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Healing the Wounded Self: Combining Hypnotherapy With Ego State Therapy

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The purpose of this article is to formulate a theoretical conceptualization for utilizing ego state therapy (EST) as an adjunct with cognitive hypnotherapy (CH) for depression. As the relationship between life events and onset of depression is very complex, it is not clear from current literature how stressors cause depressive symptoms. The notion of "wounded self," derived from the work of Wolfe (2005, 2006), is examined as a potential unifying concept for binding the role of risk factors in the precipitation of depression. By incorporating wounded self, the circular feedback model of depression, on which CH for depression is based, is expanded. This revised version provides conceptual and empirical underpinnings for integrating EST with CH in the management of depression.

Keywords: cognitive hypnotherapy, depression, ego state therapy, wounded self

Cognitive hypnotherapy (CH), which incorporates cognitive behavior therapy (CBT) and hypnotherapy in the management of various emotional disorders, is a major evidence-based sub-modality of modern hypnotherapy. This integrative approach to clinical hypnosis gained greater impetus since the publication of the influential meta-analysis by Kirsch, Montgomery, and Sapirstein (1995), which clearly proved that the addition of hypnosis to CBT substantially enhances treatment outcome. More recently, the additive effect of CH has been demonstrated with a variety of conditions, including anxiety disorders (Golden, 2012), acute stress disorder (Bryant, Moulds, Gutherie, & Nixon, 2005), bulimia nervosa (Barabasz, 2012), chronic pain (Elkins, Johnson, & Fisher, 2012; Jensen, 2013), depression (Alladin & Alibhai, 2007), insomnia (Graci & Hardie, 2007), migraine headache (Hammond, 2007) and posttraumatic stress disorder (Lynn & Cardena, 2007). Moreover, CH has been conceptualized as a recognized model of integrative psychotherapy (Alladin, 2008, 2012b; Alladin & Amundson, 2011).

CH as an integrated model of psychotherapy for depression has evolved from the cognitive dissociative model of depression (CDMD) proposed by Alladin (1992, 1994, 2006). CDMD represents a working model of depression because it holds that unipolar

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depression is analogous to a form of dissociation produced by negative rumination or negative self-hypnosis (NSH). However, CDMD does not represent a finished product; it remains a work in progress. As more information about the etiology and treatment of depression emerges, the model will be calibrated. In fact, the model has already been subjected to a revision (Alladin, 2007) as a result of accumulated scientific knowledge on the ruminative process, largely due to the works of Nolen-Hoeksema (1991, 2000) and Papageorgiou and Wells (2004). With recent advances in the understanding of the role of emotional injuries or "wounded self" (Wolfe, 2005, 2006) in the etiology of anxiety disorders and the broadening scope of EST (e.g., Frederick, 2005; Watkins & Barabasz, 2009; Watkins & Watkins, 2007), further amendment of the CDMD is in order. CFMD consists of 12 components that can be summed up under cognitive distortions, dissociation, undesirable life-events, and biological predisposition. These components serve as risk factors for depression and they are all interrelated, forming a circular feedback loop. As these components are described in detail elsewhere (see Alladin, 1994, 2006, 2007), they are not discussed here, except for "undesirable life-events" which is central to the concept of wounded self expounded in this article.

The article is divided into five parts. The first part explains how the concept of the "wounded self" can be applied to understanding and treating depression. The second part focuses on the revision of the CFMD by incorporating the wounded self within the model. The third part examines the development of the self and discusses the theoretical rationale for using ego state therapy (EST) as an adjunctive technique in the CH for depression. The last part describes various hypnotherapeutic and EST strategies for healing the wounded self in the context of CH for depression. Some of these techniques are illustrated by two case transcripts.

Undesirable Life Events

Undesirable life events are known to precipitate or maintain the depressive cycle (Schultz (1978). Klinger (1975), however, points out that it is the "symbolic transformation" of these events that is the critical factor. He believes undesirable life-events serve as cues to past traumatic experiences. Although this interaction between undesirable life events and past emotional injuries is endorsed by CFMD, the model does not provide a coherent theory of how implicit emotional injuries produce overt symptoms of depression. As this omission represents an important weakness in the model, this article attempts to address this flaw by integrating the concept of the wounded self derived from Wolfe's (2005, 2006) etiological theory of anxiety disorders. This new version of CFMD provides a unified explanation of how stressors (including negative life events) may cause depression and as such it permits a wider range of psychological interventions, including EST, for treating depression in the context of CH.

