) Internal Family Systems Therapy all transferences and countertransferences are considered to be a function of one or more parts, rather than the greater, integrated personality. In other words, transference and countertransference are manifestations of failures in integration. Thus, all transference and countertransference work is done with individual parts. The rationale for this is that the greater Self, itself, is free of problems. Conflict can only belong to the parts.

Davies and Frawley (1997) also address countertransference from their own polypsychic perspective. Although they do not do formal hypnosis, they are clear that a great deal of their work with adults who were sexually victimized as children is done with patients who are in formal trance. They also advocate self-hypnosis for use between sessions. They have noted that transference and countertransference become pluralized and shift rapidly when dissociation is present. They link these phenomena to “. . . two sources: temporal shifts in the dominance of each ego state, and intraego state changes in reaction to the therapist and to other ego states” (p. 153). They have also identified
several possible countertransference impasses or traps that might involve ego states. These include:

1. Favoring one or more ego states over others
   J. G. Watkins and H. H. Watkins (1997) explain that the therapist may countertransferentially favor an ego state. Some therapists, for example, may tend to favor abused, immature ego states, while others may be more comfortable with adult, rational, verbal ego states.

2. Emotional withdrawal of the therapist
   The therapist may “self-protectively withdraw from the powerfully ego-alien disruptions inherent in projective identification” (Watkins and Watkins, 1997, p. 162). This signals that certain aspects of the patient are not acceptable to the therapist and could destroy treatment.

3. Rejection of the possibility of the existence of trauma experiences
   Some contemporary psychoanalytic conceptualizations, especially about borderline conditions, may not embrace sexual abuse or other trauma as causative of such pathology. The therapist may countertransferentially reenact the patient’s feeling of not being believed or validated in a skeptical supervisory environment.

4. Having to look good to the patient
   Therapists who themselves are survivors of trauma may display a tendency to diffuse negative, aggressive transference reactions in order to maintain their positions as “good objects.”

The present author believes the list should be expanded to include:

1. Accessing trauma material too rapidly
   Leading and rushing ego states into accessing trauma material may distort or create trauma memory material. Therapists, who believe that the major therapeutic element of therapy is catharsis, may push patients onto trauma material access. This can also happen when the therapist has been a trauma victim and is over-identified with the patient or one or more ego states. It can also be a countertransference reaction in which the therapist wants to hurry up and get it over—a counterpart of the patient’s transference (Phillips & Frederick, 1995). In these processes the demand characteristics of the therapist may lead the greater personality and/or certain ego states astray.

2. Pushing the patient to interpret material favored by the therapist
   Patients may present with universal fantasy material that they are pushed by therapists to interpret as trauma, often trauma of a bizarre nature. This is not to say that bizarre trauma does not occur. However, some therapists may be extracting voyeuristic gratification from encouraging patients and child ego states to become more and more embroiled with fantasy as if it were reality. Unfortunately, the push to interpret or to accept hasty interpretations may result in the failure to discover what really hurt the patient. This countertransference trap can be particularly hazardous to the fantasy-prone (Wilson & Barber, 1981).
**COUNTERTRANSFERENCE THEMES IN EGO STATE THERAPY**

In Ego State Therapy the therapist is interacting with many energies, each of which has its own set of transference characteristics. Further, the situation is greatly compounded when child and adolescent ego states are present. Every Ego State Therapist is, de facto, a child therapist as well. The need for both transference and countertransference reactions to be detected and taken into account by the therapist is particularly pressing in Ego State Therapy.

Common transference themes in child ego states are: (a) Fear the therapist will not understand or care, (b) fear of retraumatization by the therapist, (c) fear of abandonment by the therapist, (d) fear of extinction as a necessary part of the therapeutic process, (e) fear of harming the therapist, and (f) fear of self-harm.

Although adolescents often develop strong transferences in therapy, small children usually do not (Harley, 1971). However, countertransference reactions to children and adolescents in therapy are often quite strong and, although this is rarely admitted, frequently negative. Bornstein (1948) noted that analysts are frequently frightened by the unpredictability, the strong highly charged emotions, and the narcissism of children, as well as their closeness to the primary process material of their unconscious minds. She also felt that children are often the subject of unrealistic therapeutic expectations and frequently evoke feelings of helplessness in therapists who may subsequently defend against such feelings by withdrawing emotionally from the child.

Ego State Therapy offers many opportunities for constructive healing work through the use of the countertransference trance, the use of developmental repair techniques, and activities that move the system toward integration. Ego State Therapists are given the opportunity to convey experiences and goals of aliveness and significance to ego state energies. These act as interventional models that can be mirrored. Eventually ego states will experience twinship with the therapist as well as with one another. Ultimately, through the process of identification, they will be able to share this sense of meaning and being alive with other ego states.

