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## Dear Ego State colleagues and friends,

What a show! I cannot believe that Ego State Therapy International is already 4 years old! Many of us recently headed back to Heidelberg for the Teiletagung (Parts Congress), where in a quaint restaurant adjacent to the City Hall, Ego state Therapy International was born. In these four years, from that initial meeting, so much has been accomplished. So many people, both on the board of ESTI and behind the scenes, have put in so much effort into making ESTI the success it is.

In February 2016, at the 6<sup>th</sup> World Congress on Ego State Therapy (yes, 6<sup>th</sup> WORLD CONGRESS ALREADY!) in South Africa, ESTI will hold its 2<sup>nd</sup> election for Office Bearers. The current Office Bearers are as follows:

- President: Dr Woltemade Hartman (South Africa)
- Vice-President: Susanna Carolusson (Sweden)
- Treasurer: Eva Pollani (Austria)
- Secretary: Jenny da Silva (South Africa)

As secretary, this newsletter formed part of my duties. And as such it has been my utmost privilege and honour to bring to you, our dear readers, the latest news in Ego State Therapy. I have been given the opportunity to interview giants in this field and bring you news and articles from across the globe. This edition, my last, is no different. This edition features an interview with Dr Maggie Phillips (USA), a true pioneer in the field of Ego State Therapy. (Seriously, I was totally star-struck when I met her a few years ago). We also feature an article by Peter

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As the curtain threatens to close on my term as secretary, I would like to sincerely thank each and every one of our ego state friends for your loyal support of ESTI over the years. It is my prayer that ESTI will continue to impact your work and the lives of your clients in remarkable ways.

From South Africa, for the final time, we wish you and your loved ones a peaceful rest over the coming festive season, a Merry Christmas and a blessed New Year.

Get ready for Act 2!

**Jenny da Silva**

**Secretary and Newsletter Editor of ESTI**

## From the President's Pen

Dear colleagues and friends,

The curtain is about to close for me as the first president of Ego State Therapy International. But as any good ringmaster, I bow out with delight, knowing that we have established Ego State Therapy International, with a firm and stable foundation for future generations, leaving the crowd wanting more.

As I look back over the past years, what satisfies me most is that we have created what John and Helen Watkins always envisaged, namely to unite professionals with a mutual interest in Ego State Therapy. This was one of their greatest wishes. We now have more than 100 internationally certified ego state therapists, a well established website ([www.egostateinternational.com](http://www.egostateinternational.com)), a bi-annual newsletter, scientific discussions and articles and a keen interest amongst professionals and students alike writing doctoral theses and dissertations and scientific papers on Ego State Therapy. What makes me proud is that soon, the 6<sup>th</sup> World Congress on Ego State Therapy will take place in Mabula Wild Animal Park, South Africa, from the 19 to 21 February 2016 and the Post Cape of Good Hope Congress in Stellenbosch, Cape Town, South Africa on the 24 and 25 February 2016. Once again we will have the opportunity to discuss and debate important topics related to Ego State Therapy, and to build bridges of understanding amongst colleagues and friends. I am surprised that we are already organizing a 6<sup>th</sup> WORLD CONGRESS on Ego State Therapy. This in itself is a hard act for any magician to follow in such a short time.

Gazing into my crystal ball, for the future of ESTI, I foresee a modernization of the theory of Ego State Therapy, an expansion of our neurophysiological knowledge of the origin of ego states, the interconnectedness of ego states and the body and the role ego states can play in embodiment. I envisage a surge of research conducted in the combination of Ego State Therapy with other therapeutic modalities and techniques and the establishment of Ego State Therapy as a well-defined scientific paradigm within the psychotherapeutic community. My wish is that we will work together to establish a standardized teaching protocol and curriculum for Ego State Therapy for professionals internationally.

As I reflect back on these years on being the first president of Ego State Therapy International, the

trail of wisdom that Helen Watkins, matriarch of Ego State Therapy, comes flowing into my mind:

“Ego State Therapy is studied as a science, but practiced as an ART!”

With these wise words, the stage has been set, the lights have been dimmed, and I now hand over the baton of this prestigious office to my successor. Good evening and good night.



**Woltemade Hartman**  
President of ESTI



### In Memorium

#### **Claire Frederick (M.D): A legacy of gifts.....**

You can shed tears that she is gone,  
Or you can smile because she has lived.  
You can close your eyes and pray that she'll come  
back,  
Or you can open your eyes and see all she has left.  
You can cry and close your mind, be empty and turn  
your back,  
Or you can do what she'd want:  
Smile, Open Your Eyes, Love, and Go

It was with great sadness that we learnt of the passing of our dear friend and colleague, Claire Frederick. She was truly a giant in the field of Ego State Therapy and her work leaves with all of us a legacy of great gifts. Not only did she make a significant contribution to the fields of trauma, dissociation, and clinical hypnosis, but also contributed greatly to the foundational intervention model of Ego State Therapy that is used worldwide today.

