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Opinion Paper

Stabilization in the treatment of complex post-traumatic stress disorders: Concepts and principles

La stabilisation dans le traitement des troubles de stress post-traumatiques complexes : concepts et principes

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ABSTRACT

Stabilization is a core element of treatment for individuals suffering from complex post-traumatic stress disorder (C-PTSD) and/or other trauma-related disorders. But what makes stabilization so central in this kind of psychotherapy? What do we mean by "stabilization"? What research supports the use of stabilization measures and what concepts of stabilization are there? This article aims to answer these questions and provide clinicians with concepts and guidelines to help them in their work with C-PTSD patients. It focuses on the concept of stabilization in somatic medicine before addressing the distinction between an "unstable" and "stable" trauma patient. It will then present the historical background and the concept of phase-oriented treatment, specifically with regard to the implications in the stabilization phase. Finally, on the basis of a critical review of PTSD studies, we will present guidelines and studies that support a stabilization phase in the treatment of complex post-traumatic stress disorders.

Mots clés :
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Lignes directrices

RÉSUMÉ

La stabilisation est un élément central du traitement des sujets souffrant du trouble de stress post-traumatique complexe (TSPT-C) et/ou d'autres troubles liés à des traumatismes. Mais qu'est-ce qui rend la stabilisation si centrale dans ces psychothérapies ? Qu'entendons-nous par stabilisation ? Quelles sont les recherches, les réflexions conceptuelles et les principes soutenant le concept de stabilisation ? Le but de cet article est de donner des réponses à ces questions centrales et de donner aux cliniciens des principes conceptuels et des lignes directrices utiles pour leur travail avec les personnes souffrant de TSPT-C. Cet article cible tout d'abord le concept de stabilisation dans la médecine somatique, puis propose une réflexion sur ce que l'on comprend par patient traumatisé instable versus stable. Le contexte historique et le concept du traitement orienté par phases sera présenté, tout particulièrement pour ce que cela implique pour la phase de stabilisation. Ensuite une revue critique des études sur le trouble stress post-traumatique nous amènera à présenter des lignes directrices et des études soutenant le besoin d'une phase de stabilisation dans le traitement du TSPT-C.

1. Introduction

The concept of complex post-traumatic stress disorder (C-PTSD) is not widely recognized and has not been extensively studied. Disorder of extreme stress not otherwise specified (DESNOS), a diagnosis proposed by van der Kolk's team (Pelcovitz

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et al., 1997; van der Kolk, 2001) has not been recognized in the DSM-IV (APA, 1994) nor, more recently, in the DSM-5 (APA, 2013). The authors describe alterations in six areas of functioning in patients with complex traumas: regulation of affect and impulses, attention or consciousness, self-perception, relations with others, somatization, and systems of meaning. There has been a proposal to include C-PTSD, which differs slightly from DESNOS, in the ICD-11 (Maercker et al., 2013). It is described as "a disorder which arises after exposure to a stressor typically of an extreme or prolonged nature and from which escape is difficult or impossible. The disorder is characterized by the core symptoms of PTSD as well as the development of persistent and pervasive impairments in affective, self and relational functioning, including difficulties in emotion regulation, beliefs about oneself as diminished, defeated or worthless, and difficulties in sustaining relationships".

This concept has been strongly influenced by the pioneering work of Herman (1992). Herman makes a precise distinction between simple PTSD as the result of a single trauma and complex PTSD following repeated or long-term traumatization. Van der Kolk uses the concept of developmental trauma disorder primarily with regard to the interpersonal and developmental disorders that result from traumatization (van der Kolk, 2005; Maercker, 2009).

The differences between simple PTSD and C-PTSD, their duration and severity have been described at length. We will address this issue below. The primary issue in the discussion on PTSD and C-PTSD is the necessity of stabilization, a necessity many experts in the field consider greater for individuals suffering from C-PTSD. This article summarizes the concepts that strongly support the principle of stabilization in the treatment of C-PTSD patients and other severe trauma-related disorders.

