THE THREE PHASE APPROACH TO TREATING TRAUMA

CAROLYN SPRING

reversing adversity

Carolyn Spring is an author, speaker, trainer and trauma survivor. She has written and published numerous books, articles, resources, blog posts and podcasts and delivered training to tens of thousands of survivors and professionals both in person and online. Through her unique blend of lived experience, research, training and consultancy, and with a distinctive communication style, she helps people to recover from trauma and to reverse adversity.

She loves to make the complex simple and to give hope for recovery from even the most extreme suffering. She brings a rare positivity and compassion to issues of abuse, shame, suicide and trauma.

For more information go to: www.carolynspring.com or find her on Apple Podcasts, YouTube, Facebook, Instagram, Twitter and LinkedIn.

Please take care when reading as some content may be triggering.

THE THREE PHASE APPROACH TO TREATING TRAUMA BY CAROLYN SPRING
Published by Carolyn Spring Publishing (Buxton, UK)
www.carolynspring.com

PHASE ONE: SAFETY AND STABILISATION

EXPERTS OR SKILLED HUMAN BEINGS?

Over the last few years, it has become very clear to me how difficult it is for so many people with complex trauma histories to find anyone willing to provide therapy to them. Many therapists haven't heard of dissociative identity disorder, or feel that working with trauma is beyond their competence. Those are valid reasons, but it leaves many trauma survivors with nowhere to turn. It is my firm belief that trauma survivors don't need 'experts' to work with them, but solid, safe and skilled human beings. If the therapist has a core sense of integrity, with a foundation of quality counselling training, then the skills can (and should) be learned.

The clinical consensus is that work with complex trauma clients is different to standard therapeutic work, that treatment is generally lengthy, and that there will be numerous challenges to the work and to the therapeutic alliance. Having a clear roadmap for the work is therefore essential and can be found in the concept of the 'three-phase approach', a way of working with complex trauma that is now generally considered to be the safest, most ethical and most effective approach. But what actually is it, what does each phase consist of, and why is there a need for 'phased' work at all?

WHY THE NEED FOR PHASED WORK?

James Chu in his excellent book *Rebuilding Shattered Lives* (2011) talks about the issues that were encountered by therapists in the 1980s and early 1990s when working with clients with a history of complex trauma. In attempting to help them work through their childhood

by Carolyn Spring

trauma, some of these clients were unintentionally harmed rather than helped. There was too often a premature emphasis on the trauma itself before the client had the skills and grounding necessary to face it. Later clinical opinion established that for people to process their trauma successfully, they would first need to build a 'secure base' with the therapist and develop grounding and other skills to manage their intolerable feelings.

Judith Lewis Herman, in her pioneering book *Trauma and Recovery* (1997) introduced the concept of a three-phase approach, building on foundations laid over a century previously by the 'father of dissociation', Pierre Janet. A wealth of clinical literature has followed and this phased approach is now the bedrock of the *Guidelines for Treating Dissociative Identity Disorder in Adults* (2011), which was issued by the International Society for the Study of Trauma and Dissociation (ISSTD).

REMEMBERING IS NOT RECOVERING

Trauma represents a serious threat to life or physical integrity, and as such it makes sense for the body to protect itself by preparing for future similar traumatic events. As a result, the brain is rewired to be hyper-aware of possible risk, and the body is geared up to respond instantly. At the same time, the brain attempts to avoid situations and people which are a 'match' for the previous trauma. Together, these symptoms represent post-traumatic stress disorder (PTSD): avoidance of stimuli reminiscent of the trauma, and a ready-to-run state of bodily hyperarousal. The survival-based 'back brain' dominates, ready to protect the body at a millisecond's notice, while the learning, thinking, reflecting 'front brain' is muted. But in order to process past trauma effectively, the reverse needs to be true: the 'back brain' needs to be muted and the reflective 'front brain' brought online.

For therapy to succeed, these issues must be addressed. If they are not, bringing the trauma back to mind will merely set off the back brain's alarm system; the front brain will be switched off; and the trauma will be re-experienced but not processed. Much of the work that took place in the 1980s and 1990s was based on the assumption that 'remembering is recovering': that the act of recalling traumatic events to mind in the presence of a validating other would be sufficiently cathartic to bring about healing. But this has proved not to be the case – at least, not consistently. Remembering can instead be retraumatising. Unprocessed trauma is relived through flashbacks and

by Carolyn Spring

symptoms, including 'body memories.' By contrast, trauma that has been 'metabolised' crystallises as a distinct, narrative event – albeit a previously overwhelming and life-threatening one – which happened at some point in the past but is no longer happening now. For this to happen, the front brain needs to be online and remain so rather than being deactivated by the back-brain alarm.

Few complex trauma clients enter therapy with the emotional regulation skills needed to turn on the front brain and turn off the back brain. But these skills can be learned in the context of a safe, boundaried, therapeutic relationship which acts a 'secure base' for exploring past trauma, and then gaining mastery over its symptoms. This preparatory work is the essence of the initial stage in the three-phase approach and focuses on safety and stabilisation in the context of the emerging therapeutic alliance. The second stage moves on to processing the trauma, and the third stage builds on these gains to develop a new life free from the disruptive impacts of that trauma. Each stage is hierarchical, building from one level to the next.

THE THREE PHASES OF REBUILDING A HOUSE

A useful metaphor to understand this sequence is that of rebuilding a damaged property, for example a house that has been hit by mortar fire. In the first stage, the property has to be made secure – fences erected around the building site, any crumbling ceilings or walls properly attended to. Necessary tools and machinery are brought on site and the right personnel engaged. Plans are drawn up for the work. Only once the site is secure does the phase 2 work of demolition take place. Gradually, in a way that does not risk the site, the rubble is cleared away. Parts of the property that were buried are rediscovered and attended to. The impact of the mortar shells is assessed. When the building site is cleared of debris, the remodelling work of Phase 3 can begin. Some walls may need to be knocked down; others are replastered. Some areas are redesigned from scratch; others are repaired. Walls are painted, flooring laid, and eventually a new life begins in earnest.

THE PHASES ARE DYNAMIC, NOT LINEAR

Whilst helpful as a metaphor, the reality for any building site, as for any therapy, is that life rarely proceeds in a steady, predictable sequence of events. So the three-phase approach is essentially dynamic in nature, rather than linear. Sometimes rubble needs to be cleared away in order to make the site safe, rather than the other way around.

by Carolyn Spring

Sometimes areas of the building can be inhabited before the rest of the building is completed. Often, the work of demolition leads to further safety issues which were previously hidden, and new scaffolding must be erected before any further work can be completed.

Similarly, in therapy, after the initial foundation of safety and stabilisation is established, there will often be a need to return to this stage. This can happen both over a period of time and even within an individual session. A key question to ask might be: is there sufficient safety for this next stage of work to proceed? Or do we need more scaffolding? Moving fluidly backwards and forwards between the stages is not a sign of failure, but of flexibility. Gains that have already been made in phase 1 work are never lost, but sometimes they need to be reinforced.

PHASE ONE IS MEASURED IN SKILLS, NOT TIME

Joan Turkus, quoted in *Treatment of Complex Trauma* (2012) by Christine Courtois and Julian Ford, talks about phase 1 work being 'measured in skills, not in time'. Indeed, some clients may never move beyond phase 1, and this is not a therapeutic failure. They may lack the resources, internally and externally, to engage in trauma-processing work, but they can still move from a dangerous, semi-derelict building to one that is reasonably safe and habitable, and the value of this should not be underestimated. The three-phase approach also makes it clear that even short-term work with complex trauma clients can be productive, as the development of safety and stabilisation provides immediate short-term gains as well as establishing a foundation for the possibility of more long-term trauma-focused work in the future.

The focus of phase 1 work, and the focus of this first article in the series, involves four key areas: establishing a 'secure base' in therapy; developing safety; increasing stabilisation; and building skills and knowledge.

1. ESTABLISHING A SECURE BASE IN THERAPY

Christine Courtois (2012) says, 'The therapy relationship *is* the therapy.' The client may have suffered unrelenting abuse, betrayal, degradation, humiliation, coercion and manipulation. The therapist is, or should be, safe, non-abusive, non-judgemental, attentive and emotionally balanced. This contrast for the client is often deeply impactful. And so this safe setting – perhaps the client's first safe setting – allows an opportunity to begin to trust and to learn to manage feelings within a 'window of tolerance', to build skills that were previously

by Carolyn Spring

unattainable without such support. It is a new relational template that is non-coercive and de-shaming, encouraging the development of new 'internal working models' and a prototype for relationships in the outside world.

But the therapeutic relationship will uncover a host of issues: trust, fear of abandonment, fear of coercion, dependency needs, and learned-helplessness, amongst many others. The therapeutic alliance is challenged on many levels and in many ways. Courtois and Ford (2012) propose five essential conditions of trauma-informed therapy in phase 1: safety, trustworthiness, choice, collaboration and empowerment.

A. SAFETY

Is the therapy safe? Is the therapist safe? Is the client physically safe both in and around the building where the therapy takes place, and is he or she safe in the therapist's office? Is the client's privacy safe – is there appropriate confidentiality? Is the work safe to engage in? Bearing in mind the client's vulnerabilities and other life stresses, is it paced appropriately, and does it have the right focus at the right times?

B. TRUSTWORTHINESS

The therapist cannot assume that the client has the basic ability to trust. Demanding or expecting trust from someone who has been multiply betrayed and abused could have further negative impacts. Trust takes time to build, and the client can be encouraged to test the therapist out and 'look for the evidence'. This is an important element of recovery as many people with complex trauma histories have become distrustful of their internal 'radar' – people who should have been trustworthy in the past have not been, and so the radar is turned off altogether. Trust is then based on closing the eyes and jumping: frequently offered to people who do not deserve it, and withheld from those who do. In addressing this, the client can be encouraged by the therapist to weigh up actual evidence – *have I ever hurt you? do I do what I say I'm going to do? have I ever actually abandoned you? have I consistently told the truth?* – and to realign their internal radar based on that information. It is an essential component in phase 1 work, because there will be many times during phase 2 work that the client needs to lean back on their trust in the therapist and, if it has not by then been established, the work will inevitably falter.

C. CHOICE

To have been chronically victimised is to have been without choice. In many settings of abuse, 'choice' has been manipulated in order to blame-shift

by Carolyn Spring

onto the victim, leaving them feeling responsible for what was no choice at all. The therapy should include as much choice as is practicable. It is a considerable achievement for the client to have chosen to enter therapy, and, where they have done so, to choose to work with this particular therapist. Therapy can build on those strengths and facilitate small but significant choices: which chair to sit in, how far to position it from the therapist, how to use the session, what to say or not to say. Recovery from trauma involves regaining the ability to choose and building relationships with people who respect our choices, as we respect theirs.

D. COLLABORATION

It can be a shock for the client to realise that the therapist is not there to tell them what to think, what to do, or how to feel, but that they are coming alongside them in a co-created, collaborative relationship. Many clients will resist this, fearing perhaps that it is a 'trick'. The therapist can help by remaining consistent within the relationship, swinging to neither extreme of abandoning or rescuing, and encouraging the client to take an active role in the relationship.