On a more personal level she will be missed for her tremendous sense of humour and her quirky spirit. She was a great mentor, master teacher, and friend to her students and colleagues alike, always encouraging, always motivating and always freely sharing her knowledge. Her memory will always live on.

Your friends and colleagues from Ego State Therapy International (ESTI)

### ESTI interviews... Maggie Phillips



**JdS:** I know that you started off your career in teaching. Tell us a bit about that.

**MP:** I started my career teaching 9<sup>th</sup>, 10<sup>th</sup>, and 11<sup>th</sup> grade high school English, speech, and drama. I had 180 students and four different preparations every day. I've never worked so hard in my life! It became clear relatively quickly that I was not going to make a career as a high school teacher. However, I really enjoyed the kids and was far more interested in their lives and personal problems than I was in whether they could recognize correct sentence structure. So I went back to graduate school and received a master's

degree in school psychology. After working as a school psychologist for a few years, I went back to school again and this time earned my master's degree and Ph.D. in Clinical Psychology. I've been working as a psychologist/psychotherapist ever since.

**JdS:** What about hypnosis attracted you to the art?

**MP:** One of my professors in graduate school at Penn State used hypnosis. I enrolled in a class with him and learned the basics. When I moved to California a few years later, I ended up living near Steve Gilligan, who is a well-known Ericksonian hypnotherapist. I really clicked with Steve and started attending the Ericksonian Congress in Phoenix and then I was hooked! I found the practice of hypnosis to be very creative and energizing since I went into trance with my clients. I read all of Milton Erickson's papers and the books written about him and I found that my work became much more effective. The utilization approach helped me to connect well with my clients and to teach them that they had resources and solutions within them that we could use to resolve many of their symptoms and difficulties. I also loved the use of language in creating suggestions that could unlock unconscious potentials. I remain fascinated with this approach.

**JdS:** Tell us how you met the Watkins' and got started in Ego State Therapy.

**MP:** As a fervent Ericksonian, I became involved in the local hypnosis society, The Northern California Society of Clinical Hypnosis, which was affiliated with the American Society of Clinical Hypnosis. I served on the board of NCSCH and eventually became president and during that time met Claire Frederick and Shirley McNeal who lived in the area and also were active in the group. Claire and I wrote a couple of articles together and she convinced me to start attending the ASCH annual conferences. At the first one I attended

in about 1990, Claire told me during a break that I should leave the workshop I had signed up for and come with her to hear Jack and Helen Watkins. I followed her advice and was mesmerized by what they were teaching, an approach they called Ego State Therapy. Claire and I began teaching together ourselves and became close friends of Jack and Helen's. We even taught together with them a few times. I found that Ego State Therapy was what had been missing in my hypnotic work and discovered that clients who did not respond to my usual uses of direct and indirect suggestions responded dramatically when I asked to find and communicate with various parts of the self. The ego state approach allowed me to help individuals that were more severely traumatized and basically opened a new world for me.

**JdS: You are known for your work in Somatic Experiencing and Ego State Therapy. Tell us about the combination of these and how they have influenced your work.**

**MP:** I had met Peter Levine when I first moved to California in the late 70's. I was known for my work in hypnosis and Peter for his work with the body. We were brought together by a mutual colleague to teach a workshop with trauma. Though we did not know each other then, we discovered quickly that the colleague knew nothing about teaching trauma. Peter somehow talked him into working the video camera for the rest of the weekend and our teaching partnership was born. We have taught together for about 30 years, most recently at "Trauma Days," an annual event in Zurich, Switzerland. I learned Somatic Experiencing as Peter was evolving it and even made some contributions. He eventually talked me into joining the SE faculty and I have been teaching in the Somatic Experiencing Practitioner (SEP) training program ever since. As I developed as an SE practitioner, I found that SE did not always work well with dissociative disorders. I discovered that by adding Ego State Therapy in combination with SE, I could work effectively with somatic ego states and reach aspects of self at preverbal and nonverbal levels

that I had not been able to access before. This combination approach is now my treatment of choice. I enjoy being able to heal fragmentation that creates dissociative disorder and also to achieve greater integration by working with the states of the self through the body.

**JdS: What would you consider your contributions to psychology?**

**MP:** I've always been interested in how to combine different methods and ideas. Years ago, I published a paper on AIDS based on my work with several AIDS patients. I realized that my approach was something like the "AIDS Cocktail" which ultimately resolved the AIDS epidemic by combining several drugs in such a way that they potentiated each other's benefits. I think that's a good metaphor for my approach. Some of my contributions have been made through my writing of four books. Healing the Divided Self (written with Claire Frederick) presents the SARI model, a four stage method of using hypnotic Ego State Therapy to heal the self that has been fragmented through trauma. My second book, Finding the Energy to Heal, combines the principles of Energy Psychology with hypnosis, EMDR, imagery and Somatic Experiencing to heal mindbody symptoms and disorders. My last two books, Reversing Chronic Pain, and Freedom From Pain (with Peter Levine), focus on a 10 Step Model to reverse the effects of chronic pain, and the use of Somatic Experiencing to prevent and resolve pain conditions that result from trauma, respectively. So I would say that my contributions have been made through Ericksonian and Somatic approaches to Ego-State Therapy and in the areas of pain and mindbody healing.

