RESEARCH MEETS PRACTICE: THE STABILIZATION CONTROVERSY

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THE DUTCH (?) CONTROVERSY

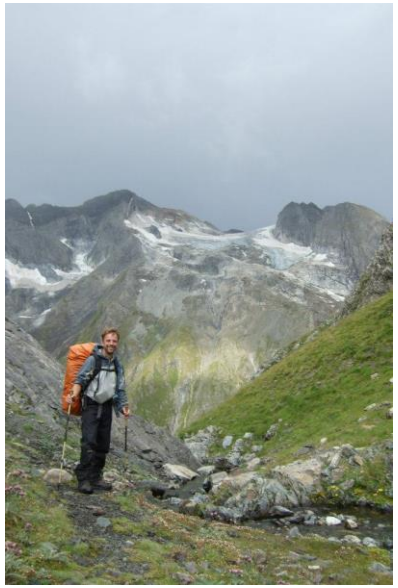
SOME SAY: START RIGHT AWAY

Analogy with the 100 meters: take your marks, ready, go!

Start with EMDR, whether there is PTSD or C-PTSD, comorbid disorders etc.

If necessary, one can always refer clients during their trauma focused treatment to stabilizing treatment

OTHERS SAY: STABILIZATION FIRST



Analogy with a hiking trip in the mountains: be prepared and take care, before and during your trip

Among the most complex cases there are clients who need additional treatment before they can start their confrontation with their severe trauma's

(…or who need extra support during the treatment)

Stabilization is essential for successful treatment of C-PTSD clients

- Complex trauma can very well be treated with EMDR
- Don't be too hesitant to offer EMDR treatment, don't deny clients our evidence based treatment
- Start straight away whenever you can: **Yes, unless…**

CONSENSUS

Yes, Unless…

HOW TO SOLVE THIS DEBATE?

- What is complex trauma?
- What does stabilization mean?
- When can we start and when can we not?
- And with whom?

WELCOME TO:

RESEARCH MEETS PRACTICE: THE STABILIZATION CONTROVERSY

EMDR EUROPE
CONFERENCE 2016

WHAT DO WE OFFER?

- What are the international guidelines and are they accurate?
- What do we know about PTSD versus C-PTSD?
- What does stabilization mean?
- What does research tell us about the necessity of stabilization?
- Window of tolerance
- Case study

THE INTERNATIONAL GUIDELINES

HERE THE DISCUSSION STARTED…

- In 2012 the "The ISTSS Expert Consensus Treatment Guidelines For Complex PTSD In Adults" were published, as an addendum to the international guidelines for PTSD.
- For complex PTSS the experts advised a phase-based or sequenced approach for Complex PTSD

PHASE BASED TREATMENT

The guidelines advise to offer treatment in three phases:

- Phase 1: achieving safety, reduction of symptoms and improvement in basic self-management skills.
- Phase 2: the review and reappraisal of trauma memories.
- Phase 3: transition from therapy to greater engagement in community life

C-PTSD

- Occurrence of core DSM-IV symptoms of PTSD in conjunction with:

(1) emotion regulation difficulties,
(2) disturbances in relational capacities,
(3) alterations in attention and consciousness (e.g., dissociation),
(4) adversely affected belief systems
(5) somatic distress or disorganization

CRITICISM ON THE ISTSS GUIDELINES

De Jongh et al, 2016

- Criticizes the validity of the C-PTSD construct
- Doubts the evidence for the phase based treatments
- Neither trauma history nor comorbidity appear to influence response to trauma-focused treatment
- EMDR improves emotion dysregulation often seen in PTSD
- **Conclusion: there is no need for stabilization or a phase based treatment**

PTSD- C-PTSD

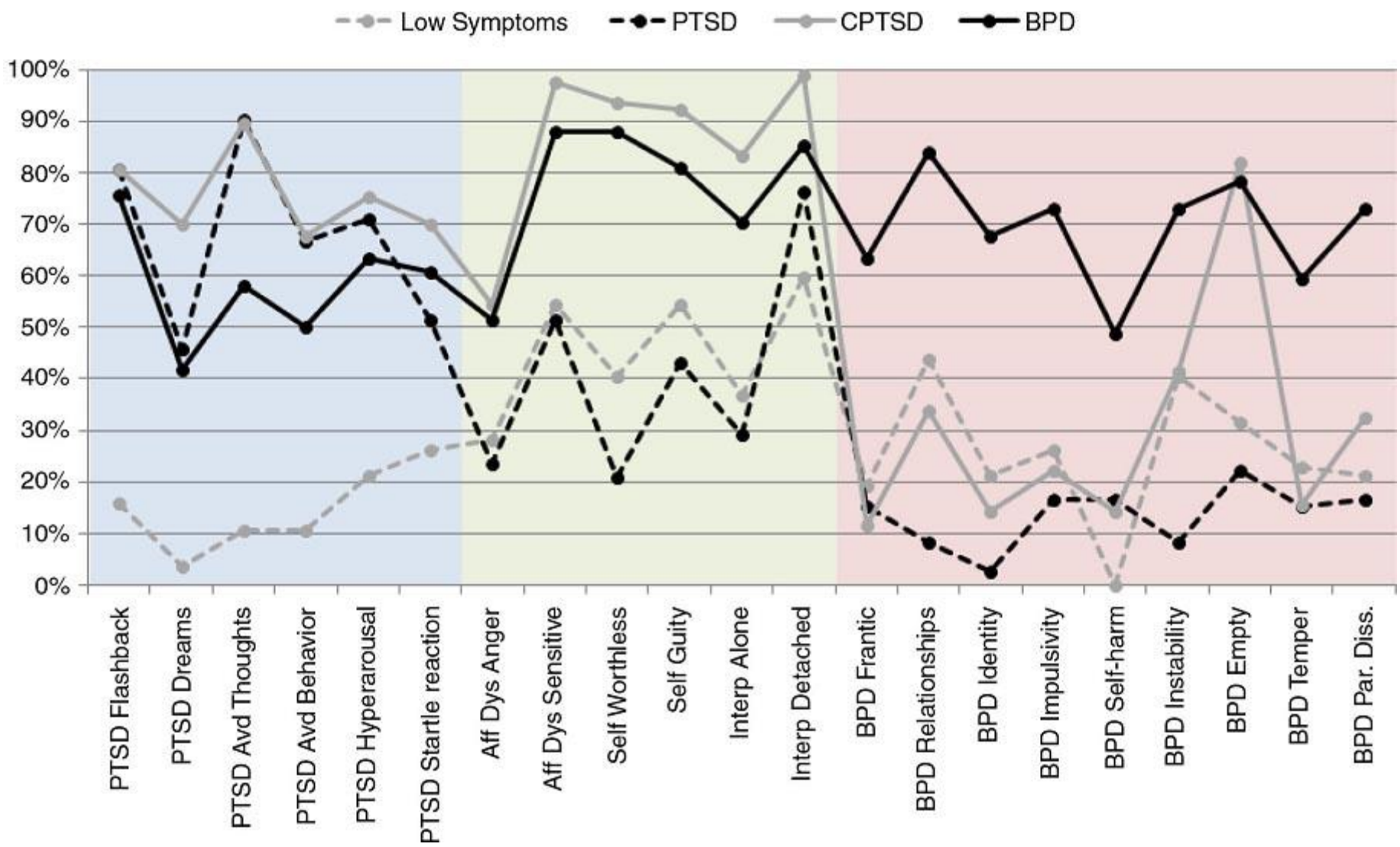
Different diagnosis or a failing construct?