E. EMPOWERMENT

In what ways might the therapeutic setting continue to disempower the client? Is their chair lower than the therapist's, leaving them feeling vulnerable and exposed? Does the therapist jump in to rescue them from their distress rather than empowering them and educating them to be able to manage and modulate their feelings for themselves? In what way can the client be empowered to be assertive both within the therapeutic relationship and outside it, such as in abusive relationships, oppressive work situations or unreasonable living conditions? The therapeutic relationship is the nursery for an empowered self.

2. INCREASING SAFETY

To be traumatised is to be unsafe. Therefore, in order to recover from trauma, the survivor must begin to establish at least some degree of safety in their life, and to be able to feel safe. Only in safety do we grow and develop, so it is a prerequisite for change. How is safety developed?

A. ASSESS CURRENT RISK

In the first instance, the therapist can help the client to assess the current level of risk in their life and identify any specific dangers. It is possible that the client, who is so used to feeling and being unsafe, has not yet realised that they *can* be safe. Furthermore, many traumatised clients are under-aware of real risks and dangers in their current life, and over-aware of perceived risks from the past. So they may feel at risk from a stranger with a beard

by Carolyn Spring

because he reminds them of their abuser, even though he poses no actual risk, but be oblivious to the risks they are posing to themselves in terms of (for example) self-injury.

B. DISTINGUISH BETWEEN EXTERNAL AND INTERNAL RISKS

There may be a number of credible risks in the external environment, such as abusive relationships, ongoing harmful interactions with past (or even current) abusers, community violence, crime, and so on. The client may be so used to these risks that they do not take them seriously, but the therapist can help the client to figure out what practical steps can be taken to mitigate these risks. Knee-jerk reactions are rarely, however, helpful: attempting to leave a domestic violence situation without proper planning and support, for example, could just escalate the risk.

Most danger faced by trauma clients, however, tends to come from internal sources, from behaviours resulting from or intending to cope with post-traumatic symptoms. Self-harm and suicidality are very real threats to a person's safety, as is dissociative fugue. With a dissociative identity disorder (DID) client, the therapist needs to begin to build an alliance with the different parts of the personality, as many of the risks to the client can result from internal conflicts and diametrically opposed survival strategies. For example, one traumatised part may attempt to feel safe by developing a relationship with the therapist, while another part of the personality may attempt to feel safe by creating distance from the therapist, whom they do not yet trust. That conflict may be externalised in contradictory or potentially harmful behaviours. It is therefore a high priority for the therapist to encourage the client to begin to attempt to communicate internally and try to begin to bring all the dissociated parts of themselves into agreement on staying safe. This is easier said than done but can be facilitated if the client understands the critical importance of safety to the therapeutic process and how phase 2 cannot be attempted without sufficient safety being in place.

As well as risks from self-destructive behaviour, some consideration should be given to threats to physical health due to issues such as eating disorders and chronic insomnia. As well as being a risk factor for developing type 2 diabetes and being exacerbated by binge eating or poor diet, chronic insomnia can heighten risks while driving, engaging machinery (for example at work) or any kind of activity where concentration is required in an otherwise dangerous setting. Although the client may dismiss it as 'normal', focusing on sleeping patterns, improving 'sleep hygiene' and, if necessary, acquiring appropriate short-term medication can have a positive knock-on effect into numerous areas of the client's life.

by Carolyn Spring

C. DEVELOP AWARENESS OF RISK

When dissociation has been used repeatedly as a survival mechanism in the face of threat, the client will be less able to be consciously aware of further threats in the future. 'Triggers', which are in effect warning signs of impending trauma (however wrongly attributed), initiate a cascade of responses resulting in the survival-based, instinctive 'back brain' taking over, and the mindful, rational, 'front brain' shutting down. A trauma survivor may therefore be less aware than others of even obvious risks, because the automatic responses of dissociation have kicked in. This prohibits planning for the future. What appears blindingly obvious to the therapist in terms of risk should not be assumed to have been noted or considered by the client.

The therapist should not therefore take responsibility for the client's safety but can help them on a regular basis to bring to mind aspects of safety and danger that they are habitually dissociating from. The client ultimately is responsible for their own safety and needs to exercise this responsibility appropriately, and to the extent of their capacity, if the therapy is to be safe enough – both for the client and the therapist – to proceed.

D. NOTICE HOW THE CLIENT PUTS THEMSELVES AT RISK, AND WHY

Traumatised clients put themselves at risk in a number of ways for a number of reasons. Firstly, they may be habituated to danger. The therapist's insistence that they attend to matters of safety can be surprising, disconcerting, and even confusing – it is possible that no one has ever previously shown concern for their safety. Putting themselves at risk may also act as a kind of attachment cry, a way of attracting attention. It is less shaming if this is understood by both therapist and client in terms of its survival value. The therapist can then work to help the client express their attachment cry in a different way – the client may never have been able to ask for help directly before, and so continues to do it obliquely until he or she receives 'permission' to express it differently.

The client may also put themselves at risk because of their core beliefs around their value and worth, and as an expression of their hopelessness for a positive future. Rather than assuming that danger and harm are inevitable, the therapist can help the client to think through the pros and cons of their unsafe, and safe, behaviours, so that they can start to make conscious, deliberate choices rather than acting out of instinctual and early attachment-based drives.

E. DEVELOP A SAFETY PLAN

The culmination of these issues can be a 'safety plan', a consolidation of all the ways in which the client is unsafe or puts

by Carolyn Spring

themselves at risk, and specific steps that they agree to take to improve their safety. Putting things in black and white can help to keep the issues clear in the client's mind, rather than dissociative processes causing them to slip out of view. It also provides a constant reference point for the future if and when further challenges to safety arise.

3. WORK AT STABILISATION

Stabilisation is required when symptoms do not pose a direct threat to safety but are disruptive, both to the client's life generally and to the work of therapy specifically. These symptoms are often intertwined or overlapping and might include physiological hyperarousal and the inability to relax, chronic insomnia, overpowering shame, overworking or depression. Anything that severely constricts the client's 'window of tolerance' needs to be addressed so that the client is best prepared for the potentially gruelling work of processing trauma. At the same time, positives need to be built in: activities or attitudes which build resilience, foster self-care or are soothing and containing. For example, one trauma survivor benefitted enormously from cordoning off part of a room in her house where she could retreat to when feeling overwhelmed. Other members of the household were primed to allow her some privacy when she entered her 'safe space'. Just knowing that it was there and could be entered when needed helped reduce her anxiety and provided a ready means of down-regulating when stressed. Other people report the efficacy of creating imaginal 'safe spaces.'

A. WORK ON THE BASIS OF 'MARGINAL GAINS'

A series of small steps – 'marginal gains' – can add up to a big change over time. An extra half hour of sleep each night, slightly calmer emotions, keeping on top of household chores, more physical energy from a daily short walk – these can all widen the 'window of tolerance' as well as giving the client a sense of triumph. Big changes don't happen overnight but are the result of a thousand small changes over a season.

B. IDENTIFY WHAT TAKES THE CLIENT OUT OF THE 'WINDOW OF TOLERANCE'

The 'window of tolerance' is a concept used by many leading clinicians nowadays, albeit under various names. It suggests that feelings usually exist within a normal range but at times things will happen to spike feelings up out of the 'window of tolerance' at the top (into hyperarousal) or to plummet feelings down through the bottom (into hypoarousal). This is true for everyone – not just trauma survivors or people with mental health problems – and that in itself is very empowering and de-shaming.

by Carolyn Spring

The therapist can help the client to start considering the following kinds of questions in order to build their self-awareness and help them develop strategies for managing their feelings:

- What does it feel like to be hyperaroused? What sensations are there in your body? What thoughts go through your mind? What feelings do you have?
- Similarly, what does it feel like to be hypoaroused?
- What sort of things lead you to be hyper/hypo-aroused? Are there particular stressors? People? Situations?
- What kinds of things bring you down from hyperarousal, or bring you up from hypoarousal?

By beginning to be conscious of stressors, and aware of the body sensations associated with hypo/hyperarousal, the client can learn to put in place specific strategies for managing their feelings when they do spike or plummet.

C. DEVELOP SOME EMOTIONAL REGULATION SKILLS

Many techniques and approaches are available which can help clients to manage their feelings, and a very helpful book in this regard is *Coping with Trauma-Related Dissociation* by Suzette Boon, Kathy Steele and Onno van der Hart. Focusing and mindfulness help not only with stabilisation but also with the mentalising work of phase 2, and the daily practice required can provide structure for clients who have stopped being able to work or whose lives have become out-of-control with the chaos of overwhelming symptoms.

One trauma survivor reports:

One of my biggest shifts was when I began to learn to breathe. It sounds silly – everyone can breathe. But I didn't realise that I used to breathe so fast and so shallowly, especially when I was stressed. I learned some mindfulness techniques about focusing on my breathing just for a minute at a time and I started doing it several times a day. I practised breathing from my tummy and focusing on the breath all the way up from my diaphragm, up through my chest, my throat, into my nose and out through my nostrils.

Then the same going back in again, noticing how the air filled my lungs, and breathing deep into my belly. I did it slowly, deliberately. I could do it when I was in the queue at the supermarket, when I was driving, when I was washing up. It felt safe to do because I didn't have to close my eyes. It became quite fun to try to focus just on my breathing for 30 or 60 seconds. And over time I've really noticed the difference. Because I've practised it when I'm not stressed, I can use it when I do get stressed too.

by Carolyn Spring

The first thing I tell myself when I realise that I'm getting out of my window of tolerance is to breathe. Wherever I am, whatever I'm doing, I just stop and focus on my breathing for a few seconds. Beforehand I would just get upset really easily and fly off the handle even at little things like not being able to find a parking space or stuff that my kids were doing. Now I feel like I've got a tool, something I can use when I'm stressed, and it helps. It doesn't solve everything, but it does help.

4. BUILDING SKILLS AND KNOWLEDGE

The average dissociative client may have little or possibly no prior knowledge of trauma, the role of the autonomic nervous system, dissociation, or the 'window of tolerance'. Many clients also have had relatively few opportunities to learn skills for maintaining safety, regulating themselves and their emotions, and negotiating relationships. Psychoeducation in all of these areas can help normalise their experiences as well as equipping them for the rest of their lives.

A. BUILD ON STRENGTHS

Trauma survivors often have very negative views of themselves. They invariably have core beliefs that they are pathetic, weak, incompetent and bad, and that their symptoms are proof that they are crazy. In phase 1 work, these self-assessments can be challenged, and replaced instead with a new focus on the client's strengths and resiliency. They have after all survived atrocious trauma as children with no support. Far from being weak, the client's survival is evidence of their strength. Far from being pathetic, they are admirable in their willingness to engage in therapy.

B. REFRAME SYMPTOMS

In addition, the client's symptoms are not evidence of 'madness' but are entirely logical and can be reframed instead as their best attempts to survive trauma. Therapy can help to address the underlying trauma as well as the symptoms and adaptations that it has caused. This reframing may be welcomed by the client, but equally may also be resisted. It may feel too good to be true, or an attempt at grooming. Regardless of the response, however, the therapist can continue to gently and sensitively reinforce the new frame, mirroring to the client their appreciation for their strengths and their compassion for their suffering.