As valuable as models of the transference and countertransference field may be, it is essential that the model selected fit the clinical situation. There is considerable theoretical foment within the post-modern theorists about models of therapeutic relationship (Teicholz, 1999). In a post-modern sense, it may be necessary to deconstruct models or to change models. This particularly applies to the issue of therapist self-disclosure. This author, like many therapists, generally favors a significant degree of containment; however, for a given therapeutic issue with a given patient, she might elect self-disclosure as a way of helping...
the patient validate reality and/or vision and co-experience the meaning of the field in which they are both involved.

**THE COUNTERTRANSFERENCE TRANCE**

Phillips and Frederick (1995), Frederick (1997a), and Frederick and McNeal (1999) emphasized the need for identifying and resolving countertransference issues in Ego State Therapy. They also noted the presence of a literature that addresses the phenomenon of trance in the treating therapist as well as an interactive reciprocity between hypnoterapist and subject. Phillips (1994) used the term countertransference trance to describe the therapist’s experience of an interactive trance state in which the transference and countertransference fields are reflected. Phillips (1994) and Phillips and Frederick (1995) recommend that therapists be able to walk in the footsteps of Erickson (Erickson & Kubie, 1940) and Gilligan (1987), both of whom emphasize the contributions of the unconscious mind when the therapist is able to enter a mutual interactive trance state with the patient. Phillips (1994), Phillips & Frederick (1995), and Frederick (1999a) call this interactive state a positive countertransference trance.

Each aspect of the therapeutic relationship is compounded in Ego State Therapy. Each ego state has consciously based relationships with the therapist, and each ego state has unconscious transference relationships with the therapist as well as with the other ego states. Moreover, the ego states also need to be thought of as having transferential relationships not only with one another as well as with the greater personality of the therapist, but also with each of the therapist’s ego states as well. From an ego-state viewpoint, the countertransference situation is equally complex.

Certain uses of the countertransference trance in Ego State Therapy will be described from a totalistic orientation that embraces the concept of the “therapeutic third” (Ogden, 1994, 1997). The proviso that is given to the reader is that it will never, never be perfectly clear what is happening. That is because so much of what is going on is at an unconscious level.

**CLINICAL CASE: THE UTILITY OF THE COUNTERTRANSFERENCE TRANCE (THE CASE OF NICHOLAS)**

Nicholas, a brilliant man in his forties, had been in therapy for eleven years and had two psychiatric hospitalizations when he began Ego State Therapy. As a child he had been abused in a child pornography ring over an extended period of time. His memory material also included his witnessing two murders, one of which involved mutilation. After a thorough evaluation, the present author made the dual
diagnoses of Bipolar Disorder, Mixed Type and Dissociative Identity Disorder (DID). The attempt was made to stabilize him with both medication (divalproex, carbenazepine, buproprion) and psychotherapy. The concentration was on developing therapeutic alliances with each of his ego states. Our work was complicated by his long-term, live-in girlfriend, leaving him just as he was starting therapy. Also stressful were problems at work that endangered his livelihood. During the first months of therapy he periodically harmed himself (as he had for years) by striking himself or hitting his head against the wall.

By the seventh month of treatment, he demonstrated remarkable improvement. Our work with certain child ego states had allowed him to be more in charge of himself, and he no longer had inappropriate anger outbursts at work. His self-harm activity had vanished. After an extended period of social isolation he had finally begun to spend more time with friends. He began a relationship with quite an interesting, caring, and intelligent woman, Diedre. These improvements placed a particular problem in the spotlight. For years, the patient had extreme obsessions about going into situations of anonymous sadomasochistic sex with a strange man. On a number of occasions in the past he had not been able to resist them.

Nicholas had been helped to work with these obsessions and compulsions in self-hypnosis. In trance he would evoke the masochistic ego states that wish to be sexually abused and tell them how grateful he and the other parts were to them for holding so much of the trauma material for them for so long. He also told them that everyone was aware of their suffering and that an important goal of therapy was to free them of this burden. Nicholas reported that these interventions were remarkably helpful in his controlling these impulses and quelling the obsessions.

In a second phase of intervention, Nicholas was helped to let the masochistic ego states know that he understood that the abusers had told the child who was being abused that he was “made for this,” that this was “the only way you will ever be able to get love,” and that this was especially true because his “parents neither loved him nor wanted him.” He addressed the belief systems of these masochistic child ego states in self-hypnosis by telling them that these were lies, that all abusers lie, and that the Internal Family loved and valued them. These interventions were also helpful.

However, Nicholas presented in a session troubled by the obsessions and compulsions, which had become “worse than they ever have been.” He doubted his ability to control his behavior, and he wondered if he should remain in his intimate relationship with his girlfriend as he had no wish to be unfair to her. As the treating therapist, I experienced a brief moment of anxiety and a sense of urgency, took a deep breath and entered into a trance state. This brought an awareness of
images from a movie seen years ago (Witness). The image was that of a man trapped in a silo being smothered in grain who could not be rescued in time. In another scene, the heroine and her father were taken away by a villain. Her father signaled to his young grandson to pull the rope that would ring the bell that would alert the community.