**JdS: You do a lot of traveling and still manage private practice. How do you maintain a good work/home/life balance?**

**MP:** It's not easy. My clients have gotten used to my travel schedule over the years. I have helped many of them learn to use the breaks when I'm away to work on "special projects" related to our work while I'm gone. I'm also available for Skype and phone sessions and can be

reached via email. The main principle for me is to stay connected with my clients, and with colleagues and friends in my home and international community. Those connections nourish me and I also make time for exercise, which is essential, and make sure that I schedule time for fun and rejuvenation in the cities I visit. One of my practices is to make sure that I visit at least one museum, and if possible, hear live music in the foreign countries I visit.

## Metaphoric Symbolised Imagery: The New Advanced Ego State Therapy Integration Technique

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### Abstract

This paper provides an introduction to the psychotherapeutic theory and author's practice of Metaphoric Symbolised Imagery. A number of case vignettes will be presented to illustrate aspects of the technique. A brief historical review of the use of imagery in psychotherapy has been undertaken. The use and technique of Metaphoric Symbolised Imagery has evolved from the author's psychotherapy practice over the past 25 years through a process of study and experiential research.

### Introduction

The first airing of my thoughts on the application of Metaphoric Symbolised Imagery (MSI) was at the

XIX Congress of the International Society of Hypnosis in Bremen, Germany in 2012. The psychotherapeutic theory and methodology of MSI is grounded in Ego State Theory. As a technique, MSI is used to effectively remediate underlying issues related to panic attack, phobic reaction, obsessive compulsion, depression, and other anxiety disorders. The technique uses the combined process of metaphor, association and archetypal symbolisation. The methodology is grounded within a series of trans-disciplinary based imagery structures that repair, resolve and integrate surface and underlying, conflicted and or 'vaded' Ego States (see Endnote 1). This is achieved on a deep psychodynamic therapy level. The work is carried out at the base cause of the underlying issue rather than by direct symptom removal.

### What is Metaphoric Symbolised Imagery?

Metaphoric Symbolised Imagery (MSI) is the process of generating a metaphoric dream for the patient, with the therapist directing the content and structure of the imagery for the purpose of remediation by 'sub-linguistic' language. MSI allows the therapist to communicate with the patient through affect-based, non-cognitive pathways. Many patients struggle to verbally identify or articulate the unconscious causation of their symptoms or life issues. MSI provides a way to circumvent resistance that is often manifest in the talking cognitive-based therapies. Therapeutic insight is achieved from within, rather than requiring patients to work from uncomfortable externally based therapy structures. In fact, language can get in the way of therapeutic communication therefore I term the process of MSI as 'sub-linguistic'.

It must be remembered that MSI is a creative process—a collaboration between the therapist and patient. The resolution and healing is achieved from within the patient's unconscious rather than being imposed from without by the therapist. MSI is not a mechanical technique, which can be manualised.

MSI is a process I developed in my own practice during the 1990s. Years later, I was able to place MSI into a theoretical context, as I became familiar with the work of Professor Gordon Emmerson's Ego State Theory (2003). The descriptive name of this process, "Metaphoric Symbolised Imagery", came about as a concept of the weaving together of these three elements in my working practice, as I believe these three components are the main constituents of the dream process.

#### Definitions

##### *Metaphor*

Metaphors are word pictures that many people use to explain unfamiliar concepts to one another. The English language is a powerful tool through which metaphor, because of its richness and complexity, can lucidly communicate ideas to the human mind. As the American lawyer Dudley Field Malone said, "one good analogy is worth three hours discussion" (see Endnote 2).

The benefit of metaphor in therapy is the unconscious ability to communicate in word pictures while allowing the process of ambiguity to provoke the patient to participate. Combs and Freedman (1990, p.25) make this point: People tend to want to resolve ambiguity. They listen closer, think harder, and become more experientially involved in therapy when there is a certain amount of ambiguity in a therapist's utterances. The use of metaphor in therapy allows us to "link sensory, affective and conceptual aspects of experience" (Kirmayer, 2004, p.37), and this in turn, creates the possibility of psychological and physiological healing.

##### *Symbols*

There is no better definition than Jung's (1964): A word or an image is symbolic when it implies something more than its obvious and immediate meaning. It has a wider 'unconscious' aspect that is never precisely defined or fully explained. Nor can one hope to define or explain it. As the mind

explores the symbol, it is led to ideas that lie beyond the grasp of reason. Symbols provide a rapid, yet indirect pathway of communication to a patient's unconscious mind. The use of symbols in therapy is the mechanism of provoking a patient to engage, discover and process the content of their unconscious.

