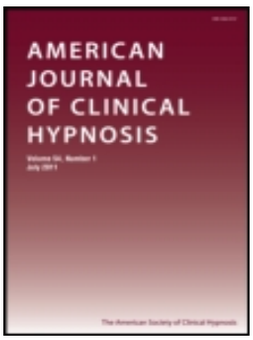

American Journal of Clinical Hypnosis

ISSN: 0002-9157 (Print) 2160-0562 (Online) Journal homepage: https://www.tandfonline.com/loi/ujhy20

Mending Fences: Repairing Boundaries Through Ego State Therapy

Maggie Phillips

To cite this article: Maggie Phillips (2013) Mending Fences: Repairing Boundaries Through Ego State Therapy, American Journal of Clinical Hypnosis, 56:1, 23-38, DOI: 10.1080/00029157.2013.789431

To link to this article: https://doi.org/10.1080/00029157.2013.789431

American Journal of Clinical Hypnosis, 56: 23–38, 2013

ISSN: 0002-9157 print / 2160-0562 online
DOI: 10.1080/00029157.2013.789431

Routledge
Taylor & Francis Group

Mending Fences: Repairing Boundaries Through Ego State Therapy

Maggie Phillips
Private Practice, Oakland, California, USA

Ego state therapy has often been cited as an effective treatment to help repair fragmentation related to posttraumatic stress and dissociative disorders. This article explores how specialized work with ego states can help to clarify and strengthen internal and external boundaries, create greater boundary flexibility, and contribute to containment and self-regulation. Applications of direct and indirect hypnosis to repair boundary issues through ego state therapy are emphasized, and clinical case examples are used to illustrate results.

Keywords: boundaries, ego state, ego state therapy, hypnosis

In human relationships, boundaries define the personal space(s) known as the intersubjective field of relational experience (Stern, 2010; Stolerow, Brandchaft, & Atwood, 2000). There are several categories of interpersonal boundaries, including verbal, behavioral, energetic, and spatial. Within these categories are boundary styles that govern their use: Strong, clear, healthy boundaries, rigid or inflexible boundaries, and boundaries which are distant, lacking in definition, or that are fused.

Navigating interpersonal levels of connection and distance can be accomplished through the processes of boundary formation, negotiation, containment, and regulation. Although these tasks are taught within many types of psychotherapy, the model of ego state therapy provides a unique approach to the resolution of internal conflicts as well as interpersonal ones (Toothman & Phillips, 1998), and is especially effective when the conflicts are due to the impact of traumatic experiences (Phillips, 1993, 1995).

The Origins of Ego State Therapy

The premise that human personality is composed of self-parts or segments began in ancient times and continued in the theory espoused during the evolution of psychology by Freud (1923) and his colleagues to explain aberrations in human behavior. There is

Address correspondence to Maggie Phillips, 2768 Darnby Drive, Oakland, CA 94611, USA. E-mail: mphillips@lmi.net

also ample research evidence that suggests that the normal human mind is a multiplicity as opposed to a unitary function (Hilgard, 1984; Ornstein, 1987).

Freud postulated that there were three basic aspects of the human personality—the id, ego, and superego, and that many intrapsychic conflicts resulted from the interactions between these energy dimensions of the self. Freud's colleague Paul Federn (1952) first proposed the term "ego state" to define aspects of the self, suggesting that they were formed in early childhood and co-existed to create both dynamic balance and imbalance. Eric Berne (1961), another colleague and student of Freud's work, transformed Freud's tripartite theory into Parent (related to superego), Adult (related to Freud's ego), and Child (related to id).

Federn suggested that psychic energy could be focused either on ego, or the self, or on object, the other. *Ego cathexis* is perceived as the investment of "self energy," as in the case of ego states, while *object cathexis* is experienced as existing outside the self. It is the interplay of ego and object cathexis that is believed to govern the formation of the defenses in the personality and the basic experience of self and other (Frederick & McNeal, 1999).

In recent years, John and Helen Watkins made important contributions to ego state theory and practice, particularly in the area of hypnoanalysis, which utilizes hypnosis to identify, explore, and repair issues within individual ego states as well as within the inner family of self as a whole (Frederick, 2005). Other therapists trained by the Watkinses have extended and expanded their work, observing that ego states come into being to close gaps in development (Frederick, 2005), that they have been formed to cope with attachment disruptions or absences (Fink, 1993), and that they relate to center core self (Torem & Gainer, 1995).

Others have explored the activation of powerful, conflict free aspects of personality, such as inner strength, (Frederick & McNeal, 1993; McNeal & Frederick, 1993). Additional areas of focus include ego state therapy techniques (Frederick, 2005; Ginandes, 2002; McNeal, 2003; Morton, 2001; Phillips, 1993) and applications to the treatment of trauma and dissociation (Phillips & Frederick, 1995).