CLOITRE ET AL. (2014)

- The concepts of PTSD, C-PTSD and BPD are different.
- 280 women with histories of childhood abuse; looked at 21 symptoms (6 of PTSD, 6 of C-PTSD and 9 of BPD)
- Conducted a LCA (Latent Class Analysis)

RESULT: FOUR CLASS MODEL SELECTED:

- Low symptoms on all
- High in symptoms on PTSD and low on C-PTSD and BPS
- High in symptoms of C-PTSD, elevated on PTSD and low on BPS
- High in symptoms of BPD with additional symptoms of PTSD and C-PTSD


Low Symptoms
PTSD
CPTSD
BPD
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
PTSD Flashback
PTSD Dreams
PTSD Avd Thoughts
PTSD Avd Behavior
PTSD Hyperarousal
PTSD Startle reaction
Aff Dys Anger
Aff Dys Sensitive
Self Worthless
Self Guilty
Interp Alone
Interp Detached
BPD Frantic
BPD Relationships
BPD Identity
BPD Impulsivity
BPD Self-harm
BPD Instability
BPD Empty
BPD Temper
BPD Par. Diss.

PTSD	C-PTSD
Re-experiencing	Re-experiencing
• Flashbacks • Nigthmares	• Flashbacks • Nigthmares
Avoidance	Avoidance
• Thoughts • People, places, activities	• Thoughts • People, places, activities
Sense of threat	Sense of threat
• Hypervigilance • Startle	• Hypervigilance • Startle
	Emotion Regulation
	• Anger • Hurt feelings
	Negative self-concept
	• Worthless • Guilty
	Interpersonal problems
	• Not close • Feel disconnected

Cloitre et al. (2014)

Wolf et al., 2014 have comments on the methods of this study and have done their own research.

WOLF ET AL., 2014

- 2695 communicity participants & 323 trauma-exposed veterans: 0.6 and 13% PTSD of which 25 to 50 % met criteria C-PTSD
- No difference in trauma exposure across diagnoses (neither greater trauma exposure nor exposure to physical or sexual assault specifically)
- They found 4 classes, but they differed in symptom severity and did not distinguish on the basis of the two proposed diagnoses

ON THE OTHER HAND:

- The research used only selfreport e-questionnaires with only 59 respondents included in the analysis and was mainly based on veterans (*N*= 42) with PTSD

AND THEY ADD:

- Greater PTSD is associated with greater and more diverse impairment

- The cumulative burden of lifetime trauma has an effect on the overall severity of posttraumatic psychiatric disturbance

CONCLUSION

- Symptoms previously thought to be unique to C-PTSD (i.e., problems with affect regulation, self-referential processing, impaired social functioning, and dissociation) are recognized to be common in PTSD.
- These symptoms are incorporated into the current conceptualization of PTSD in DSM-5.
- C-PTSD is possibly just a matter of severity

RESEARCH

COMORBIDITY

Research review by A. van Minnen, 2014

"Examining potential contraindications for prolonged exposure therapy for PTSD"

Conclusion: depression, personality disorders, dissociation, substance abuse, suicidal ideation are no valid contraindications for trauma treatment

Some have concluded: so all clients can start without extra treatment or stabilization

A CLOSER LOOK:

Dissociation:

- Emotional numbing, depersonalization, and a general tendency to dissociate did not predict worse treatment outcome. These are relatively mild dissociative symptoms

BPD:

- All the studies in this review discuss treatments in which the trauma focused treatment was combined with stabilization and pretreatment, e.g. STAIR model, (Cloitre, 2010), DBT (Bohus et al., 2011)

Suicidal behavior and ideation:

- Not a contraindication

BUT

- This conclusion is based on research of treatments including DBT (Bohus , 2011 and Harned, 2012) (= STABILIZATION!)

PSYCHOSIS

- T.TIP: Treating Trauma in Psychosis (de Bont, van den Berg, van der Vleugel et al., 2015)
- Trauma focussed treatment in PTSD patients with psychosis: a comparative study on PE and EMDR. 8 sessions EMDR or exposure. No exclusions for comorbidity.
- No stabilization or pre-therapy