##### *Imagery*

Imagery exploits our perceptions to evoke feelings by describing to our inner mind how we see, hear, smell, taste or touch something. The use of imagery allows access to affect-laden unconscious material more effectively than verbal or cognitive communication by permitting direct connection with a patient's memories, experiences and repressed unconscious material.

According to Sheikh and Panagiotou (1975, p.557): Images are less likely to be filtered through the conscious critical apparatus than is linguistic expression... images may have a greater capacity than the linguistic mode for the attraction and focusing of emotionally loaded associations in concentrated forms. It is not always necessary for the patient to understand the imagery at a cognitive level, because the patient can comprehend and integrate the message at the affect level (Jellinek, 1949 cited by Panagiotou & Sheikh, 1977, p.173).

#### **Theoretical Background**

Ego State Theory is a psychodynamically based theory that was originally formulated as a therapeutic application by Watkins and Watkins (1997) in the early 1970s. Contemporary Ego State Theory is based on Emmerson's (2003) development of Watkins' work. MSI is grounded in this theory. Ego State Theory carries the hypothesis that the personality is not made up of one homogeneous whole but by several distinct parts, known as 'ego states', that interact together to make up a complete personality.

As Emmerson (2003, p.3) states: We are not born with our different parts or ego states. We make them as we live. Our ego states are formed when we do something over and over again. This 'over and over again' learning creates a physical neural pathway in the brain that has its own level of emotion, abilities, and experience of living. The separate and distinctive parts aspect of Ego State Theory can be related back and compared to Freud's (1927) concept of the Id, Ego and Superego, as can also the parts structure of Eric Berne's (1961) theory of personality that he termed Transactional Analysis (comprising Parent, Adult and Child ego states), which emerged from the work of Paul Federn (1952) and his pupil Edoardo Weiss (1950).

Federn explained personality as the expression of several ego states that are in continual interaction within the individual. He coined the phrase "ego states" because he viewed our core self, the ego (the pronoun "I" in Greek), as innate in each state. Therefore, as states change, the "I" (the ego) changes with them into the new state.

As Emmerson (2012) suggests: No matter what state we are in, we think "this is me", or put another way, we have ego identification with each state we bring to the surface. Therefore we are always in an ego state. Each individual has a unique set of ego states developed throughout their life because each person has a unique experience of life. Similarities may exist between individuals' ego states because there are commonalities between the experiences of individuals. In conclusion, ego states exist and are developed by repetition from an individual's life experiences.

### Summary of Technique

The technique in MSI begins with ego state mapping by identifying the patient's strengths and resources from the case history. The process of MSI brings resolution to troubled underlying ego states much in the same way the natural dream process works

through and remediates troublesome everyday issues of the mind during sleep.

### Transitions

During the MSI procedure, the therapist takes the patient through a series of structured 'transitions', imagery structures that work through and bring resolution to troubled surface and underlying ego states. A transition is an image presented to the patient to provide a safe metaphorical place in which to process their experiences. MSI is a functional way of constructing a waking dream state. The process and outcome of MSI provides the patient with a sense of inner peace and a feeling of working through the elemental causes of their fears, conflicts or unresolved issues. Each transition subconsciously prompts the patient to make an internal decision within, as well as about themselves and their actions. The following are a summary of the most basic transitions that can be used:

1. The ***first transition*** is intended to connect with the traumatised ego state at an unconscious level. This is the moment the Reticular Activating System (RAS) is bypassed (see Endnote 3). This transition process starts by having a patient talk about their strengths and resources, and then naming them. The therapist assists the patient to enlist these strong parts of the self to recognise and support the traumatised ego state. In Resource Therapy terms, this would entail connecting with the 'vaded' state that is the distressed part of the patient.
2. The ***second transition*** uses the supporter states in symbolic form to emancipate the traumatised ego state from the initial critical event that is keeping the patient in a vaded condition. This second transition, which is named the 'break out', is symbolically creating an internal decision to move on

from the original traumatising event, accompanied by supporter states. Now the MSI process is moving the traumatised ego state forward into another remediating transition along with its supporters.

3. The **third transition** has a symbolic content of induced vulnerability where the patient could be exposed, along with their fears, out in the open. The therapist is unconsciously requiring the patient to take an inner risk to move themselves forward from the initial traumatising condition. The patient is still accompanied by the supporter states, so they are not alone. This is a processor to the next transition.
4. The **fourth transition** takes the patient to a place of strategic retreat and sanctuary, a place to recover from the initial trauma. There are many interactive transitions that can be used as required from any of these working points. In Ego State Theory as practised by Professor Gordon Emmerson (2014), his credo is “expression, removal and relief”. I have extended that in the MSI process to include “release, cleanse, reset and future rehearsal”. The patient works through the individual stages of the transition process using imagery structures that are prompted and defined by the therapist with the patient’s active participation and remediation in mind.