Ego State Therapy, Boundaries, and Early Human Development

Theoretical understanding of boundary formation is derived from the work of many developmental psychologists. Margaret Mahler's developmental stages are particularly useful in delineating this complexity.

Mahler (1968) suggests the following stages of development that take place during the first three years of life, each of which has important implications for the formation of intrapsychic and interpersonal boundaries: symbiotic, separation–individuation, practicing, rapprochement, and emotional object constancy and individuality.

The earliest symbiotic relationship with mother or primary caregiver begins as the infant shifts from an autistic narcissism to symbiotic fusion in associating mother

with basic comfort and satisfaction. Mahler (1968) theorizes that during this first developmental stage the infant has not developed the ability to differentiate "I" from "not I" or "inside" from "outside" the self.

During *separation–individuation*, the mother serves as auxiliary ego while regulating frustration and gratification so as to keep the child from being overwhelmed. As the child continues to grow, he or she shifts attention from inside the symbiotic unit with mother to the outside world. As the child begins to move motorically further away from mother, he/she is able to crawl and then walk, developing a stronger sense of identity as "I." This phase is termed the "practicing" phase. By the middle of the second year, the child enters a stage of *rapprochement,* struggling between developing autonomy while still depending on mother for support.

In the third year of life, *object constancy* can be achieved as the child integrates a loving, comforting image of mother that allows and helps him/her to manage distress when (bad) mother is misattuned or frustrates needs. These two polarities of "good" and "bad" have been unified into a single internal object. At the same time, given adequate attachment, the child has also developed his/her own unified self-image (Frederick & McNeal, 1999).

Boundary Formation and Repair

There are many difficulties that can ensue during these stages of boundary formation. Some patients, especially those that are psychotic, are confused in differentiating between self and other. Other patients, including those diagnosed with borderline disorder, tend to "over divide" or split their objects into "good" and "bad" or "dangerous," and also to split their own self-identity in similar ways, which prevents them from achieving self-cohesion and constancy (Mansfield, 1992). Patients on the narcissistic spectrum often have not achieved object and self-constancy (Frederick & McNeal, 1999).

Healthy boundaries are crucial to healthy development and must be both flexible and permeable. John and Helen Watkins (Watkins & Watkins, 1981, 1997), co-creators of ego state therapy, built on the model generated earlier by Paul Federn, and discussed the importance of functional boundary formation. For the Watkins, boundaries organize segments of personality or self states, as ego states are also termed. Even earlier, Pierre Janet (1907) studied dissociated parts of the self that were split off from the rest and often contributed to personality difficulties, and Watkins and Watkins (1997) further extended their ideas to focus on *covert* states that were largely unconscious, as well as the more conscious, acknowledged aspects of self. They defined ego states as "organizational systems of behavior and 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" (Watkins & Watkins, 1997, p. 25).

The center core, also called the core self, interfaces with a number of ego states that are relatively constant in a given individual and which present to the individual and to the

world a relatively consistent presentation of self. The boundaries of this core self can be expanded or contracted to encompass more or less psychological energy, depending on the activation and nature of ego state energies. These dynamic shifts are highly related to the qualities of ego states in relation to the three common ways they are believed to originate.

The self-states that connect with the core self may be segments of self that were differentiated for adaptive purposes in the course of normal development. These adaptive states help the individual cope with and adapt to the common challenges of everyday life. Others may represent the traits of introjected significant others in the life of the client. These may be positive, in the form of introjected nurturing qualities, or negative in the case of internalized aspects of a highly critical parent. A third category of ego states may have been split off from the core self because of trauma-related fragmentation (Watkins & Watkins, 1979). For example, during a traumatic event, one or more states may be dissociated from the rest of the self to contain the elements of the traumatic experience, and in some cases to launch ongoing defensive reactions against threat as if it is ongoing, so that the greater personality can be protected from the intense reactions that have been triggered (Emmerson, 2003).

Thus, the need for the formation and repair of boundaries exists within the self in terms of conflicts that arise among ego states that comprise the core self, and which are often also expressed outwardly in the case of interpersonal conflicts. Frederick (2005) has identified three primary reasons for conflicts among ego states.

First, internal ego state relationships are influenced by the nature of each state's boundaries, for example whether they are too thick or rigid, which can separate them from other states. Second, the maturity levels of states involved in conflict can also create disruption because developmental deficits may impair ego state functioning in such a way that cooperation and communication are impossible. For example, child states often think in concrete terms, and are bewildered when presented with possibilities that require abstract or symbolic perceptions (Watkins & Watkins, 1997). Third, states that engage in destructive and malevolent activities, perhaps as a result of their introjected origins, can also greatly disrupt the inner ego state system and wreak havoc in external relationships as well.

In each of the three sources of inner boundary disruption cited by Frederick above, it can be highly effective to use hypnosis to assist with clarification, repair, and formation of new boundaries (McNeal & Frederick, 1995). Hypnotic strategies include those that can be directed at the whole personality as well as those that target individual ego states.