C. EDUCATE ABOUT TRAUMA

As well as dissociation being a normal response to trauma, and the freeze response as an inherent part of dissociation, the client can be encouraged to see that they are no longer powerless

by Carolyn Spring

and that they can overcome the learned helplessness of chronic victimisation. Having hope for the first time that they are 'normal' and have nothing to be ashamed of, that other people also have similar symptoms, and some have successfully overcome them, can be tremendously empowering.

D. 'JUST NOTICE'

The client can also begin to learn, sometimes for the first time, that their feelings are separate from their thoughts, and that both their feelings and their thoughts are sometimes not in sync with reality. Sometimes their feelings and their thoughts lead to impulses, strong desires to act in a certain way, but they can learn that they are able to control their impulses and notice that they are 'just' impulses – they are not commandments to act. Being able to separate out thoughts from feelings from sensations from impulses from beliefs from actions equips them to do the hard work of 'mentalising' required in phase 2 trauma processing work.

E. BUILD LIFE SKILLS

Alongside these skills and knowledge base, phase 1 can also be used to educate and equip the client with other areas of competence such as assertiveness, problem-solving and decision-making. The client can be encouraged to develop the skills needed to erect appropriate boundaries with people, to say no, to clearly articulate their needs, and to be able to distinguish between 'safe' and 'unsafe' people. This work in many ways is ongoing right through to phase 3.

CONCLUSION

The three-phase treatment plan makes sense at a number of levels and phase 1 can be readily adapted to be used in short-term work. Even six to twelve sessions can be useful in building skills and knowledge, addressing issues of safety and stabilisation and building a therapeutic alliance that will act as a template for a 'secure base' in future relationships. In the next part, I will look at the phase 2 work of processing trauma and how all of the skills developed in phase 1 are essential if clients are to gain mastery over the trauma that haunts them. •

PHASE TWO: TREATING TRAUMA

THE NEED FOR A DIFFERENT APPROACH

Historically, survivors of complex trauma and abuse were encouraged to 'talk about' their trauma, in the belief that 'catharsis' or 'abreaction' would in and of itself solve their difficulties. However, many dissociative survivors became destabilised when they attempted to do so, resulting in rapid switching, fugue states, intense distress, self-harm and suicidality. Bessel van der Kolk and Judith Lewis Herman, among others, pioneered new approaches to treating trauma in the 1990s, with a fresh understanding that talking about trauma resulted in many survivors feeling overpowered and overwhelmed – the same effect that the trauma had had on them originally. As Bessel van der Kolk first showed in 1994, 'trauma lives non-verbally in the body and the brain' and traumatic memory is not confined to images and narrative, but also comprises intrusive emotions, sensory phenomena, automatic arousal and physical actions and reactions. Treating trauma therefore had to take a more holistic approach.

The typical response for a trauma survivor when recounting their past is bodily dysregulation: either hyper-arousal in terms of hyperventilation, shaking, crying, agitation, pounding heart, tense muscles, etc.; or the collapsed state of helpless dread and shame of hypo-arousal. This bi-phasic response is typical of many trauma survivors – in van der Kolk's words: 'They see and feel only their trauma, or they see and feel nothing at all.' In these states of dysregulation, survivors find it difficult to

by Carolyn Spring

think and almost impossible to 'process' – to mentalise, and 'metabolise' their trauma, and without their thinking 'front brain' online, little processing is possible. The trauma is recounted and relived, but nothing changes. It is vital therefore to be able to manage the physical response of distress in response to recalled trauma, so that recounting it is not retraumatising but transformative. Van der Kolk says:

Healing from trauma is really about rearranging your relationship to your physical self. If you really want to help a traumatised person, you have to work with core physiological states, and then the mind will start changing … if clinicians can help people not become so aroused that they shut down physiologically, they'll be able to process the trauma themselves. Therapists must help people regulate their affective states.

The 'all-or-nothing' bi-phasic trauma response can be seen clearly in the dissociative survivor who swings between the Apparently Normal Personality (ANP) who is emotionally flat and avoids all reminders of the trauma, and the Emotional Personality (EP) who is immersed in the trauma, with accompanying states of bodily distress and dysregulation. One of the biggest challenges in trauma work is holding a middle road, in Dan Siegel's terms, between 'rigidity' and 'chaos' – specifically the rigidity of avoidance, where the client is unwilling to engage with traumatic material at all, and the 'chaos' of hyper- and hypo-arousal, where the client is flooded and overwhelmed by their automatic responses to it. The therapist needs to help the client to stay 'grounded', within a 'window of tolerance' where they can both think and feel, whilst still being willing to engage with traumatic material rather than continuing to cope through avoidance.

THE ESSENCE OF PHASE 2 WORK

Phase 2 is the aspect of trauma therapy that is most geared towards facing and resolving the intrusive traumatic memories that plague a trauma survivor's life and manifest in forms such as flashbacks, physiological dysregulation, avoidance, numbing and re-experiencing. But phase 2 work is not a case of 'going after memories', hunting them down and then 'remembering' them. The aim is not recall that leads to emotional flooding. In fact, phase 2 work is much more concerned with memory resolution than memory recall. It is more about being able to forget, rather than being able to remember. This phase of work is not meant simply to be cathartic – the trauma has to be metabolised so that the survivor changes their relationship with it, not just merely expressing feelings

by Carolyn Spring

about it. Nor should it be destabilising: it is not meant to cause heightened distress that feels out of control and is thus retraumatising. And therapy during this phase 1 is not intended simply as a supportive discussion around 'bad things that happened', ending in an exhortation to 'move on' or 'forgive and forget': this phase of work should result in a change in the survivor's automatic responses to traumatic reminders at an implicit-memory, bodily-response level, not just an intellectualised discussion, and certainly not one that is in any way coercive in terms of instructing the client how they should think and feel about certain events.

Nor is phase 2 work the grand 'centrepiece' of trauma recovery work, the Holy Grail that phase 1 work was merely a preparation for. All three phases of the three-phase approach are equally important, and all represent the 'real' work: just as the survivor is attempting to integrate the various aspects of their identity, personality and history into one coherent whole, so the therapy itself should be seen not as different 'parts' but as an inter-related and inter-dependent series of steps which all build towards the client being able to move forwards in their life, in touch with all the different facets of themselves, with their past connected into their present, and where they can make choices freely and consciously rather than being forever dysregulated by the trauma of the past.

THE MAIN TASKS OF PHASE 2

In the first instance in this phase of therapeutic work, the client begins to create an explicitly-remembered narrative account of what happened to them, breaking the injunction to never tell, and sharing their burdens and shameful secrets with a compassionate and understanding other. Forming a narrative may only be possible to a certain degree, depending on levels of amnesia, and should always be held lightly in terms of its provable historical accuracy. Although 'remembering is not recovery' and the creation of a narrative (however incomplete) is not essential to recovery, it is nevertheless vitally important to many dissociative survivors' sense of self-identity, who can find their amnesia and disjointed sense of autobiography both frustrating and shameful. Creating some sense of verbal narrative of their life can help many survivors come to terms with what has happened to them and to reframe their coping behaviours not as dysfunction and disorder but instead as valiant attempts to manage unbearable suffering. If traumatic events are held out of mind (dissociated), it can be difficult for a survivor to understand why they act, feel, believe and react the

by Carolyn Spring

way they do. Survivors often find it easier to feel compassion towards themselves for their struggles when they can bring to mind some of the things which caused those struggles – but while that traumatic material is dissociated, the logical conclusion that they come to instead is, 'There's no reason for me to be like this or struggle so badly, so I must just be inherently pathetic and evil.'

Secondly, trauma processing involves disrupting survivors' automatic responses to the trauma. When faced with a traumatic reminder, a survivor will often instinctively respond by dissociating (in the sense of switching to another part of the personality or entering a trance state); by automatically engaging a fight/flight/freeze response; or by feeling a cascade of emotions which build towards a sense of overwhelm and catastrophe. While they continue to respond like this automatically, survivors feel out of control of their bodies, their emotions and their memories. It is little wonder that they spend so much energy trying to avoid all reminders of the trauma when those are the consequences! But if they can gradually learn to take control of these automatic reactions, and for these responses to be disrupted, they can gradually begin to feel more confident that they have the resources they need to be able to face their trauma and that it will not continue to control them. This aspect of trauma processing is therefore predominantly concerned with 'affect regulation' (managing feelings). Survivors can learn that traumatic distress hijacks the mind, and that the body responds as in an emergency, but that there are ways of learning to thwart this hijacking. They learn that they can do something to calm their pounding heart and jerky breathing, and that they do not need to remain victims of their bodies' responses. Over time this builds their confidence to be able to face increasingly distressing material, knowing that they have the capacity to manage their reactions to that distress rather than being overwhelmed by it.

Thirdly, and overlapping into phase 3 work, the client begins to make meaning out of what happened and begins to address some of the no-longer-helpful beliefs that have developed as a result of the trauma (for example, 'I am worthless', 'I am powerless and weak', 'I deserve bad things'). Understanding some of the family dynamics and 'systems' that were in place during childhood, for example those which meant that it was never safe to express a different opinion (although it is now) or required perfection (but adulthood allows for mistakes) or meant that others' feelings are more important than your own (your mother will survive

by Carolyn Spring

even though she is upset with you) – this can all help survivors move out of unhealthy relational dynamics into more self-caring, mutually respectful, healthy relationships.

It can be deeply liberating for a survivor to recognise that they were manipulated by their abusers as part of the grooming process to believe that the abuse was their fault, that they deserved it, and that they were worthless: the survivor can then begin to challenge these core assumptions that they have held all these years and begin to choose what they believe about themselves now rather than their self-worth being determined by someone who caused them harm.

Part of the work of traumatic processing therefore involves 'mentalising': not just recalling traumatic incidents to mind but standing back from them and reflectively considering the dynamics and reality of those situations, in a way that was not possible as a child. But reconsidering these events is impossible unless the trauma is first brought back to mind.

AVOIDANCE

Survivors often feel very apprehensive about the work of phase 2. After all, they have lived their lives with complex mental and emotional mechanisms in place to ensure that this overwhelming traumatic material remains out of mind, and now the suggestion in therapy is that they discard those defences and face the unfaceable! Often it is only when they realise that they can no longer keep it fully out of mind – that it intrudes too often, day or night, in flashbacks, in nightmares, in unexplained pain and other physical symptoms – that they come to a place of realising that they need to face this stuff in order to be able to deal with it. However, it is important that they realise that 'facing the trauma' does not mean being retraumatised and overwhelmed all over again. It means gradually approaching it, considering a sliver of it, being supported in it, and then 'metabolising' it – changing their relationship to this trauma so that it no longer holds power over them.