### **Brick Wall’ Transition**

This is a detailed description of one particular metaphor, the ‘brick wall’ transition, used for building resilience and innovation. It is a metaphor for establishing and reinforcing resilience, as well as thinking differently. If I get a sense that some clients need to have more faith in themselves or need to develop alternative ways of thinking, I ask them to imagine being contained in a room. I then request the patient to look around for some kind of tool like a rusty nail in the wall or sharp metal object, anything of this

nature. I ask them to imagine starting to scrape and chip away at the mortar between the bricks and to work a brick loose. Sometimes this process can take a while, and the therapist has to encourage the patient to keep going. The patient must take one brick out at a time to make a hole big enough to be able to look out and see something of symbolic safety in the distance. This can be a person, a building, forest or a refuge of some kind; a recognised haven to where the patient can escape, hide and rest. I ask the patient to visualise that safe place, which is a metaphor for hope and sanctuary. Using this symbolic image of safety as motivation to continue, I encourage the patient to scrape around the next brick and remove it, and then the next brick and remove it, then the next brick until they have a gap in the wall big enough to escape through.

I will use this symbolic metaphor if I conclude during the case history gathering stage that a patient feels trapped in a situation from which they cannot move on. I use the ‘brick wall’ transition if a patient feels they are unconsciously being held back from making a decision, or if they need to increase and strengthen their internal resilience. Occasionally patients want to give up or will comment, “it’s all too hard, I can’t do it”. If this occurs, I encourage the patient to continue and to work at loosening the brick until it is finally dislodged. I encourage them to keep going at all costs. In some cases, I will put myself into the transition with the patient to help them to continue. The process of the metaphor is to make a hole in the wall big enough for the patient to escape through, be safe and recover. Achieving this objective builds resilience and metaphorically provides inner scope for the patient to recognise that further opportunities and eventualities are possible and achievable.

### **Case Vignettes**

*“Louisa”*

Background: Louisa was a patient in her early

thirties, living in Sydney, Australia. She had a very close relationship with her father who was in Europe. They spoke on the telephone every week, and her father was her principal source of care and advice. Louisa described her father as a charismatic problem-solver and a very friendly social man who enjoyed his wine. Tom was a well known and greatly respected businessman in his local community. He was decisive and the backbone of the family. By contrast, she described her mother as weak and inactive. Louisa's father Tom died suddenly.

Presenting Issue: In her grief and anguish following her father's sudden death, Louisa wrecked her apartment, breaking things and smashing up the furniture. Louisa's flat-mate called my practice and asked me to come over quickly and help her. This I did. Louisa had always felt isolated in Australia. She couldn't afford to travel back to Europe for the funeral. She would have to borrow the money from somewhere to do that. She felt an immense sense of frustration and anger at the sudden loss of her father who she also perceived as her best friend. She described her father as "like an oak tree".

Method: Whilst looking out of the window of Louisa's flat, I noticed three trees at the bottom of the garden. I said to Louisa, "Which of those trees is a representation of your father?" Louisa chose the middle one. When I asked her why she said, "It's big, strong, powerful and dependable". I then asked if she had a bottle of wine that she felt would be a representation of her father. Louisa chose a good expensive bottle of red wine her father had brought for her on his last visit. To Louisa, the wine was symbolic of the fun and many caring moments she had shared with him over the years. I asked her to fetch three wine glasses and a bottle opener and to accompany me to the trees at the bottom of the garden. We poured three glasses of red wine, one for Louisa, one for me and one as a symbolic representation of her father. I toasted the tree, toasted her father, and

gave a short speech relating it to her father and the strengths and resources he had shared with her during his long and colourful life. Louisa did the same. I then suggested to Louisa that she toast her father's strong caring nature with the glass representing him and salute the tree by raising her father's glass to it. Louisa was then to symbolically put her father into the tree by throwing the glass of wine at the tree trunk.

Her own full glass was to follow. I then saluted her father and did the same. Next I asked Louisa to hug the tree and promise to come back and talk to her father (whom we had just symbolically put into the tree) regularly.

Louisa eventually moved out of that flat but was given permission to return to the garden so she could continue to visit her father in the tree. She would sit with her back against the tree and talk to him. This happened frequently until she decided to move back to Europe and was able to leave the tree behind and replace it with her father's grave.

Comment: This is a very early example of my use of MSI. I used symbols, metaphor and ritual by association. The main active symptoms in Louisa were the immediate feelings on hearing of her father's death: separation anxiety, grief and bereavement. The continuing underlying threat to her wellbeing was that she perceived herself to be totally on her own, the other side of the world and cut off from all support. Even though her father was so far away, she knew she could rely on him to help her to work through and find solutions to her problems. By using the tree metaphor, its symbolic size and strength, and the ritual of putting her father into the tree by toasting and smashing the full glass of wine against the tree, Louisa was symbolically able to continue her relationship with her father. What Louisa had lost by the death of her father, she had now replaced by the symbolic metaphor of the tree.

