Beyond Empathy: The Tree of Compassion With Malevolent Ego States

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Therapy with seriously dissociated patients requires the transformation and integration of malevolent ego states that produce a wide assortment of negative experiences and behaviors in the patient. During the course of therapy, they can present dangers to both patient and therapist, as well as to the therapeutic process (Watkins & Watkins, 1984). Perhaps the greatest challenges for therapists in this work are the development and the maintenance of empathy for these personality aspects. Without some degree of empathy, a healing therapeutic alliance cannot be formed, and absent a secure, healing, intersubjective experience, it is unlikely that malevolent ego states can undergo sufficient transformation for integration. Essential elements for developing and sustaining both the necessary empathy and the compassion, the altruistic activity that empathy engenders, are presented.

Keywords: dissociation, ego state, empathy, malevolent, therapeutic alliance

There are several approaches to psychotherapy that are polypsychic. They view the human mind as composed of separate parts or aspects of self. From this view, health is present when the parts (often called an internal family of selves) are functioning together in a harmonious and integrated way. Therapy with seriously dissociated patients who have malevolent ego states within their internal families can be challenging and frustrating for many therapists, regardless of their level of training. These destructive elements of the personality have potential for dangerous behaviors and lack the adequate right brain development that would allow them to possess socio-cognitive skills. These are parts that have no empathy for anyone, internally or externally. Their behaviors are often distasteful and sometimes dangerous. They can intimidate and distance therapists. It is understandable that therapists confronted with such energies would have great difficulty developing the empathy needed for adequate trance work and the formation of a therapeutic alliance.

This article will examine the nature and needs of malevolent ego states, the healing qualities of the therapeutic alliance, and the qualities essential for therapists who work with such difficult situations, especially those who use hypnosis. It also will survey

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empathy, its relationship to right brain development, trance, and intersubjectivity, as well as its healing qualities. Finally, it will turn to Aristotle's ethos/source credibility theory in an attempt to discover keys that can unlock solutions to the "empathy problem" in work with malevolent ego states.

Malevolent Ego States

Malevolent ego states (also known variously as destructive, perpetrator, demonic, and protector ego states or alters) are aspects of the personality that preside over a number of self-destructive behaviors such as suicide and homicide attempts, disturbances of mood and of cognition, somatic and somatiform illnesses, and disabling flashbacks. They are the source of many acting-out behaviors that can interfere with therapy at times. In the therapeutic process, they may attempt to intimidate both the patient and the therapist through threats as well as actual disturbing and destructive manifestations of their power. Patients commonly plead with their therapists to kill off these parts or to eject them from the body and the greater personality (Frederick, 2005; H. L. Schwartz, 2013; Watkins & Watkins, 1988). Beahrs (1985) associated them with the "not-me" of Sullivan (1953) and the Child-demon of Berne (1972), as well as with Lowen's (1967) demons and monsters. Patients with serious malevolent ego states are usually diagnosed with Dissociative Identity Disorder (DID; American Psychiatric Association, 2013).

The unifying function of these parts is their protection of the greater personality, and of fragile child parts, from dissociated, frightening, and destabilizing trauma material. Within the Internal Family Systems framework (R. C. Schwartz, 1995), they are identified as Managers or Firefighters. Like Watkins and Watkins (1997), R. C. Schwartz (1995) thinks their function is to protect child parts involved in trauma (which he terms Exiles) from the knowledge and experiences of their dissociated traumatic pasts. Many destructive ego states do not identify with their protective function. Indeed, they may deny it. Amnestic barriers can cause them to forget their origins or purposes, or to become diverted from them into the repeated, specific activities that have become their sole gratifications.

Watkins and Watkins (1988) believed them to be child parts themselves, albeit disguised, and they thought one of their important functions is to hold trauma-related, primitive rage for the entire internal family of personality energies (Frederick, 2005; R. C. Schwartz, 1995; Watkins & Watkins, 1979, 1997), thus allowing it to function. They held that these parts could undergo transformation and move to integration only after the rage had been released through abreaction. Like others (Beahrs, 1985; Blizard, 1997; Courtois & Ford, 2013; Cronin, Brand, & Mattanah, 2014; Frederick, 1996), they emphasized the important role of the therapeutic alliance in their treatment.