The presence of a supportive other during this process cannot be overstated. So much of the abuse was experienced with an intense sense of aloneness, and many clients' biggest fears is that they will have to face the echoes of this trauma once again, alone, and without support. Suggestions to journal or deal with some of this stuff whilst alone, during the week outside the therapy room, can often be met with great resistance: the fear is of being alone with this trauma once again, and being retraumatised again by the isolation.

by Carolyn Spring

Clients often have greater confidence in facing this material when there is a reasonable guarantee that the therapist will be there to help them deal with it, for as long as it takes. Consequently, threats to the stability of therapy, such as coming to the end of funding, impending holidays or prolonged absences, or relational ruptures with the therapist, can understandably increase a client's unwillingness to work on phase 2 material, and this should be respected and reframed not as resistance but in fact as self-preservation and the survival instinct: the client's inherent wisdom knows when it feels safe enough to proceed with this work. As Courtois and Ford put it:

Avoidance may begin and continue as a conscious form of coping, but it often becomes habitual, automatic and out of consciousness and control. As such it can be labelled 'behavioural dissociation'.

Avoidance has been a dissociative survivor's only or main strategy for dealing with the distress of overwhelming trauma, believing perhaps that if they can just keep the avoidance going, then everything will be ok. However, seeking help in therapy usually indicates that the avoidance is no longer a satisfactory or sufficient coping mechanism and that some if not all symptoms cannot be managed through avoidance and denial alone. Often based on prior experiences of uncontrolled reliving and reexperiencing of the trauma, without support and outside their 'window of tolerance', many survivors feel that 'remembering' will make things worse. Effective trauma processing, by contrast, takes place when a client can remain inside a 'window of tolerance', where they have neither 'flipped out' (hyper-arousal) or 'zoned out' (hypo-arousal) and where they can be reflective about what they are remembering and experiencing. They can therefore remain present and personified during the remembering ('I am still me and I am remembering being me as a child when these awful things happened').

They can also gradually learn to actively manage their own states of bodily arousal (emotional distress expressed physically such as a pounding heart, shaking, crying) with support and assistance from the therapist, so that they are neither flooded nor destabilised by focusing their attention on their traumatic past.

The aim is to think about the trauma whilst standing back from it, and to integrate all the different facets of their experience such as their feelings, their beliefs, their memories and their sensations. By doing so they come to understand the memory as 'something that happened' and 'something that happened to me'

by Carolyn Spring

rather than disclaiming ownership of it ('It happened to another part of me' or 'It didn't happen at all – I'm making it all up') and experiencing it as a past event, not as something that is happening right here, right now.

Avoidance has been a very successful and creative strategy in a client's life and should not be dismissed or disparaged. The client will need to continue to choose to 'avoid' the traumatic content for large portions of their week in between therapy sessions. The key therefore is not to discard avoidance as a strategy, but to choose when to use it in an appropriate manner, and to be sufficiently in control of it (rather than being controlled it) so that traumatic material can be confronted purposefully at the right times. Rather than all-or-nothing, the client can be helped to understand that they can choose when to avoid, and when not to avoid, and so take charge of the focus of their mind. Mindfulness meditation can be helpful in learning this skill of taking control of one's thoughts and mental focus: see for example Daniel Siegel's book *Mindsight*.

A key consideration for clients to make is whether facing the trauma in stages, as part of a structured process, with the support of a therapist and in a way that is titrated to prevent overwhelm, is preferable to being confronted by the trauma at unexpected and inconvenient times. The main focus to this work then is an attitude of intentionality: 'Let's face this trauma now, recalling it where possible to mind, feeling the feelings associated with, disrupting the automatic responses to it, changing where necessary the unhelpful beliefs that it engendered, so that we can take control of it rather than being controlled by it.'

By saying, 'Let's look at this now,' the client also implies, 'Let's not look at this at another time.' That inherent belief, that the client can gain control over the trauma rather than being controlled by it, is a first essential steppingstone towards recovery. The survivor gradually learns to manage and control their affective states of distress – the times when they become deeply upset and overwhelmed by bodily sensations of distress and the fight/flight/freeze response, resulting in either manic attempts to self-soothe using self-harm, or zoning out with dissociation into a 'not me, not here' state of avoidance.

So the basis of processing trauma is therefore learning to manage the feelings that it evokes, and the associated states of bodily arousal – it is not simply all about

by Carolyn Spring

'facing the trauma' which, as Richard Kluft described, can feel like 'a guided tour of his or her personal hell without anaesthesia.'

READINESS TO ENGAGE IN PHASE 2 WORK

Not everyone is suited to phase 2 work. Babette Rothschild says:

Work in this phase is vital to the recovery of a good portion of trauma survivors. However, it will not be indicated or even helpful for another portion of survivors.

There are a number of contraindications, for example:

- insufficient safety in current life situation (e.g. domestic violence or ongoing victimisation)
- inadequate inner resources
- lack of emotional regulation skills
- maladaptive coping strategies such as unremitting substance dependence or self-harm
- lack of time in the therapy (e.g. because the sessions are time-limited)
- lack of attachment security in the therapeutic relationship
- psychiatric inpatient status
- current, ongoing police investigation or criminal proceedings (as either victim or perpetrator)
- uncontrolled switching between parts of the personality and ambivalence amongst them towards the work, or a lack of internal cooperation and collaboration.

It is also important that the therapist has the resources and feels sufficiently skilled and supported (e.g. with specialist supervision) to undertake this work, and that they can commit to the process, which may take a considerable period of time.

Clients' readiness to proceed to phase 2 work would be signalled by a variety of factors, for example:

- having sufficient safety in their current-day life situation
- having personal circumstances that allow for the intensity of work in this phase, for example settled and suitable accommodation, no pressing demands such as a new-born baby, and financial stability to be able to continue to afford the therapy where it is paid for
- a 'good enough' relationship with the therapist that has previously demonstrated successful repair from ruptures
- an understanding of the work's nature of phase 2 and a willingness to engage with it

by Carolyn Spring

- a range of affect regulation skills and a commitment to employing them
- good social and professional support such as GP, partner, children, employer
- a sufficiently robust 'contract' between therapist and client which includes contingencies for the heightened pressure on the relationship during phase 2, and an awareness of the forms that pressure will take
- established and respected boundaries within the therapeutic frame
- some ability to pay attention to internal physiological states and to be able to regulate them through techniques such as controlled breathing, oscillating attention and sensory grounding
- a general sense of having sufficient resilience to able to take the work to a deeper level.

Moving into phase 2 work is not a 'once only' decision: the nature of phase-oriented work is that while the three stages are sequential, it is not a linear process, and there is often movement between each of those phases over a particular month or term's work, as well as even within a single session. For example, a typical session might consist of an opening phase of stabilisation and grounding and reconnecting with the therapist, followed by a segment focused on phase 2 trauma processing; and finishing either with more safety and stabilisation work if needed, or reflective meaning-making and integrating of information typical of phase 3. Similarly, it is important to prepare for holidays and breaks from the therapy not by leaving phase 2 work 'hanging in the air' but by pacing it appropriately.

It is important that the client does not feel coerced or pressured to proceed to phase 2 work, and that they make an informed decision, being aware of the nature of the work, and coming to their own place of motivation and commitment to it. Some clients will choose not to engage in phase 2 work, and this should not be seen as a therapeutic failure but as responding to individual needs and circumstances. However, it is important to recognise the potency of avoidance as a coping mechanism and to gently challenge clients to move forwards, if ready, into phase 2 work rather than colluding with their avoidance.

EFFECTIVE PHASE 2 WORK

These are some indicators of effective phase 2 work:

- the 'social engagement system' of the client is maximised – he or she is able to stay connected and in touch with the therapist during the work

by Carolyn Spring

- defences such as denial and minimisation are reduced
- traumatic material is faced rather than avoided, and processed rather than being merely re-lived
- the client can remain physiologically settled enough to both think and feel during the sessions – the client remains neither hyper-aroused nor hypo-aroused, but in a 'window of tolerance'
- the client shows an increasing ability to integrate different facets of the trauma (e.g. memories, emotions, beliefs), and hold complexity rather than splitting (all good / all bad; all-or-nothing)
- the client demonstrates personification – 'I am me and this happened to me' – and presentification – 'I am here, and it is not happening to me right here, right now; I am remembering a past event'
- the client shows dual awareness: an ability to focus their mind on the 'there-and-then' whilst also in touch with the 'here-and-now'
- increased choice and control over what is remembered and when
- decreased dissociative and amnesic barriers between parts of the personality, without destabilisation and flooding
- awareness of the body (in Bessel van der Kolk's words: 'The moment you're not feeling your body, you're gone, because the body really is the engine of aliveness, of thought. As long as people don't feel their bodies, we're wasting our time and theirs trying to do talking psychotherapy.')
- transforming maladaptive behaviours into adaptive ones (such as reducing trauma-related responses of fight, flight or freeze without falling into further avoidance and dissociation; practising self-soothing rather than self-harm)
- willingness to 'experiment' and thoughtfully consider a variety of scenarios or possibilities, rather than being stuck in either rigidity or chaos
- flexibility in pausing the trauma narrative when hyper- or hypo-arousal becomes too marked and re-establishing equilibrium before continuing with the narrative
- an ability to direct attention to the what happened as well as the sense of how it felt and what it meant
- successful disruption of automatic bodily responses and states of distress at reminders of the trauma – gaining mastery over the reflexive symptoms of trauma and becoming desensitised to them, as manifested in life outside the therapy room.

