

THE DISSOCIATIVE
TABLE TECHNIQUE:
A STRATEGY FOR
WORKING WITH EGO
STATES IN DISSOCIATIVE
DISORDERS
AND EGO-STATE THERAPY

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ABSTRACT

There are various ways to contact alter personalities (ego states) in Multiple Personality Disorder (MPD) and other dissociative disorders. This paper presents one such strategy that the author has developed over the past decade working with such patients. Keeping in mind that therapists must constantly be on guard against the iatrogenic creation of alter personalities, there are nonetheless ways in which the inner ego states previously formed and already operating in the patient's life can be learned prior to any therapeutic intervention. This assures that the search for these inner states is lead by cues from the patient and not from the therapist. This writing will outline an inter-related series of techniques which should prove helpful to those seeking a strategy to access the inner ego system of those suffering from disorder of dissociation. Not only is this a technique for accessing alter personalities, but it also offers additional strategies to assist the work with these alters throughout the course of therapy. It is not a therapy in itself, but rather a group of adjunctive strategies to be used in conjunction with the clinical approach of the therapist who may wish to use this technique.

INTRODUCTION

In order to carry out therapy with those having dissociated ego states, it is necessary to have one or more ways of making contact with the inner ego system. Sometimes an alter may present itself directly to the therapist. At other times, the therapist may use direct inquiry by requesting to speak to another part that the patient may have been aware of. Other cases may present themselves through automatic writing (Putnam, 1989). Another means of access is by hypnosis (Beahrs, 1982; Bliss, 1986; Braun, 1984, 1986; Kluft, 1982). Other contact techniques may be by indirect conversation, inner conferences, or, in more difficult cases, the use of intravenous injection of sodium amytal could open the dissociation barriers (Ross, 1989).

Faced with such a variety of possible ways to contact alters, those encountering MPD patients for the first time may well appreciate a relatively simple and structured technique to

begin interaction with the internal ego system. The intention of this paper is to provide a therapy formal, not only for the novice, but also for seasoned therapists who may find it useful to augment the techniques they have already mastered.

ORIGINS OF THE DISSOCIATIVE TABLE TECHNIQUE

In the process of establishing contact with the various alters, the therapist must also keep in mind the possibility of accidentally creating *de novo* alter personalities in either a dissociative-prone person or in addition to the established ego states in a person with MPI. This question of the possible iatrogenic creation of multiple personality has been of special concern to a number of key therapists and investigators in the field of MPD, such as Dr. David M. Caul. This problem was extensively discussed in the June 1989 issue of the journal *J/S.SOC'La 710N: Progress in the Dissociative Disorders* (Kluft, 1989a), which was dedicated to Dr. Caul. The current consensus among those studying in the field is that MPD cannot be created iatrogenically (Coons, 1991). However, a number of its phenomena can be produced with ease (Kluft, 1989b). It is thus imperative that the therapist avoid suggestions that could result in a new hypnotically induced ego state. Generally, the taking of a careful history from both patient and relatives can provide many leads to an already existing dissociative ego system. These clues may come from the nature of the auditory hallucinations experienced by the subject, or reports of unknown writings found in personal journals suggesting the presence of other ego states. Relatives may tell of distinct changes in behavior and personality identification that they observed prior to the entry of the patient into therapy. Thus, the therapist can use these clues to learn about the established functioning of the dissociated ego structure.

Initially, I had used formal hypnotic inductions in all MPD patients to contact alter personalities. I first scored these patients with the Hypnotic Induction Profile (Spiegel & Spiegel, 1978). Not surprisingly, these patients were capable of entering deeper trance states than any of the other diagnostic categories I was treating. The deeper the trance capacity, the easier the patient was to hypnotize. This high hypnotizability in MPDs has been noted by others (Bliss, 1986; Loewenstein, 1991; Putnam, 1989). It soon became apparent that these patients were able to access their own ego states *without* formal hypnosis. By merely suggesting appropriate visual images, they could readily access alters. Thus, guided imagery could be used to open the dissociative bar-

riers of their inner system without any formal hypnosis. This meant therapists did not have to be hypnotherapists in order to be able to gain access to the inner ego make-up of such highly dissociative-prone people. However, since the patient, in essence, is using self-hypnosis, the more a therapist knows about formal hypnosis, the better understood will be the phenomenology of the dissociation of each particular patient. In fact, then, one can access alter personalities through the technique of "guided imagery." [his is more than an academic point, for in some places, such as the province of Ontario, where I practice, only physicians, dentists, and registered psychologists can employ hypnosis. Fortunately, there are *no* such restrictions for guided imagery. This adds up to a larger pool of available therapists for these patients.

