CLINICAL Q&A

How to Use Fraser's Dissociative Table Technique to Access and Work With Emotional Parts of the Personality

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This Clinical Q&A article responds to a question about what process to use to access and identify ego states when working with complex trauma. The procedure for implementing Fraser's Dissociative Table Technique is explained and detailed in 8 clearly defined steps. The author builds on Fraser's original instructions and adds several innovations for use by EMDR therapists. Tips on implementing this technique are given. The article then concludes with a session transcript to illustrate the use of this powerful tool.

Keywords: eye movement desensitization and reprocessing (EMDR); emotional part of the personality (EP); apparently normal part of the personality (ANP); dissociative table; meeting place

Question: I have read about the importance of working with ego states when working with complex trauma. Is there a process that is best used to identify ego states? If so, what is this process and how do I use it?

ANSWER:

Identifying and working with emotional parts (EPs; van der Hart, Nijenhuis, & Steele, 2006) of the personality is essential when working with complex trauma and dissociation. EPs of the personality are like isolated neural networks carrying the maladaptively stored information. These EPs live in "trauma time." When they are activated, they experience the affect, negative cognitions, behaviors, thought processes, action urges, and so forth, which are stored in the unhealed traumas and typically are not correctly time oriented early in treatment. These EPs contribute to the client's instability and repetition of the maladaptive behaviors and self-beliefs. Gaining access, identifying, communicating and working with these parts are necessary in preparation for effective trauma reprocessing.

An easy yet profound way to identify these parts of the personality is a process called Fraser's Dissociative Table Technique (Fraser 1991, 2003). This technique is a must-have tool for clinicians working with complex trauma. It is a tool that needs to be used within the larger framework of a phase-oriented approach to the treatment of complex trauma and dissociation. The use of this tool requires that the clinician is knowledgeable in the treatment of dissociative disorders (Fraser, 1991, 2003; Paulsen, 2009). If you are new to working with internal parts of the personality and dissociation, it is essential that you receive training and consultation from a clinician experienced with this technique as well as the diagnosis and treatment of dissociative disorders. Using this technique too soon with some clients with significant dissociative disorders, particularly dissociative identity disorder, can be problematic. Getting good supervision while working with this population cannot be emphasized enough.

There are eight steps to this technique. I will detail these steps with specific instructions and give you tips on implementing them.

The most common place an eye movement desensitization and reprocessing (EMDR) clinician will introduce Fraser's dissociative table technique is in Phase 2 of the EMDR standard protocol. In this preparation phase for trauma reprocessing, the dissociative table helps stabilize the client by organizing and making sense of the internal experience. As parts of the

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personality are accessed and identified, the work to help them understand their roles, functions, interrelationships, and so forth helps the adult part of the personality (apparently normal part or ANP; van der Hart et al., 2006) gain more understanding and compassion for these EPs. Time-orientation techniques are frequently used at the table, which contributes to more stabilization. This preparation work at the dissociative table makes Phase 4 trauma reprocessing go more efficiently.

If the table was not introduced in Phase 2, sometimes it will be introduced when Phase 4 trauma reprocessing has been hijacked by an emotional part outside the window of tolerance. No integration of traumatic material can happen when the client is hypoaroused or hyperaroused. Gaining access to the emotional part(s) under this condition can help the clinician assess the situation and work directly with the part(s) who needs the stabilization work before returning to the trauma reprocessing.

Once the table has been introduced, it can be used to help close down incomplete sessions and to check in with the internal experience at the beginning of the next session. The table can be a place to negotiate among the parts regarding what will be worked on in the session, what parts need to be present for that work, and identify necessary stabilization needs. For example, a common question that is asked at the table before returning to Phase 4 trauma reprocessing is, "What will be helpful for you to remember that this is a memory that we are working on and it is not happening now?"

The dissociative table is an 8-step process. Here are the steps:

Step 1: Psychoeducation and introduction

To start, educate the client on the process. The introduction can normalize the fact that people have "parts." This does not mean that people with parts have a significant dissociative disorder. Do not make the mistake of diagnosing someone with a significant dissociative disorder if parts are identified in this process. This is not a screening tool for dissociation; this is a tool to identify and communicate with unhealed fragments of self that are still locked in "trauma time."