Several things became clear. One was that these masochistic ego states were still clinging to the abusers and felt helpless about it. The presence of one or more as yet unannounced, hidden inner abuser ego states was a distinct possibility. Secondly, it seemed that the ego states were, nonetheless, ambivalent. Hence the material about sounding the alarm and rousing the community to help became salient. Their attachment problems would have to be addressed more specifically. The patient was asked to enter trance, and an assembly of the ego states was requested. It was requested that the other members of the Internal Family make the problems of these child ego states a primary concern. The Internal Family was directed to hold and love these child parts. Nicholas reported that all the ego states sat down together, adults and children. Then they all went down to the seashore together. “They were very close.” The patient was instructed to facilitate this activity whenever an obsession or compulsion occurred.

Within the next two sessions, sadistic ego states were communicating through imagery of decapitation and other violence against the patient. The patient became aware of switching into a personality energy for which his relationship with Diedre seemed unreal. It was at those times that the masochistic ego states would become active.

The unconscious interaction of the transference and countertransference trance phenomena allowed issues related to sadistic ego states (identified with the abusers and triggering the masochistic states) and fear of inescapability (from the abusers/persecutory ego states). Self-soothing and more secure attachments were thus allowed to become the focus of therapy.

The countertransference trance may be deliberately produced, or it may occur spontaneously in the course of therapy. The spontaneous trance states should always be viewed as interactional. They usually contain material that is relevant to what is going on with the ego states.

**CLINICAL CASE: UTILIZATION OF THE THERAPIST’S SPONTANEOUS TRANCE**

Annette had been doing exceptionally well in therapy. Four immature ego states had made incredible strides in growth and development. When they had first been activated, each one was living in an individual cave in the side of a cliff accessible only by rope ladders that were frequently drawn up into the cave. They had moved out of the caves into a large house and interacted well. When Annette’s mother
had become ill, they had learned to allow Annette to take care of these adult matters.

In a particular session, Annette was explaining how well she was doing. Although she had some business matters to clear up for her mother, all was going well. This therapist became aware of drifting off into a trance state recalling my own experiences in the San Francisco earthquake of 1989, only a couple of miles away from the collapse of the Bay Bridge. Serious doubts arose that the building in which I was in would be able to withstand the quake. Images, thoughts, and feelings of disaster and destruction, and of my own fear, continued to intrude into consciousness. This material could well have to do with Annette’s ego states, as she was invited to do a piece of trance work.

The activated ego states had regressed. Terrified, they were hiding in the grass. I learned from them that they were terrified of having to deal with Annette’s husband. His cooperation and support were essential to Annette’s dealing well with her mother’s financial matters, and he had been negative and unresponsive. He was not a terrorizing man, but rather, one who was spoiled and selfish at times. A discussion of this reality and some much needed ego-strengthening was done with these child ego states, and the patient, out of trance, agreed to speak with her husband.

This case is illustrative of one of the ways that countertransference trance phenomena can be as vital and helpful (in this instance, as a source of information) for working with ego states as it can be in other forms of dynamic psychotherapy. Phillips (1994) Phillips and Frederick (1995), and Frederick (1999a) recommend that Ego State Therapists deliberately develop positive interpersonal trance states as an effective way of working within the transference-countertransference field. Such states can be viewed as a “positive counter-transference trance” (Phillips & Frederick, 1995, p. 222–224). Here is a rather free-wheeling spin-off of Gilligan’s (1987), Phillips’s (1994), Phillips and Frederick’s (1995), and Frederick’s (1999a) recommendations for developing such a state.

**Steps in the Development of Positive Countertransference Trance**

1. Be willing to enter an interpersonal trance state in which your ego states will enter greater and more direct unconscious communication with the ego states of the patient and, thereby, facilitate the patient’s conscious-unconscious complementarity. Increased conscious-unconscious complementarity is integrating and highly desirable (Morton & Frederick, 1999).
2. Go within, identify any physical or emotional tension and relax to remove or diminish them. You can do this while taking a deep breath or two and shifting your focus to an internal one while you are continuing to speak with the patient. Then respectfully request your own ego states
to become involved in the interaction, even though you may not be aware of that involvement per se.

3. Shift your focus from your consciously deduced “dynamics” of the ego states or the greater personality’s activities by defocusing your eyes and allowing your attention to converge on the patient’s “…breathing patterns, muscular tension, body posture, emotional state, and movements” (Gilligan, 1987, p. 77). Continue with the therapy session, realizing that you and your ego states have begun a journey that will take you closer to the unconscious mind and the ego states of the patient. You do not have to make any conscious attempt whatsoever to influence the outcome of the situation.

4. Shift your inner focus away from the patient to yourself. Concentrate on the comfort of your breathing. This allows you to go more deeply within while you are maintaining manifest activities.