Blizard's Emphasis on Attachment Needs

Blizard (1997) noted that malevolent ego states are introjects of trauma perpetrators (Putnam, 1989; C. J. Ross, 1989). She emphasized their paradoxical nature: While formed to protect patients, they also harm and abuse them. She attributed this paradox to the need of children to maintain attachments with their caregivers, even though they may be traumatizers. Blizard's insights illuminate the need for the therapeutic alliance to survive the paradoxical relational maneuvers of the perpetrator part and persist in offering the possibility of a non-traumatizing, secure base (Bowlby, 1979, 1988).

Frederick's Typology

Frederick's (1996) sample script material emphasized attachment issues and ongoing communication and relationality with malevolent ego states. She attempted to understand more about the treatment needs of perpetrator ego states by categorizing them into three types.

1. **Functionaries**. These are parts that came to help the greater personality survive intolerable abuse and believe themselves to belong to the internal family of selves. They often perceive their roles as punishers the patient deserves. These beliefs are reflections of the traumatizer's attitude toward his/her victim.
2. **Janissaries**.[1] These parts were formed during coerced abuse (H. L. Schwartz, 2013). They do not believe that they belong to the greater personality of the patient. Instead, they are completely affiliated with the perpetrator(s), to whom they regard themselves as primarily attached and deeply connected, and for whom they have deep loyalties. Often they regard their purposes to be those of the perpetrator(s), and they are frequently involved in the persecution and internal abuse of other ego states. Other reasons they are particularly difficult to work with therapeutically are that often they are silent or concealed and also are under interdiction from the perpetrator to reveal their purposes or even the nature of the abuse. Frederick (1996) also described their ongoing fears of harm from the perpetrator(s) should they disobey instructions given years earlier. They also are burdened by significant attachment fears in the transference. Both their fears and their loyalties maintain their behaviors and entrench them into their identities.
3. **Daemons**. These are personality parts that are psychotic and delusional. They also no longer have accurate memory for their origins or purposes, and they tend to surround themselves with fabulous fables and pseudo-myths. They are parts that run amok within, for reasons that tender no rational explanations.

Frederick (1996) observed that identifying the type of the malevolent part present could assist in treatment greatly. She recommended that the therapist have a secure, containing,

and interactive relationship with every malevolent part. She empathized relationship, understanding, and cooperation within a phase-oriented treatment model, used direct and indirect ego-strengthening, and addressed transference fears early in treatment:

> The transference fears of the hostile ego states need to be addressed soon after the therapist is able to get in touch with such personality parts. Among the most common transference fears is the belief that the therapist wishes to annihilate the ... part. This fear is often connected with false beliefs about the nature of integration. Many ego states fear fusion and its accompanying loss of identity (Beahrs, 1985; Watkins & Watkins, 1988). Early explanations about the nature and goals of integration in terms of communication, empathy, and cooperation among ego states (Phillips & Frederick, 1995) can be extremely helpful to the therapeutic alliance. Other prevalent transference issues include the fear of re-traumatization by the therapist, fear of abandonment by the therapist, fear that the therapist will favor and side with other ego states, fear of being tricked or manipulated by the therapist, fear of loss of power to the therapist, and fear that cooperation with the therapist will lead, if not to annihilation, to a purposeless and boring existence. (p. 3)

Developmental Failures

Since therapy cannot be successful unless destructive ego states are able to be integrated into the greater personality (Beahrs, 1985; Blizard, 1997; Frederick, 1996, 2005; Kluft & Fine, 1993; Putnam, 1986; Ross, 1989; Watkins & Watkins, 1988, 1997), a number of issues may need resolution before this is possible. Attachment is the developmental issue that is most often discussed in the literature (Blizard, 1997; Frederick, 1996; Watkins & Watkins, 1988). However, other developmental factors are also salient. Frequently, malevolent ego states have failed brain development and do not possess a capacity for empathy or "state of mind" (the ability to identify with the position of another) (Baron-Cohen, 2011; McGilchrist, 2009). Schore (2003) reminds us that, additionally, this failure leads to a general failure in social cognition that is accompanied by misperceptions of others' intentions as well as one's very own bodily cues. Mentalization capacity (Allen & Fonagy, 2006) is poor and they may regress to part object representations. These ego states may also lack object permanence (Piaget, 1954) and/or object constancy (Mahler, 1968). Failed brain development and their psychological concomitants must undergo repair for these parts to become motivated to alter some of their behaviors (Baron-Cohen, 2011; McGilchrist, 2009; Schore, 2003, 2012).