The Wounded Self

The Wounded Self in Anxiety Disorders

Wolfe (2005, 2006) has developed an integrated perspective on anxiety disorders, consisting of two interrelated theories: (1) an integrative etiological theory of anxiety disorders, and (2) an integrative psychotherapy for anxiety disorders. Both theories represent a synthesis of the major extant perspectives of anxiety disorders and their treatment, including psychodynamic, behavioral, cognitive-behavioral, experiential, and biomedical perspectives. The guiding premise of Wolfe's (2005, 2006) etiological model is that anxiety disorders are related to patients' chronic struggles with their subjective experiences. According to Wolfe, the experience of severe anxiety in selected situations gives rise to conscious anticipations of impending catastrophe, which at an implicit level reflect a fear of exposing unbearably painful views of the self. The exposure of these self-wounds is accompanied by overwhelming affects such as humiliation, rage, and despair.

According to Wolf, self-wounds are painful self-views that represent organized structures of painful self-related experience—or generalizations of such painful experience—that are stored in memory. These wounds may be known directly in one's immediate experience of a damaged sense of self (i.e., the extremely painful feeling or image of the self that arises in the moment) or conceptually in terms of the ideas, beliefs, and propositions one holds about the self. Self-wounds are mainly outside the person's immediate awareness but are often very close to the surface (i.e., preconscious). They nevertheless influence one's decisions, choices, feelings, and actions. Self-wounds not only limit one's emotional life but also profoundly affect one's behavior. They largely determine the people we choose to have in our life, the environments in which we choose to interact, the emotional experiences we deem acceptable to experience, and the risks in life we are willing to take (Wolfe, 2005).

Wolfe (2005) refers to the self as one's reflexive awareness of one's own behavior, thoughts, and feelings, or one's personhood. In other words, self refers to an experiential or conceptual awareness of the person in interaction with the world (Westen, 1992). Human beings are thus viewed as constant meaning makers as they are involved in a continuous process of acquiring and constructing emotion-laden or emotion-free beliefs about the self, others, and the world. Many of these become deeply held beliefs that are not immediately apparent to the person as they may be preconscious or unconscious. The self is increasingly regarded as a core locus of psychopathology and the ultimate site of therapeutic change (Wolfe, 2005). For example, psychoanalytic theories have focused on the unconscious organization of the self, CBT has centered on self-schemas, while experiential theorists have viewed the individual's self-experiencing as central to mental health and psychopathology (Greenberg, Rice, & Elliott, 1993). In the context of EST, the self is described as analogous to the concept of ego state. Watkins

and Watkins (1997) define an ego state as an organized experience whose elements are bound together by some common principle, and which is separated from other such states by a boundary that is more or less permeable. Each ego state is distinguished by a particular role, mood, and mental function, which when conscious (executive) assumes the person's identity. Ego states are a normal part of a healthy psyche that start as defensive coping mechanisms, but with repetition they develop into compartmentalized sections of the personality that becomes executive (conscious and overt) when activated (Emmerson, 2003). Some ego states may act like complete "persons" while others may appear as personality fragments. Moreover, they may have quite differing interests, purposes, and values, and often in conflict with one another, creating tension, anxiety, psychosomatic symptoms, the desire for fight, and other maladaptive behaviors.

In Wolfe's model of anxiety disorders, wounds to the self result from the interaction between damaging life experiences and the cognitive and emotional strategies designed to protect individuals from their feared catastrophes. External and internal cues that provoke anxiety are developed through one's perception of the relationships between certain painful life experiences and intense fear—that is, certain experiences are perceived as self-endangering. The cues themselves often function as a kind of shorthand for the painful memory that exists beyond the individual's conscious awareness. For example, an agoraphobic patient's fear of losing control is signaled by a feeling of light-headedness, which reminds the patient of the same feeling that he/she experienced when he/she panicked for the first time at the sight of physically disabled people many years before. In this case the anxiety symptoms symbolize fear of becoming physically disabled, which is intolerable to the patient. Wolfe believes all painful views of the self suggest a perception and experience of the self as being unable to cope with the rigors and realities of everyday living. Wolfe's observation is supported by Kendall and Hollon (1989), who found patients with high levels of anxiety to have automatic thoughts about uncontrollability, threat, or danger, as measured by the Anxious Self-Statements Questionnaire. Because realities of life are unavoidable, anxious individuals create indirect coping strategies and defences (e.g., avoidance, cognitive rituals, and emotional constriction) that both protect them from intolerable affective states and keep them from facing the realities head on. Although these strategies may temporarily reduce anxiety, unfortunately they reinforce the patient's underlying maladaptive self-beliefs. Therefore psychological defenses in this model serve as self-defeating efforts to protect one's image of the self (Wolfe, 2005). Wolfe believes, in response to the initial anxiety (the wounded self), anxious patients typically engage in "cogitating" about being anxious, that is, they become preoccupied (ruminate) with their anxiety, avoid fear-inducing objects and situations, and engage in negative interpersonal cycles. In this article, Wolfe's concept of cogitation is considered to be analogous to the concept of negative rumination or negative self-hypnosis which forms part of the CFMD.