5. Briefly, allow yourself to call up an image or images (if such exist) of your own ego states as a way of reinforcing their participation.

6. Allow your breathing to become synchronized with that of the patient with whom you can now develop a more filtered or “soft” eye contact.

7. Allow your own thoughts, images, feelings, and bodily sensations to flow freely through your consciousness with interest, but without judgment.

8. You will, at some point, become aware of some mental content and/or wish to speak with the patient. This is desirable, and all you need to do is let the material that has been unconsciously processed communicate itself. You may discover that you are telling a story in a different way, or responding to a piece of history in a new and meaningful fashion. Perhaps you will hear the patient differently.

9. Remember that the countertransference trance may occur spontaneously in therapy. When it does, it can be utilized.

10. Foster your own conscious-unconscious complementarity. In your trance state you are able to be more aware of your observations and evaluations of your emerging unconscious material.

In the next chapter the creation/modification of ego states and the usefulness of positive ego states will be discussed.

CHAPTER VII
POSITIVE EGO STATES
THE CREATION AND MODIFICATION OF EGO STATES

Most of the clinical literature in the field of Ego State Therapy is chiefly devoted to resolving pathology. It deals with ego-strengthening, developmental issues, trauma resolution, and symptom relief. Successful Ego State Therapy has always utilized the cognitively and affectively able, more cooperative, and more mature members of the
Internal Family in the treatment process. Such ego states are not Center Core phenomena but, rather, are aspects of personality that have arisen out of the interaction of the person and his/her world. Often these adult ego states are capable of functioning as co-therapists or internal nurturing energies. Some of them function in this role with innate ability. Others are able to learn to function more positively and more constructively. As treatment progresses, some of these high-functioning ego states can become the administrators of many of the therapeutic internal activities that need to go on between sessions. Frederick (1996) and Frederick and McNeal (1999) have called these more mature ego states “conflict-laden ego states” to distinguish them from conflict-free states such as Inner Strength. The role of these helping ego states can at times be so vital to treatment that if such states cannot be discovered, some clinicians have found it worthwhile to create them. The activation of conflict-free ego states such as Inner Strength also represents the use of positive ego states.

**THE CREATION OF EGO STATES**


Gainer (1993, 1997) used the creation of helpful ego states in the treatment of Reflex Sympathetic Dystrophy and other severe chronic pain syndromes. Frederick and Kim (1993) described how the creation of helpful ego states resulted in the elimination of performance anxiety. These techniques worked quite well with two patients who had crippling performance anxiety problems. However, Frederick and Kim (1993) wondered what actually happened when ego states were therapeutically created. One important question they entertained was whether there was actual creation of an ego state de novo, or whether dormant ego states had been activated and possibly re-motivated or even modified. Indeed they called their technique the “. . . activation/modification or ‘creation’ of ego states” (p. 56), because they believed that they lacked the ability to know the precise nature of the interventions. They realized that Federn (1952) had maintained that ego states were formed only in childhood.

However, Frederick and Kim (1993) had noted that there was a literature in both the Nineteenth and Twentieth Century on the experimental creation of “alters.” Binet (1977a, b), like many of his era, believed consciousness to be divided. He created “alters” experimentally in very highly hypnotizable subjects. He also observed the development of an intimate relationship between these “alters” and the hypnosis operator, since the “alters” would only respond to their creators. Janet
also created alters experimentally (Ellenberger, 1970). More recent reports of alter behavior creation in the laboratory have come from several investigators, including Harriman (1942a, b), Kampman (1976), Leavitt (1947), Spanos (1986), and Spanos, Weekes, Meanry, and Bertrand (1986).

Frederick and Kim (1993) also noted that adult patients with Dissociative Identity Disorder frequently created alters as a part of a dissociative lifestyle. In such cases, getting the patients to stop producing new alters, is a necessary treatment move. What Frederick and Kim (1993) were pointing to, and was later demonstrated more amply by Frederick and Sheltren (2000), was the flexibility of the personality and what we would now think of as the plasticity of the brain as well.

In creating ego states, Frederick and Kim (1993) used material from the past, the present, and the future. Their intention was not to attempt to create ego states “out of the blue,” but instead to use some of the patient’s own imagery as the cloth that would be stitched up into a new function and a new identity. Their formula for ego state creation was threefold:

1. They first had their patients visualize positive future outcomes to their symptom situations. “... to establish the capacity for the mental experience of success” (p.55).
2. Using age regression, they captured images from childhood that could become modified and personified to deal with the symptoms of the present and to produce the favorable outcome pictured in the future. It is possible, but not necessarily so, that the images were activations of dormant states that had previously been formed in childhood.
3. The modified imagery/ego state was projected into the future and experienced by the patient as a “helper” state, one that was different in quality and function from the images of the past.