In view of the many issues at play, therapists can have difficulty establishing an adequate therapeutic relationship through which transformation and integration can be facilitated. It is common for work with these personality parts to be rife both with therapist countertransference problems and therapy-interfering acting out (such as suicide attempts, substance abuse, promiscuous sexual behavior, or combativeness) on the part of the patient. Both can be hazardous for the patient, the therapist, or both (Comstock & Vickery, 1993; Putnam, 1989). In many ways, therapists can, at times, mirror the empathy and "state of mind" deficits of the malevolent ego states, and therapists may feel deskilled, hostile, indifferent, or even hopeless about their abilities

to facilitate change. Like the malevolent ego states, they also may find themselves repeating behaviors that yield nothing new. How are therapists able to develop and sustain the needed for work with personality parts that regard them as their enemies and with whom they sometimes countertransferentially identify? How can they develop empathy for parts that perceive them as enemies with whom they must struggle?

The Therapeutic Alliance

There is agreement, buttressed by robust research, that the formation of an adequate therapeutic alliance is essential for all effective therapy (Barber, Connolly, Crits-Christoph, Gladis, & Siqueland, 2000; Hilsenroth, Peters, & Ackerman, 2004; Konzag, Bandemer-Greulich, Bahrke, & Fikentscher, 2004; Lorentzen, Sexton, & Høglend, 2004; Miller, 2004; Shedler, 2010). Moreover, the maintenance and repair necessary to protect that alliance from deterioration over the course of therapy is equally critical (Barber et al., 2000; Luborsky, 1993; Safran, Crocker, McMain, & Murray, 1990). Although there has been historical development of models of the therapeutic alliance, and many models exist (Atwood & Stolorow, 1984; Frederick & McNeal, 1999; Meissner, 1996; Watkins, 1978), Cronin et al. (2014) have noted that there is evidence that most therapists are able to agree on three elements present in every alliance (D. J. Martin, Garske, & Davis, 2000). They are (1) an "affective bond," (2) agreement on certain common goals, and (3) agreement about therapeutic tasks. They also referenced the value that clinicians place on the positive effect of certain personal qualities of the therapist (Laska, Smith, Wislocki, Minami, & Wampold, 2013).

Cronin et al. (2014) have surveyed the literature concerning the effects of the therapeutic alliance in trauma and dissociative disorder populations. Strong therapeutic alliances have been found to be associated with outcome improvement in abuse survivors (Cloitre, Stovall-McClough, Miranda, & Chemtob, 2004; Paivio & Patterson, 1999; Price, Hilsenroth, Callahan, Petretic-Jackson, & Bonge, 2004). Further, as we look to the population within which malevolent ego states are commonly found, the dissociative disorders (C. A. Ross, Norton, & Wozney, 1989), a robust validation of the connection between patients' very positive perceptions of their therapeutic alliances and positive treatment responses, have been identified in a significant population sample ($N = 132$; Cronin et al., 2014).

Since Freud (Breuer & Freud, 1893–1895/1961) identified collaboration as a necessary factor in therapeutic work, there have been many changes in the way we conceptualize the therapeutic alliance (Atwood & Stolorow, 1984; Frederick & McNeal, 1999; Meissner, 1996; Mitchell, 2010; Ogden, 1997, 2004; Stolorow, 2011). Much of this change is based on radical shifts in philosophical thinking (Hageman & Frederick, 2014; Osoweic, 2014), from post-Cartesian and Kantian perspectives to phenomenology's rejection of the concept of an attainable knowledge of "reality." This has been accompanied by movement from the highly individualistic views of human perception

and motivation, to the interpersonal or relational, and even to more community-oriented perspectives (Rosemont, 2015). The thoughts, feelings, sensations, and behaviors of the contemporary therapist are thought to exist with those of the patient inside a vast interactional field that is conceptualized as having a life of its own. It has been called "the analytic third" (Ogden, 1994, 2004). The preponderance of this intersubjective field (Atwood & Stolorow, 1984; Stolorow, Brandschaft, & Atwood, 1983) is unconscious.