Via the tree metaphor, she could continue to talk

with her father after he had passed on. Toasting the tree with a wine that her father would also have enjoyed provided her with a ritual to farewell him in place of the funeral she could not attend. The tree had become a transitional object while time healed her. When I spoke to her in a follow up phone call a few days later, she was still experiencing grief, but it was a natural grief rather than an incapacitating emotional wound.

*“Annie”*

**Background:** Annie was a young woman who was attacked in the lift of her apartment building. A man raped her while forcing her to participate in her own restraint. He did this by threatening to kill her if she didn't keep her hand on the button that kept the lift stopped between the floors. Annie complied with this instruction, terrorised and incapacitated by fear.

**Presenting Issue:** Annie was experiencing an ongoing high degree of anxiety and violent agitation (post-traumatic stress) complicated by the feeling that she was complicit in her own assault. This was further complicated by her assailant's allegations during his trial that she had engaged in consensual sex with him, arguing that her action in holding down the lift button proved this.

**Method:** The initial transition in this case involved a symbolic confrontation between the traumatised part of Annie and her attacker. The transition imagery I put to Annie, was of a cell underneath an old building, specifically designed to evoke the feeling and atmosphere of a lift (elevator) but without being in a lift. This allowed her to symbolically confront her assailant in a relatively safe environment. Using the structured imagery supplied, Annie imagined a representation of her attacker, which she described as like a spectre. At this point I was careful to check in with her feelings of safety, and encouraged her to populate the scene with supporters, including myself. The spectre image emerged from a shadowy corner.

Checking with my patient, Annie was feeling extremely fearful. Annie then spontaneously transitioned from feeling extremely frightened to extremely angry.

In this transition, Annie destroyed the spectre. I then took her out of that transition (confrontation) and provided her with a different metaphoric transition, whereby she could look back, review and come to an internal decision to move on. From this safe place she decided that the building where the spectre lay also had to be destroyed. I asked her to imagine a plunger detonator attached to the building by wires and to push down the double handled plunger, blowing up the building. She let out a big whoop of excitement as she did this and told me that she felt “really good”.

I constructed two further transitions to metaphorically reinforce her feeling of safety and to allow Annie to deal with her sense of complicity in the attack. The suggested transitions involved her in a symbolic ritual of cleansing and making a lasting internal decision about the person she wanted to be in the future.

**Comment:** A number of transitions were used in this case to move the patient through one feeling state to another. The transitions allowed Annie to symbolically and metaphorically work through the content of her trauma subconsciously without her having to re-live it on an activated (RAS) conscious level with the risk of re-traumatising her. The important feature of the specific MSI transitions used is that they empowered the patient and her imagination by helping Annie to achieve an inner confidence about herself and a different pictorial perspective regarding possible outcomes. These outcomes were evoked by the symbolism used and the metaphor of the transition.

*“Cathy”*

**Background:** Cathy was a woman in the process of divorcing her husband. She had two grown children. Her husband was a wealthy businessman

who had for several years engaged in a process of verbal humiliation by attacking her self esteem, telling her that as she did not own anything and that he paid for everything, she was therefore worthless. He had not allowed her to work during the marriage and had not shared any business decisions with her but Cathy had confided in me that she had supplied a lot of feedback, support and business advice. (Cathy had, prior to meeting her husband, achieved a postgraduate degree in business.)

Presenting Issue: Cathy had a deep-seated valid concern that she would be left penniless at the settlement with no income-earning capacity or ability to provide herself with a home. She had been subjected to ongoing intimidation and long-term bullying, culminating in a very poor self-image.

Method: The transition I used with Cathy was a metaphor, imagining herself in the schoolyard standing up to a school bully with her supporter states (resource states) present and with me as an extra 'invisible back up' resource state because Cathy firmly believed she did not have enough internal resources available to be effective. I asked her, using her own words, to tell the school bully she was not scared and to portray remaining calm and in control. I further asked Cathy to verbally point out to the school bully and to reinforce the idea there were structures in place that would protect Cathy and punish the bully should they continue. Cathy was to verbally list out loud all the authority figures available within the school structure including teachers, parents and other authorities that she could and would inform, regarding her distressing situation with the bully.

Comment: This transition took Cathy from a paralysing feeling of helplessness to an internally based feeling of empowerment. Cathy had to first internalise the concept that it was possible for her to stand up to her husband. During the initial case mapping I discovered she had successfully stood

up to bullies in an incident at school in her teenage years. This provided a metaphor base from which we could work to connect to her already established inner assertive resource state. As part of the general counselling approach, I directed Cathy towards appropriate professional support so she could find practical legal and accounting advice of the standard required to deal with her husband's business affairs. Cathy re-discovered and reinforced those internal resources, which allowed her to access her more authoritative 'schoolyard' self in dealing with the divorce settlement process.