Although Frederick and Kim (1993) spoke of the creation of ego states, they believed:

The real question is whether we are addressing a process in which a new ego state has been created or whether old states are merely activated and pressed into service.” (p. 55)

Ginandes (2004) described the creation of a Monitor ego state in her work with mind-body problems. This state’s function was to monitor and report on the precise nature of the patient’s internal physical and mental condition. Frederick and Sheltren (2000) called their approach as creating/activating non-dissociative positive ego states. This description suggests that although therapists may “create” healthy ego states, the precise nature of what the product of these therapeutic activities might be is still very much a matter for speculation. Frederick and Sheltren (2000) also felt it was legitimate to ask what became of
ego states that had once functioned quite well and then apparently vanished. They noted that Weiss (1960a) stated that:

Ego states of earlier ages do not disappear, but are only repressed. In hypnosis, a former ego state containing the corresponding emotional dispositions, memories, and urges can be reawakened in the individual. (p. 15)

Sheltren and Frederick (2000) believed that the question may not be subject to solution, as it may be impossible to create a suitable research design to explore it. This view may be too pessimistic in view of the emerging potential of neurophysiological research.

Frederick (2003a) has added another chapter in the creation/modification of ego states. She devised a hypnotic technique in which a conflict-laden ego state (someone close to the patient who has died) is transformed into a conflict-free ego state. This is done by investing the conflict-laden state with the qualities of “being fully realized.” The new ego state has all the qualities of a Center Core phenomenon. This technique was created as a way of resolving grief issues.

**THE FOSTERING AND CREATION OF POSITIVE EGO STATES**

*Self-Created Positive Ego States in Children and Adolescents*

Frederick and Sheltren (2000) were interested in the roles of positive ego states in children and adolescents. They believed that with few exceptions (J. G. Watkins, 1978b; Watkins & Watkins, 1997) little had been said about the practicality and advisability of promoting strong positive ego states in children and adolescents. The implications of positive ego states for mental health, pedagogy, and successful adult life are enormous. Frederick and Sheltren (2000) noted that it is accepted that the self-creation of positive ego states is a normal part of human development. However, it frequently assumed that ego states that arise as the result of trauma and separation will often be purveyors of dissention and symptoms in adult life. Trauma and separation can also produce ego states that are positive and healthy (Frederick & McNeal, 1999).

To illustrate this, Frederick and Sheltren (2000) pointed to a fictional character in an autobiographical novel, David Copperfield (Dickens, 1850/1952). David Copperfield’s story is that of a little boy whose mother remarries a cruel man after his father dies. The new stepfather imposes both heavy discipline and severe corporal punishment on David, and when his childlike mother dies, David’s stepfather misappropriates David’s inheritance, sending David into a life of harsh labor among strangers.

Little David had learned early on to escape the pain of living under the regime of his new stepfather by identifying with the heroes of
novels his own father had left. Eventually, these characters became positive ego states within David.

I believe I should have been stupefied but for one circumstance... It was this. My father had kept a small collection of books... to which I had access... Roderick Random, Peregrine Pickle, Humphrey Clinker, Tom Jones, the Vicar of Wakefield, Don Quixote, Gil Blas, and Robinson Crusoe, came out, a glorious host to keep me company. They kept alive... my hope of something beyond that place and time... The Captain never lost his dignity for having his ears boxed with the Latin Grammar. I did, but the captain was a hero, in despite of all the grammars of all the languages in the world, dead or alive... This was my only and constant comfort. (Dickens, 1850/1952, p. 67)

Frederick and Sheltren (2000) remind us that Copperfield’s story is not that of an abandoned and traumatized child developing Dissociative Identity Disorder (DID). Rather, it is one of a child benefiting from his positive ego states and incorporating them into what will eventually become the identity of a writer and a social reformer who not only exposed societal abuses, but also led his reading public to some understanding of the psychology of children by depicting their inner processes in his works of fiction.

Positive ego states are often taken for granted, or it is assumed that they will develop normally to meet the individual’s needs as they arise or be created in trauma or abandonment/neglect to help the individual cope, as Dickens’s positive ego states functioned. The reality is that therapists can actively add to the resources of the patient through the creation/promotion of positive ego states. Such therapeutic activities can play an invaluable role in psychotherapy, in preventive medicine, and in pedagogy.

The Creation/Fostering of Positive Ego States in Psychotherapy

Although a great deal of positive ego state activation/fostering may be done automatically and even unconsciously in our work with adults, it becomes particularly noticeable in work with children and adolescents. One reason for this is that they may not have time to acquire the reservoir of positive states they need. The obvious need for the activities of positive ego states and the therapist’s inability to locate one within the patient’s current available Internal Family can be an indication for a more active creation/promotion of such a state by the therapist. Positive ego states can be fostered and created in both direct and indirect trance. Children respond well to Ego State Therapy (Hartman, 1995a, b), and for some, it can be the treatment of choice. The creation/fostering of positive ego states can become necessary elements in Ego State Therapy with children.