Therapist Qualities and Skills Essential to the Formation of the Therapeutic Alliance

Frederick and McNeal (1999) examined the therapeutic alliance, and concluded that "The personhood of the therapist is an important key to the degree he may be able to succeed in his endeavors" (p. 3). They agreed with Diamond (1984) that therapy facilitated by hypnosis was dependent on "an interactional hypnotherapeutic relationship." Although Diamond believed the skill of the therapist determined his/her ability to develop and maintain this relationship, it appears that some of his requirements are not necessarily skills-related. Instead they involve such adult capacities as brain anatomy and function, levels of intrapsychic development, relationship abilities, and so forth. For Diamond, the therapist needs a plenitude of abilities, as well as other internal resources (Erickson & Rossi, 1976). Diamond (1986) compared the therapist who has these internal resources, together with excellent skills in inducing and working with trance, with Milton Erickson, in that he/she unconsciously creates/offers a special holding environment for the patient. This is a shared internal space of safety, boundaries, containment, and secure attachment. His criteria for the effective therapist include sufficient maturation of relationship abilities and object relations development, as well as various integrative functions, and tolerance for deep levels of human interaction. Another quality Diamond deemed essential for effective therapists is the capacity for empathy.

Empathy

Empathy is a universal response in humans that is associated with both mirror neuron (Rizzolatti & Craighero, 2004; Rizzolatti, Fadiga, Fogasi, & Gallese, 1999) and spindle neuron (von Economo neurons) (Cauda, Geminiani, & Vercelli, 2014) activity in humans, certain other mammals (Frans & de Waal, 2008), and some birds (Fraser & Bugynar, 1991; Rizzolatti et al., 1999). It is thought to be connected with a vast array of socio-cognitive skills, including communication (Baron-Cohen, 2011). Wickramasekera II (2015) has theorized that it is the essential element of hypnosis. His empathic involvement theory (EIT) proposes that all hypnotic phenomena are "inherently characterized by their deep involvement with processes of empathy and the self" (p. 330). His comprehensive approach combines detailed evidence from psychological and

neuroscience research and presents a view of vast interconnectedness among empathy, selfhood, relationality, intersubjectivity, and trance.

Empathy is usually classified as cognitive (Gerace, Day, Casey, & Mohr, 2013) or affective (emotional) (Frans & de Waal, 2008). The brain provides us with both modes for understanding our fellow beings (Baron-Cohen, 2011; Cox et al., 2012), and each has specific usefulness. The cognitive mode is less physically and emotionally exhausting. It provides a greater contextual appraisal of what has caused distress (Frans & de Waal, 2008). It is emotional empathy, however, that is the primary response. de Waal (2003, 2005, 2008); Frans and de Waal (2008) examined occurrences of empathic behaviors in both nature and in the laboratory. Also, they conducted an extensive review of ethological studies. They concluded that the primary emotional empathic response triggers altruism. The companion cognitive reflection, although secondary, helps with the creation of reasonable perspectives and assists in targeting altruism so as to make it truly helpful. Targeted altruism, also termed compassion within this theoretical framework, is a translation of the empathic response into helpful action. There is evidence that compassion produces stress reduction in mammals, such as chimpanzees (Fraser, Stahl, & Aureli, 2008) and mice (L. J. Martin et al., 2015). This suggests that when the skilled and able therapist is able to translate empathy into compassionate action manifested as effective therapeutic activity, he/she may experience stress reduction.

Many studies contribute to our understanding of the brain's essential roles in components of what we think of as social consciousness. These include empathy, relationality, intersubjectivity, and identification with others (Decety & Chaminade, 2003; McGilchrist, 2009). Empathy develops in childhood (Baron-Cohen, 2011; McGilchrist, 2009) and is associated with "theory of mind," "a capacity to put oneself into another's position and see what is going on in that person's mind" (McGilchrist, 2009, p. 57). This capacity is fully acquired by children by the time they are 4 years old.

Developing and Maintaining Empathy and Compassion With Malevolent Ego States

"Empathy means to share, to experience the feelings of another human being" (Greenson, 1967, p. 368). Regardless of theoretical orientation, most clinicians agree with Rogers (1975) that empathy is essential for successful psychotherapy. Certain principles, when followed by therapists trained and experienced in the treatment of dissociative disorders, can activate/create and maintain empathy in the therapist. Empathy inexorably draws the therapist into altruistic activity. For therapists, that activity consists of skilled therapeutic interventions that lead to transformation, and eventually to integration of malevolent ego states.