The Wounded Self in Depression

The self-wound model can be easily incorporated within the CFMD to account for the relationship between life events and the onset of depressive disorders. As the relationship between adverse life events and the precipitation of depression is very complex, currently it is not clear how such wide range of stressors as separation, divorce, loss, failure, etc.—often referred as risk factors—produce depressive symptoms. The concept of wounded self may serve as a potential golden thread that binds stressors or risk factors together in the provocation of depression. The golden thread alludes to Theseus, the hero from Greek mythology, who entered the complex labyrinth and slew the monster Minotaur, who thrived on slaughtering lost adventurers. What helped Theseus safely find his way in and out of the seemingly endless corridors was the ball of golden thread that his paramour, Ariadne gave him. Many hypotheses or vulnerability factors have been proposed to explain the interaction between life events and onset of depression. Some of these factors include non-conscious information processing, cognitions, self-schemas, cognitive specificity, early experience, traumas, and personality. Nonetheless, it is not clear what mechanisms or common thread connects all these factors in the provocation of a depressive episode. This question is not just academic, the answers to this question have significant ramifications for treatment, particularly when the definition, diagnosis, and treatment of depression are riddled with confusion and uncertainties (see Alladin, 2013). How the above-mentioned factors trigger depression are briefly reviewed before discussing the role of wounded self—the golden thread that may tie all these risk factors together.

Preconscious and Unconscious Information

Cognitive theories of depression have always alleged negative or depressogenic self-schemas to be interlinked with tacit cognitive structures (core beliefs) associated with global, stable, and negative evaluations of the self (e.g., Segal & Muran, 1993). Although these views from Beck's (1976) cognitive theory of depression stresses the importance of both conscious and unconscious information processing, they do not explain the origin and the underlying meaning of the depressive cognitions. According to Wolfe (2005, 2006) the symbolic meanings of the depressive cognitions are rooted in the wounded self.

Importance of Cognitions

Cognitive theories of depression have proposed that it is not the stressors that cause the emotional response, but people's perception of the stressful events. Beck (1967) proposed the concept of the "cognitive triad"—negative view of oneself, the world, and the future—to describe the stereotypical content of automatic negative thinking in depressives. Although numerous studies have provided consistent evidence that depression is

characterized by the cognitive triad (e.g., Mathews & MacLeod, 2005), Beck has not elaborated on the origin of the cognitive triad, except for stating that they are related to self schemas. It is proposed that the cognitive triad originates from the self wounds.

Self Schemas

In order to explain why some people are negatively affected by certain stressors while others are not, Beck (1976) has proposed the concept of "schemas." Schema refers to organized representations of past reactions and experiences that form relatively coherent and persisting body of knowledge capable of guiding subsequent perception and appraisals (Strauman & Segal, 2001). Beck theorizes that the schemas of depressed persons include themes of loss, separation, failure, worthlessness, and rejection. However, he has not expanded on the origin of depressive schemas, except for the inference that they stem from adverse life events. From the wounded self perspective, it is hypothesized that negative self-schemas stem from self-wounds sustained from emotional injuries earlier in life. These schemas represent emotional injuries caused by loss, separation, failure, experience of unworthiness, and rejection respectively. Because of these underlying self schemas, originating from emotional wounds, depressed individuals exhibit systematic bias (cognitive triad and cognitive distortions) in their processing of information or environmental stimuli.

Cognitive Specificity in Depression

According to the *cognitive specificity hypothesis*, schemas are activated by "congruent" life events, thereby starting the vicious cycle of negative automatic thoughts, processing biases, and depressed mood (Beck, Epstein, & Harrison, 1983). Because of their biases in thinking, depressed people attend selectively to negative stimuli in their environment, and interpret neutral and ambiguous stimuli in a schema-congruent way. From a self-wounds standpoint, these stimuli are not neutral or ambiguous, but congruent with the inherent self-injuries, although the person may not be aware (or may be unconscious) of the relationship.

Early Experience

Although schemas represent the product of a lifetime of experience—thus subject to change or revision—they are formulated mainly during childhood or adolescence. Maladaptive early childhood experiences that teach the child to see himself or herself as vulnerable, not valuable, not loved by others, or incompetent are incorporated into his or her adult self-schemas. Bowlby (1985) noted that most psychopathologically relevant schemas are developed early in life when the individual is relatively powerless, and dependent on caregivers. Therefore schemas can be dormant or "silent," until they are

activated by an environmental stimulus that is relevant to a particular type of vulnerability (Clark, Beck, & Alford, 1999). There is considerable evidence that confirms the role of dysfunctional information processing in depression (e.g., DeRubeis et al., 1990). Moreover, the evidence clearly indicates that due to maladaptive early childhood experiences depressives exhibit negatively biased responses to congruent life events. From the wounded self perspective the maladaptive childhood experiences represent emotional injuries. Therefore it is the self wounds sustained by emotional injuries that edify the child to see himself or herself as vulnerable, not valuable, not loved by others, or incompetent that are incorporated into his or her adult self-schemas. The wounded self thus represents the diathesis or vulnerability to depression and the congruent psychosocial stressors serves as triggers of depressive self-schemas.

