Utilizing Hypnosis and Ego-State Therapy to Facilitate Healthy Adaptive Differentiation in the Treatment of Sexual Disorders

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Much of the literature focuses on the pathology that falls to the far right of the Watkins (1997) differentiation-dissociation continuum, such as Dissociative Identity Disorder and Dissociative Disorder NOS. Adding a “far left” to this continuum, as well as a construct of what the “far left” looks like, makes apparent the value of healthy adaptive differentiation for those individuals that fall to the “far left” of the spectrum; those who don’t differentiate enough. A discussion of sexual dysfunction at this end of the continuum and cases of Hypoactive Sexual Desire Disorder and Vaginismus demonstrate the clinical effectiveness of an approach combining hypnosis and ego-state therapy to facilitate healthy adaptive differentiation.

Keywords: Adaptive differentiation, dissociation, Ego-state therapy, sexual dysfunction, sexual self, vaginismus

Multiplicity has been described as a helpful and protective gift for those who have endured severe childhood trauma (Gil, 1990). Another author on Dissociative Identity disorder describes it as a “lifesaving defense” (Haddock, 2001). This author contends that multiplicity is a gift given to us all. We all have a need to differentiate from other aspects of our personality in an “adaptive” manner at one time or another. Ego state theorists and their predecessors have strongly advocated similar positions throughout the literature (Beahrs, 1982; Federn, 1952; Frederick & McNeal, 1999; Frederick & Phillips, 1995; Freud, 1923; Weiss, 1960; Watkins, 1978; Watkins & Watkins, 1997). The Watkins state that when pathological, multiplicity is “simply the result of excess in adaptational and defense processes used by all individuals for protection and survival” (1997).

Ego-state therapy, a psychodynamic approach co-founded by John and Helen Watkins (1997) is based on the premise that we all develop different parts of our personality called ego states. They define an ego state to be an “organized system 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). In other words, ego states are the parts of our personality that make up our entire self. These parts give us the ability to adapt, think, act, and respond differently in different situations.

Normal differentiation and the formation of ego states develop out of a need and response to different situations, people, and/or behaviors. However, ego states also can develop out of trauma, and from the introjections of significant others (Watkins & Watkins, 1997). In order to conceptualize this further, and understand ego states and the boundaries that exist between them, it is helpful to review, the Watkins’ (1997) differentiation-dissociation continuum (see Figure 1).

This continuum demonstrates that well-adjusted individuals have very permeable boundaries, which means information can be shared and great awareness

![Figure 1: The Differentiation-Dissociation Continuum](image1)


![Figure 2: The Other Side of the Differentiation-Dissociation Continuum: “The Far Left”](image2)
exists among the ego states, unlike dissociative disorders where the boundaries among ego states become very rigid and exist with less or no awareness from one ego state to the next (Watkins & Watkins, 1997).

Much of the literature focuses on the right side of this continuum because that is usually where trauma disorders and the most evident pathology lie. In simple terms, these individuals differentiate too much. So where on the continuum do those who don’t differentiate enough lie? Even the Watkins’ report, “it is probable that the best personality adjustment occurs a little to the right from the extreme left (where there would be no boundaries, and thus no separate ego states)” (Watkins & Watkins, 1997). This speculation leads to the proposition of the other side of the differentiation-dissociation continuum, the “far left” (see Figure 2).

When viewing the “far left,” the benefit of adaptive differentiation becomes very apparent. These individuals usually feel out of touch with whom they are. They have a limited capacity of function and perpetually feel the void of being “stuck” in a unitary role, even if it’s one that provides intermittent pleasure.

It’s important to note that just because one appears on the far left doesn’t mean they don’t have other ego states or aspects of their personality. They have just lost or never learned the ability to differentiate in an adaptive manner, such as the workaholic who takes no time for play. Although there are many reasons that encompass one’s ability to lose sight of their other ego states or the ability to access them, the purpose of this paper is to focus more specifically on the loss of the sexual self, and how learning to differentiate in an adaptive manner, can help those who struggle with such a loss.

**Sexual Dysfunction At the “Far Left” of the Continuum**

On the “far left” (Figure 2) of the continuum, we have those individuals whose lives are identified by one entity. One common example would be the mother whose sole purpose of living is for being a parent, such as a mother who neglects or loses touch with all other aspects of who she is other than her parental role.

These individuals often present with depression, anxiety, and marital difficulties, including sexual concerns. They will often report, “That it seems like I’ve lost myself” or “I don’t know who I am anymore.” Their spouses will complain that they no longer know how to have fun.