Clinical Case Examples

A series of three case examples is presented to illustrate the use of hypnotic ego state therapy to intervene in each of the three types of boundary problems mentioned above.

Clinical Case 1: Hypnotic Resolution of Boundary Conflicts Related to Competing Needs

The first case example illustrates the type of conflict created by competing needs in ego states that function to help the greater personality adapt to different challenges and requirements of everyday life. Hypnosis is used to help them develop co-consciousness of each other and cooperative collaboration, and to harness the patient's previous experiences with self-hypnosis.

Amy, age 63, was referred for hypnotic treatment to improve her response to kidney dialysis. At the time of her first appointment, she was in her second cycle of dialysis. The first four-year cycle had been relatively successful, but she returned to this treatment after a six month interval after struggling with multiple respiratory and sinus infections. Her responses to dialysis were mitigated by intense stresses related to her job as executive director of services for a healthcare startup company and the fact that she was commuting back and forth from her east-coast home to her position on the west coast.

In addition to failing kidneys, she suffered from the complications of four secondary conditions which included Wagner's disease, Reddiner's disease, fibromyalgia, and cervical pain related to a serious multiple car accident she experienced more than 10 years before having kidney problems. Because of her multiple complex problems, Amy had been told that she "would be on dialysis the rest of my life and would just have to learn to live with it."

As a healthcare professional, she had studied hypnosis but had had only one trial as a client herself, and was told by that hypnotist that she was "un-hypnotizable because she was so strong-minded." Because that experience had predated her hypnosis training, I asked Amy how she might view that feedback now. Amy replied that she believed that the practitioner had not known how to work with her or that perhaps it had not been a good fit in other ways.

During the first few sessions, we discussed her family history, health complexities, her responses to dialysis, various resources in her life that had sustained her through many crises, and her beliefs about healing and illness. Amy also clarified that she wanted to attempt hypnosis again because of all that she had learned during the training workshops she had completed and because she trusted that hypnosis might be powerful enough to help her achieve her goal of fully stabilizing her health and remaining free from dialysis treatment.

After discussing prior experiences with hypnosis and her successes with self-hypnosis during her first cycle of dialysis, we decided to utilize what had already been helpful to her. Amy reported that while she had been guided into self-hypnosis practice through a series of prepared CD's, she had located two internal helpers who looked like "jolly gondoliers." They were dressed appropriately in uniform and glided through her bloodstream and kidney tissues to bring healing. Amy believed that the "jolly gondoliers" had helped her to increase her urine output and lower her creatinin levels,

while also helping her to intervene during infections to increase her white blood cell count.

When I asked Amy what might be preventing her from finding and using these resource states now, she replied that she had been distracted and overly focused on her job, as well as stressed by her frequent air travel. She also described her current experience while receiving dialysis as frustrating, explaining that she could distract herself for the first two hours by reading or watching TV, but that the last hour or more she was restless and agitated, often focusing on the other patients there and how they were responding. She stated that she was most engaged when one of them had a problem of some kind and she watched the staff work to resolve it.

I commented that it was as if the "nurse" in her might not be able to focus on receiving her own treatment, because of the way she had been trained to respond to any signs of distress in another person. Amy was intrigued by this observation and for several sessions we pursued the theme of communicating indirectly with her own internal "nurse" state. I made several suggestions including the invitation and challenge that her inner nurse needed to learn how to take at least as good care of her own needs for healing as she did her patients and the healthcare professionals she supervised. This indirect hypnotic strategy was followed by an improvement in Amy's general energy, a deepening of her sleep, and a somewhat improved, less restless response to dialysis.

As we pondered our next hypnotic step in a later session, I wondered aloud whether the inner nurse might be able to work cooperatively with the gondoliers so that her healing might increase further. Amy said, "I don't think that will work. You know, we nurses are trained to take charge, to be more active than any other person around us." I agreed with her and suggested that we check with the gondoliers to find out their ideas for how to relate to the nurse state.

To accomplish this, we used direct hypnosis with a short induction for relaxation and the suggestion that she find her way back to the state she had entered when she had practiced self-hypnosis. At her head signal that she was sufficiently relaxed and ready, I invited her to summon the gondoliers and to let me know when they appeared. When her head nodded yes, I asked about their responses so far and she smiled and said, "Oh they're delightful. They have the best time just gliding in their boat. When they notice dead cells or signs of disease, they use their fishing poles to capture and then flick the material into my ureter, where it can be naturally expelled. They don't like the idea of working with the nurse because they don't think she will let them do their job."

Although I then used a similar suggestive process to find out whether Amy could find the nurse, we seemed to reach a dead end. "When I try to find her," Amy said, "it's like everything goes grey inside and nothing seems clear." In response to this information, I determined to utilize her response style and suggested that it might be better instead to keep our primary attention on the gondoliers, while communicating with the nurse on a more unconscious level. Still in hypnosis, Amy described the gondoliers' progress as noticing that they took their time in a relaxed way and enjoyed doing the job they knew

so well. “It’s like no time at all has gone by. They are just as helpful to me as they were before.”