Traumatic Experience

The above descriptions of self-schemas subsume adverse or traumatic life experiences to cause depressogenic schemas. However, the relationship between early life experiences and depression is not that clear-cut as: (a) not all individuals with severe stress develop depression (Brown & Harris, 1989), (b) not all depressed people report recent life stress (Monroe, Slavich, & Georgiades, 2009), and (c) the onset of depression is not always associated with a stressor (e.g., Monroe & Depue, 1991). However, Kendall-Tackertt (2002) from his review of the literature on the relation between early childhood abuse and its behavioral, social, cognitive, and emotional sequelae, concluded that depression is one of the most common consequences of early childhood abuse and the risk for depression is four times greater among adult survivors of childhood sexual abuse compared to those who do not have a history of abuse. Moreover, although not all traumatized people develop symptoms of psychopathology, all individuals who present psychological symptoms have been traumatized or adversely affected at some point in their life, particularly during childhood. Furthermore, children who have been maltreated have high rates of disorganized attachment, negative views of themselves, lower cortisol reactivity (Barnett, Ganiban, & Cicchetti, 1999), neuroendocrine abnormalities (Jungmeen & Cicchetti, 2006) and various cortical changes (Kaufman & Charney, 2001). From the above evidence, it is not unreasonable to conclude that childhood negative experience, although not in all cases, cause self-wounds, which in turn cause negative self-schemas, or ego states related to failure, helplessness, hopelessness, inadequacy, lack of control, loss, rejection, separation, and worthlessness.

The Role of Personality

Over the past 15 years both cognitive and the psychodynamic theories of depression have examined the role of personality factors in the mediation of dysphoric symptoms. Two personality dimensions have received a great deal of theoretical and empirical attention. The first of these dimensions focuses on the interpersonal domain and involves needs for

intimacy, affiliation, and dependency. This interpersonal orientation has been variously labeled as "sociotropy" (Beck et al., 1983), dependency (Blatt, 1974), or anxious attachment (Bowlby, 1977). Sociotropic individuals experience depression when their needs for intimacy, affiliation, or dependency are not met. By contrast, the second personality orientation involves *goal achievement* and *individual autonomy*. These individuals focus on goal-related achievement and personal independence, and appear to experience depression in the face of achievement failure or restrictions in personal freedom. From these descriptions, it is apparent that self-schemas, which includes personality traits, interact with the wounded self to produce depressive symptoms in the face of stressful life events.

An Integrative Approach

Each of the risk factors discussed above has some merits, yet each is unable to explain the unifying mechanism that underlies the role of stressors in the precipitation of the onset of a depressive episode. A unifying perspective of emotional injuries is proposed that seems to unite all stressors and risk factors in the onset of the depressive episode. The wounded self as a unifying factor binds the impact of stressors on the human psyche. From the above reviews it is clear that the majority of the population is not affected by adverse life events. However, all those who are affected appear to have sustained some sort of emotional injury and therefore the common thread appears to be the wounded self. Hence it would seem that (a) damaging life experience lead to (b) painful views of the self that generate (c) a secondary process of feeling bad about feeling bad (negative rumination), which in turn increases the intensity of the contemptuous self-related affect (Wolfe, 2005). Therefore when exposed to a stressor it is not the cognitions alone that govern the intensity of the depressive affect, but the whole integrated emotional meaning of an event. This integrated perspective provides the rationale for utilizing experiential strategies such as hypnotherapy and EST for accessing and healing the wounded self. EST is particularly useful as an adjunctive therapy as it can directly addresses ego states related to self-criticism, fears of abandonment, feelings of helplessness, and feelings of unworthiness.

Healing the Wounded Self

The circular nature of CFMD promotes intervention simultaneously at multiple levels. The major contribution of this conceptualization beyond its value as an organizational framework is its emphasis on functional autonomy and circular causality, so that factors such as cognitive distortions, negative ruminations, distressed relationships, self wounds, and neurochemical changes are seen as both symptoms and causes at the same time. As CH for depression is fully described elsewhere (e.g., Alladin, 2007, 2008, 2009, 2012a), it will not be covered here. In accordance with the theme of this Special Issue,

this article will mainly focus on hypnotic and EST strategies for uncovering and healing emotional injuries. However, it should be emphasized that EST is not recommended as the sole treatment for depression; it should be used as an adjunct to CH, CBT, or psychodynamic therapy (C. Frederick, personal communication, December 1, 2012). Moreover, when EST is used as an adjunct to CH, it should be introduced later in therapy, when the patient has acquired sufficient experience with CBT and hypnotherapy. CH generally consists of 16 weekly sessions, which can be expanded or modified according to patient's clinical needs, areas of concern, and presenting symptoms.