Rarely do these individuals focus on their needs, sexual or otherwise. Usually they are not even aware of what their needs are. They rarely experience sexual desire and if they do, they have become experts at shutting it off. They may see it as interfering with their parental duties, or their parental duties may leave them too fatigued and exhausted to think about sex. Consequently, the parental self leaves no room for the sexual self to exist.

The second to the “far left” of the differentiation-dissociation continuum (Figure 2) represents someone that clearly has separate ego states for functioning, but they are always “on,” and they have difficulty differentiating from one state to the other. In other words, one could say, they are overly aware of their other ego states. For example, the woman who hears the pastor’s sermon running through her head while she’s trying to be sexual with her spouse, or the woman who is preparing mentally for her business meeting the next day. Certainly, sex is not going to be satisfactory or even enjoyable if
you are thinking about God watching, or you can’t differentiate from your professional self. It is quite frequent that the spiritual or religious self interferes with the sexual self in some way or doesn’t allow room for the sexual self at all.

Certainly, sexual trauma can and does lead to sexual problems and concerns. Although these individuals usually fall towards the right of the differentiation-dissociation continuum, they still need to differentiate in an adaptive manner. For example, making sure that when they are sexual, the traumatized children aren’t “out.” In this author’s experience, it is quite common for people with DID to have developed an ego state or cluster of sexual selves for the purpose of sexual behavior. It becomes problematic if the system isn’t a collaborative one and the sexual selves abandon the traumatized children during sexual acts or if they engage in unhealthy and/or dangerous sexual behavior without the values, knowledge, and experience of other, wiser, healthier, and/or more mature ego states. Because of the complex nature of sexual dysfunction at the right end of the continuum, the content of this paper focuses more specifically on those who fall to the far left.

**Conceptualizing the Sexual Self as an Ego State**

Although many sexuality authors include the “Sexual Self” in their book titles (Ferder & Heagle, 1992; Foley, Kope, & Sugrue 2002; Mazza, 2001; Offit, 1978; Sedgwick, 1992; Wottitz, 1989), it is difficult to find one that includes an adequate definition of what the “sexual self” actually is. Perhaps, Foley, Kope, and Sugrue (2002) come close when they describe sexuality as “an essential part of every woman’s identity.” It is feasible that part of the identity could be an ego state driven by sexual energy. If ego states develop from the need for a specific behavior or situation as the Watkins (1997) suggest, the existence of the sexual self as an ego state becomes very apparent. Certainly, being sexual is a specific behavior that requires a different mind-set than other functions of daily living.

This article includes cases that dramatically demonstrate the effectiveness of conceptualizing the sexual self as an ego state, and applying hypnotic and ego-state therapy techniques to treat disorders of sexual dysfunction.

**Facilitating Healthy Adaptive Differentiation in the Treatment of Sexual Disorders**

Although hypnosis has been utilized in the treatment of sexual dysfunction for a number of years (Aaroz, 1982, 1998; Aaroz & Bleck, 1992; Biegel & Johnson, 1980; Crasilneck, 1979; Hammond, 1984, 1985, 1990; Zilbergeld & Hammond, 1988) this author couldn’t find any literature specifically on hypnosis and ego-state therapy in the treatment of sexual dysfunction. The following treatment approach for sexual dysfunction will demonstrate the value of hypnosis combined with ego-state therapy applications and techniques when applied to this population.

As with any psychotherapy, a thorough psychological assessment needs to be completed, including an assessment for sexual functioning. If sexual concerns are present, a more thorough sexual history is needed. Robert Birch (1996) offers a number of assessment questionnaires for specific sexual concerns.

Sexual concerns are usually dealt with later in treatment after other clinical issues have been addressed and the client is in a safe and stable position. It is also imperative that the client can get to an “internal” safe place hypnotically prior to doing...
any ego-state work. This needs to be practiced and reinforced. It can then be an effective place to start and finish ego-state therapy sessions. It’s also consistent with the SARI model developed by Claire Frederick and Maggie Phillips (1995) that emphasizes safety and stabilization first.