However, Frederick and Sheltren (2000) caution about the use of formal trance for this or any other purpose with this population. Even
as therapists, we may continue to share the societal denial about the frequency of child abuse and may not want to remind ourselves that a significant number of our child and adult patients are abuse victims. Some of them may even be involved in active abuse situations while they are in therapy. The prevalence of child abuse mandates extreme caution in introducing direct trance inductions in children until a number of other essential matters have been addressed: (a) First, a thorough evaluation must be done. This consists ideally of extensive interviews with the child’s or adolescent’s parents. Several interviews with the child alone (if possible) must occur. At times evaluation must be ongoing for a variety of reasons; (b) A therapeutic alliance must be in place before formal trance is used; (c) The therapist must have a solid, definite sense that the is no reportable abuse that will be revealed later on. Frederick and Sheltren (2000) remind us that . . . . the subsequent credibility of the information could be jeopardized in the court system simply because it was revealed in trance. In general, we recommend the use of informal techniques, rather than formally induced trance, should the young patient disclose sexual or physical abuse. (p. 8)

Nevertheless, formal trance can be used with children and adolescents if certain precautions are closely observed. Formal trance is particularly indicated for the creation/activation of positive ego states with children who can be taught to use self-hypnosis and are motivated to employ it for self-help. The following case, adapted from Frederick and Sheltren (2000), illustrates this.

**Clinical Case Example: Stella**

Stella was twelve, and she was definitely a star in a family of high achievers. She made As, excelled at sports, played the piano and did ballet. If her family could be faulted for anything, it might be that they were all too good, too strong, too generous, and too perfect.

One evening Stella saw a TV program about the abduction of a little girl about her age. She had been missing for a number of months until her body was found. Stella suddenly developed a severe phobia about being alone in the house and was seen on an urgent basis. She was living in an escalating state of terror when she was at home in the evenings. Stella insisted on sleeping on the parental bedroom floor. Everyone in the family was exhausted.

A rapid assessment of Stella was conducted that involved a session with her father and one with Stella. She was a child in a loving and non-abusing family who showed no evidence of having been seriously traumatized. There was also no evidence for Obsessive Compulsive Disorder (OCD), mood disorder, or psychosis.
Stella was hovering on the verge of puberty. She could picture standing before a door. Once she opened it, she would face the inevitable path to separation from her exceptionally safe and caring family into growth and into life’s dangers and vicissitudes. The decision had to be made as to whether to attempt to use therapeutic maturation techniques with the terrified child ego state that was assumed to be present, possibly committing Stella to ongoing therapy. Alternatively, activation of a positive helping ego state could be attempted. The latter choice seemed to be developmentally more sound as it would foster her autonomy.

Formal trance with Stella was employed to produce deep relaxation and to help her locate a safe place. The session was taped. When Stella was out of trance it was said to her “Stella, there is a part of you that can tell the difference between what is really dangerous and what is not.” Stella nodded her head. “And that part is going to get a lot stronger now that you are on the verge of becoming a teenager. She was given the tape and told, “Every time you use this tape, it will help the part that knows how to tell the difference between real danger and just ‘scary stuff’ to grow even stronger.”

At the end of the session, Stella’s parents were asked to join us. They were instructed to set up a cord from Stella’s bedroom to theirs with a bell at their end. Stella could signal her parents that she needed them by pulling the cord. Stella agreed to use the tape when she became frightened and to ring the bell at any time she felt overwhelmed.

The first night Stella “flunked.” She didn’t even use the bell. She simply crept into the parental bedroom in a state of terror. In our next meeting she was told, “That’s OK. All that means is that you haven’t really found the part of you that knows when there is genuine danger. It’s important for that to happen because that part will protect you from all sorts of real dangers as you continue to move toward becoming a teenager.”

Stella was seen weekly, and she began to use the tape and to use the bell as well. Within five weeks Stella was sleeping in her own bedroom all night long. She looked back on her fearfulness with some mild amusement and a good deal of residual embarrassment. Her therapy was considered to be successful. No medications were used.

Some years later, the present author encountered Stella’s father at a professional event. He reported, “Stella has done so wonderfully. She hasn’t had any more trouble since she saw you. I’m starting to feel old. She’ll be going away to college next year.”

A case could be made that Stella had undergone behavioral therapy and that no mature ego state had been located or fostered. From a behavioral perspective, that might be true. From an Ego State Therapy perspective, Stella had learned to find and rely on a positive, reality-based mature aspect of her self — a positive ego state. Was the state
located unconsciously by Stella or was it created by the therapist? Like Frederick and Kim (1993), Frederick and Sheltren (2000) believe that what may appear to be happening clinically may not always have theoretical clarity.