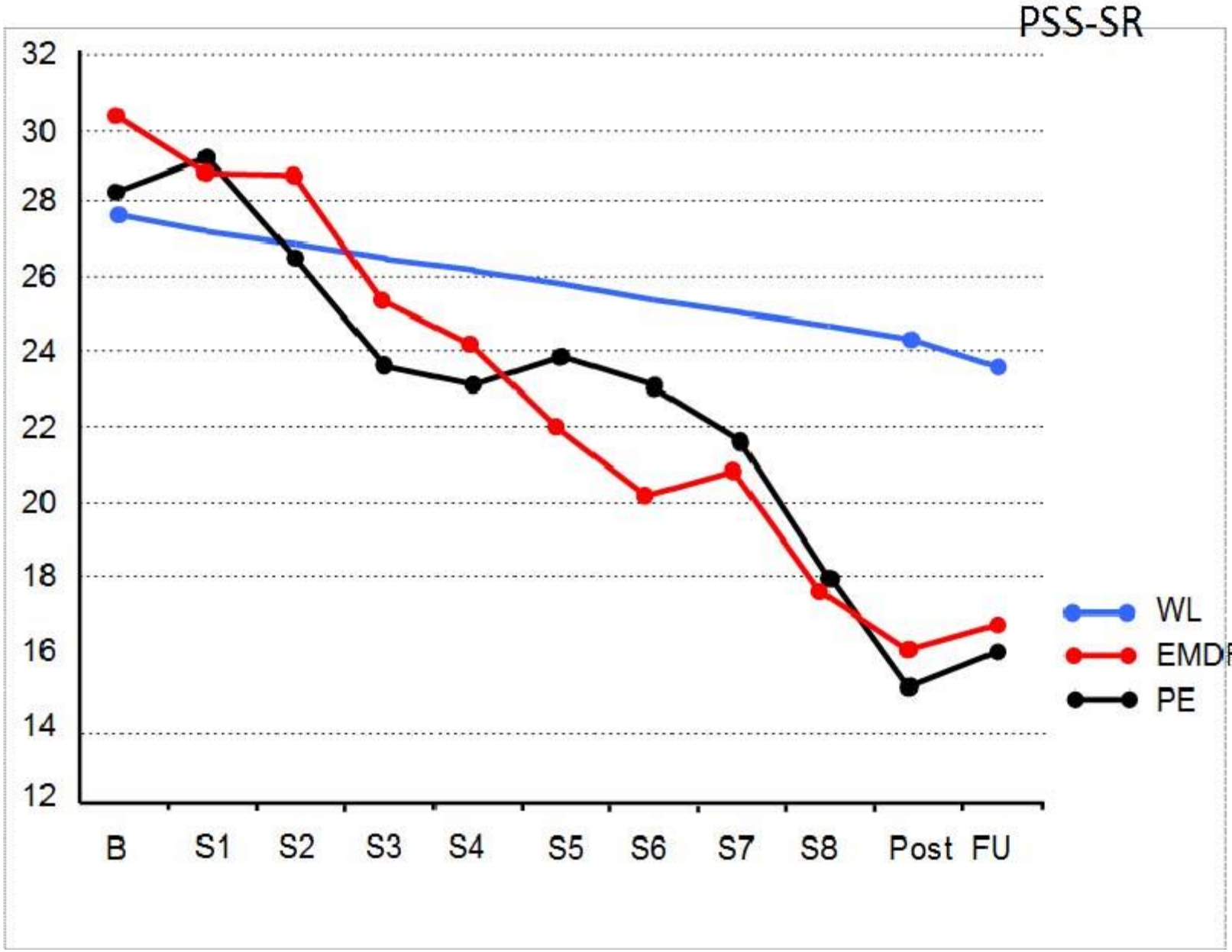
- 61.3% schizophrenia
- 29.0% schizoaffective disorder
- 10% other psychotic disorders

Most participants experienced repeated and severe childhood traumatization and all met criteria for PTSD

RESULTS

- Trauma treatment works for clients with psychosis and it is safe, both EMDR and PE.

- The treatment was not less effective or adversive in its effect with clients with severe childhood trauma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DISCUSSION:

Does this mean that any client can start straight away?

…Or just that psychosis is not a contraindication for EMDR?

CRITICAL VIEW ON THE PHASE BASED TREATMENT (revisited)

De Jongh et al (2016) doubt the evidence for the phase based treatments

- Criticizes that the guidelines are based on only 9 RCT studies, out of which 4 only investigate the efficacy of a stbilization program
- Questions Cloitres research on STAIR. De Jongh argues there should have been a condition IE without STAIR or support.

- States that two studies in the guidelines examined and proofed the efficacy of trauma-focused treatment without stabilization. In these studies (Chard (2005) and Clasen (2011)) however, the confrontation with the trauma is preceded by a series of group sessions which can be defined as stabilization.
- De Jongh adds the research of Resick (2002 and 2008). She found no difference in the effect size for women with or without childhood trauma. The studies didn't research stabilization programs.

- The authors state that comorbidity does not effect the efficacy of the trauma focused treatments. De Jongh mentions the research of Van Minnen et al (2012) as an argument for this point of view.

  That is curious…

- Conclusion of De Jongh et al.: there is no need for stabilization or a phase based treatment.

- Comment: even if the evidence supporting phase based treatment would be weak (which is questionable), or based on too few research (which is arguable), it doesn't mean the opposite is true!

STABILIZATION

BASIC CONDITIONS IN THE OUTSIDE WORLD

- Some (very) basic conditions have to be fulfilled before we can do anything in therapy:
- Patient stays alive
- Patient can come to the therapy
- Patient can focus on the therapy (no current new traumatization going on)

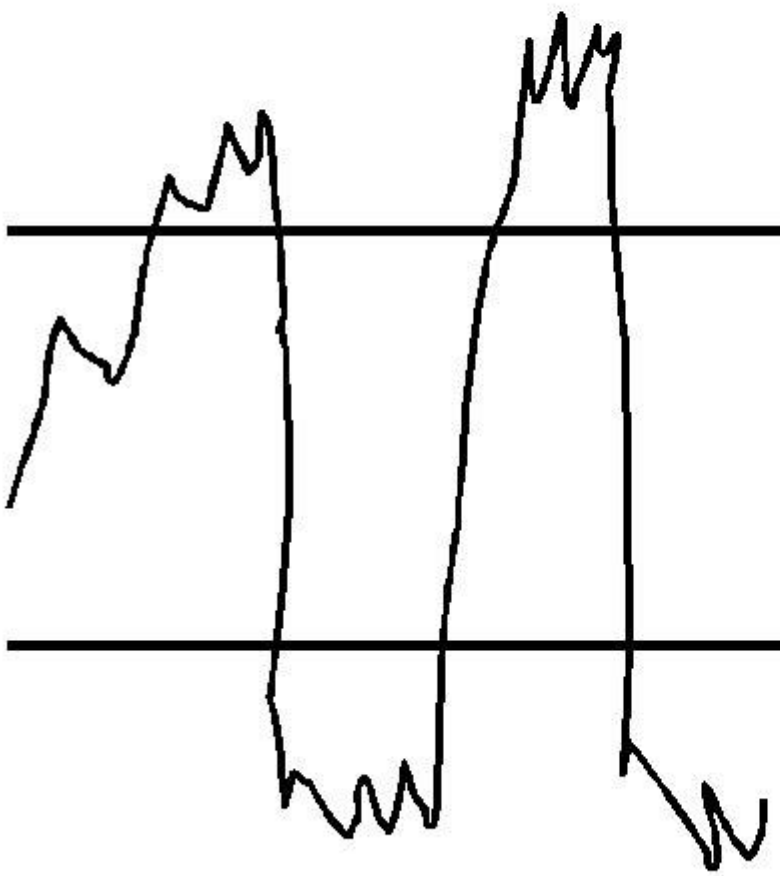
LET'S START WITH: WHAT IS TRAUMA PROCESSING?