Once an internal “safe place” has been established, ego-state exploration can begin. The meeting room technique, which is an adaptation of Fraser’s (1991) “Dissociative Table Technique,” is an effective way to identify and elicit information about the client’s ego states. This consists of imagining a room where all the parts of an individual can come together. When exploring sexual issues, it is helpful to ask for the sexual self or any others that know something about the sexual self. A typical script would sound something like the following:

Imagine a room, where all of the parts of you can come together, the room can be however you’d like it to be, perhaps there is a table with chairs for each part, I’m not sure, but make it just how you’d like it to be for you. I know that you have __________ (list any parts that you are already aware of), but I’m not sure who else might be present. Notice where everyone is, how old they look, and where they are in relation to each other. I know we’ve been discussing sexual issues, so maybe your sexual self is there or perhaps others that know something about your sexual self. Just notice everything you can, and if it would be ok, you can now let me know what or who you see.

Occasionally, clinicians will encounter a client that has trouble with “the meeting room” technique. If this is the case, there are a number of other techniques that are also effective. Frederick and Phillips (1995) outline a number of successful techniques to elicit ego states, as do the Watkins (1997).

Many clients are not able to see the sexual self, and if they can, it may be caged, hiding, or barely visible. Common traits of the ego states that surface when asked if there are others that may have information about the sexual self, include parental, sexually traumatized, religious, phobic, guilty, shameful, and critical, especially with regards to self-image.

The goal is to help the other ego states to allow room for the sexual self and to teach ways for the sexual self to differentiate in an adaptive manner so that the sexual self doesn’t have to be under the umbrella of a parental identity, an unhealthy self-image, excessive religious guilt, or a traumatized child. In other words, when choosing to be sexual, one can differentiate from their other ego states so that the sexual self can be “completely in the moment.” Once the ego states are identified, therapeutic interventions that work towards resolving inner conflicts and achieving a sense of balance among the entire self are utilized.

If the sexual self can’t be seen, which is common for those individuals at the “far left” of the differentiation-dissociation continuum, a hypnotic age regression to a time when the client felt sexually alive (assuming this is known from obtaining a thorough sexual history) can help her reconnect with that part of herself. The client can then be encouraged to notice herself, how she feels, how she looks, and to even give the sexual self she sees a name if she would like.

Now, certainly, this is not done with those on the far right of the spectrum. It is,
however, very beneficial for those individuals who don’t differentiate enough. It’s quite common that individuals give names to their genitals and Birch and Ruberg (2000) even recommend it. They describe it as a playful way of reducing shame associated with the stigma that individuals have about their genitals and the names that have referred to them. Giving a name to the “sexual self” is a similar process; it gives permission for her to be there and validates to the client that she is really there. It also separates her from the ego state that is presenting with the sexual dysfunction. The sexual self can be encouraged to have all the sexual feelings, desires, and passion that she was meant to have. She can differentiate from the spiritual self that thinks sex is sinful, the traumatized self who thinks sex hurts, or the parental self that is too exhausted.

Clinical Cases

Case 1: Vaginismus

Jan was a 30-year-old married female who presented with generalized anxiety that also included depressive symptoms. Once her initial presenting symptoms had improved, she disclosed her “real problem.” She reported that although she had been married for 10 years, she had never had sexual intercourse and that repeated attempts for penetration would always fail. She and her husband did engage in other sexual activities on a regular basis, and she reported being happily married. Although not adverse to their sexual activities, she did not experience any sexual desire or pleasure and only engaged in them to please her partner. Attempts for digital penetration would also fail. Although seemingly supportive, she feared that her partner would eventually leave her. She had an incredible amount of shame regarding this and had never talked about it before. She avoided medical treatment due to the fear of what an exam would involve and/or reveal.

Jan clearly fell to the “far left” of the continuum in that she initially could see only one ego state and she identified her as “Fear.” She described Fear to be holding a gigantic boulder blocking the path to her other selves, including her sexual self. She also reported that Fear was never going to allow for anything inserted in her vagina, because of the pain she was sure it involved. She had remembered that a friend once told her that sex was very painful, and she also had felt a sharp pain during her initial attempt at intercourse years ago.

My initial thoughts were to start with finding and identifying helpful ego states that could assist Fear. I knew Jan had recently lost 80 pounds which for most people is a much more difficult task than having sexual intercourse, so I elicited the part of her that could tackle such a feat, and she termed this ego state “Determination.”

Although Determination was very helpful later in keeping Jan motivated with her sexual assignments and her sexual healing, she was no match for Fear, and Fear would not allow that boulder to budge.