Having had training in hypnosis, transactional analysis, neurolinguistic programming, and Gestalt therapy prior to my work with MPD, these disciplines were an influence in the formation of this treatment strategy which I call *The Dissociative Table Technique*. Some of these strategies were discovered serendipitously, and others were invented in response to pressing clinical circumstances. Over the years, these strategies blended in a way that provides the therapist with a simple and logical format to work with the patient's internal dissociative system. Within the dissociative table technique are both new and adapted strategies that are combined in a special way to access the inner dissociative ego states, be it MPD, other dissociative disorders, or a template for Ego-State Therapy (Watkins & Watkins, 1981).

It must be cautioned, however, that any use of guided imagery in dissociative-prone people can have a profound effect. Their inner make-up allows them to readily respond to any suggested imagery. As a consequence, there are two cautions that must be considered in the use of the Dissociative Table Technique. Firstly, it should only be used by a qualified therapist or by someone in supervision or consultation with a person who is knowledgeable of dissociative phenomena. Secondly, the *Dissociative Table* set-up should not be used to open the inner ego system unless there is a plan for follow-up therapy that can deal with the resultant structural changes. It would be unethical to open up the dissociative barriers and leave the patient without the resource of a therapist to deal with the consequences of opening the dissociative doors.

DISSOCIATIVE TABLE TECHNIQUE

The following strategies that make up *The Dissociative Table Technique* will be discussed:

1. Instruction in relaxation imagery
2. Dissociative table imagery
3. Spotlight technique
4. Middleman technique
5. Screen technique
6. The search for the *Center-Ego State* (Inner Self-Helper, ISH)
7. Memory Protection Technique
8. Transformation Stage Technique
9. Fusion/Integration Techniques

As mentioned above, multiple personalities may develop new apparent personalities in response to therapeutic intervention techniques. However, these new personalities do not have past histories (Kluft, 1989b), and can generally leave as quickly as they appeared once it is made clear to them that they are neither welcome nor needed. It is not surprising that a person who developed new personalities to handle stressors might tend to develop yet another to handle the new stressor of therapy (Kluft, 1989).

It would take too much space to discuss how each technique evolved, though each has an interesting history. I will, however, briefly mention the origin of some of them.

Once you have made a tentative diagnosis of MPD, other dissociative disorder, or wish to commence Ego-State Therapy, the patient is told that it is important to understand the make-up of their inner ego structure. Since many alters/ego states fear their extinction, it is important to immediately assure that no alters can or will be eliminated. Instead, you will be teaching them *a new way* to relate to each other; a way that shows respect for all alters/personalities/ego states (whichever you prefer to call them).

INSTRUCTION IN RELAXATION IMAGERY

The first step I use in preparation to gain access to the inner personalities is relaxation imagery. The wording used in this paper is essentially what I use. Therapists should make adjustments to suit their style of speaking. "I would now like you to close your eyes and visualize a scene that is very relaxing and safe. It may be a beach, a country scene, a favorite room, or any place that you feel is safe. I would like you to also place yourself in that scene and describe for me, in as many sensory modalities as possible, what you are experiencing."

This is a common relaxation imagery which prepares the patient for the dissociative table imagery. The aim here is to test the patient's ability to use guided imagery. Most can readily experience a visual image and elaborate it with other sensory modalities. By asking the patient to describe the scene, you are establishing a verbal bridge between the inner visualization and yourself. This also teaches them that they are able to verbally communicate any imagery they will be experiencing in the upcoming techniques. By asking that they see themselves in the scene, you are preparing them to include the presenting personality in the strategies.