A typical script to educate and introduce the client to the process is

we need to find a way to communicate with all the various aspects of you. Everyone has "parts" or "facets" of self. These parts vie for airtime and contribute to the conflicting feelings and chronic struggles that you have. You've heard the language: "One part of me feels sad and another part feels mad" or "On one hand I want this but on the other hand I want that." This does not mean you have multiple personalities. It just means you have conflicting internal experiences. It will be helpful to identify these various factions of yourself to help us resolve the issues you want to resolve. Are you willing to give it a try?

Step 2: Establish that your client can visualize

Fraser states that people who cannot visualize cannot do this technique (personal communication, G. A. Fraser, October 30, 2009). Most people are visualizers but you will come across a few who aren't. If you have already developed and installed safe place, you know your client is a visualizer so this step is complete. If you have not installed safe place or other imagining skills to calm and stabilize, take the time to do this. If your client cannot visualize, you must alter the rest of this technique by eliminating all instructions to visualize and replace them with instructions to list the various aspects of self.

Step 3: Get your client in a calm state

Fraser did not list this as a separate step in his articles (Fraser, 1991, 2003). He only explained the previous step to assess that your client can visualize by using imagination to calm. If successful, then the client entered a calm state. EMDR clinicians are trained in the EMDR Basic Training to administer the safe place technique in Phase 2 of the EMDR standard protocol (Shapiro, 2001). Therefore, EMDR clinicians develop and install a safe place with their clients early in treatment. I recommend this is done before considering the dissociative table with a client. Clinicians need to know their client can calm and get themselves out of disturbance to help them assess when the client is ready for the dissociative table. This also establishes that the client can visualize, thus completing Step 2 of Fraser's dissociative table technique. So, when it is time to do the dissociative table, Step 2 has already been accomplished. But it is still necessary to get your client into a calm state so I have added this as a separate step. Simply ask your client to go to the safe place imagery, take a few calming breaths or use another calming skill the client likes. An internal calm state decreases the adult part's (ANP) resistance to the EPs and increases the EPs' willingness to participate and become present. If the client is activated into dysfunctionally stored material, this technique will be harder to implement as fewer parts may be willing to come to the table. You will have to work to deactivate the distress before you can return to identifying the parts.

Step 4: Develop the table/meeting place imagery

Fraser uses instructions to develop imagery of an internal table. The instructions are

> *now I'd like you to leave your calm place and imagine a room with a table in it. This room is pleasant where no harm can come to you. The table in this room is a special table. It can be as big or small as you need, with just the right number of chairs. When you have this image of the table, let me know.*

Some clients may be triggered by images of a table. If you are concerned about this, make the instructions more general and call it a meeting place. This is a deviation from Fraser's instructions but I have found this to be quite useful in some cases. A suggested script is

> *now I'd like you to leave your calm place and imagine a meeting place where all the various aspects of yourself can come and gather. Create this meeting place so it is pleasant and comfortable. This meeting place has just the right amount of sitting places. When you have this meeting place in your mind, let me know.*

It is not advisable to combine the client's safe place imagery with the imagery of the dissociative table/meeting place. Clients with complex trauma typically need more calming skills and although the dissociative table is usually stabilizing, many tough issues will be addressed at the table/meeting place. It's important to not contaminate safe place so the client can still rely on the safe place skill when needed.

Step 5: Vivify the imagery

This step is another addition I have made to Fraser's directions. EMDR clinicians are trained when developing and installing safe place with their clients to vivify the image and make sure the imagery will not be easily contaminated by maladaptively stored information. I have found this process to be invaluable when developing the dissociative table with clients. I simply ask the client to describe the imagery and "is it a 'new to you table/meeting place'?" I want to confirm they have the imagery and that it does not incorporate images of a table/meeting place that is associated with unpleasant memories. For example, if the imagery is the conference room at work where harassment happened or the kitchen table where childhood abuse happened in the client's history, ask your client to develop new imagery that is more neutral. The same is applicable if the meeting place imagery incorporates the previously installed safe place imagery used for calming. Ask the client to develop a separate image to keep safe place imagery available for calming.

Step 6: Instruct the adult part of self to enter the imagery and take his or her place

Ask the adult part of self to imagine going into the room and take his or her place at the table. A typical script is

> *now I want you to imagine going into this room and take your place at the table. When you are settled in, let me know.*

If you are using the concept of a meeting place instead of a table, a suggested script is

> *now I want you to imagine going into this meeting place. Find just the right place for you. When you are settled in, let me know.*

Clinicians have asked why don't we instruct the client to take a place at the head of the table. I think this is too directive, and it may be inserting the clinician's ideas on how the table should be "set" rather than letting the client set the table in a way that represents his or her own internal experience. The raw clinical data on where the ANP sits in relation to the EPs is valuable information. It is better to leave the instructions open ended so the client can have his or her own authentic experience.