The Principles of Therapeutic Engagement

There are several elements that interact in numerous ways as therapy proceeds. Although they will be presented in a linear fashion here, their interaction is complex, predominantly unconscious, non-linear, and dynamic. Much is omitted here, including the need for ongoing evaluation for safety of therapist and patient, the training requirements for therapists who do this kind of work, the benefits and hazards of counter-transference, the need for a phase-oriented treatment framework, and the critical need for therapists engaged in therapy with malevolent ego states to be well trained and experienced (Frederick & McNeal, 1999; Phillips & Frederick, 1995; Frederick, 2005).

1. **Always act with goodwill**. The most pressing concern for the therapist is that of credibility. Malevolent parts have no reason to believe anything good can come from communicating with a therapist, let alone entering into a cooperative relationship with him/her. As it is the therapist's task to persuade these parts otherwise, McCroskey and Teven (1999) noted that the same principles used by Aristotle for persuasive communication apply today. Aristotle believed that credibility in the eyes of another depended on the image the other had of him/her, and he named the presentation or image of the self when conducting persuasive communication, the *ethos* (Cooper, 1932). According to Aristotle, *intelligence, character*, and *goodwill* were the three necessary elements of the ethos (Cooper, 1932; McCroskey, 1992; McCroskey & Teven, 1999).

McCroskey and Teven's (1999) analysis of the communications science literature on the ethos/source credibility construct notes various "updates" of Aristotle's terms for the elements of the *ethos* and numerous research attempts to quantify them. However, they were impressed that *goodwill* seemed to have vanished from consideration. They defined it as the "'intent toward the receiver'" and described it as "the 'lost dimension'" (p. 90). McCroskey (1992) had identified "perceived caring" as an integral factor in *goodwill*, as it had been clear to him that receivers of persuasive efforts would view someone who had their best interests at heart to be more credible than others. From his and McCroskey and Teven's (1999) perspective, *goodwill* deepened and broadened *understanding, empath*y, and *responsiveness*. They also maintained that reciprocally, the exercise of the three Aristotelian elements increased perceptions of the communicator as caring.

McCroskey and Teven (1999) were able to corroborate with robust results Teven and McCroskey's (1997) pilot study with teachers and students, demonstrating that *goodwill*, or perceived caring by the communicator, was a strong predictor of the receiver's perception of the persuasive communicator as credible, trustworthy, and competent. The clinical implications of this research within the field of communications (McCroskey, 1992; McCroskey & Teven, 1999) has great implications for the field of psychotherapy in general and work with hostile ego states in particular. Goodwill cannot be manufactured. Although its definition is based on the subject's perception, it springs naturally from the therapist's usual inclination

to be helpful to the other (Norcross, 2002). The feigning of *goodwill* can often be a manifestation of therapist anxiety as he/she approaches malevolent ego states. This anxiety alienates him/her from natural emotions and expressions, and substitutes inadequate cognitive attempts to supply what is needed. It will usually be identified as counterfeit by patients, should it fail to be genuine.

It is helpful for the therapist to prepare for the session by reviewing, mentally, the nature of these beleaguered parts and the reasons for their suffering. Such a review will create cognitive empathy within the therapist and will dampen down reactive therapist anger, judgmentalism, competitiveness, and over-identification with other parts that are being harmed by malevolent ego states. Although the therapist may not have developed affective empathy as yet, he/she can begin with communications that reflect cognitive empathy. These may be direct or indirect. The patient may be in formal trance for the kinds of interventions that follow, but it is not a necessary condition for the therapist to "talk through" the greater personality of the patient (Frederick, 2005) to the part(s). This kind of therapist involvement, however, leads often to interactive trance states, and it is not unusual for the patient to enter trance as the therapist proceeds.

> I understand there is no reason for you to trust me. After all, you don't even know me, and I have the impression that you have many reasons for not trusting almost anyone at all.
>
> But this is something that might help us learn to understand one another. I encourage you to watch me, to listen to me, really very closely so that you can decide for yourself whether I am like the people who hurt [name of greater personality].