- Connecting dysfunctional (trauma) information with functional (adaptive) information
- Necessary conditions (inner world):
  - The patient needs to be within the window of tolerance
  - The adaptive information needs to be available / accessible

WINDOW OF TOLERANCE

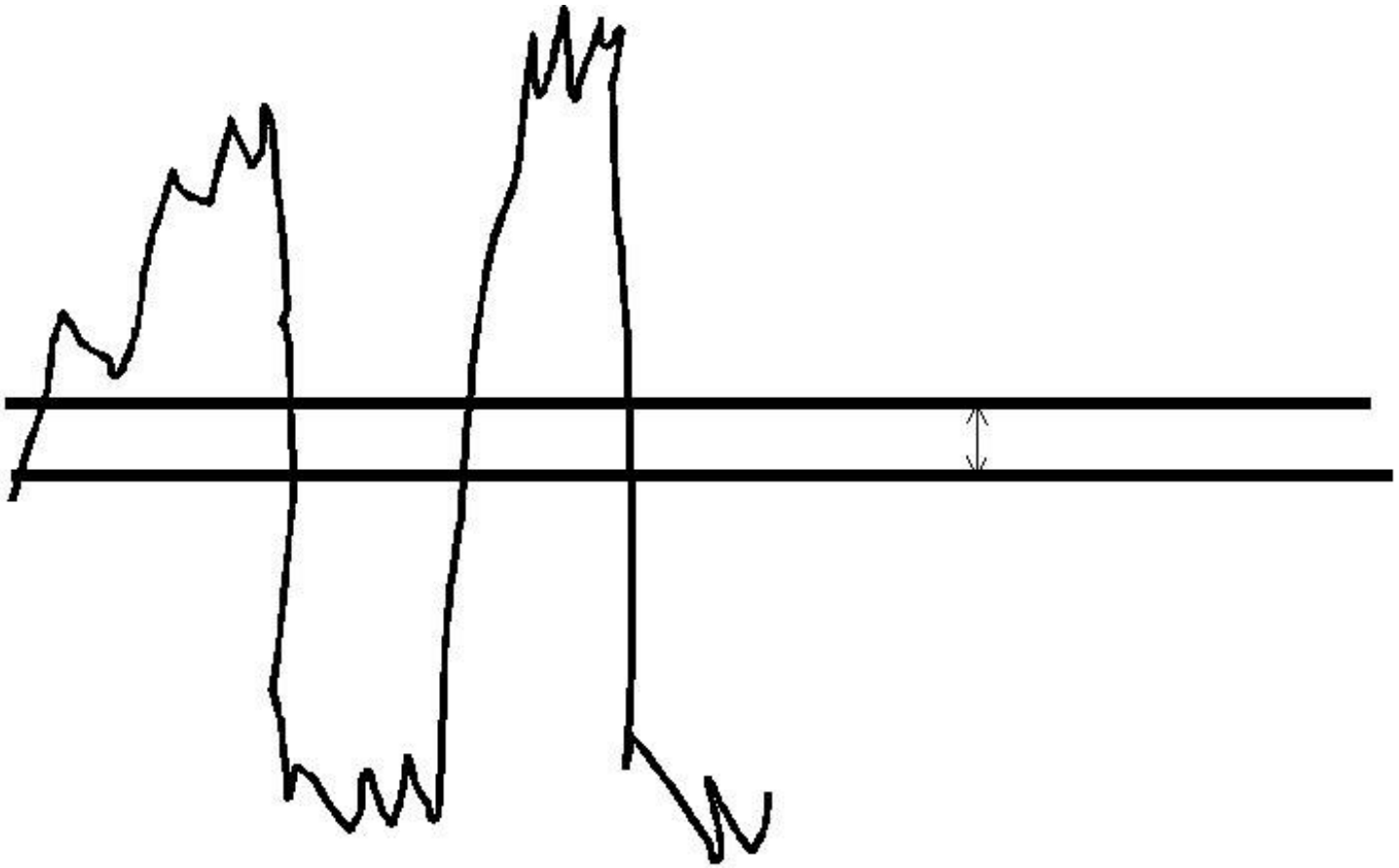
- Width of the window of tolerance is determined by affectregulation, attachment, and self-compassion
  - Affectregulation: sadness, anger, fear
  - Attachment: being connected with a positive attachment figure
  - Self-compassion: your own friend/ally or your own enemy?

WINDOW OF TOLERANCE



- Hyperarousal
- Optimal arousal Window of Tolerance
- Hypoarousal

- Ogden and Minton (2000)



Sympathetic-dominant Hyperarousal: Emotionally flooded, reactive, impulsive, hypervigilant, fearful, angry. Intrusive imagery and affects, racing thoughts Flashbacks, nightmares, high-risk behaviour Efforts to reduce this state may include suicide planning, self harm, compulsive cleaning, abuse of alcohol or opiates	Freeze Mute, terrified, frozen defence responses. High arousal coupled with physical immobility*
Window of Tolerance Optimal arousal zone, encompassing both intense emotion and states of calm or relaxation, in which emotions can be tolerated and information integrated	
Parasympathetic-dominant Hypoarousal: Flat affect, numb, "empty" or "dead" Cognitively dissociated, inability to think Collapsed, disabled defensive responses Helpless and hopeless Efforts to reduce may include suicide planning, self-harm, compulsive	

- Corrigan, Fisher and Nutt, 2010

WINDOW OF TOLERANCE

- → Broaden the window of tolerance by teaching skills (= stabilization)
- Affectregulation: permission, expression
- Attachment: staying connected
- Self-compassion: treat yourself as you would treat your best friend / your child

LACKING GENERIC RESOURCES

- Responsibility: NO ADULT COMPASSION
- Safety: NO SAFE HERE-AND-NOW, IT'S NOT OVER
- Choices: I STILL HAVE NO CHOICES