At that point, I suggested Amy drift even deeper, trusting her gondolier helpers to take care of her, surrendering to their exceptional expertise, and observing the results of their work whenever she felt curious. I then began to talk indirectly to the nurse inside, inviting her to take a well-deserved rest, using the appearance of the gondoliers as a signal for the opportunity to go deep inside where she could be restored and renewed for the next day’s job of guiding Amy through her busy day of meetings and patient consultations.

This approach used over several sessions resulted in a gradual increase in Amy’s positive responses to dialysis including increased relaxation and physical comfort while receiving dialysis, decreased every day stress, better sleep, and the ability to focus on “her date with D,” as she sometimes called dialysis, as an opportunity for her to focus more deeply on the healing resources within her.

Our next plan was to work toward bringing the “gondoliers” and the “nurse” states more closely together into a healing team, using both direct and indirect hypnotic suggestion and techniques. During a recent hypnotic session, we acknowledged the “nurse” state for all of her hard work in helping Amy excel at her training and her work with patients and other professionals and invited her to consider helping Amy in a new way by getting to know the “gondoliers,” whom she was unaware of, and supporting the healing work they were doing within the body. The “nurse” state agreed to travel from the head of the body, where she “lived,” down to the kidneys, riding on each exhale.

She reported that she could see the gondoliers and that they seemed to be working very hard and enjoying their work, traits which she admired. When she waved at them to come closer so she could talk to them, however, she reported that they shook their heads and worked even faster. I suggested that perhaps she could simply cheer them on somehow, rather than interrupting their hard work. She immediately responded with an image of waving a bright yellow flag. When encouraged to try that out, the “nurse” reported that they both smiled and laughed and seemed to work even harder. The nurse commented that she was happy to help in that way and said she would like to help even more. She was then offered the job of helping Amy remember to focus directly on envisioning her creatinin levels testing lower in her next set of lab reports and viewing the kidney tissues becoming more and more pink and vital, and following the pathway of her fluids as they moved through her kidneys, became purified, and exited the body.

Amy defines the biggest benefit of our work so far as finding a strong sense of hope for her future, one of the positive prognostic indicators for the success of therapy (Phillips & Frederick, 1992). She feels confident that she can make the changes she needs to make to succeed with dialysis so that she can terminate her need for it, reduce her sensitivity to infection, and increase her immune function and overall health and well-being. At the conclusion of 10 sessions, her creatinin levels had improved by 70% and she has remained free of infection for the last four months (i.e., the last four sessions). She remains in therapy working with hypnosis to meet those goals.

This first case illustrates hypnotic work with two adaptive ego states that were active at different levels of consciousness because of very different boundary formation. The "jolly gondoliers" had very flexible boundaries, which made them accessible to the patient, while "the nurse" had rigid boundaries, which separated her from consciousness and from other ego states. These two states also possessed very different communication styles and purposes. Accepting their differences while utilizing their creative resources resulted in a more integrated approach to mind–body healing.

Clinical Case 2: Hypnotic Repair of Boundaries Related to Self-Protection

The second case example involves work with an ego state that likely originated from the internalization or introjection of benevolent energies related to the patient's grandfather, and then was further developed through creative embellishment by her own creativity.

Monique, age 42, sought treatment for several musculoskeletal symptoms including neck and shoulder pain that did not respond to chiropractic, acupuncture, relaxation, or other appropriate treatments and disrupted her sleep. As a top executive, she was concerned that these problems were compromising her work performance and was considering a medical leave if there were no forthcoming improvement. Before taking this step, however, she made an appointment to determine whether hypnosis might offer her relief.

During the first few sessions of history taking and establishing a working alliance, Monique revealed that she had a background of childhood trauma that included emotional abuse by her alcoholic father, and abandonment by her mother each time she reunited with her husband throughout a series of separations, during which Monique served as her confidante and primary relationship. Monique also believed that she might have been sexually abused by a neighbor. This suspicion was based on vague memory material that surfaced in the form of nightmares, activating significant terror, and also because she had learned in adult life that the neighbor had later been imprisoned for sexually abusing his own daughter, when she was about Monique's age.

Because she sought a trial of hypnosis, possible hypnotic approaches were presented and discussed. We agreed that ideomotor signaling might provide a way of exploring the source of her symptoms as well as their solution. During the first hypnotic session, Monique responded easily to this method, and after first using signals to establish inner safety and to elicit ego strengthening resources, we began questioning to investigate her symptoms.

When asked whether her unconscious would be willing to share information about the creation of discomfort in her neck and shoulder, her yes finger clearly signaled. Follow-up exploration revealed an image of a coat of armor, which Monique found interesting, though no clarifying information seemed available.