A tremendous amount of the fostering/creation of ego states takes place in trance that was not formally introduced. When children are engaged in play therapy they often appear to be in a hypnoidal state (Linden, 2003), and they are extremely responsive to storytelling and metaphor. Both direct approaches as well as storytelling and metaphor can be used with the utilization of this state to evoke, foster and/or create positive ego states. Frederick and Sheltren (2000) think that this process occurs:

1. When we use metaphor (the patient can be in informal or spontaneous trance, or the approach can be indirect storytelling).
2. Through identification with the greater personality of parent, teacher, therapist, historical heroes, public figures, or fictional characters in books, movies, television productions, etc. The therapist’s role may be simply to reinforce the child in that direction.
3. When children and adolescents make a strong identification with positive, helpful ego states in the therapist, parent, or teacher.
4. In adversity as a non-dissociative phenomenon as exemplified by the positive, helpful ego states of the fictional David Copperfield and similar ego states presumed to have been created in the author, Charles Dickens. It is important to distinguish these ego states from those that are dissociated and created at the time of trauma, abuse, or neglect.
5. Through direct, open validation and reinforcement of the positive, helpful ego states by the therapist, parent, or teacher.

Positive Ego States in Education

Serious psychopathology is not the reason many intelligent children and adolescents have academic difficulties. Nor do they necessarily have to be severely learning disabled. Some of them may have a variety of Attention Deficit Disorders. For whatever reason, many of them are children who have simply not learned how to study (Frederick and Sheltren, 2000). The present author has had extensive experience with one-on-one tutoring within such a population of poorly performing children and adolescents who were quite intelligent. It is interesting that no one was aware of each child’s intelligence or abilities until he/she developed academic success. The following material is adapted from Frederick and Sheltren (2000).

PEDAGOGICAL EXAMPLE: BILLY

Billy was 9 years old, wore coke-bottle thick eyeglasses, and was consistently getting Ds in school in every subject. At the time, the
present author was a twelve-year-old tutor in the summer before becoming a high school freshman. Billy was sent to me because of low cost to his family, it would give him a summer activity related to his school performance, and it was supposed it would do no harm. At our first meeting, Billy heaved a bunch of books on the table, presented a look of despair and even heaved a sigh.

Billy was told that he was guaranteed to have a good time at every session. He was incredulous. It suggested “Let’s look at what we have to do.”

Billy brought out his bête noire, English grammar and gave a look that said, “If you think this is fun, you’re nuts!” Then Billy began his first experience with the Claire Tour of Grammar that day. Walking around the room together a contest was held to see who could find the silliest nouns. Billy began to laugh. The next visit was in the same vein, and quite soon Billy began to look forward to his tutorial sessions—and he was learning to identify the parts of speech.

Billy had fun that summer. He learned to picture things in entertaining ways that would help him both understand and remember them. For example, cartoons were drawn about grammatical relationships. Feeling confident in his English abilities, mathematics was dealt with in a similar fashion.

When the school bell rang at the end of the summer, a new Billy went to the classroom. He became a straight A student, and he never deviated from that all the way through high school. Seeing him again the following summer, it was clear that Billy’s “change” was permanent.

The author’s reminiscence concerns the creation/activation/development of positive, learning ego states in her student, Billy. Another interpretation of Billy’s transformation could be that Billy had reframed what good study habits were. Another might be that he learned to use informal awake, alert trance states to improve his learning (Wark, 1996). A third possible explanation is the possibility that Billy had some form of Attention Deficit Disorder that was ameliorated by the utilization of the awake alert trance states he developed while “having fun” and developing imagery (Barabasz & Barabasz, 1992, 1996, 2000). It is also possible that the positive feedback in the tutorial relationship ameliorated some symptoms of an undiagnosed Attention Deficit Disorder (Diener & Millich, 1997), or that spontaneous hypnosis facilitated behavioral shaping in the relationship. Any of these dynamisms may have been in play, but from an egostate point of view it appears that Billy’s fun tutorial experience permitted a new, positive ego state to develop within him, one that had developed a positive attitude about learning and could turn it into fun. This ego state was new for Billy because it used humor and imagery and held an attitude that was new as well: Everything can be understood if you just ‘break it down’ into its components.
This ego state knew that the dour concept of “good study habits” presented a dull and unnecessary path of duty that was a dead end to curiosity and creative mastery of academic material. Billy’s new, positive ego state became self-reinforcing. Each success it produced strengthened it. So it will come as no surprise that Billy lost his hang-dog look, developed confidence in himself, and grew up to be an accountant. (Frederick and Sheltren, 2000, p. 9)

Positive ego state development in children and adolescents may be valuable. Similar development in therapists can be pivotal to successful outcomes.

The Creation/Fostering of Positive Ego States in Caregivers

Although the child therapy literature speaks of parents being engaged in positive reinforcement, giving the child increased attention, and resolving the problems that are interfering with their abilities to care for the child, there is little in the ego state literature to advise the therapist about how to actively promote positive ego states in the parents of children in therapy. Frederick and Sheltren (2000) have addressed this issue specifically.