In keeping with the ego state therapy principle that every ego state is important and has a purpose (Frederick & Phillips, 1995; Watkins & Watkins, 1997), I decided to align with Fear and validate her reason for existence. Fear was praised for the tremendous job she had done to protect Jan from what she thought would be pain. It was recommended that she keep up the excellent job of protecting Jan, and to stop Jan from proceeding with anything that “felt” like pain. It was important for Fear to maintain the sense of complete control, especially with the gynecological exam, and later with the
vaginal dilator therapy, which involves utilizing a set of four dilators resembling penises that increase in size.

Eventually Fear, coupled with Determination, allowed for the possibility of scheduling a gynecological exam to assist with diagnosis confirmation. Associational cues had been given hypnotically to help Jan get in touch with Determination, and all ego states were taught skills for relaxation and calmness. Fear was reminded to stop anything that “was” painful but had agreed to allow discomfort. Once Jan could tolerate and get through a hypnotic “imagined exam,” she felt strong enough to proceed with the scheduled appointment. The gynecologist confirmed that there were no physical abnormalities and that she also suspected vaginismus; a sexual disorder the DSM-IV (1994) characterizes by the “recurrent or persistent involuntary contraction of the perineal muscles surrounding of the outer third of the vagina when vaginal penetration with penis, finger, tampon, or speculum is attempted.”

Due to the negative images and messages Jan had about sex and her anatomy, along with her incredible fear of pain, she had completely shut out her sexual self. Once Fear realized she’d continue to be in control and was needed to protect Jan from pain, she was willing to allow for the exploration of the sexual self. Because she was deeply hidden, a hypnotic age regression was utilized to get Jan in touch with her. She envisioned a young maiden named “Monique.” Monique represented a part of her that was courageous and adventurous as well as romantic. She had picked this name as her French name years ago when participating in a foreign exchange program in France, and now it seemed “fitting” for her sexual self. Monique was then encouraged to have the sexual feelings and desire she was born with and was given many assignments to help encourage this in and out of trance.

When Jan would be discouraged, and didn’t think she could engage in the exercises or the dilator therapy, she was reminded that even if she couldn’t, Monique had the desire and courage, and the sexual will to see her through it. Monique’s courage and determination were reinforced and strengthened all throughout her treatment.

Slowly, Jan began to progress. First, by agreeing to watch the video, *Treating Vaginismus* (The Sinclair Institute, 1984) that demonstrated how to utilize the dilators. Once she was successful and skilled in progressive muscle relaxation, she was able to purchase and bring the dilators home with intent to use them “sometime.” She eventually was able to “touch” them and utilize them just to stroke her body. Fear was continually involved and Monique could only proceed as long as there was no pain. She eventually was able to use the dilators and before she even tried the fourth, she was engaging in sexual intercourse with her husband. She has also since experienced sexual pleasure, desire, and achieved orgasm.

Although ego-state therapy proved to be a necessary adjunct to deal with Jan’s fear and to rediscover her sexual self, many therapeutic strategies were employed, including education, ego strengthening, behavioral assignments, bibliotherapy, online anonymous support, progressive muscle relaxation, vaginal dilator therapy, marital therapy, and psychotropic medication.

**Case 2: Hypoactive Sexual Desire disorder**

Rhoda is a 48-year-old married woman who has struggled intermittently with depression most of her life. She and her spouse married late and had trouble conceiving,
but were eventually able to adopt three children. Her spouse is a farmer and she chose
to be a “stay at home mom.” She grew up in a farm family and is the youngest of eight,
all boys except for one sister. She was sexually abused by two of her brothers and
reports growing up in a “sterile and cold” environment.

Her faith has always been of huge importance to her and she felt accepted
within the church environment. In her early twenties a priest that she went to for
guidance sexually exploited her. She later ended up in a pattern of developing sexual
relationships with priests, most of which she initiated. Although she felt special because
of the nature of these relationships, she had an incredible amount of guilt with regards
to the sexual pleasure she experienced. Consequently, sexual encounters would
invariably leave her full of shame and in tears.

Rhoda had previously worked on her sexual abuse and spiritual exploitations
with another therapist. Although she found that therapy very helpful, it didn’t address
her current lack of sexual desire.

Theoretically, Rhoda appears to fall to the “far left” of the continuum. She
reports feeling like she’s lost her own identity and feels perpetually stuck in the role of
“mom or the farmer’s wife.” In other words, she’s been neglecting her other ego states
and possibly has lost touch with their existence, including her sexual self.