Postulating that she may have experienced posttraumatic fragmentation, I asked Monique while she was still in hypnosis, whether there was a part inside who could

explain more about this image. Her yes finger responded, and Monique became aware of a self-part connected with the need to protect her. Further questioning directly with this ego state suggested that this state was named "protector" and that his function was to wear a coat of armor to protect Monique's body from being violated. He had learned to perform this function during childhood when Monique had been touched inappropriately on several occasions by the neighbor. Monique later commented that this state reminded her of her grandfather who was an active sportsman and with whom she had felt completely safe.

During subsequent hypnotic sessions, "protector" was helped to receive appreciation for the role he had played in the past and to connect with current information that there was no threat of violation in the here and now. This state was helped to see that his "armoring" was no longer needed and to adopt a new way of protecting Monique when she was in a situation where her boundaries were not being respected. He agreed to voice his concern rather than to "put on his armor." An example of this shift occurred when a colleague continued to push her after Monique set a boundary that she was not available to attend a series of work meetings after work hours.

On this occasion, Monique reported that she heard an inner voice sending the message, "Watch out; he is trying to manipulate you to give up what you need and instead do what he wants." She further disclosed that because of protector's communications, she felt more confidence while standing her ground with her co-worker. Over the next few sessions, the protective state shifted from communicating through nonverbal somatic fear and constriction to more direct inner verbal interactions with Monique and other internal states, including a child state who contained much of the terror of her early trauma experiences and periodically awakened during the night with feelings of anxiety. As these shifts occurred, Monique's physical symptoms gradually subsided and her sleep stabilized.

The example illustrates how internal boundaries related to an introjected protector state can be clarified, transformed, and strengthened using hypnotic ego state therapy. Clinical outcome also indicates significant improvement in the effectiveness of external interpersonal boundaries as well as a deeper sense of safety within the whole personality.

Clinical Case 3: Hypnotic Ego State Therapy With Severe Posttraumatic, Developmental, and Boundary Issues

The third case presented here demonstrates how ego state therapy can be used to repair internal ego state problems, including boundary issues, involving traumatized states that have been dissociated from the rest of the personality. In this example, several traumatized states have developmental issues that prevent the patient's positive responses to medication and other approaches used to relieve his chronic pain condition. Hypnosis is used to identify and work with these states, to resolve boundary confusion, to repair multiple developmental and maturational issues, and to regulate overwhelming sensory and emotional posttraumatic triggering as well as dysfunctional dissociation.

Frank (Levine & Phillips, 2012), age 48, had had more than 20 surgical procedures on his right knee, including three full knee replacements. For most of the procedures and surgeries, he was dissociated from his body and so had manageable pain afterwards. When he approached the final surgery that ultimately brought him to treatment, however, he was scared for the first time, scared of the pain and scared of what the effects of the procedure would be.

During our first meeting, he told me that when he woke up from this recent surgery in the hospital, he was in excruciating pain and asked for more medication. When the nurse explained that the doctor had not left orders for more medication than she had given him, Frank announced that if she did not find a way to give him the medication, he would literally tear apart the ICU. The nurse apparently was so aware of Frank's rage that she gave him the medication immediately.

When questioned about his pain levels before the last surgery, Frank responded that from time to time he had had difficulty but had good responses to physical therapy following each surgery and gradually moved out of debilitating pain. His pain following the last surgery still remained excruciating at a 9 out of 10 points SUD (subjective units of distress) rating. Because of this severity, he was heavily medicated, taking 16 oxycodone tablets per day and as many as 10 percoset for "breakthrough pain" that did not respond to the oxycodone. He also was not responding well to physical therapy and reported high anxiety about his lack of progress. Both pain and anxiety disrupted his sleep, which led to a vicious cycle, robbing him of rest needed for healing, and leading to more anxiety and pain. This phenomenon has been referred to as a "pain trap" (Levine & Phillips, 2012) and is a common factor that can maintain chronic pain at high levels.

History taking revealed that his initial knee injury had resulted from a very severe motorcycle accident at the age of 18. The surgeon had wanted to amputate his knee at that time but Frank had convinced the doctor to "save" his knee with a full knee replacement, with the understanding that he would likely require multiple surgeries and ongoing treatment and rehabilitation for much of his life. His knee had remained fairy functional until he had two work-related truck accidents in which his knee was slammed violently in the same area as his initial injury.

After the second of these work accidents in his early 40's, Frank's pain began to be less manageable and he became unable to perform his work duties, which required him to travel constantly to supervise and inspect the installation of plumbing systems. He had his second full knee replacement at that time and even after extensive rehab, he was not able to return to work and remained on full disability. His third and last full knee replacement shortly before referral to me for hypnosis appeared to be the "last straw" for his body, resulting in completely unmanageable pain.

Further history suggested that Frank had also experienced trauma as a scuba diver several times when equipment malfunctioned, and later on in his work as a firefighter when he or his co-worker's had become trapped in burning buildings. He was not aware of further trauma and denied the occurrence of childhood trauma or abuse, though he

acknowledged that he had experienced the loss of his mother starting at the age of 8, when she was institutionalized for multiple sclerosis and later died when Frank was 13.