This kind of display may well produce some complementary empathic response in the part that could be the beginning of some kind of trance activity (Wickramaserkera, 2015).

2. **Communicate persistently**. Communication is the true path in this work, and like empathy, it activates the social brain. Therapists who succeed in working with malevolent ego states are active in both direct and indirect communication. Direct communication to silent, non-participating parts includes psychoeducation about the nature of the internal family of parts, or self-energies, and the importance of every part. A response, let alone a true dialogue, may not develop for some time, and the value of tenacity in reaching out to these parts cannot be overemphasized. Ideomotor signals may help establish a two way communication within which parts can communicate when they are unable yet to utilize speech. There appears to be a direct relationship between the therapist's untiring attempts at communication and the development of therapist empathy. This reaching out to frightening parts that conduct reprehensible activities, with simple and concrete education, has the additional value of placing the therapist in touch with parts' childlike aspects. It also fosters the development of empathy. As the therapist begins to describe to the ego state what he/she surmises about it: childhood betrayals, trauma, and neglect; as the therapist addresses some of the

unspoken transference fears, he/she will begin to move from purely cognitive empathy into the early development of affective empathy into the situation.

3. **Address transference fears early**. As the therapist reaches out, certain transference fears will be addressed explicitly (Frederick, 1996), and the use of ideo-motor signaling may be the beginning of hidden ego states' participation in communication. Questions and statements like these are meaningful:

It must be scary for you to communicate with me at all. . . . I can understand that, you know . . . it would be for anyone who has been through what Jimmy (the greater personality) has. . . . After all, you don't know whether I might want to get rid of you. It is very brave of you to talk to me at all . . . perhaps you're afraid I want to harm you in other ways.

I know Jimmy said he wants me to get rid of you. . . . I told him that's not right, that I don't get rid of parts, because every part is important, just as important as every other part . . . the other thing is that you have some wonderful qualities that the other parts need . . . you are very powerful, you know.

The use of statements, for example, that reflect the therapist's understanding of and cognitive empathy for the part's fears kindles greater empathy within the therapist who is actually addressing these fears verbally and interactively.

1. **Always repair identified empathic failures**. Therapists are not perfect. We are subject to misperception, failures in awareness, narcissistic preoccupations, and countertransference interference. We also are affected by our lives outside the consultation room. Every therapist has a bad day once in a while. Additionally, all human relationships are imperfect. As we are able to identify our empathic failures and openly work on their repair (Safran et al., 1990) with malevolent ego states, we bring even more *goodwill* into the therapeutic milieu.

2. **Use trance and interactive trance states**. Interactive trance has been defined as a situation in which the therapist has ongoing communication with the patient who is in trance, and solicits both conscious and unconscious feedback (Hammond, 1990).

However, there is another tradition of interactional (also known as interpersonal) trance that comes from the Ericksonan tradition (Gilligan, 1987; Yapko, 1990) of setting aside the therapist's role of authority in favor of fostering a more equal therapeutic relationship. According to Yapko (1990), "hypnosis is considered a natural outcome of a relationship in which each participant is responsive to the following and leading of the other" (p. 76). Therapists who use interactive trance in their work with patients suffering from trauma and dissociative problems (Frederick & McNeal, 1999; Frederick, 2005; Phillips, 1994; Phillips & Frederick, 1995) affirm their connection with the Ericksonian tradition as they maintain that the deeper state of mind produced by hypnosis in mutual trance makes unconscious resources more available to both patient and therapist, and strengthens the therapeutic alliance (Brown & Fromm, 1986; Gilligan, 1987; Yapko,

1990). They specifically agree with Erickson and Kubie (1940) that unconscious interaction is the primary force in therapy. On a conscious level as well, this trance state places the therapist more deeply in touch with the intersubjective field, where there is greater apprehension of the part's terror, rage, and compromised developmental level. Interactive trance has the potential for increasing empathy in both the therapist and the malevolent ego state because in it, the therapist is able to place his/her own self aside and experience, consciously and unconsciously, what it is like to be the other. This leads to diminution of fear on both sides. The less the part is experienced as alien by the therapist, the greater the opportunity for the therapist's empathy for the part and its dilemmas to grow. Empathy becomes a two way street, as greater interpsychic closeness with its increased mutual understanding and decreasing mutual fears, allows the part to begin to cooperate with someone it is learning can be trusted.