PROCESSING

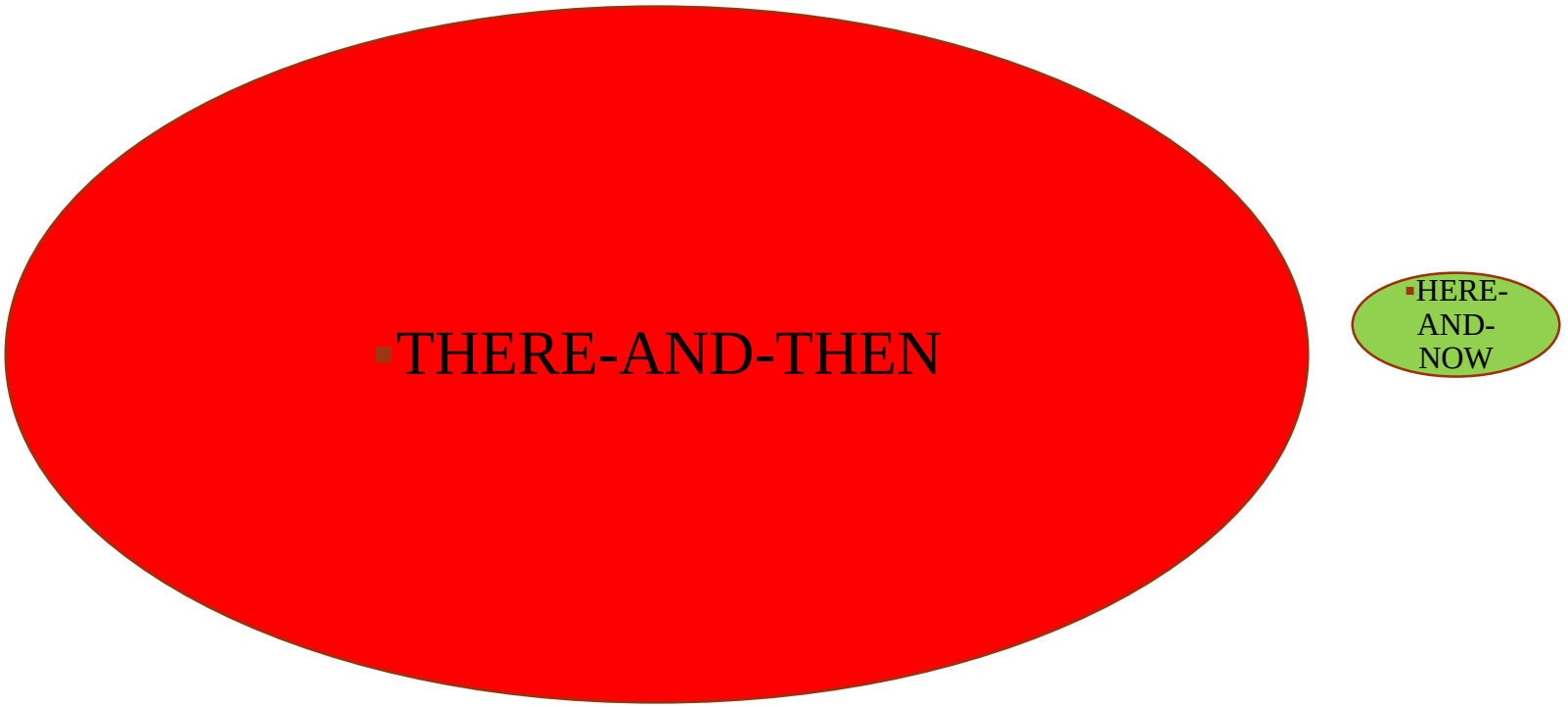
- THERE-AND-THEN

- HERE-AND-NOW

DAMAGED PART OF THE CLIENT

HEALTHY PART OF THE CLIENT

PROCESSING



DAMAGED PART OF THE CLIENT

HEALTHY PART OF THE CLIENT

NECESSARY CONDITIONS FOR TRAUMA PROCESSING

- Necessary conditions:
  - The patient needs to be within the window of tolerance
  - The adaptive information needs to be available / accessible

ADAPTIVE INFORMATION: RESOURCES

- Cognitive interweaves help to bring in the adaptive information, where it is needed but missing
- Simple truth:
- What is not there cannot be activated

GENERIC RESOURCES

- Responsibility: ADULT COMPASSION, LOVING ADULT PERSPECTIVE
- Safety: THE SAFE HERE-AND-NOW, IT'S OVER
- Choices: I HAVE CHOICES NOW

STABILIZATION: BRINGING IN ADAPTIVE INFORMATION

- By building up lacking generic resources
- or by strengthening underdeveloped generic resources

- Once the adaptive information is there, it can be used in interweaves

ALTERNATIVE CONCEPTUALIZATION

PTSD

PTSD AS AN ANXIETY DISORDER

- Anxiety disorder
- Trauma in the domain of powerlessness
- Trauma on the foreground, accessible
- Start immediately in almost every case, fast recovery, work along the protocol
- Emphasis on desensitization EM**D**R