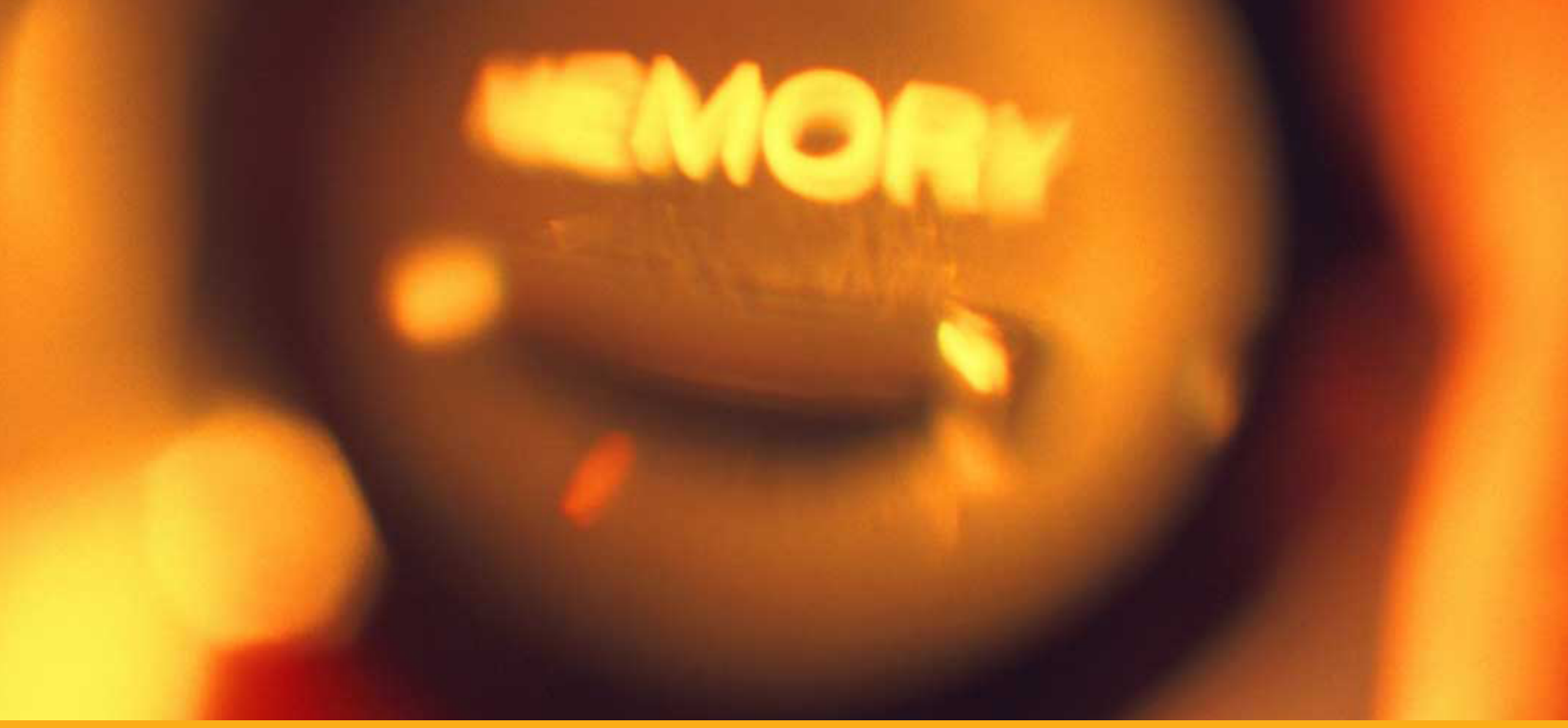
by Carolyn Spring

CONCLUSION

Phase 2 work in the treatment of trauma builds on the foundations of the first phase of developing safety and stabilisation and, using that safe platform, begins to address some of the dissociated trauma that previously has been too overwhelming to be able to face and has therefore been kept out of mind. As survivors grow in their ability to regulate their physiological arousal in response to reminders of the trauma, so they can begin to face this trauma and neutralise it, by bringing it into mind and disrupting their automatic, procedurally-learned responses to it.

Staying within a 'window of tolerance' where they can both think and feel, the survivor learns to be in control of their body and mind, directing their attention to the trauma when they want to, to process and metabolise it, and avoiding it when that is also adaptive, for example whilst at work or play. Over time it therefore loses its power and becomes part of their narrative history, something that happened in the past, rather than recurring in the present, and something that happened to them, rather than to a 'not-me' part of the self.

By bringing traumatic incidents to mind, survivors can then begin to think about the meaning they have made of them, viewing them and reappraising them through adult eyes, and changing some of the unhelpful beliefs and cognitions that they have held regarding them. This leads on then into the work of phase 3 of trauma treatment, which focuses on integrating both the trauma and the self into a new, coherent whole, and developing or rebuilding a new life free from the overwhelming effects of trauma. •



‘DON’T MAKE ME VOMIT SLOWLY’ – MY EXPERIENCE OF PHASE TWO WORK

THE THREE PHASE APPROACH

When I first started therapy in 2006, I didn’t know much about trauma and nothing about ‘the three-phase approach’. My counsellor didn’t know much more. So although I’d like to say that we started by carefully doing the phase 1 work of safety and stabilisation, the reality was a great deal messier than that. It took a few years for us to settle into a pattern of work that I can now look back and identify as ‘phase 2’. For several years I hopped from week to week, like a cat on hot coals, backwards and forwards between phases 1 and 2. It certainly wasn’t textbook, but somehow it was effective.

One of the things that surprised me most about processing trauma was not the feelings of dread, terror, hopelessness, horror, grief and despair that swirled around like a Canadian snowstorm. It was the more unexpected feelings – specifically the aloneness. It washed up over me and drenched me through. Back then, when I was a child, I evidently felt so alone in it all. There was no one – literally no one – to reach out to for comfort, for support, for protection, for love. Those memories would wash back over me in intense spasms of aloneness in the here-and-now, and it took me some time to realise that they were memories, my subjective experience of the trauma, rather than feelings from the here-and-now. The presence therefore of this ‘other’, the therapist, an actual someone in the room, at times perfectly attuned, at times misattuned, but always there,

by Carolyn Spring

was in itself probably one of the most restorative and reparative experiences I had during that work. It was awful to 'go there', to revisit that material. But it shifted something profoundly not to do it alone.

The backdrop to much of my therapeutic work in phase 2 was the various therapists I have worked with helping me to learn to contain my feelings. I grew up believing that feelings were wrong, shameful, and weak. I stuffed them down, or I dissociated from them. But then, in this therapy room, they were allowed to be. They could come, we could notice them, they could rise, we could notice them, they could form into a fist wanting to hit or tears wanting to fall, we could notice them, and we could let them be.

I learned gradually to let feelings come, to notice them, to tolerate them: and all the time in the presence of another person – without shame taking over. That was a long, hard process. It felt so shameful to be feeling feelings, let alone expressing them. I was stuck for a long time in procedurally-learned habits of hiding my feelings in order to survive. That took a lot of relearning: I wanted to apologise for my feelings, I wanted to do them on my own, alone at night, so that I wouldn't do them in therapy; I wanted to be sensible and clever and clear-thinking and rational, not shuddery and tearful and hopeless and enraged.

But ultimately, in 'going there' with these traumatic memories, I had to learn to feel my feelings and then not be overwhelmed by them. Whatever the memory, whatever slice of the traumatic pie we were cutting open, the aim was learning to feel feelings rather than dissociating away from them, and learning to contain and manage them, rather than being overwhelmed by them. As my tolerance to distress grew, so we could look at deeper levels of trauma without me being completely destabilised by it.

MINOR ISSUE FOCUS VS. MAJOR ISSUE FOCUS

Even after many years' work, I still felt by default that I couldn't 'go there'. I automatically avoided it all. I got busy with work, I let minor issues be the focus of my session, I scurried from the therapeutic relationship, I argued theory or danced around the issue – anything other than 'going there'. The instinct to avoid was burned deep in me. And then at other times – usually with other parts of me – the trauma was imminent, and we were in it, steeped thick up to our necks in it, and we couldn't hold back, couldn't avoid, couldn't think about anything else, couldn't do anything other than explode it all out of our heads in a frantic, desperate

by Carolyn Spring

collapse of defences. We wanted to get it all out, and we wanted to get it all out, now. 'Don't make me vomit slowly,' is what I would say when we were in this state of mind. 'Let's just do it – I don't care – I can't stand this – I need to get it out.'

And so I would proceed to vomit this trauma out of my deep unconscious, and by the end of the session not only was I retraumatised by the reliving, but my therapist very probably was too. It took me a long time to accept that slow is fast, and that being destabilised by the telling achieves nothing at all. It was always a difficult balance to attain: too much avoidance versus too much flooding. I'm not sure anyone gets that balance right all the time – perhaps not even most of the time. All I know is that when I blurted out too much stuff too fast, I achieved nothing, because I just switched and dealt with it by dissociating – so none of it was integrated, none of it was done in a 'window of tolerance' where I could still think and feel. It was wild catharsis without any form of resolution.

I eventually learned that this stuff would only shift – the trauma would only be processed and metabolised – if at least to some extent I was able to own it as mine, rather than disowning it into the various traumatised parts of me. I had to work at integrating, at making associations, rather than dissociating – 'This is me, and this is my trauma; these things happened to me; I am me; I am still me now remembering what happened to me.' Owning it, accepting it, was (still is) hard – I've had a lifetime of coping with it by disowning it, by disremembering it, so it's a new way to live, a new way to think and to be.

Shame kept me away from a lot of it for a long time – a desperate, overwhelming shame that said, 'That can't have happened to me, it can't have' because I felt so horrifically tainted and contaminated by what I was remembering. But shame eventually gave way to anger, once I felt safe enough to feel it: 'That's so wrong that that happened to me!'

Only once I had sufficient physical and emotional distance from the people who abused me could I begin to touch the edges of that anger. Previously I had avoided my anger through the shame that says, 'I don't deserve to be angry, because I deserved the bad things that happened to me'. That had kept me safe from them as a child – anger would have been met with the most severe punishment! But it was unhelpful now as an adult, where I continued to pay the price of shame rather than being able to straighten my spine and lift my eyes and walk purposefully into life. I had to feel safe enough to feel that anger towards them rather than directing

by Carolyn Spring

it instead towards me. So physical safety and emotional distance from them was important before I could even begin to 'go there' with much of this stuff.

MEMORIES AND AMNESIA

Working through the amnesia was not what I expected. I don't really know what I expected – I suppose I imagined that a 'memory' would just pop back into my head and that I'd say, 'Oh I remember now … this happened.' But it wasn't like that at all. It was a gradual seeping, through every medium in my brain, with the 'visual' memory last, if it came at all. It would be dreams and nightmares that hinted. It would be body memories that built to a crescendo over a period of weeks – pain in my shoulders, pain in my pelvis, pain in my genitals; strange feelings of suffocation or tightness or not being able to run. It would be sudden, out-of-the-blue waterfalls of emotion – of terror and dread and panic and stuckness. It would be little things that jarred my attention. And it would be that relentless sense that if I didn't work really hard, mentally, to keep this stuff at bay, then it would overwhelm me.

I 'disappeared', in fugue states, to try to run from it. I wanted to die. I wanted anything and everything other than to look at this 'thing' that was emerging into my consciousness. It brought with it such a state of overwhelm and terror that everything in me wanted to twist away from it and never go back to therapy again. Eventually I learned – with much encouragement and many reminders – that it couldn't kill me, that it was an echo, not a repeat, and that if I could direct my attention towards it rather than trying to dissociate from it, I could face it and process it and the feelings would abate.

Much of that 'facing' was done in therapy, with the gentle prompts, the and-then-whats, matched with the breathing in, the breathing out, the lets-take-a-moment, the keeping me somewhere within a window of tolerance. But some of it was outside too, in journalling, in 'diagramming': big sheets of A3 artists' paper, with collections of phrases or thoughts or memories, written randomly on different parts of the page, in different colours, and then lines linking them, questions in purple, emotions in green, stand-out sensations in red. Just filling up the page with everything that came to me, with everything that came to other parts of me, and then seeing what sense arose out of it, what it was that I didn't want to see, what it was that I didn't want to feel.

I've always been amazed at what ink on paper can achieve in the psyche: it's the doing it, the engaging with it, the choosing to focus on it, that makes the shift. The end

by Carolyn Spring

result to an outsider was just a seemingly meaningless jumble of words, but to me it meant that I had thought about things that I could never think about, and that I'd stood back from it and mentalised, and brought it then into the space of a therapy room, to let it sit between me and another person: admitting things for the first time, accepting things for the first time – letting things be, rather than running from them or obliterating them.

'Processing' doesn't happen with flashing blue lights and a two-tone siren. There's nothing to announce, often, that it's taken place. It's only in retrospect that I realise that there is something now from my past that I can talk about, that it's 'something that happened' and 'something that happened to me'. It doesn't plague me so badly in my dreams anymore, or force its way out through my body. It has become part of my narrative history that stops threatening to kill me. I've never had a moment of thinking, 'Ah, that's that then – that's processed, that's changed.' It takes a lot of small steps to add up to a big journey, and at no point was the journey achieved in just one stride. It's only when you look behind that you realise how far you've come.