Rarely, they may experience nothing with their initial imagery testing. Possibly this is because an error has been made in diagnosis, and the patient simply cannot experience visual imagery. More likely, however, this could be due to "resistance." As a colleague said, sometimes resistance is a form of protection against delving into their dissociation before they are ready to cope with the results. This inability to visualize is uncommon in my clinical experience with patients having high dissociation capacity. If this happens, I would suggest that you reconsider dissociation as a diagnosis, or take a very close look at possible reasons for resistance. In most cases, the relaxation imagery is easily accomplished and the patient is ready to be introduced to the "table" imagery.

THE DISSOCIATIVE TABLE IMAGERY

This is the most interesting and probably the most important of all these interventions. It had its origin in Gestalt Therapy, though here it has been expanded and adapted for use with MPD. Some colleagues who have tried this *dissociative table imagery* have also referred to it as a *boardroom* or *conference room* technique (Ross, 1989). I believe it to be one of the easiest and most effective ways to be introduced to the group of alters in NIT patients. My verbalization is approximately as follows:

"Now I would like you to change that relaxing scene to that of a pleasant room. In this new room is an oval table. Around that table are a number of chairs. This is a very safe room. In this room, no one gets hurt. I don't hurt you - you don't hurt me (I especially emphasize the latter if there is a history suggesting violent alters!). One of the chairs is reserved for you, the rest are for the others that you suspect are within you. (I let the patient decide how many chairs are present.) Nod your head when you see yourself in one of the chairs. (I await for the nod which will be given in most cases unless resistance arises.) Now I would ask you to invite the others" or "those who belong to the voices you have been experiencing ... or those your friends have reported meeting." I try to use the terminology used by the patient to refer to suspected ego states. Sometimes the number of chairs may be the first indication of the number of alters present: empty chairs can indicate alters not ready to engage in therapy yet. "Ask them to choose a chair and join you at the table."

About half the time the patient will, within a minute, report people taking their place in the chairs. At other times, there may be some resistance, and the patient may state, "there are chairs, but, not one has come into the room." At that point, I simply say, "look toward the door in the room and invite them to enter. Reassure them that no one will be hurt in this safe room." (Generally this is shortly followed by a number of alters entering the room.)

Some patients, perhaps, have been abused at home in a room with a table and may tell you "rooms with tables are not safe." Square or rectangular tables can sometimes cause problems, and an alter may complain, "How come so-and-so gets to sit at the head of the table?" The other problem could be with round tables. Round tables could have "ritual abuse" associations. The use of an oval table generally bypasses such problems.

For those who cannot handle rooms with tables, one could suggest they gather in a field, or perhaps on a rock by a stream, or wherever they feel safe. Most are able to use the table, but not all. In any event, I proceed, but take note of what image they have selected.

"Now that those who feel safe have arrived, I would like you to describe who is sitting at the table (or whatever is appropriate to the image they chose)."

What must be pointed out is that this simple table imagery suggestion can unveil a lot of new information. The patient can immediately identify many (sometimes all) of the personalities, their approximate ages, sex, and many emotional characteristics of their internal ego system. Be aware that

often not all alters come to the first table setting! Some may wait weeks and even years before they trust *enough* to reveal themselves to the therapist. Some may come but not sit, others may *be* seen hiding in the shadows. I have learned to accept their initial limited area of trust. Eventually, they all come to the table.

The *most* important happening in this simple maneuver is that for many patients/clients, *this may be the first time they can actually see the people within.* Even more intriguing is that what they visualize by this technique is *not what* they (as the presenting personality) expect is the image related to the voices they hear, or ego states they have been told about -*instead, they see the image that each ego state has of itself!*

So the *Dissociative Table Imams*, in as little as sixty seconds, can produce a gigantic leap in conceptual awareness of the alter ego system.

Dialogue Set-Up

Now that the "group" has come to the table, I suggest that those who have been reluctant, to come, at least listen in or watch from the background. That will give them a better idea of what is going on in therapy. Now that they can see each other, it is necessary to set up the lines of inner communication.