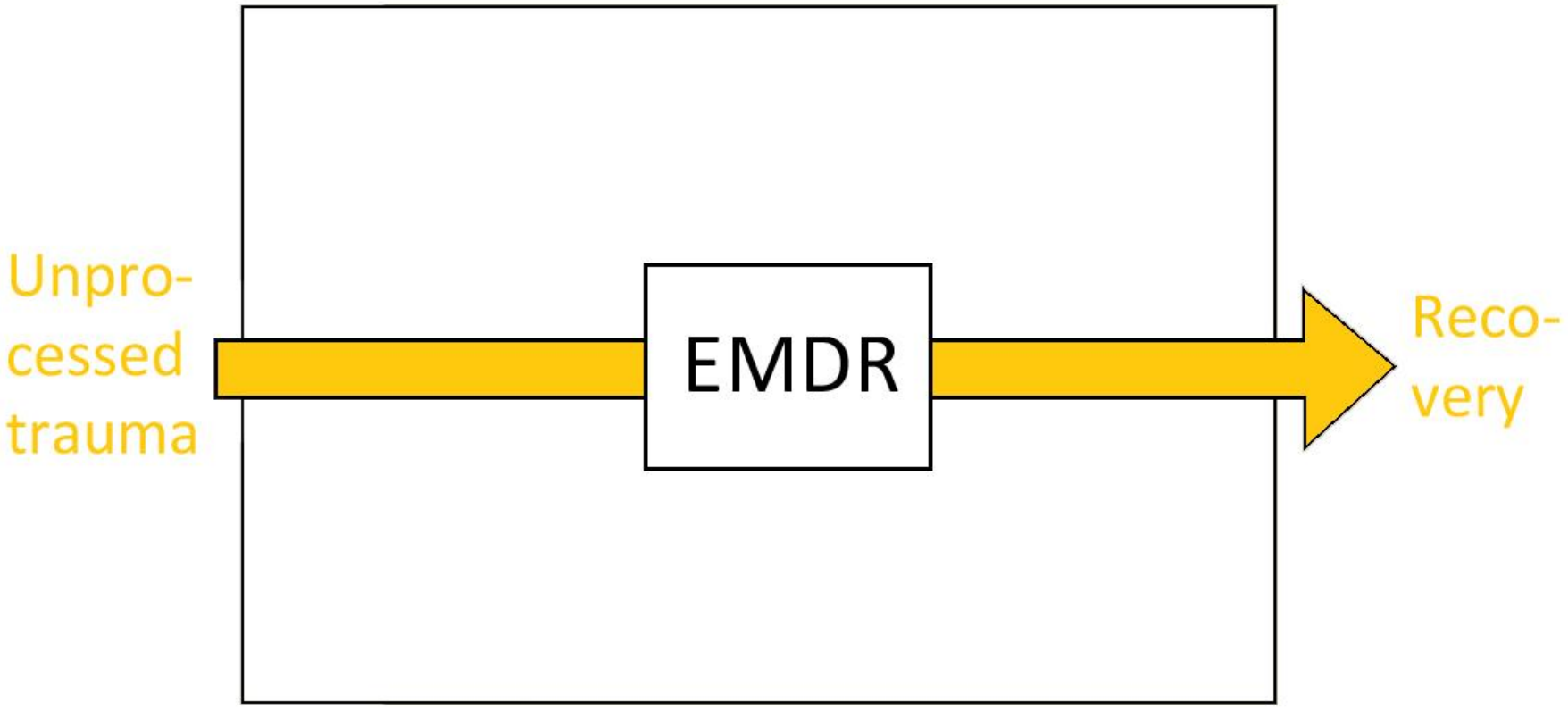
"PTSD-PLUS"
INJURY ON A STRUCTURAL LEVEL

- Anger, sadness and anxiety
- Core cognition mainly in the domain of self-image and guilt
- Trauma damaged the personality development and is partly covered
- Treatment should start after a good preparation and/or be combined with other interventions
- Emphasis on the reprocessing EMD**R**

A BROADER CONCEPT OF STABILIZATION, A PROPOSAL

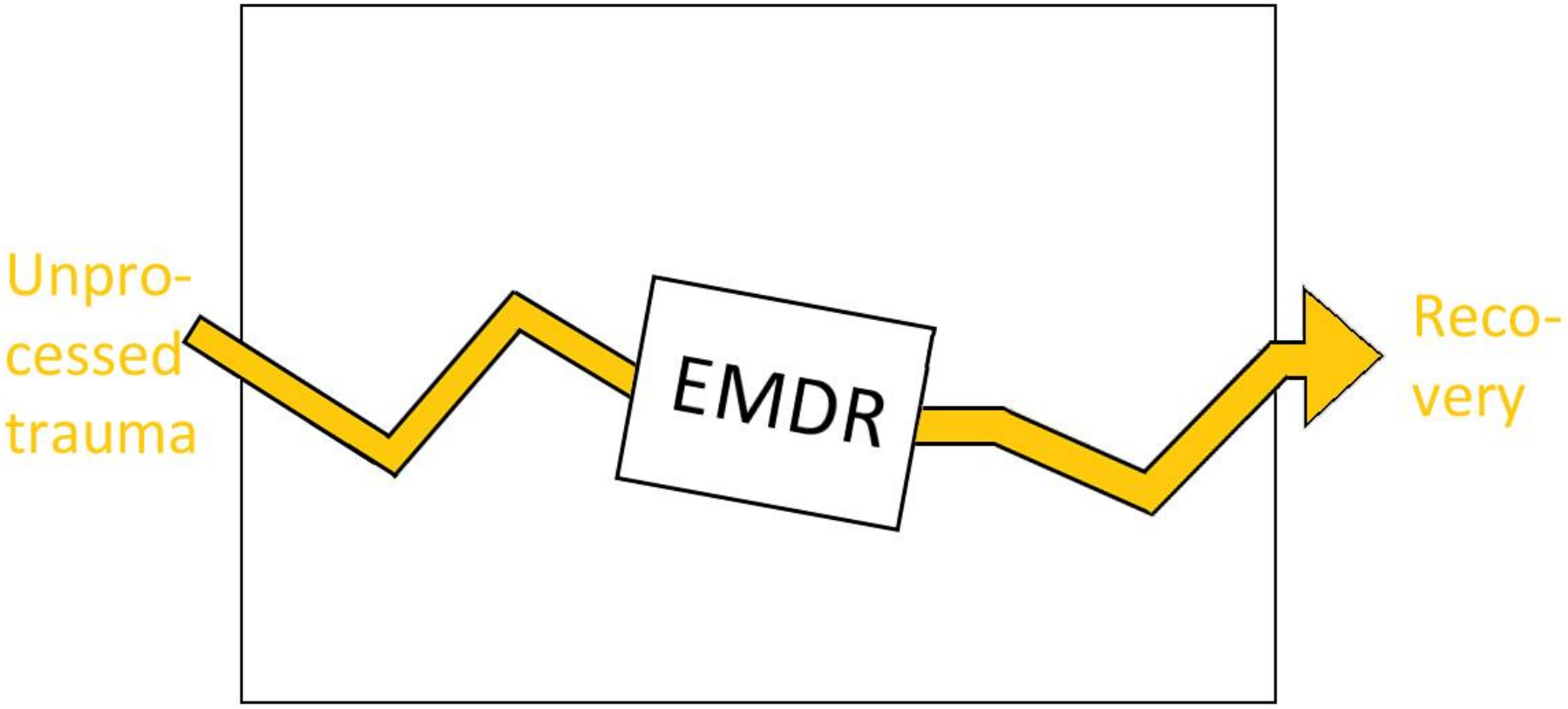
- Stabilization is often considered as a preparation phase
- In the clinical practice with the most complex trauma clients stabilization is offered at the start but also during trauma treatment
- The question must be: what does the client need to get through his treatment? Does he have what it takes or is extra help necessary?