Step 7: Invite the emotional parts to enter the imagery

A typical script is

> *now I want you to invite all the various aspects or parts of yourself to come into this room (or meeting place) and take their places. Watch them as they come in. If they can't come to the table, perhaps they come to the side of the room or to an adjoining room (or meeting place). When they are all there, tell me who and what you see.*

The phrase "who and what" you see is my addition to Fraser's instructions. I have found this invaluable because, with complex trauma, there can be EPs that are not human. There may be shadows, aliens, animals, monsters, black holes, fog, demons, colors, flashes, and so forth. The mind is creative in its need to manage overwhelming material. Asking for "who and what you see" gives permission to disclose those parts of self that might otherwise be overlooked.

Step 8: Gather the clinical information

Begin gathering the clinical information on (a) who is there; (b) names; (c) functions; (d) ages; (e) alliances and phobias among and between them; (f) degree

of time orientation; (g) degree of coconsciousness among the parts, and so forth. Take notes. You will need to remember names and ages for attunement purposes. Some clinicians draw the table/meeting place on their notepad and place the names and information about the parts around the table in the order that represents the description given by the client. Some clinicians put this on a whiteboard and take a digital picture for placement in the client's chart. Some clinicians use sandtrays or other therapy aids to help the client communicate this clinical information. It is like an internal family meeting. Use your family therapy skills.

Fraser was trained in ego state therapy and hypnosis. He detailed numerous hypnotic techniques to use at the table to help the various EPs remain stable. Some of these techniques are the use of containers, projective screens, spotlights to facilitate communication, and so forth. You can consult his articles for more details.

Here are a few more tips I have learned through my own implementation of this technique and providing consultation to many clinicians doing the same. First, in the introduction, do not give your client examples of other people's parts or what their parts might be. This is not the time to suggest that they might have a little child and an angry teenager. You want your client to have an authentic exploration of his or her own internal experience. These clients can feel "crazy" and if you organize this "craziness" for them, they may feel relieved that they are not "that crazy" and conform to your list of parts rather than explore their own unique internal landscape.

The first time you administer the dissociative table technique with a particular client may not successfully identify emotional parts of the personality. If this happens, evaluate the reasons. Perhaps you suggested what parts might be at the table in your introduction, which limited your client's ability to turn inward and have an authentic exploration. Another reason may be the client's resistance to accessing this information. This is more often the case. If this is true, then return to other stabilization strategies and reintroduce the table when you think your client is more ready. Sometimes a client is so shut down to his or her internal experience or so phobic to it that the table will not work until more stabilization is present.

In cases of significant dissociative disorders (depersonalization disorder [DD], dissociative disorder not otherwise specified [DDNOS], and dissociative identity disorder [DID]), not all EPs will come present the first time you do this table. This is not a statement of your skill. This is a statement of the degree of resistances and phobias among the parts (van der Hart et al., 2006). As more stabilization occurs, more parts will become present. Be sure to get consultation on these cases from someone experienced with this population.

The imagery of the table may change over time. Likewise, who is at the table may change over time as more coconsciousness is developed or when the parts integrate. I have clients who have gradually changed their imagery of a table to meetings in a garden, snuggled in a warm giant bed, outside in a gorgeous meadow, a bench under a tree, and so forth. The imagery is not clinically significant. The shifts and changes that symbolize more stabilization and integration or more destabilization and fragmentation are clinically significant.

Some clients will bring representations of loved ones from their external life to the table. For example, parents, grandparents, and/or spouses and children. Sometimes a client will place the clinician at the table. If these representations are stabilizing, that is fine. However, the clinician needs to carefully watch all the internal parts' reactions to these representations. Sometimes these representations are resources for stabilization and are not part of the defensive action system (van der Hart et al., 2006). Sometimes these representations are introjects of abusive family members or other perpetrators and therefore come from the defensive system and are EPs of the personality, sometimes called protector, persecutory or perpetrator-imitator parts. All parts need to be welcomed but the resource parts don't need the treatment that the EPs need.