In discussing treatment options, Frank was particularly intrigued with hypnosis, commenting that the friend who referred him thought that hypnosis might help him experience an unconscious breakthrough with his pain. Keeping in mind the fact that Frank's rage reaction in the ICU might have been related to the collapse of dissociative barriers that had protected him for many years from severe pain after surgery and at other times, I agreed to start our work with hypnosis. I theorized that his successful defensive use of dissociation for many years against pain might assist him in mobilizing a positive response to hypnosis.

During our first hypnosis session, after giving some suggestions for general relaxation, I utilized some of his favorite past sensory experiences, especially enjoyable times in nature. During several subsequent sessions, we evolved a hypnotic deepening sequence that began with Frank imagining that he was standing on the cliffs at the ocean, looking out to sea, and listening to the rhythm of the waves. When Frank signaled that he felt ready, he began sensing that as each wave moved toward him, he could feel the power of the wave lifting out some of the discomfort in his knee, and as the wave moved out again, he could experience the pain being carried far away from his knee and into the middle of the ocean where its energy could naturally be recycled.

Further deepening suggestions were given that as he began to feel his knee pain decrease and his relaxation increase in hypnosis, he could feel himself dropping down under the surface of his mind as he used to drop down under the surface of the water when he went scuba diving for pleasure. As he dropped down deeper, Frank experienced the sensations that his body could move freely as it was designed to move with complete freedom from pain.

This deepening sequence was highly effective, guiding Frank into a deeply relaxed state where he became unresponsive verbally to further suggestions. We established ideomotor finger signals, which allowed him to respond to a series of questions about barriers to his healing from severe pain since his last surgery. His finger responses to a series of yes/no questions administered over several months of weekly sessions indicated the presence of several preverbal and nonverbal ego states that were connected to various aspects of his pain experience, as well as to healing possibilities.

The first to emerge was a resource state called the "Hero," who volunteered to explore inside Jim's body at specific pain sites to determine what was needed to create greater healing. The "Hero" added a variety of healing resources including application of a special kind of foam that is commonly used by firefighters, to reduce inflammation and swelling in and around his knee. He also installed an internal intravenous drip of the "brain's pain medicine," which at various times included additional doses of internal "Toradol," (ketorolac) the medication that ultimately worked best for him following his last surgery for breakthrough pain, some virtual sleep medication, and a special pain "cocktail." This cocktail was created with the Hero's help in the control room of the

brain, and appeared to possess the unique benefits that it worked instantly, there were no side effects, and it could be set on a timer during pain flare-ups to be administered 24 hours per day. Frank's ideomotor responses and his weekly reports offered consistently clear confirmation that these resources were put into place and working well. When the Hero state was asked whether he was willing to communicate in words instead of the nonverbal signals, however, we consistently received no response.

The second ego state, a preverbal part we referred to as "the young part" responded ideodynamically only with head movements indicating yes and no. He made his presence known when Frank made slight sucking responses while he was in a deep hypnotic state. When asked whether he was connected to the severe pain that had been persistent since the last surgery, the young part's head moved "yes." When asked whether the surgery and pain had scared him, the yes head movement repeated.

Continuing in this fashion, we determined that the young part was connected to sleep disturbance, to surges in pain when he was frightened, and to the inability to feel comforted by medication, physical therapy, or by hypnosis. Further exploration indicated that if we added suggestions directed to the young part for additional safety and security during hypnotic induction, such as a creating a safe place to rest, his fear reduced significantly. We also asked the Hero ego state to help him practice finding his safe place when under stress, and the young part indicated more comfort.

After 3 months of hypnotic work, Frank reported that his pain levels were consistently in a 4–6 SUD window, which represented a significant reduction from 9–10, where we had started. He had reduced his use of medications to 4 oxycodone per day and no more than 4 percoset. When physical or emotional stresses threatened his stability, he felt confident that he could listen to the audio recordings we had made of the different hypnotic interventions, and return to a place of balance and regulation.

Six months into treatment, Frank was scheduled for a procedure to drain fluid from his knee. In the past, before the last knee replacement, Frank would not have been concerned about the pain. At this point, however, Frank was very worried that his pain levels would go up again and he might be back in uncontrollable pain. During ideomotor inquiry, Frank indicated that the young part was particularly scared about the procedure. Deciding to add an additional resource, and considering the early loss of his mother, we decided to create an ideal mother, who sat by his bed every night in a rocking chair and would be with him throughout the medical procedure. The young part indicated that he felt comforted by her presence and by knowing that she would always be there whenever he needed her. Since the use of an Ideal Mother state has been linked to effective repair of early loss and separation (Frederick, 2005), this is the hypothesis for development of successful self-soothing in Frank's case.