I know I have more work to do when the tell-tale signs re-emerge of unprocessed, unintegrated content: when shadows loom large in my mind, when my body complains, when my sleep is fragmented, when unutterable terror begins to vomit, deep from within me. I never know what it is that I'm 'processing'. I don't turn up and say, 'Today I'd like to talk about what happened to me when I was six …' – it's not clear enough for that, not verbal. It is the trauma that resides in the body and the unconscious. It needs to emerge and to be given shape, for words to be hung on it and an outline to emerge. It's hard work, because everything in me tells me that I will be safest if I just avoid it, ignore it, suppress it, dissociate from it. But I've been doing that all my life, and it's just like the brown envelope that gets buried under a pile of others: out of mind, but still needing to be paid.

Phase 2 work is like picking up a stash of unopened mail and working through it methodically, intentionally, at a pace that is manageable, until the full horror of the contents is laid bare and a new plan for life is formed. It's good when it's over, but it takes courage to do. I don't regret doing any of it – I do regret trying to rush it, trying to vomit quickly, as if I could speed through it to avoid feeling anything as I ripped open the envelopes.

But I have learned, gradually, that it's only by thinking and feeling, only by bringing those two aspects together, that this stuff

by Carolyn Spring

can shift. But I've also learned that it does shift, and the process, painful though it is, is worth it.

WHAT HELPED – WAYS WE 'PROCESSED' TRAUMA

How do you process trauma when you can't even remember it? That was the struggle I faced, like so many other survivors. But what I eventually realised was that it was not a case of 'all or nothing' – that I either remembered it or I didn't. Usually, the bigger problem was that I couldn't face recalling it, at least not all in one go, and what I did remember was not 'integrated': it was not joined up. There was a fragment here, a visual image there, a feeling here, an automatic flinching there. The hard work of phase 2 was actually bringing all of those things into consciousness and then starting to join them together. There were a few different 'techniques' that we used to do this:

INSTALLING A 'RESOURCE'

A typical traumatic memory for me usually involved some horrific act of abuse, and me feeling overpowered, helpless, stuck and frozen. And that is exactly what it was like for me as a child. But as we worked it through, we started to look for 'resources' that we had at the time too. How had I survived? Some horrendous things were done to me, things that were unbelievable and unthinkable, and yet I survived them. How? What had I done?

Usually my survival had been achieved by things that I had always considered shameful – not fighting back, not running, not screaming for help, not doing anything at all. But then I began to understand: the way I shrunk myself down and became small and subservient and didn't move – that wasn't pathetic. It was smart. It meant that I didn't ignite their wrath. It meant that the abuse was over and done with more quickly. I had always seen it as weakness and my compliance as consent. But I began to be able to reframe it as my best attempt to survive.

So in re-running through that memory, it was important to focus on what I did to survive, and to feel good about that, and strong, and competent, rather than the shame I'd felt up to that point. And sometimes we added on a 'new ending': something totally fictional, made up, but something that tricked my mind and helped to free it from its frozen, overwhelmed state. Most of my memories had very little of an epilogue to them – they were snatches of memories of being overwhelmed, but very little of the 'what happened next' to get free.

by Carolyn Spring

So we created an imaginal ending, one where the police came with their sirens blaring, and all the baddies arrested and taken away. Or where I ran around the house with a meat cleaver like some kind of mini-girl-Rambo, chopping off the offending body parts of my abusers. This competing memory of efficacy, strength, resilience and autonomy seemed to neutralise some of the trauma of the original memory, and for years, whenever the memory swam into my mind, so did the picture of the meat cleaver and my ravenous delight of exacting revenge.

We 'installed' this resource by pausing the narrative and noticing how different I might feel in my body if I had a meat cleaver, or the police had arrived. We paused on that, let the feeling of power and freedom nestle down into my guts and inflate every muscle, and then 'practised' that mental state for the next few days and weeks until every time we thought of that particular incident, instead of the terror and humiliation, the competing emotions of strength, anger and righteous revenge came through instead.

CHANGING THE IMAGE

Borrowing techniques from Neuro-Linguistic Programming and Parks Inner Child Therapy, we would often pause the narrative of the trauma and, again in our imagination, place it as a black-and-white image on a TV in the corner of the room; or imagine the abusers as cartoon characters, or dressed in fairy costumes – anything to break up the automatic trauma-reaction to those images, and to gain back a sense of control over the memory.

I began to understand that memory is fluid and that it doesn't have to control us. We can press pause, stand back, change the channel, change the colour, make it bigger, make it smaller, mute the sound, invite 'snow' and interference, and a whole host of other interventions. It was like graphically editing – Photoshopping! – my memories. It gave me a sense that I can control my memories, rather than them controlling me. The key wasn't so much what was on the 'screen', but the reaction in my body, so I had to change the picture until my body settled, and then I could proceed to the next frame. It was like retraining my brain, one image at a time.

ENGAGING THE BODY

Much of the Sensorimotor Psychotherapy that I went through focused relentlessly on the body: 'Just notice where you're feeling that in your body'; 'What does your body want to do?'; 'Let's just notice

by Carolyn Spring

what your breathing is doing now.' The focus was on learning to take mastery over traumatic responses by calming the body, by switching attention away from the left-brain narrative into the 'noticing' front middle brain. We considered the actions I could employ to change my response. When I was recalling traumatic incidents of sexual abuse where I was frozen and nauseous, what did my body want to do? It certainly didn't want to do what it had been made to do. It wanted to get up, push back, get away, hit out. So we paused the narrative and let my body do that.

You can feel really daft, pushing against a wall and focusing on how strong you feel, but it does work. It is about not trying to change the mind until we've changed the body. Let the body feel strong and powerful and then we will have a different relationship with ourselves, instead of feeling, eternally, that we need to make ourselves small and submit.

I learned to stand up – to really stand up. To feel strong and powerful and competent and brave standing up, rather than the automatic weakness and impulse to collapse that I had at first. We identified that being told to stand up was often a prelude for me of abuse, hence my automatic reaction of crumpling and terror. But when I learned, slowly, to stand up and notice that nothing bad happened – to pause and think and reflect and feel it in my body that nothing bad was happening – it began to transform my bodily reactions.

'CHRONICLING'

Sometimes the trauma narrative, especially when I switched to a 'younger' part of me, came tumbling out all breathless and disjointed and full of stammering terror. So we invented 'chronicling' – a term we used to describe something that we tried just once as an experiment and which was so effective that it became the go-to-technique for much of our phase 2 work. It involved sheets of paper and my therapist writing, verbatim, what I was saying. It worked – I think! – because it slowed things down. It allowed the parts of me that didn't want to 'vomit slowly' to feel that they were being heard and listened to, but it also made them pause to the speed of my therapists' writing. And in the pauses they learned to breathe, to calm a little, to just nudge down slightly, back into the far edges of their window of tolerance. And then move onto the next sentence. Even though a lot of the time it was all feeling and no thinking, it did get it out. And then the next session, or in the second half of the same session, back it would come to me as thinking, reflecting, adult-me, and we would go through it, line

by Carolyn Spring

at a time, and try to stop and pause and face it and listen to it without dissociating. I was very rarely successful in staying present to read it the first time around. But it stopped me avoiding it completely, and bit by bit, in sessions and outside of them, I could sidle up to this stuff and just take a glance at one or two lines of it. And then work on my breathing and notice what I was feeling – notice in my body what I was feeling – and breathe through the panic-response, and the shame-response and the terror-response, until I could think about it maybe just a little.

In mentalising it, I tried then to develop some self-compassion for it: to offer myself the comfort and empathy that I so desperately needed. It was a slow process, but it meant that traumatic content wasn't just splurged or vomited out into the air, in a kind of 'I'm not looking, I'm not listening' kind of a way, but that it was put down on paper for me to go back to at a later point, to approach slowly, and to finally own as 'This is me.' •

PHASE THREE: CONSOLIDATION, INTEGRATION AND RECONNECTION

Much has been written about the work in therapy in stages 1 and 2 of the phase-oriented approach to treating trauma, but less so about the third stage. The work in phase 3 aims to consolidate the gains acquired in the early stages and to apply these to everyday life in order to develop 'a life worth living'. To recap, the three phases follow a standard pattern, described in various ways:

- Safety and stabilisation
- Processing traumatic memories
- Consolidation, integration and reconnection – resolution and recovery.

As Courtois and Ford put it (2012, p.142):

The three-phase treatment model for complex trauma is designed to give the therapist a road map of treatment tasks that are sequenced and approached in a hierarchical way.

THE PHASES

Phase 1 establishes a solid foundation of relationship-building and affect regulation to ensure a sufficiently safe treatment frame, providing the basis for all future work. Phase 2 confronts some of the direct symptoms and manifestations of trauma, working to process traumatic memories and address the body's automatic, neurobiologically-oversensitised responses. Phase 3 then works to draw together the gains and insights, the emotional regulation, the increased self-confidence and sense of relational security acquired during the first two phases, and establishes a platform for life post-therapy. Whereas phase 2 in particular tends to be backward-looking, the focus of phase 3 is definitely forwards, directing energies which had previously been expended coping with the symptoms

by Carolyn Spring

of trauma towards building a new and fulfilling future.

Phase 3 work is seen by many as the culmination of the therapeutic work, but some clinicians instead view this integrative phase as being interwoven throughout the entire process, with gains from the first two phases being applied to daily living at every step of the way. Babette Rothschild (2010, p.60) says:

...for any trauma therapy to be successful, integration – both in phase 1 and phase 2 – must build bridges to relevant points in the current life of the survivor. For example, if one of the trauma elements was being isolated, being unable to talk with anyone, a major integrative step might be helping the client to talk with selected friends and family members about what happened.

In many respects, phase 3 work resembles 'normal' psychotherapy: it is where many non-dissociative, non-traumatised people begin their work. But dissociative clients also have an essential foundation to lay in phases 1 and 2, which, due to their childhood experiences, may at the start of therapy be non-existent: building their capacity to trust and establishing a working alliance with the therapist; learning to manage intrusive trauma-related symptoms such as flashbacks and body memories; developing co-consciousness and co-operation within the dissociative personality system; and developing affect-regulation skills which allow them to feel and express emotion without either using dissociation and avoidance as a blocking mechanism, or becoming hyperaroused and distressed.

Clients may naturally progress to phase 3 work: when they are no longer unduly affected by memories of trauma, when they have at least a rudimentary and coherent narrative for their personal life, and when they are able to reflect through mentalisation upon their experiences. If the goal of therapy is simply to reduce symptoms, however, some clients may not wish to progress to phase 3 work at all. They may feel that they have achieved enough at the end of phase 2, or even phase 1, or their access to therapy may be curtailed. However, great rewards lie in store for those who push through into the third phase and begin to establish the kind of life that they may always have wanted but previously had not thought was possible.