REGULAR PTSD TREATMENT



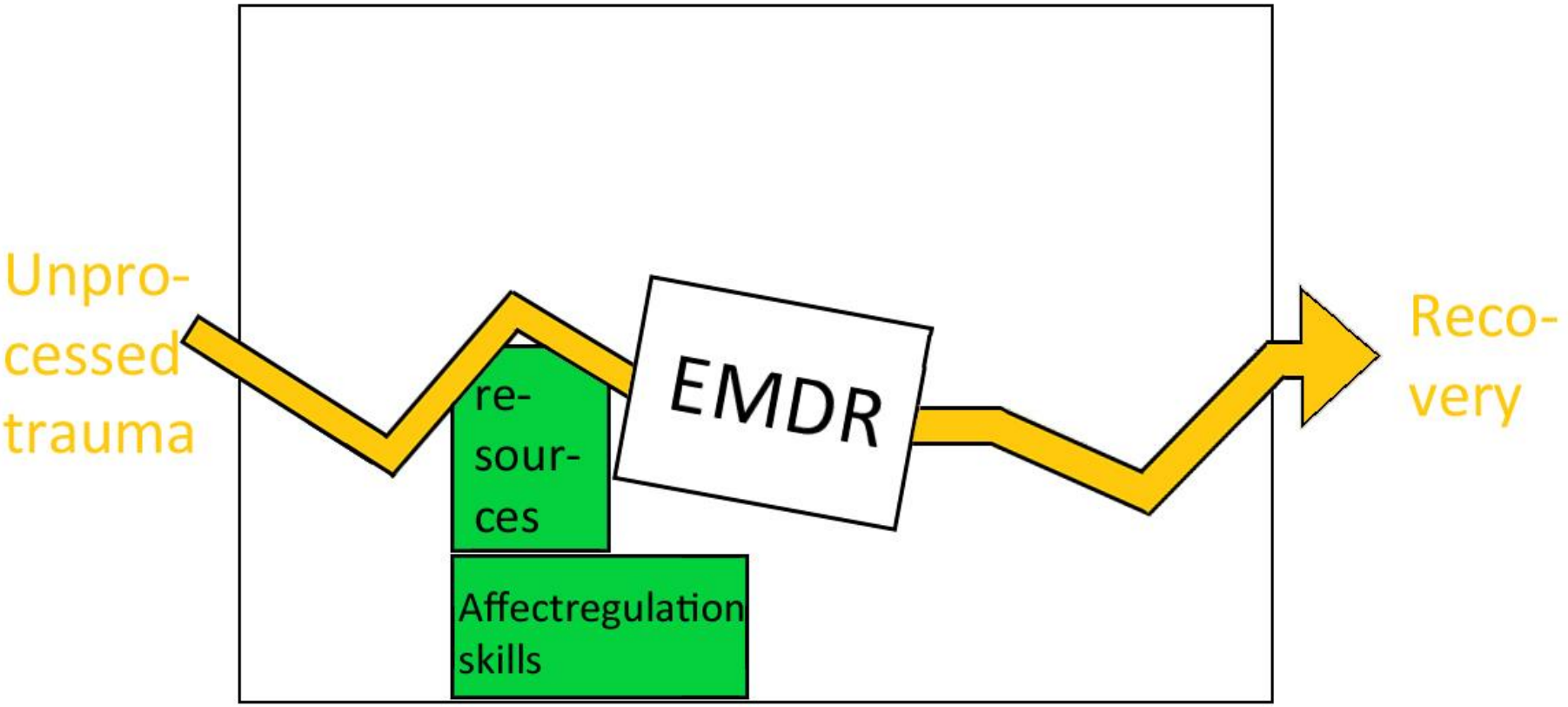
Straightforward, like in the 100 meters running