To address the wounded self in CH, the therapist goes beyond CBT strategies. In addition to focusing on the relationship between events and cognitive distortions, the following psychodynamic approaches (Gabbard & Bennett, 2006) are recommended: (1) careful evaluation of the stressor that triggered the depression; (2) assessment of whether the stressor produced a sense of loss, humiliation, or despair; (3) assessment of whether the stressor reawakened early childhood losses, traumas, or self wounds; and (4) identification of what meaning did the patient attributed to the stressor.

CH initially focuses on developing therapeutic alliance, ego-strength, and symptomatic change to give the depressed patient a sense of control over the symptoms. Once a patient has gained some control over the depressive symptoms, the next stage of therapy, if needed, focuses on exploring and modifying the underlying causes of cognitive distortions. The goals for unconscious exploration include: (1) accessing of negative cognitions preceding depressive affect in cases when patients were unable to remember the cognitions triggered by an event (e.g., "I don't know why I felt depressed at the party last week"); (2) accessing of self-schemas and core beliefs; and (3) reframing of experiences associated with guilt, doubt, or fears. A variety of hypnotic strategies have been used in the context of CH for accessing and restructuring cognitive distortions under hypnosis, including: (1) regression to recent event, (2) regression to the original trauma, (3) editing and deleting unconscious files, and (4) symbolic imagery techniques for dealing with a variety of emotional problems such as guilt, anger, fears, doubts, and anxieties (Alladin, 2007; Yapko, 1992, 1997, 2001, 2006, 2012).

Hypnotic Accessing and Healing of Wounded Self in Depression

By integrating wounded self and EST, CH attempts to produce a deeper level of change in depressed patients. This is achieved by having the depressed patients confront, experience, and ultimately revise the self-views that generate overwhelming affects such as despair, failure, helplessness, hopelessness, humiliation, lack of control, loss, and sense of inadequacy. In CH, hypnosis is used to access, amplify, and heal the wounded self, and it consists of the following steps:

- Induction of deep trance;
- Ego-strengthening;

- Full awareness of the whole range of affect, cognition, physiological reaction, sensations, and behaviors (syncretic cognition);
- Recalling of the latest experience of dysphoria or other negative affect;
- Awareness of feelings and sensations associated with the dysphoria or negative affect;
- The experience is then amplified and patient guided to focus on syncretic cognition;
- While experiencing syncretic cognition, the patient is directed to identify implicit meaning of depression, particularly the underlying self-wounds;
- Painful self-views are differentiated from those that are based on facts and from those that are based on inaccurate or toxic opinions (e.g., empty-chair dialogue or split-screen technique can be used here);
- Learning to experience and tolerate painful realities and begin to develop a remediation plan to transform liabilities into strengths (e.g., through behavioral rehearsal, empty-chair dialogue, or split-screen technique);
- Transformation of toxic and inaccurate views of the self into adaptive self-views via behavioral rehearsal, ego-strengthening, or post-hypnotic suggestions; and
- Resolution of the catastrophic conflicts that have helped maintain the self-wounds (two-chair dialogue, behavioral experiments can be used).

The following transcript adapted from Alladin (2006, pp. 164–165; 2008, pp. 41–42; 2010, pp. 173–176) describes the hypnotic procedure used with Rita to access and restructure her non-conscious cognitive schemas related to a recent situation where her husband wanted to be intimate with her, but she had no memory of her cognitions related to the event. The approach described here represents a more traditional view of hypnotherapy, where the wounded self was indirectly addressed. The second transcript (see the section on Ego State Therapy) related to Mark uses a more formal approach to EST.

When first seen by the author, Rita was a 39-year-old homemaker with 2 teenage boys, married for 16 years to a 45-year-old businessman. She was diagnosed with recurrent major depressive disorder, panic disorder, and hypoactive sexual desire disorder. The transcript describes how Rita's full attention was directed to achieve the syncretic content of the recent upsetting experience. First, she was guided to focus her attention on a specific area of concern and then to establish the link between her cognition and affect. Once the negative cognitions were identified, Rita was directed to restructure them (as learned during her CBT sessions) and then to attend to the resulting (desirable) responses. The transcript begins while Rita was in a deep trance and bolstered by ego-strengthening suggestion.

Therapist: I would like you to go back in time and place in your mind to last Tuesday night when you felt upset and wanted to withdraw yourself from your husband. [*Pause*] Take your time. Once you are able to remember the situation, let me know by nodding your chin up and down.

The ideomotor signals of chin up and down for "yes" and shaking your head side to side for "no" were set up prior to starting the regression. After a short while, she nodded her chin.

Therapist: Become aware of the feelings, allowing all the feelings flow through you. Become aware of your bodily reactions. Become aware of every emotion you feel.

Her breathing and heart rate increased and the muscles in her face started to contract. It became noticeable that she was feeling upset and anxious.