Before the knee procedure, we practiced with this resource so that the young part could consistently retrieve the sense of comfort and security he received from ideal mother, the safety of his safe place, and the practical help he obtained from the Hero. Frank also planned ahead with his doctor for the use of keterolac during and after the

procedure, since he had developed confidence in this medication as it had worked well in reliably reducing his pain with few side effects on other occasions.

Although Frank had a brief increase in pain due to the fluid draining procedure, he was able to return within 2–3 weeks to his 4–6 pain baseline. On discharge, Frank's pain was down to an average of 0–2 SUD most of the time and his medication had reduced to one oxycodone and occasional Percoset. His pain management doctor has continued to monitor him and his pain remained manageable at low medication levels at four years follow-up, after we stopped our work together.

This case is a good example of the effective use of hypnotic ego state therapy to resolve more severe posttraumatic symptoms including severe physical pain, as well as remnants of attachment trauma and resulting issues with dissociated internal boundaries, affect regulation, self-nurturing, and self-soothing. Because Frank was a highly suggestible client, he responded well to hypnotic deepening techniques and to the use of ideomotor signals, which allowed highly dissociated ego states to communicate with the therapist and within the personality at a nonverbal level.

Discussion

This article explores the process of establishing more healthy boundaries through the use of hypnotic ego state therapy. Individuals with unresolved trauma tend to have significant difficulty with boundaries. Because of early life attachment trauma, as well as subsequent traumatic experiences throughout life, many patients experience confusion about how to establish healthy closeness and distance within the self as well as in relationships with others. Frequently, there is confusion about how to be separate from other states or people, and yet still feel connected. This may be compounded by the phenomenon of various parts of the self generating action to push people away, while other self-parts appease people in order to prevent rejection and abandonment (Boon, Steele, & van der Hart, 2011).

The three cases presented above represent hypnotic work with the three main types of ego states, states that help the personality cope with demands of everyday life, states that are based on introjected qualities of significant figures in early life, and trauma-related states. In each case, hypnosis was used effectively to identify, activate, promote connection and collaboration with other states, and to enhance the state's inherent purpose.

In the case of Amy, the utilization principle originating from Ericksonian hypnosis, helped her to bypass an earlier sense of uncertainty about her hypnotic abilities and to focus intensively on her own resources developed through self-hypnosis as the basis of further hypnotic work (Gilligan, 1987; Phillips, 2001; Phillips & Frederick, 1995). Because she was able to focus naturally on her inner experiences and was comfortable in describing them verbally, hypnotic induction itself was straightforward. The utilization approach was also helpful in recognizing the rigid, conflicting quality of boundaries that

separated the "nurse" and "gondolier" ego states due to significant dissociation, and to create an avenue for collaboration that built on the similar positive intentions of very different states. This boundary work helped to establish a degree of co-consciousness that was comfortable and helpful to both states and the greater personality in maximizing the use of healing potentials.

The second and third case examples of Monique and Frank indicate clinical situations of greater dissociation resulting from more significant trauma. In both cases, ideomotor signals were used to access ego states that unlocked the unconscious nature of the problem. For Monique, these signals gave her a sense of control and security, as she learned that the involuntary "yes" and "no" responses of her fingers indicated boundaries that were acknowledged and respected by the therapist. In both cases, these signals allowed access to deeper unconscious states that contained both the damaging effects of early trauma as well as the ego strengths for their solution. The ideomotor method in hypnosis can be invaluable when communicating with ego states that manifest somatically or symbolically, as was true of the "nurse," the "protector," and the "young part" (Frederick & Phillips, 1996; Phillips & Frederick, 2010).

In all three cases, hypnotic ego state therapy allowed clients to access their deepest potentials for learning and healing, and facilitated the creation of the boundaries of both inner collaborative boundaries as well as those for a positive therapeutic alliance. It is important for the therapist to remember that healthy alliances with the client's whole personality and with ego states provide models for alliances that can develop among ego states and move them toward integration. Relational experiences with the therapist need to include empathic acceptance, re-nurturing experiences, and interactions that clarify and strengthen interpersonal boundaries (Frederick, 2005).

For Monique, boundary work that occurred during hypnotic ego state therapy naturally resulted in improvement in her interpersonal boundaries. Further recommendations for extending the work explicated in this article are to encourage the active use of new learning related to internal boundaries to strengthen and expand external boundaries with others. Monitoring and facilitating this process is an important role for the therapist and can result in greater integration of ego state work into the client's experience of self as well as into relationships with others.

References

Berne, E. (1961). *Transactional analysis in psychotherapy.* New York, NY: Grove Press.

Boon, S., Steele, K., & van der Hart, O. (2011). *Coping with trauma-related dissociation: Skills training for patients and therapists*. New York, NY: Norton.

Emmerson, G. (2003). *Ego state therapy*. UK: Crown House Publishing.

Federn, P. (1952). *Ego psychology and the neuroses*. New York, NY: Basic Books.