### **A Brief Review of Imagery Use in Therapy**

Freud and Jung both recognised the function of intra-psychoic representation that occurs from both dreams and daydreaming in the waking state. Freud (1954) often used "waking images" prior to his development of free association as a discovery procedure. Jung (1964) also used waking fantasy images as a process to analyse the content of the imagery much as he did with his dream interpretation and analysis. Most of the imagery-based therapies that have followed Jung have made use of his symbolism and transformations (Panagiotou & Sheikh, 1977).

The use of imagery in psychotherapy as a technique has an extensive history dating back to Freud and his studies of hysteria with Breuer in 1895. The German psychiatrist Kretschmer with his *Bildstriefendenken* (translated as "running a film in the mind") demonstrated how closely related was Freud's dream work and the connection of imagery with affect and emotion (Leuner, 1969).

Hanscarl Leuner's technique of *Symbol drama* consists of ten standard imagery situations suggested by the therapist. Leuner's technique always begins with the meadow. This structural component of the method is followed regardless of the material brought by the patient (Leuner '69)

From the meadow the patient is to make their way toward or follow a stream, forest or mountain or whichever scene spontaneously evolves. The patient is trained to verbally describe their progress and experiences as they explore their structured imagined environment. When using Leuner's (1969) *Symbol drama*, the therapist "is continually reading and interpreting the symbolic contents with the intention of connecting the symbolic content of the clients' history and dynamics of the symptoms".

Milton Erickson was perhaps the 20<sup>th</sup> Century's most prominent exponent of the art of metaphor in psychotherapy. His use of metaphor was theorised in collaboration with Ernest Rossi (Erickson & Rossi, 1979). Their work described how metaphor could be combined with therapeutic intervention to communicate directly with the affect-laden right side of the brain. This approach was considered faster and more effective than traditional psychoanalytic work because it "...was in contrast to the conventional psychoanalytic approach of first translating the right hemisphere's body language into the abstract patterns of cognition of the left hemisphere, which must then somehow operate back upon the right hemisphere to change the symptom" (Erickson & Rossi, 1979, p.144).

Erickson's work was innovative and ground breaking and is still used extensively in psychotherapy today. He had what Roffman (2008) has described as an acceptance of and a "pragmatic willingness to make use of what the client presents – symptoms, behaviours, attitudes, beliefs, emotional reactions" to create metaphoric bridges to new experiential meanings.

Helen Watkins' (1980, cited by Krakauer, 2009) Ego State Therapy 'silent abreaction' release is a comparative technique in its inclusion of a therapeutic image which does have a metaphoric component to it in that the patient imagines coming along a path to a boulder which is covered in moss and dirt (a metaphor of a long or chronic

existing issue) where Watkins suggests the patient picks up a stout stick and starts hitting the boulder with it. The boulder metaphorically represents a person or traumatic experience where accumulated frustrations were not previously vented. Watkins encourages the patient to beat the rock until completely exhausted. The technique was designed primarily to release anger. The rock technique is also used to express and vent feelings of sadness, frustration or oppression.

Kopp (1995) believes it is important for the therapist to not help the patient create metaphors. In contrast, MSI encourages the patient to further develop the content of the metaphor created by the therapist. However in MSI, the therapist has specific therapeutic goals in mind for which particular metaphors have been constructed. The methodology of MSI creates a symbolic metaphor through previously elicited traumatic events from the case history.

Therapists such as Desoille (1965, cited by Panagiotou & Sheikh, 1977), Jellinek (1949) and Leuner (1969) consider images to be the unconscious communication of the mind using its own language. Horowitz (1968) believed that much of the value of imagery whether symbolic or metaphoric was significant for uncovering repressed unconscious material. Horowitz (1968) considered that mental imagery contained further clues towards affect or belief, which the patient is unable to articulate on a conscious level. Imagery, "because of its primordial forms, has a special function as the 'direct voice of the unconscious'" (Panagiotou & Sheikh, 1977). In MSI, I refer to this process as 'sub-linguistic' language.

### Conclusion

Metaphor provides different ways to communicate using language. Symbols provide depth of meaning and access to the unconscious. Imagery contains greater emotional content and provides a

better conduit to link to emotional experience. Metaphor, symbols, imagery and their association with the patient's existing reality, speak directly to the unconscious. Thereby, negotiation for change can occur at a deep level by the unconscious process of sub-linguistic language. The case vignettes presented in this paper demonstrate the usefulness of MSI in allowing a patient to internally and symbolically work through the content of their trauma without having to re-experience it on a literal and conscious level. The research and development of the Metaphoric Symbolised Imagery technique is an ongoing process by the author by which the application, methodology and theory will be further explored and published.

### Endnotes

1. 'Vaded' is a term invented by Gordon Emmerson who fused the words "invaded" and "Darth Vader" to signify an ego state occupied and dominated by trauma.
2. US lawyer Dudley Field Malone was co-counsel with Clarence Darrow in the 1925 "Monkey" trial, where school teacher John T Scopes was on trial in the state of Tennessee for teaching evolution against State laws.
3. The Reticular Activating System (RAS) has:
  - ...a critical role in determining states of awareness and arousal level, and how an organism can effect directed or selective awareness, rather than to all available stimuli... The RAS is a kind of alarm... it responds in the same way to any sensory stimulus, whether from hearing, sight, touch or whatever. Its response is simply to arouse the brain, not to relay any specific message, so that when the signal arrives at the specific centre in the cortex, the brain can identify it (Blundell & Cade, 1972).