Therapist: How do you feel? [*Pause*] Take your time, and you can speak up; speaking will not disturb your trance level.

Rita: I'm scared . . . it's unfair . . . no one told me he was going to be sent away. [*Starts to cry*]

Rita described two traumatic incidents that occurred when she was 10 and 12 years old respectively. When she was 10 years old, her brother Ken (2 years older than her), was sent away to live with the grandparents. Ken was considered to be a very disobedient child, whom the parents could not handle, and therefore they "got rid of him" by sending him away to the grandparents in a different city. Rita was very distressed by the event because she was very close to Ken and she was never informed that Ken was going to be sent away. She cried for days when Ken was sent away and for several nights she could not sleep. One night while she was lying in her bed, the thought of a dark cave came into her mind and she saw herself being in that dark cave. Although it was frightening to her initially, later on she felt a sense of comfort, as if cocooned in a warm blanket, and her mind felt blank, devoid of any bad thought or negative feeling. From this night, whenever she felt upset she would go into the cave in her mind and imagine herself cocooned and locked inside the cave. The second incident happened two years later. One Saturday morning the family got the news that Ken (was still living with grandparents) died from drowning in the local swimming pool. Immediately, it flashed in her mind that she lost the person she loved most. She felt very upset, but only briefly, because she quickly cocooned herself in the "dark cave." From the hypnotic regression it became apparent that Rita (1) retreats inside the dark cave whenever she feels confronted or stressed out, (2) her self-wounds are associated with the painful emotions attached to loss and needs for intimacy—she finds it unbearable to have this sense of loss and lack of support forever in her life, and (3) she is fearful of getting closer to anyone who loves her (including her husband) in case she loses that person.

Therapist: I want you to come back to Tuesday night when you felt upset. I want you to become aware of the thoughts and images that were going in your mind.

Rita: I can't deal with this. It's too painful. I'll lose him. I don't want to lose him. [*Starts to cry*]

Therapist: From now on you will become completely aware of all the thoughts that go in your mind when you are upset so that you begin to see the connection between your thinking and your feeling.

The procedure helped Rita identify the unconscious negative cognitions that were associated with her upsetting feeling and, consequently, she was able to restructure her thinking and control her emotional and behavioral reactions. Four more sessions were utilized to help Rita deal with the two uncovered traumatic events and heal the wounded self. Her negative experience and the associated faulty cognitions were "reframed" by utilizing the empty-chair dialogue. The dialogue was between her current self (adult ego state comprising of her varied and rich experience in life, successes, and wisdoms) and the wounded self (in the empty chair). By using her "adult ego lenses" she was able to reflect on the incidents from a mature and realistic perspective and then share this with the wounded self in the empty chair. She was also able to hear sympathetically everything the wounded self had to say about her traumas and then Rita was able to discuss coping strategies with the "wounded self" for dealing with sense of loss and the importance of building existing or new relationship (to avoid isolation and build realistic dependence on others, particularly her husband). Following these sessions Rita's anxiety and sexual difficulties dramatically improved. Through her "adult ego lenses" she was able conceptualize that it was no longer necessary for her to retreat into the dark cave and she came to realize that there is no direct relationship between loving and losing. Consequently, her relationship with her husband significantly improved. Moreover, the frequency and intensity of her depressive affect significantly decreased. To a large extent, her depression was reinforced and maintained by her anxiety attacks and sexual dysfunction.

Other hypnotic uncovering or restructuring procedures such as affect bridge, age regression, age progression, and dream induction can also be used to explore and restructure conscious, preconscious (automatic), and unconscious cognitive distortions and negative self-schemas (Brown & Fromm, 1986; Ewin & Eimer, 2006; Yapko, 2012; Watkins, 1971; Watkins & Barabasz, 2008) related to the wounded self.

Ego State Therapy

EST provides an additional hypnotic strategy for dealing with unconscious self-schemas and self-wounds. EST is defined as the utilization of individual, family, and group therapy techniques for the resolution of conflicts between different ego states that constitute a "family of self" within a single individual (Watkins & Barabasz, 2008; Watkins & Watkins, 1997). EST involves a kind of internal diplomacy that may employ a variety of therapy approaches such as behavioral, cognitive, analytic, Rogerian, or humanistic in conjunction of hypnosis to integrate the different ego states. However, these techniques are not directed toward the whole individual but toward the part-persons represented by the ego states. Hypnosis is required because ego states do not usually

become overt spontaneously. Through hypnosis, the therapist can focus on one segment of personality or the wounded self to produce conflict resolution. As the EST techniques are very well described elsewhere (e.g., Emmerson, 2003; Frederick, 2005; Watkins & Barabasz, 2008; Watkins & Watkins, 1997) the treatment procedures are not described in detail here. The goals of EST listed by Frederick (2005) are equally applicable when working with depressed patients. However, when utilizing EST with depressed patients, the therapist should look out for ego states that have needs for intimacy, affiliation, and dependency, or needs for achievement and personal freedom. Moreover, Frederick (personal communication, December 1, 2012) has pointed out that as many ego states may carry many false beliefs based on their own developmental history, CBT may be a necessary part of EST. In CH, EST consists of the following steps (Emmerson, 2003; Frederick, 2005):