THE SPOTLIGHT TECHNIQUE

This was developed after I read *The Minds of Billy Milligan* (Keyes, 1982). Billy was a patient of a departed friend and respected colleague, Dr. David Gaul, who was previously mentioned. The book relates how the alters of Billy "imaged" themselves as having a stage spotlight shining on the alter who was the one in executive control of the body. Thus, I have adapted this and say to the ego states, "While you are sitting at the table, you will notice a spotlight over the head of the person who has been speaking to me. Whoever this light shines on is the one who is able to communicate directly with me. You can move that spotlight to shine on another person at the table so I can get to meet that person. As you look around the table, find someone who is willing to speak to me. Nod your head when someone has agreed. Okay, as I count to three, gently move the spotlight to that person. Ready - one, two, three. Okay, whoever now has the spotlight shining on them can directly speak with me. Would you like to speak to me with your eyes open or closed?" This technique promotes co-consciousness, so the other personalities, including the presenting personality, are able to hear all the conversations held at the table, be it internally or externally with me.

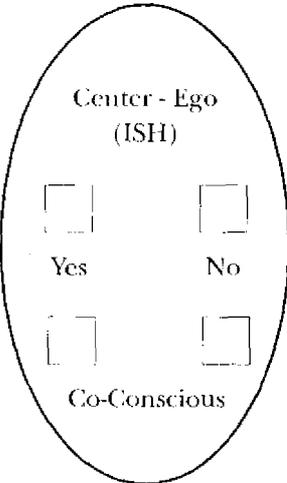
This step generally allows for the establishment of communication for the first time between therapist and alter. At times, the use of the spotlight has proven helpful in even revealing those who may conceptualize themselves as hiding in the shadows. It may be better, however, not to rush such reluctant alters to participate until they are ready and come to the table on their own.

Some people feel very uncomfortable with a spotlight. In some cases this could be because they were exploited through pornography. If the spotlight is a problem, I sag-

TABLE I
Dissociative Table Technique (Inner Organization Plan)

Name _____ D,O,B. _____ Age _____
 File # _____ Intake Date _____
 Session Date _____

Presenting



Others _____ Others _____

D.E.S. Score _____ Complete _____
 11.1.P. Score _____ Complex _____
 N.O.S. _____
 Ego-State _____

Therapist

UPPER SECTION: The oval refers to the table. The lines refer to the chairs, and the personalities' names are entered here. Sometimes the seating arrangement is important. The name of the personality who came to therapy originally is put in "Presenting" line. Inside the oval are two groups of boxes. Check whether a Center-Ego (honer Self Helper) has been contacted and, also, whether other personalities are co-conscious when that state is in executive control during the therapy. This varies from patient to patient. "Others" refers to ego states who do not want to come to the table yet, or are in the shadows.

LOWER SECTION (OPTIONAL): D.E.S. Score: Refers to the Dissociative Experience Score (Bernstein & Putnam, 1989). H.LN. Score: Refers to the Hypnotic Induction Profile Score (Spiegel & Spiegel, 1978), Complete: Check if classical MPD. Complex: Check if poly-fragmented MPD. N.O.S.: Dissociative Disorder Not Otherwise Specified. Ego-State: Cases which may not have a formal dissociative state diagnosis, but in which Ego-State therapy is being used.

gest that, instead, they could use a *microphone and* pass it to each other to exchange executive control as each speaks to me.

At this stage, I caution the reader that you are entering into a system that may never have related in this manner before. Some alters may have only been out in moments of aggression, fear, or violence. It may be very threatening for these personalities to relate to you, so I state, "If you do not feel safe to be out now, or fear you may harm me, you may not be ready to come out yet." (The word "yet" is a very powerful word in the language of imagery, for it implies that there will be a time in the future when this *will* be possible.) If some are not able, or are reluctant, to speak with me, and this is conveyed to me by a report from another alter, I can resort to the middleman technique.