Sometimes a client will only bring his or her external loved ones to the table. If this happens, assess why. Perhaps your client did not understand the introduction. Perhaps your client is too phobic for this strategy at this time. If you think it is the former reason, then reintroduce the table and ask the client to go back inside to see if there are facets of one's internal self that can come present. Again, do not give examples of what parts may be there. If the client cannot access internal EPs, then cease using this strategy until a later time when you think it is clinically appropriate.

Clinicians often ask if dual attention stimulation is used in this process. I do not use dual attention stimulation in the process of setting the table. However, I use dual attention stimuli after the table has been established to install resources and treatment gains. Examples of treatment gains are more compassion toward a part; the development of tolerable coconsciousness, empathy and cooperation between parts; establishment of correct time orientation; a reduction

in arousal; an understanding that a despised part was created by the entire personality to help manage the traumatic material; an insight or adaptive information linking in, and so forth. Under these conditions, the dual attention stimuli is similar to the slower and fewer number of passes and sets used in resource development and installation. The goal is to highlight or install the treatment gain rather than begin to reprocess the maladaptively stored information.

Administering this technique will feel awkward the first few times you do this especially if you are not already skilled in working with EPs. Your comfort level will increase the more you use it. And, remember to get consultation on your work with all clients but particularly with clients with a significant dissociative disorder. There is so much information to keep track of and so many ways the treatment can go awry. Working with a consultant who specializes with these disorders is a must.

Transcript of a Dissociative Table

The following is a transcript of a dissociative table with a male client. You will note that all communication with the EPs is through the ANP of the personality. The EPs do not have executive control, thus the need to talk through the ANP. Comments reflecting the therapist's thoughts are in italics. Please note that the clinician is always watchful of the window of tolerance and works to keep all parts inside that window to maintain stability.

Therapist: Would you be willing to experiment with finding a way to communicate with the different parts of yourself? I know you don't have what is called a multiple personality. But we all have different facets of ourselves. I'm sure you know the phrase "on one hand I feel this; on the other hand I feel that." Or "one part of me wants to do this, but another part of me is screaming no." Or "one part of me is sad and another part of me hates being sad." We all have these different facets or fragments. Having the ability to talk and negotiate with these parts can be very helpful. Are you willing to experiment? (*This completes Step 1.*)

Client: Yes.

Therapist: OK. Let's begin. (*Safe Place had previously been installed so I knew this client can visualize, completing Step 2.*) I want you to take a few breaths just to bring yourself into a more calm and relaxed state. (*I watched the calming take place. It was quite apparent. Step 3 is now complete.*) Good. Now, I want you to imagine a special room. The room is pleasant and no harm can come to you in this room. In this room is a special table. This table can be as big or small as you need it to be, with as few or as many chairs as necessary. When you have the image of this room with a table, let me know. (*Step 4*)

Client: OK

Therapist: Can you describe this image to me? *(I want to make sure the client has the image and that this is a table that will not be contaminated by maladaptively stored information. Step 5)*

Client: Yes. It is a big conference room. The table is in the middle with lots of space to walk around it. There aren't many chairs there.

Therapist: Is this a new-to-you table?

Client: Yes. I have never seen this table before. It's like a big legal board room.

Therapist: Good. Now let yourself go into this room and find just the right place for you to sit and settle in. Take your place. Nod when you are there. (*Step 6*)

(After about 20 seconds, client nods.)

Therapist: Yes. Now I want you to invite all the various parts of yourself to come into this special room and take their places. If they can't sit at the table, perhaps they can sit or stand on the side of the room or in an adjacent room. Let yourself watch them come in and take their places. When they are all there, let me know who and what you see. (*Step 7*)

Client: (*About 1 minute passes while the client is in an internal process. The rest of this transcript is Step 8.*) I am in the center. To my right is Grad Student who has a stern look on his face. To my left is the 10 year old. Next to the 10 year old is a younger one. I think that one is about 4. Yes 4. That's right. He even has on those bib overalls. Next to him is someone who is really fuzzy. Almost like behind a veil. There is a huge space between that one and Grad Student. That one is afraid of Grad Student. (*I want to keep to the task of identifying as many parts as possible before I start addressing the phobias among the parts.*)

Therapist: Is there anyone else around the table or elsewhere in the room or adjoining rooms?

Client: Yes, there is the teenager leaning against a counter. That one doesn't want anything to do with anyone at the table.

Therapist: Anyone else?