Fink, D. (1993). Observations on the role of transitional objects and transitional phenomena in patients with multiple personality disorder. In R. P. Kluft, & C. G. Fine (Eds.), *Clinical perspectives on multiple personality disorder* (pp. 241–251). Washington, DC: American Psychiatric Press.

Frederick, C. (2005). Selected topics in ego state therapy [Monograph]. *Journal of Clinical and Experimental Hypnosis*, *53*, 339–429.

Frederick, C., & McNeal, S. (1993). From strength to strength: Inner strength with immature ego states. *American Journal of Clinical Hypnosis*, *35*, 250–256.

Frederick, C., & McNeal, S. (1999). *Inner strengths: Contemporary psychotherapy and hypnosis for ego-strengthening*. New York, NY: Erlbaum.

Frederick, C., & Phillips, M. (1996). Decoding mystifying signals: Translating symbolic communications of elusive ego states. *American Journal of Clinical Hypnosis*, *38*, 87–96.

Freud, S. (1923). *The ego and the id*. New York, NY: Norton.

Gilligan, S. (1987). *Therapeutic trances: The cooperation principle in Ericksonian hypnotherapy*. New York, NY: Norton.

Ginandes, C. (2002). Extended, strategic therapy for recalcitrant mind-body healing. *American Journal of Clinical Hypnosis*, *45*, 91–102.

Hilgard, E. R. (1984). The hidden observer and multiple personality. *The International Journal of Clinical and Experimental Hypnosis*, *32*, 248–253.

Janet, P. (1907). *The major symptoms of hysteria*. New York, NY: Macmillan.

Levine, P., & Phillips, M. (2012). *Freedom from pain: Discover your body's power to overcome physical pain*. Boulder, CO: Sounds True.

Mahler, M. (1968). *On human symbiosis and the vicissitudes of individuation (Vol. I)*. New York, NY: Norton.

Mansfield, P. (1992). *Split self/split object: Understanding and treating borderline, narcissistic, and schizoid disorders*. New York, NY: Aronson.

McNeal, S. (2003). A character in search of character: Narcissistic personality disorder and ego-state therapy. *American Journal of Clinical Hypnosis, 45*, 233–244.

McNeal, S., & Frederick, C. (1993). Inner strength and other techniques for ego-strengthening. *American Journal of Clinical Hypnosis*, *35*, 170–178.

McNeal, S., & Frederick, C. (1995, March). Good fences make good neighbors: Boundary formation in ego states as precursors to integration. Presented at the Annual Meeting of the American Society of Clinical Hypnosis, San Diego, CA.

Morton, P. (2001). Ego state therapy in female reproductive issues. *Hypnos, XXVII*, 124–131.

Ornstein. R. (1987). *Multimind: A new way to look at human behavior*. New York, NY: Houghton Mifflin.

Phillips, M. (1993). The use of ego-state therapy with post-traumatic stress disorder. *American Journal of Clinical Hypnosis*, *35*, 241–249.

Phillips, M. (1995). Our bodies, our selves: Treating the somatic expressions of trauma with ego-state therapy. *American Journal of Clinical Hypnosis*, *38*, 109–121.

Phillips, M. (2001). Healing the divided self. In R. Corsini (Ed.). *Innovative therapy: Second edition*. New York, NY: Wiley.

Phillips, M., & Frederick, C. (1992). The use of hypnotic age progressions as prognostic, ego strengthening, and integrative techniques. *American Society of Clinical Hypnosis*, *35*, 90–108.

Phillips, M., & Frederick, C. (1995). *Healing the divided self: Clinical and Ericksonian hypnosis for posttraumatic and dissociative conditions*. New York, NY: Norton.

Phillips, M., & Frederick, C. (2010). *Empowering the self through ego-state therapy*. Available at http://www.reversingchronicpain.com/prof.html.

Stern, D. (2010). *The present moment in psychotherapy and everyday life*. New York, NY: Norton.

Stolerow, R., Brandchaft, B., & Atwood, G. (2000). *Psychoanalytic treatment: An intersubjective approach*. New York, NY: Routledge.

Torem, M., & Gainer, M. (1995). The center core: Imagery for experiencing the unifying self. *Hypnos, XXII*, 125–131.

Toothman, D., & Phillips, M. (1998). Coming together: Working with couples from an ego-state therapy perspective. *American Journal of Clinical Hypnosis*, *41*, 174–189.

Watkins, J. G., & Watkins, H. H. (1979). The theory and practice of ego-state therapy. In H. Grayson (Ed.), *Short-term approaches to psychotherapy,* (pp. 176–220). New York, NY: Human Sciences.

Watkins, J. G., & Watkins, H. H. (1981). Ego-state therapy. In R. J. Corsini (Ed.), *Handbook of innovative psychotherapies* (pp. 252–270). New York, NY: Wiley.

Watkins, J., & Watkins, H. (1997). *Ego states: Theory and therapy*. New York, NY: Norton.