MIDDLEMAN TECHNIQUE

One of the potential problems with the spotlight technique is that the ego-state with the light or the microphone may refuse to speak for a host of possible reasons. Besides a simple refusal to speak, it might be an ego state that is too young to speak, electively mute, speaking a different language, or, though much less likely, it could be a non-human alter.

In such cases, the middleman technique is a possible solution. I address one of the ego states who has established contact with me, and ask that it act as a go-between, negotiator, or interpreter between myself and the reluctant alter. I say, "Since you are not ready to speak to me yet, would you speak to the person under the spotlight who has been speaking with me, and tell that person a little about yourself and why you might be having difficulty speaking directly with me." Though the middleman conveys the messages to me in the third person, I continue addressing my questions in the second person to the reluctant alter. In almost every case, within a few minutes, this reluctant alter begins speaking directly to me as it appears to get impatient going through the middleman. If the alter is mute, I pass a pen and pad and ask that the communication be written. If it was a very young child, I might ask that a picture be drawn. This itself may lead to some insights, and I might gain further information by asking an alter who knows the child alter to interpret the drawing. If the problem is one of a different language, one can usually find an interpreter sitting around the inner table. If there is still no communication, I might elicit the help of the inner self helper, which will be discussed.

Once these first two techniques are done, the therapist is now in a position to use two diagrams which can be used for quick reference (Table 1.)

The Inner Organization Plan ("Table 1) can be kept in the patient's file or in a separate binder so it can be kept in an easily accessible area for a quick reference during therapy. It may have to be renewed a few times during therapy as new alters emerge and others merge.

The Individual Profile (Table 2) is used as a quick reference sheet, and lists the main personality traits of the ego-states. It can be kept in the same location as the Inner

Organization Plan.

SCREEN TECHNIQUE

Discovering the secrets of dissociated memories is an essential, though emotionally painful, process. In the course of memory retrieval, the patient often relives the fear, the hurt, and the terror, as if the event were happening all over again. In an abreaction, the patient may regress in time and could even confuse the therapist as one of the abusers. These abreactions at times can become too strenuous and exhausting and may not be appropriate for any place but a protected inpatient setting.

Because I work in an outpatient setting where many other neighboring offices, I had to devise a more moderate way of memory recovery. Drawing on my memory of the hypnotic techniques I learned from Herbert and David Spiegel at their hypnosis courses, Columbia University, I recalled they frequently used a screen to project images in some of their hypnotic strategies (Spiegel & Spiegel, 1978). This had potential for a strategy that would allow for a controlled abreaction. I decided to add a movie screen or TV monitor in the room with the dissociative table. The alters could now project the scene of the abuse memos on the screen and be safely sitting at the chair at the dissociation table. While this somewhat (but not always) distances the intensity of the recalled memory, it generally offers adequate emotional connection to be effective without having a difficult abreaction to manage. Since everyone can see the screen from the table, that memory can be seen by all who are willing to watch. They also can see and experience the emotional reaction of the person who is showing/sharing that memory. The suggestion that they have a *remote control* unit allows them to stop, start, rewind, or fast forward that scene. I state, "you will notice that to the side of the table is a screen (or a TV monitor). Each person can share memories, along with the feelings that go with them, on that screen. The person reviewing the memory, or anyone else, can narrate what is happening so I can know what you are recalling. If the scene becomes too difficult, just press the *stop button*, and we can continue at a later time. Okay, who is ready to share a memory?" Some therapists prefer to review memories chronologically; others by working through one personality's memories, then to the next, and so on; others may prefer to allow the alter to select their own memory review schedules.

Some personalities may use the screen to view the *knowledge* of the memory, but still try to distance the *emotional* connections (Braun, 1988). To guard against this, check every so often to ensure that there is the emotional connection with the memory being reviewed. If not, I say, "as (name of alter) is showing the memory, I want you all to join hands and connect with the feelings that go along with this memory."