1. Establishment of communication with the ego states or the wounded self.
2. Each ego state or self is treated as being important and serving an important function.
3. Help ego states form alliances with one another in the quest for a mutual endeavor.
4. Ego-strengthening of the ego states and the internal family as a whole in order reduce emotional injuries caused by loss, separation, failure, experience of unworthiness, or rejection.
5. Address separation–individuation and attachment issues that led to the formation of immature ego states or wounded self.
6. When needed use techniques that are often used with individual patient (e.g., split-screen technique).
7. Do developmental repair with certain immature ego states or wounded self.
8. Help to deal with trauma issues without retraumatization.
9. Create or restore harmony within the internal family of selves.

The following transcript describes how "Emotional," the wounded self, was accessed and healed. To a large extent, Mark's depression was caused by the emotional hurt he carried since he was 10 years old. Mark was a 22-year-old second year university student taking philosophy and political science when first seen by the author. Mark has been struggling with dysthymia since he was 10 years old, which progressed into double depression in the past 4 years (before seeing the author). The author has been seeing Mark regularly for individual psychotherapy for the past 2 years. He was referred to the author for CBT by his psychiatrist when his depression got worse. Mark comes from a professional family. Both his parents are lawyers and they expect Mark to become a lawyer as well, and hence they encouraged him to major in either philosophy or political science. Mark is a very bright young man and he got through high school doing very little studies. However, since university he has been finding the studies very hard and his grades have been declining. He does not enjoy studying and does not care whether he graduates or not. Moreover, graduate studies, particularly studying law, does not interest him.

Mark has been showing good response to CH, particularly to CBT, ego-strengthening, expansion of awareness, and deep relaxation. However, he continued to have recurrent headaches, which would often spiral down to severe depression. The author therefore suggested using EST to do some deeper work to which Mark readily agreed (as he had a solid alliance with the therapist). The “resistance bridge technique” (Emmerson, 2003) was used to accessing Mark’s ego states that required resolution. The resistance bridge technique (RBT) is a hypnotic strategy for accessing and resolving issues that may be maintaining or exacerbating the symptoms. It combines the resistance deepening technique (Emmerson, 2003) and the affect bridge (Watkins, 1971). The RBT uses patient’s resistance to hypnosis as a focus to achieve trance and the affect bridge assists clients regress to the origin of an unwanted symptom. The following is a script that begins with Mark being in a moderate trance.

Therapist: How are you feeling?
Mark: Very relaxed.
Therapist: I wonder if you are aware of any reluctance to let go completely?
Mark: I am really very relaxed.
Therapist: What part of your body would you say is least relaxed at this point?
Mark: I feel a bit of a pressure in my head.
Therapist: Tell me exactly what you are feeling inside you head?
Mark: I feel the pressure building up.
Therapist: On a scale of 0 to 100, how much pressure are you feeling in your head?
Mark: About 50.
Therapist: I would like you to go inside your head and turn it up to 75.
Mark: I feel it about 70.
Therapist: Could you go inside and turn it up to 80 or more, really feel it.
Mark: It’s 80 now and it is beginning to hurt and making me feel depressed.
Therapist: Stay with the feeling of hurt inside your and you are beginning to feel depressed.
Mark: It’s hurting and I am feeling very upset.
Therapist: How old do you feel right now?
Mark: Ten years old.
Therapist: I would like you to go back in time and place to when had these feelings for the first time when you were 10 years old. Hang on to these feelings.
Mark: It’s very painful.
Therapist: Hang on to these feeling. Are you inside or outside a building?
Mark: I’m inside a building.
Therapist: Are you alone or with someone else?
Mark: There’s my teacher and many children.
Therapist: Describe exactly what is happening.
Mark: My teacher is angry at me because I got 100% on the test. She is ignoring me and talking to the girl behind me who got 60%. I used to be happy, she destroyed my happiness. [*Starts to cry*]
Therapist: What can I call you there feeling the way you do at ten?
Mark: [*Still crying*] You can call me Emotional.
Therapist: Emotional, can you tell me what’s happening? Why is your teacher angry at you.
Emotional: She does not like boys. She does not let the boys go to the washroom. She calls me a moron because I am top of the class. She favors the girls. The girl sitting behind me got 60% on the test. She praised her and gave me dirty looks. [*Crying*]

It's so unfair. I was not able to go to school for two months. I was scared of her and started having this pressure in my head and started having bad headaches. The headaches depressed me because I could not do anything and I could not be happy.