"PTSD-PLUS" TREATMENT

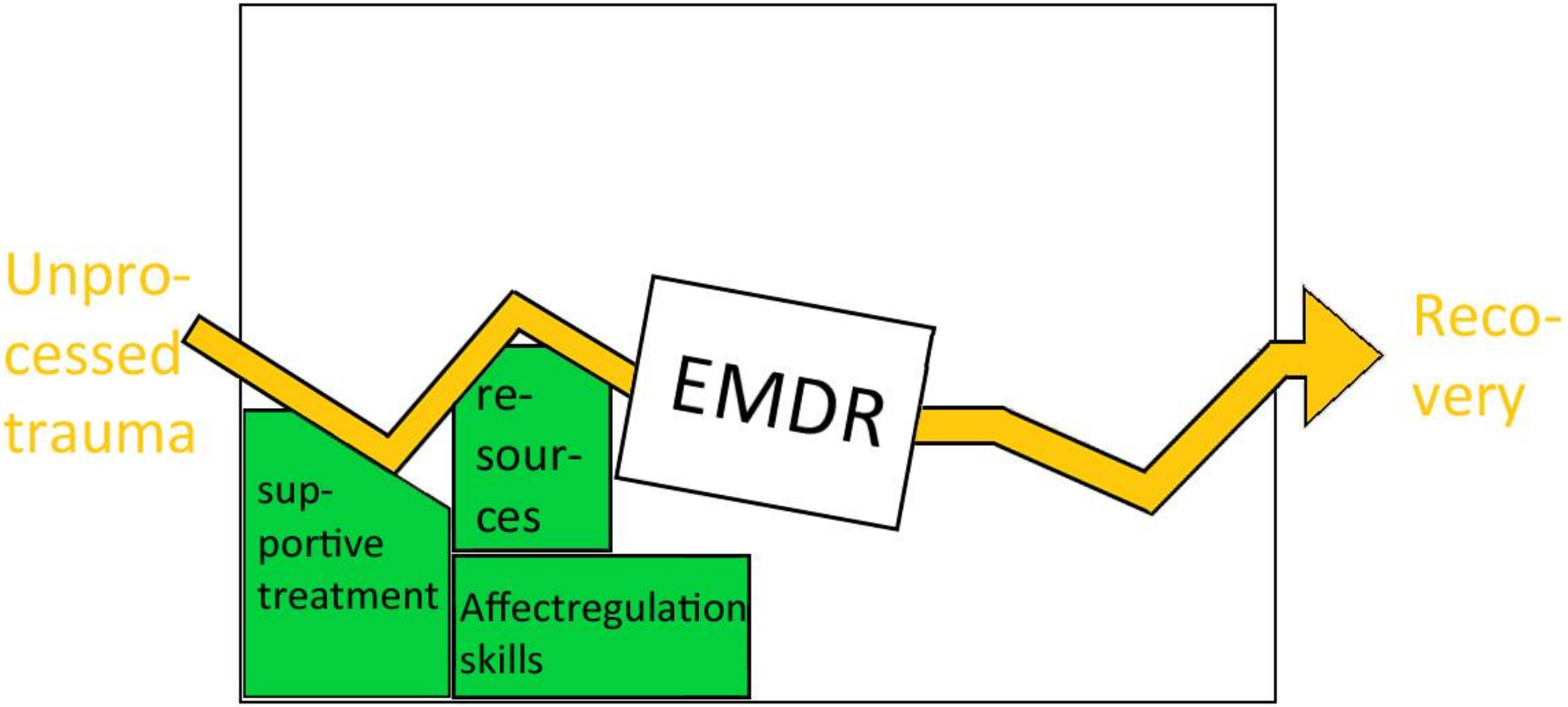


The routing for the most vulnerable clients however is more difficult

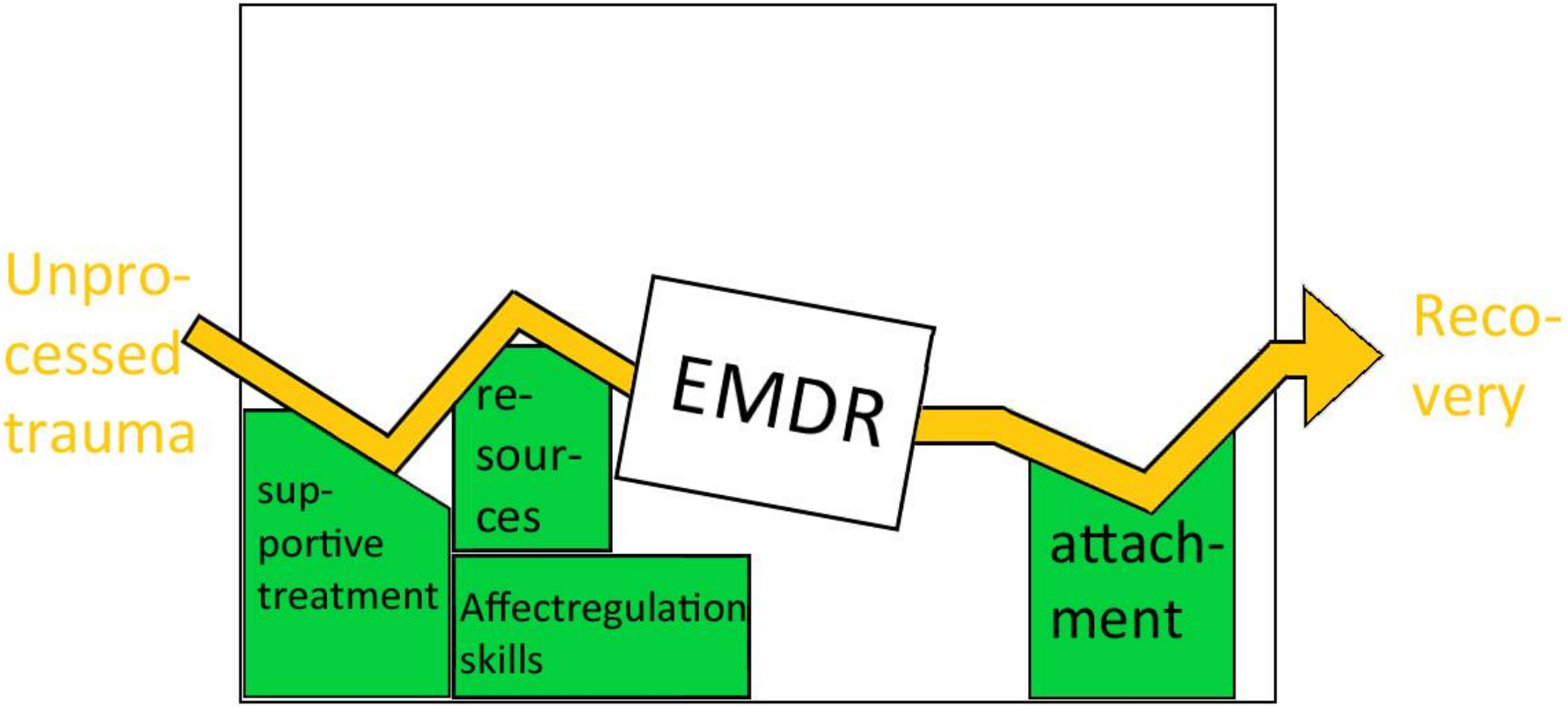
EXTRA TREATMENT BEFORE AND DURING THE EMDR



It needs to be supported by sufficient resources, affectregulation skills, …



supportive treatment, …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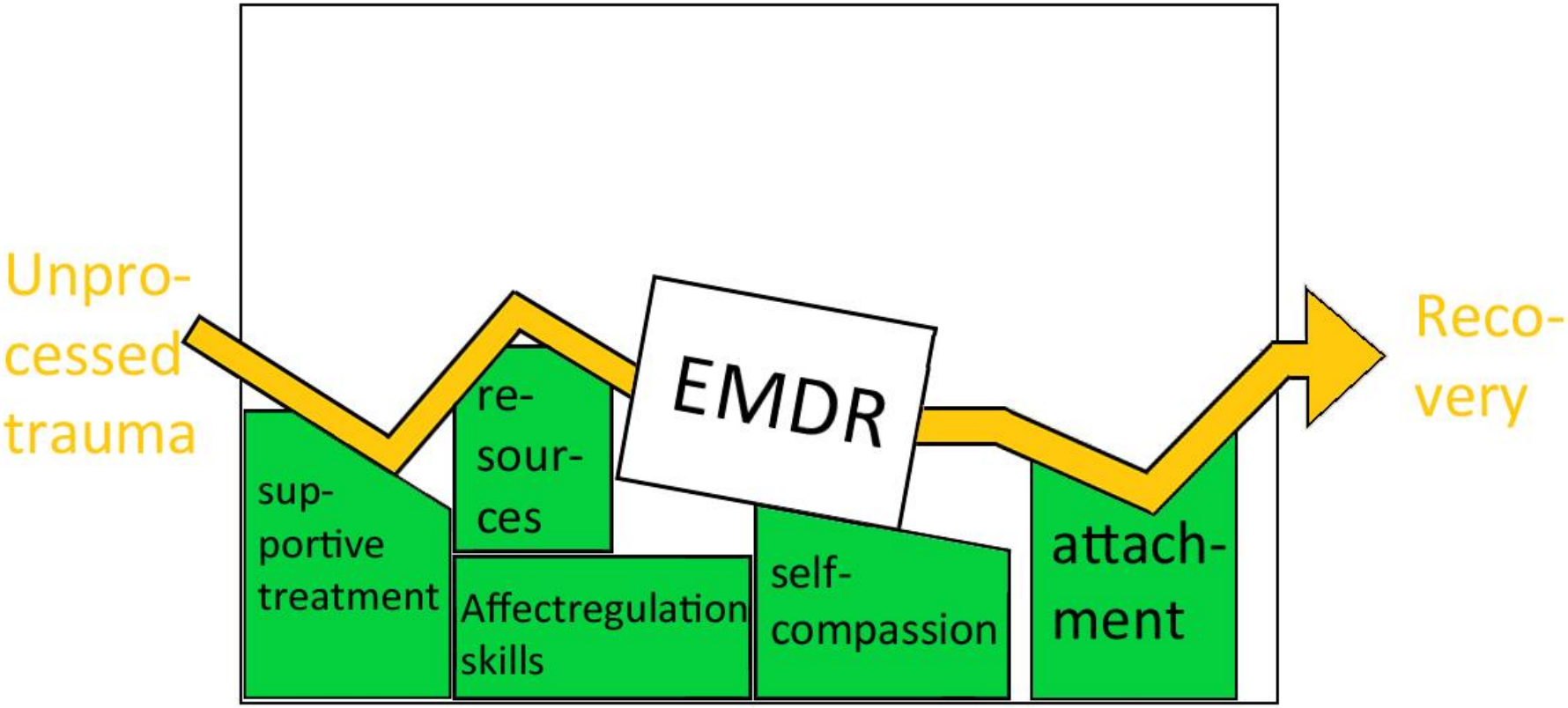

… and self-compassion

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