THE SEARCH FOR THE CENTER-EGO STATE (INNER SELF HELPER, ISH)

Most know this as the Inner Self Helper (ISH), as coined by Dr. Ralph Allison (1974), though earlier therapists,

including Pierre Janet, were also aware of this special ego-state. Articles have been written on this subject, but there is still little consensus on its universality or even of its need in therapy (Adams, 1989; Allison & Comstock, 1987, 1989; Kluft, 1989b). Since I have found it useful in many cases, I will include the technique I devised to allow access to this state. There can be various alters who consider themselves to be inner self helpers but do not correspond to Allison's descriptions. This can cause confusion at times. Consequently, Christine Comstock, an MPJ therapist who has also spent considerable time studying this state, and I have preferred to refer to the ISH as the "Center Ego State" (Comstock, 1991). Essentially, this is an ego-state which appears to have the knowledge of the entire ego structure and the histories

of the alters. This ego-state can sometimes be helpful in providing a better understanding of the system. It is a special state which seems to have a function of keeping some sense of background continuity of time for the system. It appears to be more logical than emotional and often believes itself not to be a personality (Fraser, 1987). Nonetheless, I believe this is just a special purpose ego state that can, but need not, be used in therapy. Descriptions by this state are much in the style one hears in other patients who have spoken about *out of body* experiences and have felt as if they were *observing* themselves from without. My studies of those states make me suspect a Center-Ego originates as a result of the very first dissociation of the traumatized child. In any event, until more is known, this will remain a controversial issue. I will

TABLE 2
Individual Profile

CHART #

Name _____ Age _____ Sex _____
Profile

Name _____ Age _____ Sex _____
Profile

Name _____ Age _____ Sex _____
Profile

Name _____ Age _____ Sex _____
Profile

Name _____ Age _____ Sex _____
Profile

Name _____ Age _____ Sex _____
Profile

describe how I contact this state. Some therapists have reported that this state has presented spontaneously during therapy. Some treat it as a co-therapist. I view it as a helpful ego state of a patient/client but keep in mind that, while I may consider its suggestions, I must be the one in charge of the therapy.

"There may be an ego state that has memories of all your personalities. (I realize this is a *leading* question, but used non-directive questions while developing this technique.) This would be helpful as a possible guide to better understand the origin of each other. Would you mind if I used a special technique to locate this state? " If the patient agrees, I continue... "I would like you and all the other personalities to return to your chairs at the table. Look at the screen, and I would like you to select a scene or a movie which you would like to place on that screen. Then each can select your own movie if you wish. Now, as you begin to watch, I want you to become so involved in your picture that you can feel yourself entering that scene. I will call you back soon; in the meantime, enjoy your movie."

Then, as I address *the body* left in my office chair, I continue... "please nod your head when they have all left my office." This, of course, is a double-bind situation. Next, I say, "since all the personalities have left, I wonder if you could let me know where *you* fit into the system?" Sometimes an alter who had not yet presented itself to the table may think this was a trick to find him/her. If so, and this state emerges, I quickly thank this state for agreeing to reveal itself and invite it to join the others at the table, watching a movie. More likely, I will, in fact, have the Center-Ego (ISII) who will state something like, "I am the one who watches." Without asking leading questions, I want to know if this state qualifies as Center-Ego, i.e., has knowledge of memories of all the alters, though may not consider itself as anything more than an observer. While I do not believe Center-Egos are essential for therapy, in many cases I have found them to be a valuable aid. Sometimes they may be surprised you found them and even more so that they can communicate. Questions ofiatrogenous often arise in connection with this state (Kluft, 1989b). Special precaution was taken to avoid iatrogenesis as this technique for finding the Center-Ego was being developed in conjunction with the dissociative table strategies.

MEMORY PROTECTION TECHNIQUE

Sometimes a memory on the screen is very painful and causes such distress that the patient just cannot go on with that memory work. If so, I use the following way of creating a *new protective memory* to be associated with the *recalled traumatic memory* in order to gain mastery. Here, one can combine imagery with audio-visual technology.

I may say, "it seems that the little child in that scene is very frightened and lonely. Why don't you get up from the table, walk right into the screen, and hug and nurture that child. Tell her that she is not bad, and soon she will be safe with you." One could also say, "perhaps there is something you may wish to say to that adult who is hurting the child. Let's go into that scene, and I'll back you up as you let him know what you think of what he is doing." This has often

had very positive effects, allowing the client to pass through a memory scene that was very traumatic. You have superimposed a protective image into a former traumatic image.