The child psychotherapy tradition of working with the parents in order to help the child can be extended to Ego State Therapy. Frederick and Sheltren (2000) have focused on the importance of the therapist’s identifying the positive aspects of the parent’s personalities, validating them and encouraging further maturation of these parts. They believe that it is one of the functions of the child therapist to help the parent recognize his/her strengths. Therapists can listen for and call to the parent’s notice occasions when the parent was just what the child needed: understanding, capable, confident, adept, and/or skilled, and so forth. The therapist response to the positive ego states in the parents mirrors the kinds of responses that parents needs to give to their children. The therapist helps the patient’s parents learn how to identify parts of themselves when they show up, often using the language of Ego State Therapy.

From their clinical experience in working with children and adolescents as well as with their families, Frederick and Sheltren (2000) created a rudimentary road map for activating positive parental ego states in the parents of their patients. Clearly this road map can be useful in working with individuals who are seeking help with their parenting skills.

ROAD MAP FOR ACTIVATING POSITIVE PARENTAL EGO STATES

1. Begin the meeting with the parents or with the entire family by asking the parent(s) what has gone well. This will probably elicit the positive parental ego state at the beginning of the session.
2. Affirm this ego state through comments such as: “That’s great! It always feels good to be a responsive parent,” or “Good for you! Sometimes it’s hard to be firm, but that’s what good parents have to do sometimes.”

3. The positive parental ego state is alluded to repetitively throughout the session. For example: “You know, I’m hearing one more time that the wise parent part of you is learning to tune in to your child.”

4. The theme of further maturation of the positive parental ego states is introduced. “Many parents find that they become even better parents, more patient parents, more supportive parents, more protective parents just through the very experience of raising their children. Do you see the growth in those parts of you that I see?”

5. Offer opportunities for the parent’s positive parental ego states to become even stronger by forming identifications with others. Stories that begin with “Once I knew a mother who…” can provide strengthening and expanding models for identification by the positive parental ego states.

6. Do not hesitate to use metaphor. Metaphor has been recognized as a powerful method for the creation/activation of positive ego states. For example: “And you know, that little tree could not possibly have grown if the little boy’s parents hadn’t been sensible and caring enough to put that little fence around it.”

7. The therapist must also activate his/her own positive nurturing ego states. These will allow for the kind of careful listening in that the therapist is able to identify and give feedback to the parent about times when the parent was able to respond positively. The therapist then helps the parent to understand how to apply those strengths to other situations (Frederick & Sheltren 2000, p. 5).

Frederick and Sheltren (2000) remind us that the creation, fostering and promoting of positive ego states in caregivers has therapeutic, preventive medicine, pedagogical, and even political implications. The presence of healthy, functioning positive ego states in caregivers can be of inestimable value. This is particularly true when the child or adolescent is highly stressed, is dealing with conflict, or has issues resulting from trauma, and/or attempting to recover from trauma. The promotion of such ego states has enormous potential for advancing and accelerating learning, enhancing the achievement of performance goals (e.g., in scholarship, the arts, athletics), and helping the child or adolescent cope with emerging developmental issues. It can become a royal road to learning and creativity.

**CONTRAINDICATIONS TO THE CREATION/PROMOTION OF POSITIVE EGO STATES**

As practicable and salutary as the approaches described above can be, there are some contraindications for its use in the treatment of children and adolescents: (a) They should never be used unless an assessment that is appropriate to the referral has first been done, (b) they are strongly contraindicated for children and adolescents who have a heavy involvement...
with substance abuse or with any other activity that does not allow them to form proper treatment contracts, (c) it should never be used with overtly and delusionally grandiose children or with children who are otherwise psychotic, (d) it must never be used without total sincerity. That is it must never be employed “... as an attempt to “engineer” a misbehaving or troubled child” (Frederick & Sheltren, 2000, p. 22).

As indicated earlier, some might question whether the creation/activation/ fostering of positive ego states really differs from behavioral approaches that also emphasize reinforcing positive behavior. Frederick and Sheltren (2000) have concluded that it does differ because viable and active therapeutic alliance and therapeutic relationships are formed with the positive, helpful ego states, and frequently the creation/activation of positive, helpful ego states occurs more rapidly than is often associated with those generally seen with cognitive behavioral therapy. It is necessary to keep in mind the fact that therapists will see many cases in which direct work with traumatized, suffering ego states would be more appropriate. However, this approach should be considered with many children and adolescents simply because “... it is so natural, it is organic, it veers away from regressive trends, and it leans heavily toward self-generated internal solutions on a more unconscious level” (Frederick & Sheltren, 2000, p. 23).

REFERENCES
Alexander, F. (1930). The psychoanalysis of the total personality. Nervous and Mental Disease Monographs, 32.


Frederick, C. (2003a, March 22). You are always in my heart: Grief as a resource. Paper presented at the First World Congress of Ego State Therapy, Bad Orb, Germany.