COMMON ISSUES

Rather than focusing on stabilising and reducing symptoms, or processing traumatic memory, therefore, the third phase of work covers a range of issues common to many people entering therapy, for example:

by Carolyn Spring

- addressing core beliefs and making meaning
- learning life skills
- establishing new blueprints for both the self and relationships with others
- developing support systems outside of therapy
- increasing independence
- negotiating peer relationships
- exploring issues of intimacy and sexuality
- parenting skills and issues
- career and vocational choices
- improving physical health
- pursuing potential prosecutions against abusers if desired and if possible
- developing a 'survivor mission'
- existential and spiritual questions
- potential integration/fusion of alternate personalities
- dealing with endings, and moving on from therapy.

As has been emphasised in previous articles, progress through the three phases is rarely linear, moving efficiently from phase 1 through phase 2 and finally into phase 3. Again in the words of Courtois and Ford (2012, p.XV):

The three phases are not neatly subdivided but tend to overlap, and treatment tasks may need to be repeated numerous times before emotions, beliefs, and cognitions are sufficiently reprocessed and integrated.

A client may therefore move repeatedly from phase 3 work back to phase 2 or even phase 1, repeatedly covering old ground and reinforcing previously acquired skills. Challenges and skills that had been faced or learned in earlier phases may reappear in phase 3. This should not be seen as a 'failure', either by the therapist or the client. In fact, it signifies the contrary: that the client is able to revisit past topics from a different, higher vantage point, and is integrating what he or she has previously known with this new, wider perspective. At many points during phase 2 work, for example, the client will need to return to working on issues of safety and stabilisation, and emotional regulation skills will need to be strengthened to cope with the higher levels of distress accompanying more profoundly traumatic memory.

The same is true of phase 3 work: very often the client, in pulling together a number of threads to integrate traumatic material into his or her autobiographical narrative, will need to revisit further traumatic material in order to gain a more holistic viewpoint or mentalising stance.

Phase 3 provides a focus for all the work in therapy that has already taken place, to establish and integrate into daily life the therapeutic gains and the resilience that

by Carolyn Spring

has been developed. As James Chu puts it:

I am convinced that insights in therapy are only the beginning, and the roots of self-esteem and a positive self-image are in actually doing things in life. Summoning up the courage to reach out and connect with others, going to work reliably, following through with an exercise program, and engaging in recreational activities are some examples of types of functioning that begin to instil new positive ways of thinking about oneself to replace the old negative ones (e.g. 'friendly', 'productive', 'fit', 'fun-loving'). Over time, healthy functioning in all domains – relational, vocational, educational, and recreational – leads to self-esteem and a positive self-identity. (2011, p.128)

CONFLICTS OF THE THREE PHASE APPROACH

Many conflicts emerge in the midst of phase 3 work. As the client is less assaulted by unwanted feelings, flashbacks and body memories, so new energy arises. This energy can be directed towards building a future, with a wealth of possibilities in both relational and vocational domains. But it can also lead to the emergence of conflicts: does the client want to be well, or does the idea of engaging in 'normal' life feel too terrifying?

Some dissociative survivors took on the sick role and/or the child role, or that of a submissive victim, as their only means of surviving, and it served them well. It was adaptive during the abuse: compliance and submission limited the duration or extent the abuse, to get it 'over and done with' more quickly. But it becomes problematic in a new, non-abusive environment, where instead as adults we are expected to demonstrate assertiveness, make choices, and actively defend ourselves. This can be terrifying for many survivors.

Stepping into a new role, not as victim or child, but as autonomous adult, carries with it not just the difficulties of adjusting to a role never before experienced, but can also carry the traumatic reminders and injunctions, embedded in procedural memory, that it is dangerous to step up and make choices, to be independent and not to hide in the shadows. It is therefore important that clients are helped to reassess the role they have played in life, frame it in terms of survival necessity, but then be empowered to take on the most adaptive role for their current and future circumstances.

Some survivors lack basic life skills, having focused purely on survival until this point, and cannot imagine being well enough to hold down a job and live without support from mental health or other professional services. For some, 'stable multiplicity' is their informed choice for the future.

by Carolyn Spring

However, many others do want to move away from their label and their place in society as being perceived as 'mentally ill', and phase 3 work can focus on building the necessary resources to facilitate this: skills such as assertiveness, planning, and relationship-building, coupled perhaps with vocational or career training/re-training.

Previously, a great deal of energy has been used simply surviving and managing the discontinuities and 'glitches' of a dissociative mind. With increased co-consciousness and control of switching, this energy can now be redirected towards managing the demands of family/relationships and career/vocation, without the safety net of welfare benefits or mental health services. Therapy should not therefore be terminated soon after the main chunk of phase 2 work, but plenty of time should be allocated to working through the challenges of phase 3 in order to prevent a later relapse: it is all too easy for daily life pressures to mount up for a client who has spent all their life just surviving trauma and the resultant dissociation, and feels ill-prepared to tackle 'normal' life at the end of it.

Social pressures too can keep clients in the role of 'victim': these include therapy itself, when the therapist is invested in the work and the individual relationship to such an extent that they are consciously or unconsciously unwilling for the client to gain independence and move beyond therapy. In many scenarios the power dynamics of abuse can be unwittingly replayed as the therapist, the 'expert' who holds all the knowledge and all the power, takes a one-up role of superiority over the client. To an extent this is unavoidable, but it is important that the therapist remains aware of it and of the potential for abuse.

The therapist should not foster a belief that the client is dependent on the therapy and the therapist, but should instead imbue them with a belief in themselves as an equal human being who has suffered (and survived!) extensive trauma and so who is a resilient and resourceful human being. The mindset of 'victim', 'inferior' and 'powerless' can be particularly resistant to change, and so it is essential that the therapist does not reinforce it in any way. Within a therapeutic setting where they are being encouraged to grow and gain independence, the client must also co-operate with this process if they are to see real transformation. They must be willing, with help, to leave their victimhood behind. James Chu (2011, p.128) says:

Late phase therapy involves consolidation of gains, achieving a more solid and stable sense of self, and increasing skills in creating healthy interactions with the external world.

by Carolyn Spring

The resolution of the all-encompassing and overwhelming past events reduces patients' inevitable narcissistic preoccupation with their symptoms and difficulties, and allows them to have more appreciation of others as separate individuals. Moreover, an empowered sense of self leads patients to have increased confidence in their abilities to participate successfully in interpersonal relationships and other activities in ways that previously eluded them.

This echoes one of the central paradigms of Judith Lewis Herman, in her seminal book *Trauma and Recovery* (1994), who talks about the third phase 1n terms of 'reconnection'. She argues that trauma separates people from people – it disconnects. Part of recovery, therefore, is to encourage reconnection.

For dissociative survivors who have been used to living life through the lens of multiple parts of the personality, it can be a challenge to begin to relate to others in a non-traumatised way: as an adult, as a peer, not requiring care or over-solicitously providing it, and with a consistent, integrated, narrative memory for day-to-day events. This should not be underestimated: for someone with polyfragmentation of the personality, it is a whole new challenge to remain consistently 'one' and engage with others on the basis of a new sense of identity – as someone who was traumatised but is now living 'beyond trauma' – rather than the previous roles of 'patient', 'victim', 'mental health service user', even 'survivor'.

Understandably, therefore, some clients will find it difficult to fully embrace this final stage of moving on because it represents entirely new territory, and they may feel that they have no map or guide for it. A large part of phase 3 work therefore can consist of adjusting to this new identity and life, and developing the self-esteem and positive self-identity, as well as the life skills and understanding of social 'rules', to be able to function healthily in these challenging new domains. Without a focus solely on survival, phase 3 provides space for many previously unfaced feelings to emerge. It is not surprising that this stage is so often accompanied by a great deal of grief: for lost opportunities, and for the burden of symptoms that so frequently prevent a survivor from experiencing positive physical health, family life, career success and enjoyment of life. It is not surprising that many clients struggle with this phase of the work, as the full force of their feelings – anger, rage, resentment, hatred, outrage, indignation, amongst many others – are experienced and felt, perhaps for the first time. The injustice of all their losses may be keenly felt, and it can take some time to process these

by Carolyn Spring

feelings adequately so that a new life can be established, rather than sabotaged because of the ungrieved losses of their traumatised past. Elizabeth Howell (2011, p.183) says:

As patients shift their focus from their traumatic pasts to their current lives, many core beliefs emerge and need to be re-examined. These may include such things as continuing to feel and believe that one is worthless, continuing to believe that comfortable intimacy is not possible, facing existing unhappy relationships and work problems, as well as learning some of the 'blueprints' for adult life for the first time. Perhaps even more painfully, these core issues also include facing the narcissistic personality structure that is often the residue of the dissociative personality structure (Howell, 2003; Schwartz, 1994, 2000). As Kluft has frequently said, following work on the problems posed by DID, patients increasingly must deal with the everyday problems of 'unitary personality disorder'.

It can be challenging for many survivors to realise that day-to-day difficulties exist for all people, not just people who like them have been traumatised, and that having experienced atrocities in childhood does not preclude further tragedies in adult life. One of the many sequelae of childhood traumatisation is a significant increase in risk for long-term physical disease, in particular some cancers, autoimmune disorders, heart disease and diabetes. It can feel like a double whammy to have experienced trauma in childhood and then, even upon processing the trauma in therapy, to be faced with physical health battles. But this nevertheless is the statistical reality, and so an important emphasis in phase 3 work is on developing, or redeveloping, good physical health, especially when the client has previously coped with the pressure of unprocessed trauma through alcohol or drug abuse, eating disorders, a sedentary lifestyle rooted in a physical freeze response, smoking, disrupted sleep and circadian rhythms, or a generally inadequate diet. Having processed and metabolised much of the trauma in phase 2 work, many survivors begin in phase 3 to experience their inner worlds – the dissociative parts of the personality – in different ways. With a reduced need for segregation of memories and feelings, parts of the personality often spontaneously 'fuse'. Some clinicians favour the use of 'fusion rituals' to encourage the removal of dissociative and amnesic barriers between parts of the personality, often using visualisation or imagery. However, many survivors feel deeply uncomfortable with this. Many express their fear that 'integration' equals 'death', and it may require repeated explanations that parts of the personality cannot 'die' or cease to exist, and that fusion or integration means

by Carolyn Spring

that the dissociative client is in touch with more of themselves, rather than being so disconnected and subjectively experiencing themselves as different identities. The ISSTD Guidelines (2011) explain this well:

Fusion rituals are useful when, as a result of psychotherapeutic work, separateness no longer serves any meaningful function for the patient's intrapsychic and environmental adaptation. At this point, if the patient is no longer narcissistically invested in maintaining the particular separateness, fusion is ready to occur. However, clinicians should not attempt to press for fusion before the patient is clinically ready for this. Premature attempts at fusion may cause significant distress for the DID patient, or, alternatively, a superficial compliance wherein the alternate identities in question attempt to please the therapist by seeming to disappear. Premature fusion attempts can also occur when the therapist and patient collude to avoid particularly difficult therapy material.