TRANSFORMATION STAGE TECHNIQUE

I suggest that there is a special stage area to the side of the dissociative table. When they go on that stage, it can transform their age or their sex when they request this as part of the process leading to eventual fusion/integration. I also suggest there is a mirror to the side so they can see the changes that will come about.. This technique is helpful when alters feel too small, too young, or of the wrong sex, and want to be in harmony with the biological reality.

"You will notice to the side of the table a special stage area. As you stand in that area, I can help you advance to the new age (or sex) we have discussed. I will count to five when you are there. While I am counting, you will notice yourself change to that age (or sex). Ready? One, two, three, four, five. Okay, now look in the mirror and notice the change." Sex changes are only done when going from one that is in variance with the biological sex, and only when that alter is ready.

FUSION/INTEGRATION TECHNIQUES

Finally in therapy, there comes the day that personalities are ready to come together. While many call this *integration*, I still use the term *fusion* to indicate the actual act of *physically joining*, and *integration* to refer to the process of learning to work together, which can begin before and continue after fusion (Kluft, 1988).

The alters often lack basic trust and expect trickery from the therapist, leading to their elimination. Thus, I do two types of fusion prior to the final fusion. One is called *partial fusion* and the other is *temporary fusion*. In *partial fusion*, I will just fuse or unite two, or a few personalities, so the others can observe that it is safe, and nobody gets lost or eliminated. In *temporary fusion*, I use a similar technique as we near the *time* for fusion of all personalities. I will assure them that they do not have to stay fused forever if they do not like it, but they should at least give it a chance for an hour or a few days, and then come apart and decide for themselves the advantages of fusion (and eventually a harmonious integration).

FUSION TECHNIQUE (*whether temporary, partial, or final*)

"To fuse, I want you to do the following. While at the table (or at the side of the table, or whatever imagery place they now have), I want you to join hands in a circle (this has not caused problems in ritual abuse survivors). As I count to five, you will walk together into each other, joining as one. Ready?" After I slowly count, I say, "Now that you are joined together as one, open your eyes and experience what it is like being together. Each of you is aware of his or her own existence, but notice you share your thoughts and feelings. Notice, too, that there are no voices because you can now all think together." Sometimes I will do a roll call - if not

too many ego-states are involved - to assure them that they all exist in this new unit of fusion.

UNFUSION TECHNIQUE

Of course, to have a partial or temporary fusion, you must *have an unfusion or defusion* technique before permanent fusion is attempted. I have made this a simple variation of the fusion technique.

Technique

"Now you are ready to return to your individual states. Close your eyes. As I count backwards from five to one, merely step back into your original circle and let go of hands. Ready?"

Permanent or final fusion is done usually after a number of trials of the above fusions, and when the personalities have shared their memories and have overcome their need of separateness. Some patients comment on the physiological hyperawareness, at the novelty of fusion, such as the brightness of colors, and at the solidity of objects in the environment. However, for many, by the time of final fusion, they have experienced so many exciting things during the course of therapy that this is more of a special day than a novel experience.

SUMMARY

I have adapted techniques from hypnosis and other disciplines to a guided imagery strategy for the therapy of MPD and other disorders of dissociation, including Ego-State Therapy. Since the MPD patient lives in a dissociative state, he or she does not need formal trance induction and can utilize guided imagery quite readily without requiring the use of hypnotherapy. Techniques are based on a dissociative table imagery. The imagery of the alters sitting around a table in a safe room is the more or less stable image in which the other strategies are adapted. This allows a controlled single setting for the management of the dissociative aspects of the multiple personality patient from *day one* to the day of final fusion. These basic techniques can easily be adapted to a variety of therapeutic styles. They are meant only to be adjuncts to the real work of the therapist --- the psychotherapy. It is hoped that these techniques will be helpful in facilitating the management of those who have been divided by abuse. ■

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