Therapist: Tell her what she needs to know.

Emotional: I can't, she will yell at me and I will have the pressure in my head.

Therapist: In order to relieve this pressure in your head and to stop the depression, you will have to tell her. Tell her how you feel about her. Tell her everything you feel. What is she doing now?

Emotional: She is staring at me as she always did.

Therapist: What are you feeling now?

Emotional: Scared. The pressure is building in my head. [*Starts to cry*]

Therapist: What do you feel about her?

Emotional: She is a monster. She said I have a learning difficulty. She is so unfair. She has no right to do this to me.

Therapist: Tell her what she needs to know. This is your chance to tell her. I am here with you. I won't let anything happen to you. Tell her that what she did to you was wrong.

Emotional: I hate you. You have no right to treat me the way you do. It's unfair to treat the boys the way you do. I am not a moron, I am top of the class. I don't have a learning disability. You were telling me all these because you wanted me to fail. You wanted the girls to do better than me. I am sorry I disappointed you. I am still top of the class. It's your problem, you have to deal with it.

Therapist: What is she doing now?

Emotional: She is just staring at me.

Therapist: Right now I want you to become your teacher who is looking at this little boy. I want you to be her. When you are the teacher, say "I'm ready."

Emotional: [*Takes a deep breath and raises his head*] I'm ready.

Therapist: What can I call you, teacher?

Emotional: You can call me "Miss Monster."

Therapist: Miss Monster, did you hear what Emotional just said to you, that he hates you and consider you to be unfair and cruel?

Miss Monster: I heard.

Therapist: What does that make you feel?

Miss Monster: I don't want Emotional to hate me. I am a good teacher. I care for him and I want him to do well in his academic career. I don't give you as much attention in class because you are very bright. The other students, especially Jennifer, who sits behind you is very distressed that she is not as bright as you are. Everyone knows you are top of class. I had to encourage Jennifer, so I gave her the attention. But I was very happy that you got 100% in your test, although I did not congratulate you in front of others.

Therapist: Now that you heard what Miss Monster said, how do you feel, Emotional?

Emotional: I feel better, knowing what Miss Monster think about me. But why she did not let the boys go to the washroom?

Therapist: Miss Monster can you tell Emotional why you don't let the boys go to the washroom.

Miss Monster: I don't prevent the boys going to the washroom. However I was keeping an eye on Josh, who sits right in front of my desk because he was going to the washroom too often as he feels nervous staying in class for too long. I was discouraging him to go to the washroom to help him deal with his nervousness. I am sorry if I gave you the wrong impression.

Therapist: Emotional, did you hear what Miss Monster said?
Emotional: I heard.
Therapist: How do you feel now?
Emotional: I feel better knowing Miss Monster does not hate me and that she thinks I am very bright. I was confused that she hated me because I am top of my class. Now I know she admires me and believe that I will go far.
Therapist: Miss Monster, can tell Emotional that you are sorry for giving him the wrong impression and can you tell him that he is a very bright student.
Miss Monster: I am sorry for hurting you, Emotional. I did not intend to hurt you. I was trying to increase the confidence of other kids. You are very bright. But now I realize my mistake. I should also congratulate students who are very bright. I am sorry that I did not congratulate you.
Therapist: What do you feel now, Emotional?
Emotional: I feel good that my teacher thinks I'm very bright and that I will do well in the future. Now I don't have to have this pressure in my head. I don't have to hate going to school. I feel good knowing that other people think I am bright. I don't have to prove it.
Therapist: I thank you Emotional for having the courage to talk to me and to tell your teacher how you feel about her. I also would like to thank Miss Monster for talking with me and for apologizing to Emotional.

Effectiveness of EST

As EST is a fairly new and specialized form of hypnotherapy, its recognition is largely based on clinical experience rather than on controlled research. However, some studies have found EST to be effective with somatic symptoms (Emmerson & Farmer, 1996; Gainer, 1993) and acute stress disorder (ASD) and posttraumatic stress disorder (PTSD; Barabasz, Barabasz, & Watkins, 2011, 2012; Barabasz, Barabasz, Christensen, & French, 2013; Christensen, Barabasz, & Barabasz, 2013). With the broadening of the scope of ego state therapy, it is hoped that there will be an increase in the empirical investigation. The manualization of brief EST for ASD and PTSD, and the recent publications by Barabasz and his colleagues, are likely to generate further clinical interest and studies in the future.

Conclusions

This article focused on the latest revision of the CFMD. By including the concept of the wounded self, the model provides a theoretical and clinical rationale for using EST in the psychological treatment of depression. EST expands the treatment range for accessing and restructuring preconscious and unconscious self-wounds that may trigger and maintain depressive affect. Moreover, EST provides a very effective method for healing the wounded self. It is hoped that this article will encourage therapist to integrate EST more frequently in their approach to hypnotherapy when treating depression.

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