1. **Learn from the intersubjective field**. Very early in this process, the therapist and the malevolent ego state have entered a deep intersubjective relationship (Atwood & Stolorow, 1986; Ogden, 1997, 2004). In a sense, the verbal therapeutic interventions can be compared with the lyrics of a song. The intersubjective relationship is the music; complex and consisting of many elements. This relationship extends the empathic triggering of the altruistic therapeutic activity known as compassion into a deep healing "I–Thou" relationship (Buber, 1937), in which empathy and action are intimately entwined. In this field, the therapist becomes intimately involved with the fears, wishes, thoughts, and urges of the malevolent ego state. Its sufferings become the therapist's via the intersubjective field, which manifests itself in many ways including affect, behaviors, sensory phenomena, and dreams. As the therapist is increasingly experiencing and understanding what it is to be the patient, empathy grows. The use of the Countertransference Trance (Frederick, 2005; Phillips, 1994) increases access to intersubjective information. This is a trance state which the therapist may choose to enter during the therapeutic session in order to gain experiential information about his/her countertransference involvement (images, affects, thoughts, etc.). Gilligan (1987) has noted long traditions across many schools of psychotherapy for the therapist to choose to enter trance during the therapeutic session and cites Freud, Rogers, and Asante as standing in relationship to Erickson's interpersonal hypnotic orientation. He created formal directions (Gilligan, 1987, pp. 76–78) for therapists to enter "... an *externally oriented interpersonal trance state*" (p. 76). Phillips (1994), and Frederick (2005), created their own versions of scripts modified from Gilligan's (1987) script. Although this trance yields information about the therapist, its greater usefulness is usually the increased understanding of the patient that emerges. Gilligan (1987) observed that this interpersonal trance state increases therapist responsiveness and amplifies empathy.

2. **Become a model for empathy and mentalization for the entire internal family**. The development of both kinds of empathy by the therapist is essential for the other members of the internal family, including victim parts. It allows them to learn how to develop cognitive empathy by observing the therapist. Integration is always defined in terms of relationality. Frederick and McNeal (1999) emphasized the need for empathy to be extended to every member of the patient's internal family. As the therapist works to develop relationships with malevolent ego states, he/she is also explaining to the rest of the internal family what these problem parts are all about, what they are trying to accomplish, how they got that way, and so forth. Deepening of the therapist's empathy models for the other parts and usually their own empathy will lead them onto compassionate activity as well. The good therapist is working with the entire system, helping it as a whole to become more empathic, more compassionate, and more altruistic. As its members model empathy, their sense of containment within a secure base increases.

Discussion

It is goodwill, the natural inclination to have caring intentions toward the other, tethered to a positive vision for the outcome of the therapeutic process that allows increasing empathic connection within the skillful and able therapist's vision of the part's sufferings and dilemmas. Even if the conversations are one sided, the therapist with goodwill can adapt to the process, much as one would to the hard work of climbing a mountain. With this repetitive, scarcely rewarding work, empathy increases. Because of their innate adaptive natures, most malevolent ego states will eventually respond. This is especially true when the therapist demonstrates understanding of parts' needs and speaks to countertransference fears. While therapist tenacity slowly establishes a secure base of therapeutic containment, it also ignites hope and the risk-taking behaviors of ego state communication and early cooperation. The ongoing goodwill creates a time and place of containment, safety, and secure attachment. Out of all this a therapeutic alliance emerges, and with its development, affective empathy and healing trance states grow. Empathic failures will occur, but their repair increases nurturing and empathy. Increased empathy leads to stronger dedication to identifying and resolving problems. This is the fruit of compassion, and the healing skillful activity engendered biologically and psychologically by empathy, the essential ingredient. Although *goodwill* may be the key to the engaging the therapist's growing empathy, empathy is increased and maintained by many factors such as trance, alliance, and intersubjectivity. It is both the catalyst and the inevitable binding of all therapy, holding it together as it unfolds.

Note

1. Janissaries were the elite troops of the 14th-century Turkish Sultan, who were fiercely and fanatically loyal to carrying out his wishes. They were reputedly the children of Muslim fathers and Christian mothers, and were slaves.

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