Client: I hear a whiny little child someplace but I don't know where it is. I can't see it. It sounds pathetic.

Therapist: Anyone else?

Client: No. That's it.

Therapist: I want to thank all these parts for meeting us at the table or in this room. If there are others,

they can come and join us at any time. They, too, are welcome. (*Always assume that even if parts are not identified or present, they are still listening in. The therapist must model a curious, welcoming, and respectful attitude toward all parts at all times.*) Now, let's get to know more about these parts. Let's start with Grad Student. Is Grad Student familiar to you? (*I started with Grad Student as that was the first EP identified by the client.*)

Client: Oh yes. Grad Student is the one who keeps me going to work every day. The one who thinks if we stop, people will find out that we really don't know what we're doing. Grad Student isn't happy. He's stern. Grad Student cracks the whip. Nobody likes Grad Student. Grad Student doesn't have any fun. Grad Student is all work and no play.

Therapist: Is there anything Grad Student wants to say?

Client: Grad Student doesn't like this. Grad Student thinks we should be doing something more productive. Grad Student just sits there with hands folded on his chest with a disgusted, stern look. It's making some of the others fidgety.

Therapist: (*The client is inside the window of tolerance so I can continue. I want to join with Grad Student by acknowledging the importance of its job before moving on to learn about the other parts.*) OK. I think it is very helpful that you can notice Grad Student and the others. I want to thank Grad Student for being here. I think Grad Student is there for a very good reason and we'll get to understand all those reasons as time goes on. Can we check in with the one on your left—the 10 year old?

Client: The 10 year old thinks everything is OK. The 10 year old just wants to do magic tricks and ride his bike. The 10 year old doesn't want to upset anyone. He just wants people to get along.

Therapist: OK. Is there anything he wants to say?

Client: No.

Therapist: OK. I want to thank the 10 year old for being at the table. Can we move on to the 4 year old?

Client: The 4 year old is a wimp. The 4 year old is always just on the verge of crying. Grad Student hates the 4 year old and is glaring at him.

Therapist: Is there anything the 4 year old wants to say?

Client: No. The 4 year old wants Grad Student to stop glaring at him. The 4 year old thinks he's done something wrong.

Therapist: (*I want to be careful to not activate the phobia between these parts at this time so I will continue the task of checking in with the rest of the parts.*) Thanks. I also want to thank 4 year old for being here. Can we move on to the one next to 4 year old, the one who is really fuzzy?

Client: (*Client gets agitated and starts to speak, then stops, several times. It looks like the client is still inside the window but nearing the edge of intolerance.*) No. Grad Student just stood up and the 4 year old just started to cry.

Therapist: Is Grad Student going anyplace?

Client: (waits a few seconds) No. Just standing there looking very sternly at that side of the table.

Therapist: Do you know what has activated Grad Student? Perhaps you can ask Grad Student.

Client: Oh. I don't have to ask. Grad Student does not want any whimpering brats hanging around. Grad Student makes that perfectly clear.

Therapist: OK. Your psyche is telling me that it isn't time to contact the Fuzzy One. Can we agree that the Fuzzy One can be at the table but we won't try to communicate with it right now? (*My intent is to keep Grad Student inside the window of tolerance.*)

Client: Yes. That's better. Grad Student is still on guard but things are a little less tense around the table right now.

Therapist: Good. The Fuzzy One is there for a very good reason, and I want to thank the entire psyche for tolerating its presence at the table. We will understand all the reasons why the Fuzzy One has to be guarded so much as time goes on. How is Grad Student doing now?

Client: Grad Student is still standing but not ready to jump.

Therapist: Good. Does Grad Student hear that I am no longer asking about the Fuzzy One? (*I want to develop an alliance with Grad Student.*)

Client: (pauses and is in an internal process) Grad Student wants you to be careful.

Therapist: How does Grad Student want me to be careful?

Client: (pauses while in an internal process) Grad Student wants you to stay away from that one. Grad Student has a hard enough time keeping that one down and doesn't want you making his job harder.

Therapist: Thank you, Grad Student, for giving me this information. I will be careful. I promise I will not ask for more contact with the Fuzzy One today. Is that OK with Grad Student?

Client: (pauses again while in an internal process) Yes. But you better keep your word. Grad Student will be on guard.

Therapist: Yes. I will keep my word and I've learned something very important about your internal experience. I want to thank the entire psyche for tolerating what just happened. How is Grad Student doing now?