After hypnotically establishing a safe place that was accessible to Rhoda, we
began ego state therapy. At the first appearance of her sexual self, tears rolled down
Rhoda’s face. When asked if she could tell me what the tears were about, she reported
the following:

There are so many parts…that are just frightened little girls. An angry
and a judgmental one, and it’s like all the parts are …not all, but most
of the parts are so screwed up that I’ve lost that…the truth…I’ve lost
who the sexual me really is. It’s not clear because it’s been pulled and
distorted in so many ways…it’s not real anymore…it’s been bashed
in, pulled at, yelled at, and hurt so it’s lost all of the reality of it, it’s
lost the sense of the naturalness of it, its ah…

When asked, “Is it as if the sexual self can’t even be in the room?” she replied:

She’s there but she’s so beat up that she…It’s like she can’t really
take…its like she’s so beat up she can’t really get rid of that outer skin
and be the good natural um…ok part of her.

Once the ego states had been identified, they knew what they needed, and
appropriate suggestions were given to assist in meeting those needs. Internal helpers
were revealed and utilized as well as a “spirit guide” that the client called Mary. She
described Mary as someone God had sent her years ago to help her with spiritual
issues but indicated that Mary “was not a part of her,” that she was external.
Nonetheless, we still utilized her to assist with the frightened children, and Rhoda
found this very comforting.

Once the other ego states were tended to, the sexual self was free to experience
the “naturalness” of her sexuality; her sexual desire. She was able to envision herself
redeveloping her sexuality with healthy support and encouragement from other ego
states. Rhoda was then given therapeutic assignments such as reading and self-
pleasuring exercises to strengthen and encourage further development of her new found sexual self.

The dramatic transformation of this client’s sexual self was remarkably noted when revisiting the meeting room while hypnotized. Rhoda was asked, “What she sees now? ” Immediately, a beautiful smile came across her face as she replied:

I see a young girl about thirteen…she’s just becoming a teenager…just becoming fresh and new and she’s just…she’s got…she’s beautiful and she’s got energy and she’s got spirit and the others are crowding around her, and kind of saying…“Yeah! We’re so glad you’re here! Way to go girl! And welcome and your gonna have…your gonna do great things…your just gonna be incredible!” and she just feels so…um…welcomed and supported and um…part of the community and part of the group, um…it’s like um…it would be a whole group of women welcoming this new young woman…and she’s just saying you know, guide me and I’m ready…and the women are saying…“Welcome and yes…um…you are entering a new stage of your life and we’ll be here to support you and we’ll celebrate with you and um…help you in anyway that you need help and your gonna do great girl!”

Not only did the image of her sexual self change dramatically, but she also was able to get in touch with, and utilize the internal support that she was lacking in her external life. This, ultimately transpired into positive cognitive changes in her thoughts about sex, changes in her desire, and more positive and pleasurable feelings with sexual behavior.

**Discussion**

The objective of this paper was to demonstrate the value of healthy adaptive differentiation in the treatment of sexual disorders, especially for those that fall to the “far left” of the differentiation-dissociative continuum. The presented cases, although different in diagnosis, theoretically appeared to the “far left.” Neither was consciously aware of the sexual self that resided within, nor were they consciously aware of their own inner resources. By applying ego-state therapy principles and techniques, unconscious inner conflicts could be resolved and their sexual selves could be rediscovered.

Hypnosis coupled with ego-state therapy proved to be a valuable adjunct to the repertoire of sex therapy techniques utilized. The hypnotic reawakening or reuniting of the sexual self was experienced as a powerful shift within both clients. With that shift, came hope, healing, and obtainable sexual goals.

It should be noted that because this author works mostly with women, this paper focused primarily on the treatment of female sexual dysfunction; however the theoretical concepts and therapeutic applications suggested certainly could be applied to men as well.

Another point worth noting is the benefit of healthy adaptive differentiation for individuals that fall to the “far left” of the continuum that struggle with other clinical concerns besides sexual. For example, when applying ego-state therapy principles and
techniques to a woman that had little sense of who she was, other than her professional self, it was discovered that she had given up playing at the age of 5, after her 3-year-old brother drowned in the context of their play. Ego-state therapy helped her resolve related internal conflicts and reconnect with her “playful self,” thus beginning a process of achieving more balance between her professional and personal life.

Everyone has the freedom to be the person they are; however, if important valuable aspects of the entire self are consciously or unconsciously neglected, internal conflicts can interfere with living a well-balanced life. Hypnosis coupled with ego-state therapy proves to be an excellent resource in working to achieve that balance for those who have difficulty differentiating in an adaptive manner.

References


