

Practical information

Treatment of post-traumatic stress disorder

Phase 1 - Stabilization

Why a phased treatment?

Phased treatment is essential for safe effective treatment of PTSD. This approach aims to reduce the risk of retraumatisation and to ensure that the patient is ready to gradually face the traumatic memories.

Recommended by :



- ISTSS (2020)
- NICE (2018)
- OMS (2013)
- Phoenix (2020)
- VA/DoD (2023)

Stabilization

Reprocessing

Integration

What is the stabilization phase?

The stabilization phase is a **crucial stage** in the treatment of PTSD. The aim is **to help patients regain a sense of safety and manage trauma-related symptoms** before addressing the traumatic experiences themselves.



Goals

- **Restoring a sense of safety:** Creating a safe environment where the patient feels protected
- **Emotional regulation:** Learning techniques to manage intense emotions and stress reactions
- **Strengthening personal resources and coping mechanisms:** Identifying and developing the patient's strengths and skills to face challenges
- **Reducing immediate symptoms** (stress, flashbacks, dissociation, etc.)
- **Developing interpersonal skills**

Managed by whom?

Qualified professionals from several fields can manage the stabilization phase, provided that they are trained in post-traumatic stress disorder:

- Clinical psychologists
- Psychiatrists
- Psychotherapists certified in approaches adapted to trauma (TF-CBT, EMDR, etc.)
- Nurses (mainly in hospitals)
- Psychomotor therapists (for body regulation)



- **Support purely for "well-being"** (coaching, non-therapeutic personal development) is not enough to stabilise PTSD.
- **The stabilization phase requires reliable recognised clinical training**

Duration

The duration of this phase **may vary according to the patient's individual needs**. It can last from several weeks to several months, depending on the severity of the symptoms and the patient's capacity to commit to the process.



PTSD

3 to 6 sessions

Complex PTSD

a few months (less than 6)

PTSD with comorbidity

prolonged stabilization, sometimes without direct work on the trauma

Evaluation

An initial assessment might be useful to monitor the development of stabilization skills



PTSD symptoms
(PCL-5;
CPC; ITQ; ITQ-C*)



Dissociative symptoms
(DES-II; SDQ-20;
CDC; A-DES*)

Suicide risk
(C-SSRS; SIQ; SIQ-JR*)



Post-trauma cognition
(PTCI; CPTCI*)

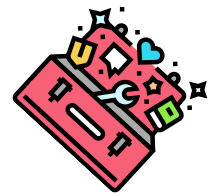
Emotional regulation skills
(DERS; CERQ; ERC-vf;
ERQ-CA*)



Social support
(SSQ6; SSQ; SDQ*)



*For children and adolescents



In practice ?

Individual or group

Safety



- **Establishing benchmarks in the therapeutic relationship** (clear, predictable, transparent framework)
- **Co-constructing alarm signals:** recognising when things are getting too intense
- **Creating a safety plan:** Establishing strategies to address crises and triggers (people to contact, places to retreat to, calming activities)

Psychoeducation



- **Explanation of PTSD: symptoms, mechanisms, how it works (brain, traumatic memory, etc.)**
- **Giving meaning to post-traumatic reactions**
- **Presentation of the therapeutic framework:** the therapy used and the different stages + phased work (stabilization → Reprocessing → Integration)

(e.g. readings, personal accounts, videos, films, series, etc.)

Emotional regulation



- **Relaxation exercises** (diaphragmatic breathing, progressive muscle relaxation)
- **Cardiac coherence and mindfulness**
- **Sensory grounding:** self-grounding techniques (e.g., visual, auditive, tactile grounding)
- **Self-compassion** (gentle internal dialogue or acceptance and commitment therapy)
- **Self-soothing and other body techniques** (self-care techniques)



Adaptation skills



- **Identification of current risk situations** (stress triggers)
- **Learning adaptive strategies:** problem-solving, time management, realistic affirmations
- **Enhancing psychological flexibility:** the capacity to adjust behaviour according to the context
- **Developing alternative scenarios or thoughts:** what can I do or think differently today?
- **Preparing for the unexpected:** planning responses to potential triggers



Internal resources



- **Creating a safe place through guided visualisation**
- **Personal skills:** courage, intuition, humour, willpower, creativity
- **Memory of success:** memories of overcoming adverse circumstances
- **Coping strategies already used successfully**

External resources



- **Social support:** friends, family, therapist, discussion groups or peer support
- **Living environment:** stable housing, daily routines, job or structuring activity
- **Access to care:** medical, psychological and community resources
- **Comforting objects:** photos, symbolic objects, pets
- **Safe spaces:** real places that provide a sense of safety



Benchmarks for moving on to phase 2

- The patient can **identify and name their emotions** without feeling overwhelmed
- They effectively use at least 2 **emotional regulation strategies** outside of sessions
- They are able to **remain grounded in the present** even when traumatic memories resurface
- They are emotionally stable enough to **cope with activation without major decompensation**
- **The patient's environment is stable**, and there are no major stress factors in their life

Key points

- The stabilization phase is **essential to prepare the patient to safely face traumatic memories**
- It **enables the acquisition of tools for emotional regulation, and to build physical and emotional safety**
- The **transition to phase 2 must be made with discernment**, once the patient has control over their emotions and has acquired a certain stability
- **Do not rush the process:** Each patient progresses at their own pace, and the stabilization phase may last longer for some people
- **Training in PTSD support is essential**

Further information

There are procedures that focus on the stabilization phase, such as:
 -STAIR (Skills Training in Affective and Interpersonal Regulation) for adolescents or adults (Cloitre et al., 2002)
 -The ARC (Attachment Regulation Competence) treatment framework (Kinniburgh & Blaustein, 2005)
 -and others such as PRACTICE (Cohen and Deblinger, 2006) for children, which includes them entirely in the procedure.