Client: Grad Student is relaxing a bit more.

Therapist: Can Grad Student relax enough to sit again? I am keeping my promise.

Client: Yes. That's better.

Therapist: I want to let Grad Student know that I think his job of keeping others from getting activated must be pretty hard. And I imagine this job has gone on for a long time and that this job has been very necessary. I will want to have more conversations with Grad Student about his difficult job as time goes on but now I'd like to move on to checking in with the Teenager. Would that be OK?

Client: (pauses while in an internal process) Yes.

Therapist: Tell me about the Teenager. Is there anything the Teenager wants to say?

Client: The Teenager couldn't be bothered by what just happened. The Teenager thinks we're all just a bunch of crazies and just wants us to get over it. The Teenager basically brushes off Grad Student and thinks the whimpering brats just need to grow up. The Teenager just does his thing.

Therapist: I want to thank the Teenager for joining us in the room. Now there is one more part. The one you could not see, but only hear.

Client: (gets agitated again)

Therapist: Is this experience you are having right now very similar to the experience you had when I asked about the Fuzzy One? (*My assumption was Grad Student was activated but I wanted to be certain.*)

Client: You bet! Grad Student is on his feet again, all red in the face.

Therapist: The psyche just told me some very important information and I want to thank all of you for that. You are telling me it is not time for us to contact that part. Am I interpreting this right?

Client: Yes.

Therapist: Is there something we can do to calm down the alarm I just set off?

Client: You can promise Grad Student you won't ever do that again.

Therapist: I can promise Grad Student that I won't ask any more questions about that part today. Would that be OK for Grad Student? (*I will join with Grad Student's phobia today in the interest of keeping my client in the window of tolerance, but I won't put myself in a bind by agreeing to never work with that part again.*)

Client: Grad Student wants you to promise forever.

Therapist: I'm learning how important Grad Student's job is. I can promise Grad Student that if I ever contact that part again that I will try to do it in a way that is acceptable with Grad Student. Can we be in agreement that I won't try to contact that part anymore today?

Client: Grad Student agrees but is wary of you. He doesn't know if he can trust you.

Therapist: Fair enough. I expect that Grad Student will keep close tabs on me and that is how it should be. And I want to thank Grad Student for working with me. I think we will find ways to work well together. Can you tell me, in general, what the mood is around the table and in this special room?

Client: Teenager just said, "Grad Student finally met his match." The others are a little wary and Grad Student looks like a reprimanded little child but he'll survive. He's a little flustered right now. (*This is important clinical information. I still need to develop the alliance with Grad Student and exploring Teenager's perspective on this might reactivate Grad Student. Besides, we are nearing the end of the session so I want to start closing it down.*)

Therapist: Is there anything that Grad Student needs right now?

Client: What do you mean?

Therapist: Is there something that would help Grad Student feel better, feel more calm?

Client: Once we leave and go back to work, we will be fine. (*My client can use work addictively.*)

Therapist: Yes. I know that. But I'm wondering if we can help Grad Student calm some more, even before going back to work.

Client: How?

Therapist: How about we use that calm place image we worked on several weeks ago and invite Grad Student and any other part who can, to hang out in that image. Would Grad Student be willing to try that?

Client: Yes. But don't insist on those other parts being there.

Therapist: OK. I agree. Can we move into your calm place image now? (Client nods.) OK. Go to the Mountain. Feel the cold air, hear the quiet. Feel the pleasure of being at the top after your muscles had a very good workout. Just let the calmness and pleasure of Mountain permeate your body and your internal experience and see if Grad Student can also feel this. If any other part wants to experience this calmness, that is OK, but I particularly want Grad Student to notice it if he can. (*I give the client time to hang out in this image, watching relaxation grow on his face and body.*)

Because time was short, the session was successfully closed down. However, it is clear that more work must be done with Grad Student before work can be done with the other parts. Grad Student obviously is a protector of the traumatic, unwanted material from coming into consciousness. Developing the treatment alliance with Grad Student is the first order of business.

Summary

The 8-step dissociative table technique is a simple and efficient way to access and identify the internal parts of the personality. The table/meeting place serves as a forum to communicate and work with the parts throughout treatment. Overall, this technique is a must-have skill in all clinicians' toolkit in working with complex trauma. And, don't forget to get consultation when working with clients with a dissociative disorder. This technique is simple yet quite powerful and must be used within a phase-oriented treatment for good treatment outcomes.

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