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This Academic Paper was first published in The Australian Journal of Clinical Hypnotherapy & Hypnosis (Vol 36. No 2) Spring 2014.

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## **Ego State Therapy across the Globe**

### **South Africa**

In South Africa the focus in Ego State therapy is currently on Ego State Therapy with children and Ego State Therapy with creative expressive arts. This year, Jenny da Silva focused on utilizing various forms of media in Ego State Therapy with children to address different issues such as performance anxiety, suicide, self-harm and anger. Dr Elzette Fritz offered an exceptionally creative workshop for professionals based on the new Pixar movie 'Inside Out'. This new movie is a wonderful illustration of ego states linked to emotions and illustrates the concept of core memories and how these core memories have a significant role to play in the creation of "personality islands". This is a *must watch* movie for anyone working with Ego State Therapy, especially in children. Dr Woltemade Hartman focused on his new approach in dealing with malevolent introjects and ego states in his workshop titled "The Devil Wears Prada" and on his innovative approach in combining Ego State Therapy and body work.

### **United Kingdom**

At the recent Paris ISH congress I was amazed by the number of French societies and institutes offering hypnosis training. I overheard them motivate new candidates to consider their training and not referring to another training course that could be more accessible to the interested party. And (Rather: In my opinion...) there is nothing wrong with this as long as we are able to train and develop more competent therapists.

On the other hand, ESTI being relatively new in the business, I am urging friends and colleagues to share and cross reference. We are able to do so, as from the beginning we introduced training standards. We are fortunate within the European Union, that a new therapist will be able to, for example, do the Fundamental course in one

country and then move to another, just to continue the training there. Should we not have enough numbers and the candidates are fluent in English, I would love to see a mixed nationality group being trained in country A and for the same group to attend the next level of training in country B. Why not – Imagine the exposure to different ideas and problems?

The first United Kingdom Fundamental Training in Ego State Therapy will be facilitated by Dr Woltemade Hartman (8–10 July 2016). I am still holding out on the venue as I would want to accommodate our European friends. I firmly believe that if we were able to facilitate the first Fundamental course, Ego State Therapy will kick-off and grow in the United Kingdom.

### Switzerland

EST-training is developing and growing in Switzerland. Our seminars are fully booked most of the times and participants are eager to learn more. Additionally, we are proud of having Gordon Emmerson and Maggie Phillips teaching in Zürich this year.

Max Schlorff taught EST at the Sports Psychology-Congress in Berne (Bern) this summer, Silvia Zanotta for a children and adolescents counselling institution in Berne.

We also help to spread the EST-knowledge to other countries: Silvia Zanotta presented EST with children and adolescents at the hypnosis-Congress in Paris and will present new ways of EST at the Parts' Congress in Heidelberg as well as at the Psychotherapy Congress in South Africa. She will teach an introduction to EST-seminar in Avignon, France in November and will also teach at the MEG in Rottweil (EST with anxiety and phobia), at the Psyseminare-Congress in Essaouira, Morocco, for MEG in Wigry, Poland, in Koblenz (EST – supervision and self-care) and at Kai's institute in Berlin (EST and somatic approaches) in 2016.

### Poland

The first Ego State Therapy training in Poland will take place from October 2016 till January 2018. The programme was composed by and will be run by Susanna Corolusson, Eva Pollani, and Silvia Zanotta. Polski Instytut Ericksonowski and Kris Klajs will sponsor it. I hope we will promote Ego State Therapy with good results.

### Upcoming Congresses 2016

Please diarise the following international congresses

**19–25 February 2016, MEISA:** Changing Faces of Psychotherapy Congress, including the 6<sup>th</sup> World Ego State Therapy Congress, South Africa  
19–21 February, Mabula Game Lodge, Limpopo  
24–25 February, Stellenbosch, Western Cape  
[www.meisa.biz](http://www.meisa.biz)

**3–6 March 2016, MEG Jahrestagung/Congress,** Germany [www.meg-hypnose.de](http://www.meg-hypnose.de)

**3–6 November 2016, Child Psychotherapy Congress in, Heidelberg, Germany** [kontakt@meg-rottweil.de](mailto:kontakt@meg-rottweil.de)

### Thank you

Once again a big thank you to our colleagues, friends and especially to the representatives of our member countries for tirelessly promoting Ego State Therapy in their own countries and abroad. We once again invite all interested in the furthering of Ego State Therapy to share your ideas, comments and input.

Our warmest regards,



**Woltemade Hartman**  
President of ESTI



**Jenny da Silva**  
Secretary of ESTI