The clinical literature suggests that the best long-term outcomes are associated with higher levels of integration or fusion of parts of the personality, although it is generally accepted that clients may redissociate at later points when under extreme stress, even if they present in day-to-day life as fully 'integrated' Integration does not imply the absence of 'parts': rather, integration refers to an overall process of connecting and associating previously disconnected (dissociated) mental processes. Richard Kluft (1993a, p.109) defines integration as:

an ongoing process of undoing all aspects of dissociative dividedness that begins long before there is any reduction in the number or distinctness of the identities, persists through their fusion, and continues at a deeper level even after the identities have blended into one. It denotes an ongoing process.

Meanwhile, fusion is defined in the ISSTD Guidelines (2011) as:

the point in time when two or more alternate personalities experience themselves as joining together with a complete loss of subjective separateness.

The Guidelines go on to elaborate many of the factors that preclude some survivors from either pursuing or achieving integration of all their personality states:

- chronic and serious situational stress
- avoidance of unresolved, extremely painful life issues, including traumatic memories
- lack of financial resources for treatment
- comorbid medical disorders
- advanced age
  significant unremitting DSM Axis I
- and/or Axis II comorbiditiesand/or

by Carolyn Spring

significant narcissistic investment in the alternate identities and/or DID itself.

It is therefore reasonable for the client to set their own therapeutic goals and the extent to which they desire to achieve 'stable multiplicity' or push further forwards into complete fusion and integration. But it is equally important that clients and therapists alike realise that a new, 'post-post-traumatic' (Spring, 2015) world is possible. In Judith Lewis Herman's words (1994, p.196):

Having come to terms with the traumatic past, the survivor faces the task of creating a future. She has mourned the old self that the trauma destroyed; now she must develop a new self. Her relationships have been tested and forever changed by the trauma; now she must develop new relationships. The old beliefs that gave meaning to her life have been challenged; now she must find anew a sustaining faith. These are the tasks of the third stage of recovery. In accomplishing this work, the survivor reclaims her world.

This is the challenge, and the reward, of phase 3: reclaiming the world. The client can discover, or rediscover, aspirations and ambitions. Although there is much mourning to be done for what has, irrevocably, been lost, nevertheless the ultimate purpose of mourning is to clear the ground for new crops to be sown.

This phase 3 work helps the survivor see that, although he or she has been a victim, revictimisation is not a certainty and skills can be learned to protect against it; safe relationships can be nurtured whilst building boundaries to protect against unsafe relationships. In effective phase 3 work, the client learns from the past – learns that abuse is never a child's fault, but also learns to live free of abuse through the choices that they can make now as an adult. In Judith Lewis Herman's words (1994, p.199):

The survivor is free to examine aspects of her own personality or behaviour that rendered her vulnerable to exploitation only after it has been clearly established that the perpetrator alone is responsible for the crime.

Phase 3 work, although daunting and difficult, does open the door to a brave, new world. •

MY EXPERIENCE OF PHASE 3 WORK

I wish I could sit down with a marker pen and draw out a nice, neat sketch of the work I've done in therapy, with periods of time, like 2007-2009, 2009-2012, 2012-2015. That would be lovely. Phase 1: all that safety stuff, all that trying to calm things down and beginning to 'just notice', and learning to breathe, and building some trust. Phase 2: the yukky-memory stage, all the explosive out-of-the-unconscious surges of fragmented memory that start to take shape and join the dots together of a narrative timeline. And then finally (finally!), Phase 3: just tying it altogether, reaching forwards to create a new future, and everything, everyone, all of my parts living happily ever after, amen. But it's not been like that, and I don't think anyone really ever thinks it is.

Time and again, I've read about the fact that it's not 'linear', that no one expects it to be. But are people just saying that? Do they really believe it? Because for me it's always been three steps forwards and two steps back, and it's hard not to feel that you're 'failing' in some way when right in the middle of things going well, suddenly, you're back to basics again and you're spending a session knee-deep in self-harming and suicidal tendencies. One of my therapists used to talk about how she'd come back from some training, and she'd have it all neatly lined up in her mind that first this, then that, and hurrah. But then ten minutes into the session with me and it was all just merged into one like someone stirring milk into custard.

by Carolyn Spring

It has only been in retrospect, from a mentalising stance (and, I'm sure, some rose-coloured spectacles), that she could make out any kind of distinction between the different phases in our work together.

I understand that the phases are sequential: they give some kind of road map to both therapist and client of what to work on and how to build a treatment plan. And I understand that they are hierarchical: there needs to be a foundation of stability before undertaking trauma work, and the reaching forwards into a future life comes because of the stability and the processing that has gone before it. And I would say that it has in many, many respects been like that for me. But it doesn't look like it at the time. I used to struggle to understand what phase 3 could possibly be about, because my life was so consumed with just surviving, and then so consumed with working through traumatic material to neutralise it, that I imagined that therapy would always be like that, and that once it was no longer happening, there would be no more need for therapy. I do see an end to my it, but only as I outgrow it and not because we're not dealing with trauma every week.

And in the meantime, this phase 3 work seems to be ever more important. It makes me realise how much we used to 'process trauma' over the space of several sessions, and huge gains would be won, but then I would try to put it out of mind. Dissociation is such a habit that even after neutralising a particular traumatic event, I would still tend to avoid it. So it became part of my narrative history only in the sense that it remained in a box with 'Do Not Disturb' written on it. Phase 3 work has helped me to assimilate the contents of that box into my daily life, for it to become part of my narrative history that I 'own' and admit is mine. It's neither centre nor outside; it's allowed to be part of my life, but I don't need to concentrate on it. There grows a companionable silence with this traumatic past —something that I don't need to talk about, but I could do, if I wanted to, because it no longer stings. When trauma is something that has burned a hole in your skin for so many years, when trauma is something that you have lived your life avoiding, it is a strange thing to be able to sit in a room with it and just let it be, without it hurting (or at least, not hurting as much).

Phase 3 for me has been a lot about figuring this stuff out at the level of how it affects me, right here, right now, and what I want my life to be. It's been about building a future, a life that is resilient because it has survived and then processed trauma, and yet doesn't focus exclusively on it. A large part of

by Carolyn Spring

that has been the shift in my dissociative personality system. I had hundreds of parts—the proliferation of them previously seemed to serve the purpose of allowing me to avoid, and continue to avoid, and continue to continue to avoid. Flitting from part to part, I didn't ever have to hold the whole of the trauma in my mind. I was like a dazzling light show on the inside of me, the colours ever shifting, ever changing, nothing constant, nothing still.

As I worked through the trauma and the reasons for my switching, the lights began to settle, and pure colours began to emerge. I settled eventually onto a dozen or so alternate personality states, each with a purpose, each with a meaning, each a tinted aspect of myself. And then gradually, softly, their colours began to merge into one another as they lost their separateness.

I've never tried to 'fuse' or 'integrate' my parts. I've always figured that there's a reason for their separateness, and when that reason ceases to serve a function, so the separateness will dissolve. And I've found that to be true. I'm always vaguely suspicious of grand claims of complete healing or integration: I see us all as being on a spectrum and we slide along that spectrum based not only on our resilience within, but on the stresses without. At times everyone faces events in their life that are so overwhelming, such as sickness or bereavement, that they fall back towards more primitive ways of coping. If we claim to be completely 'integrated' or 'fused' then we can feel a failure when, under extreme stress and in the absence of other options, we revert to dissociation as a coping mechanism. Personally, I wouldn't see this as 'failure', 'loss of healing' or anything else. So I don't claim to be 'integrated' because I know that if the stakes are too high, I'll do whatever I can to survive and it's possible that I'll turn again to the tools I used as a child.

So phase 3 for me has not focused on 'integrating' or 'fusing' parts, but it's still true to say that I am not nearly as dissociative as I used to be. I am largely co-conscious, except perhaps when tackling still-tricky subjects in the context of therapy. And I enjoy a high degree of internal collaboration: the sense within me, most of the time, is that all my different parts are pulling in the same direction. My focus has been on building a new life, a 'post-post-traumatic' life as I've called it elsewhere, rather than trying to twist my multiplicity, through force, into a single braid.

by Carolyn Spring

I've grown enormously in self-acceptance, which has been key as I've worked through some of the wider life issues of phase 3: relationships, vocation, physical health, becoming who at core I am meant to be. I tried so hard, in the dark days before therapy when I was unaware of my dissociativity, to make myself better either by sheer force of will or by harsh self-castigation. I've now learned that compassion is truly transformative, and so phase 3 for me has been about nurturing and growth, of figuring out what I want my life to be, and being encouraged towards it, rather than just running scared from my past, my self, and my selves, or desperately trying to force things to work.

Indeed, much of the phase 3 work in practice for me has been akin to life coaching. I've had to come to a realisation that I can do life, and even do it well, despite not yet being 'sorted'. I've understood, at last, that I don't have to wait until some point in the future when everything is resolved before I start living, but that the journey is forever and the journey is now. Having DID is no longer an impediment, because I am in control of it far more than it is in control of me: I can use dissociation as a tool to keep some of the trauma out of mind some of the time, so that I can focus on other things, but it no longer lives my life for me. In Judith Lewis Herman's terms, I've got back a sense of control, connection and meaning: control over my symptoms, at least most of the time; connection with other people, with myself and with my narrative history; and meaning in terms of the existential and spiritual sense I ascribe to my life and what has happened to me. I no longer believe that I was abused because I was bad. I no longer believe that I did anything to cause it. I no longer believe that I am unworthy of love, incapable of relationships, or deserving only of bad things. A lot of the beliefs that I have carried around with me all my life have been brought under the microscope, and reformulated. It takes a lot of standing back from the imminence of flashbacks and fight-flight-freeze to see the bigger picture and to realise that there is a lot of evil in the world, but I am not evil; to realise that I was powerless as a child, but I am not powerless now; and to realise that dissociation is logical, but it's no longer the only way to manage my feelings.

And so in many respects the work of phase 3 is about pulling together all the threads of phases 1 and 2 and weaving something beautiful with it. It's not about denying that phases 1 and 2 took place, or were essential, but it is about learning

by Carolyn Spring

from them and applying it to daily living, so that we can do more than just survive atrocities - so that we can live.

Every so often, I dip back into phase 2 work - as new material emerges, as new issues rise to the fore - but always from a fresh perspective, from a higher place up the mountain. Sometimes stuff that we worked on years ago is revisited - not as a repetition, but rather as a reworking. I look at things that happened when I was little, not just as the terrorised four-year-old reliving it, but as the adult who understands some of the culture of the 1970s, some of the cognitive distortions of abusers, some of the dynamics of abuse. I'm looking at my abuse, effectively, with the eyes of my adult self, rather than just experiencing it from within as the traumatised child, which is what it's like in a flashback or a dissociative state.

So it's integrative: it draws together the me-as-adult-me now, and me-as-traumatised-child from back then, and makes me one complete person. I can remember some of the trauma now with the sense that this is me, as an adult, looking back on me as a child (the me who is the same person as adult-me) and I'm no longer in it but I'm just remembering it, and I'm thinking about it, and letting feelings come up, but the feelings aren't overwhelming me. That's a long way to have come. I've still got a way to go, but I know that I'm on the right tracks, and I know that I'll get there. •

WWW.CAROLYNSPRING.COM