2. Stabilization as a medical concept

Clinicians understand that there are differences between stable and unstable patients. In fact, the concept of stability was not conceived by psychotherapists; it has long been used in medicine. As in somatic medicine, psychotherapy patients rightly expect the psychotherapist to carefully assess their stability, i.e. whether the patient meets the conditions for a given intervention. Medical doctors learn to determine, for example, whether a patient is stable enough to undergo surgery or other type of intervention. Prior to any specific intervention, medical professionals thoroughly examine patients, and if necessary, prepare accordingly (except in emergencies). A further basic principle in medicine is that doctors intervene only if they understand the possible complications of the intervention in question and are able to treat them. We believe that this principle should be observed in the debate over stabilization.

We believe that medical and thus psychotherapeutic treatment is based on two principles: the first is evidence and the second is clinical experience and effectiveness, particularly in those cases in which there is a lack of scientific data. In such cases, the treating physician must rely on "phronesis" or the wisdom derived from experience (see also medical ethicist Svenäus, 2003). Even Aristotle pointed out that alongside technical knowledge ("techne"), scientific knowledge ("episteme"), theoretical or philosophical knowledge ("sophia") and intuition ("nous"), there must be practical wisdom ("phronesis"). According to Aristotle, "phronesis", more than the other areas of knowledge, contributes to "the good life" and requires experience.

2.1. The stable versus unstable patient in psychotraumatology

There are several factors to take into consideration when distinguishing between a stable and unstable patient.

In particular, therapeutic approaches often fail to differentiate sufficiently between several discrete experiences in the case of a stable personality and a complex PTSD. Exclusively supporting avoidance-oriented coping strategies is just as problematic as ignoring disorganized attachment patterns (Rosner, Henkel, Ginkel, & Mestel, 2009; Beutel & Subic-Wrana, 2012).

What distinguishes a stable from an unstable patient? In psychodynamic therapies, we speak of "ego strength" when referring to stability; in cognitive-behavioral therapy of "self-efficacy" and "self-management" as well as, more recently, "self-compassion" (Neff & Davidson, 2016; Neff, 2012).

In both cases, dealing with the triggering event(s) involves a reconstructing encounter with the traumatic experience(s). Above all, the goal is to bear painful emotions, affects and bodily memories such that dissociative disorders and other self-harming trauma coping strategies do not become necessary; these include, in addition to the above-mentioned dissociative disorders, psychotic or somatic decompensation, suicidal tendencies and substance abuse.

The therapist must determine and evaluate the situation before taking any measures to confront trauma. If we refer to the concept of "window of tolerance" proposed by Ogden and Minton (2000), the patient should not be in a state of either hyper-arousal or hypo-arousal (above and beneath the window of tolerance), otherwise she/he may not be able to regulate the emerging emotions and sensations. This can lead to self-damaging coping behaviors.

It is also important to determine whether the patient is in the most secure position possible and to ensure that there is a secure attachment between the patient and the therapist.

Many patients need relatively little time to create a safe relationship, particularly if they have experienced a single trauma as adults. Others need a great deal of time before they can develop a modicum of trust. Some traumatized patients have a high degree of stable ego strength or self-management skills while others have hardly any when they first begin therapy. Thus, the phase of thorough diagnosis and anamnesis is indispensable. This phase also involves determining resilience factors.

The requirements of stabilization do not emerge solely from a diagnosis; rather, they often emerge from concrete psychic and behavioral features related to instability associated with the diagnosis. Nonetheless, it is clear that patients who can be diagnosed unequivocally with classic PTSD symptoms find stability more often than those who suffer co-morbidities or especially a complex post-traumatic stress disorder (Herman, 1992).

But even patients with a "classic PTSD" sometimes exhibit a high degree of depressive and anxious behavior and seem unable to confront the triggering event. A study by Cloitre et al. (2014) shows how different diagnoses (PTSD, C-PTSD, borderline personality disorder) and severity of symptoms can occur in a group of 310 patients, all with a history of childhood sexual and/or physical abuse. Thus, therapeutic steps on the basis of clinical findings need to be taken.

3. The phase-oriented treatment: 3-phase model of psychotherapy for trauma-related disorders

Much has been published on phase-oriented treatment (POT), albeit under other names and with different numbers of phases (van der Hart, personal communication, 2014). It is safe to say that there is now a broad consensus on the utility of phase-oriented treatment for patients suffering from trauma-related disorders (i.e. ISSTS guidelines: Cloitre et al., 2011; Guidelines from the ISSTD – International Society for the Study of Trauma and Dissociation, 2011). Phase-oriented treatment is a structured therapy model