

Practical information

Treatment of post-traumatic stress disorder

Phase 3 - Integration

Why a phased treatment?

Phased treatment is essential for safe effective treatment of PTSD. This approach aims to reduce the risk of re-traumatisation 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)



What is the integration phase?

Phase 3 of PTSD treatment focuses on reconnecting and rebuilding the individual after treating the trauma. The aim is to help patients re-engage with the outside world, re-establish healthy social and professional relationships and rebuild a more positive and functional self-concept.



Goals

- **Social and professional reintegration**
- **Restoring self-concept**
- **Strengthening interpersonal relationships**
- **Reviewing fundamental beliefs**
- **Relapse prevention: developing strategies to manage triggers and post-traumatic stress to avoid reactivating symptoms**

Managed by whom?



- Qualified professionals from several fields can manage the integration 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.)
- Social workers or nurses in a supporting role in reintegration processes
- Psychomotor therapists

Professionals in supporting roles for phase 3 must all be specifically trained in PTSD management because:

- PTSD involves complex neuropsychological mechanisms (dissociation, traumatic memory, etc.)
- Phase 3 can reactivate latent trauma
- It requires detailed understanding of post-trauma dynamics (ambivalence, guilt, etc.)

Duration

There is no set duration. It depends on the severity of the trauma, the developmental history and personal and social resources.



In general: a few months to over a year



Depending on the model and the author, several terms can be used to describe this 3rd phase of treatment: **reintegration, reconnection, consolidation, etc.**

Reintegration

(Herman, 1992)
(Courtois & Ford, 2013)

Consolidation

(Cohen, Mannarino & Deblinger, 2006)
(Foa, Hembree & Rothbaum, 2007)
(Courtois & Ford, 2013)

Reconnection

(Herman, 1992)
(Cloitre et al., 2011)
(Courtois & Ford, 2013)

(Resick, Monson & Chard, 2016)
(Shapiro, 2018)

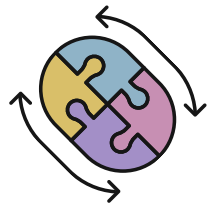
Things to monitor and prevent

- **Social isolation:** some patients may withdraw once they start to resume social activities. It is important to gradually encourage them to open up.
- **Excessive stress:** reintegrating stressful situations (such as a rapid return to work or family conflicts) can reactivate symptoms. This stage should not be rushed.
- **Realistic expectations:** Expectations must be adapted to the patient's pace. It is important to avoid putting excessive pressure on the patient to "move on" too quickly.
- **Long-term comorbidity:** Anxiety disorders, depression, addiction or personality disorders can interfere with consolidation.



Benchmarks

- The capacity to make plans for the future
- Resuming social, professional and creative activities
- Stabilization of mood and interpersonal relationships
- A feeling of control or internal coherence
- A marked reduction in symptoms (hypervigilance, avoidance, etc.)



In practice ?

Social and professional reintegration



- Assessment of the level of social isolation and the impact of the trauma on the patient's career path
- Identifying personal and external resources for gradual return to work
- Support with returning to work (employment, studies, voluntary work, personal projects)

Strengthening self-concept



- Helping the person to restore a coherent and dignified and valued self-concept
- Exploring deep values and redefining the post-traumatic identity
- Working on the body and body image (particularly after sexual violence)

Strengthening interpersonal relationships



- Restoring the capacity to connect in a safe way
- Learning to set limits, recognising toxic relationships, rebuilding attachments
- Analysing post-trauma attachment patterns: avoidance, dependence, mistrust.
- Relationship education: non-violent communication, conflict management, asking for help
- Support in building or restoring healthy emotional relationships
- Specific work on sexuality and intimacy (if appropriate)

Adapting to new beliefs



- Identifying and restructuring beliefs about self, others and the world that were altered by the trauma
- Work on the 3 major beliefs acquired:
 - Safety: "the world is a dangerous place"
 - Trust: "others are unreliable"
 - Control: "I am powerless"
- Questioning post-trauma generalisations
- Supporting the construction of a more nuanced, realistic belief system

Relapse prevention



- Identifying internal and external triggers (sounds, places, interactions, emotional states)
- Drawing up a trigger management plan: counteracting avoidance, strengthening adaptive responses.
- Reviewing emotional regulation tools acquired in phase 1 (grounding, breathing, mindfulness)
- Personalised crisis plan for use in the event of acute reactivation

Post-trauma growth



- Helping the person to make sense of the traumatic experience without denying it
- Valuing potentially positive transformations (resilience, meaning, spirituality)
- Developing personal narratives that integrate the event without reducing the person to the status of victim
- Working on fundamental values that are rediscovered or affirmed through experience
- Reflecting on ways to help others or bearing witness (if desired)

What therapy contributes to these areas of work?

- **TF-CBT** : trauma focused cognitive behavioral therapy
- **PE** : prolonged exposure
- **CPT** : cognitive processing therapy
- **EMDR** : eye movement desensitization and reprocessing
- **NET** : narrative exposure therapy
- **WET** : writing exposure therapy
- **STAIR** : treatment focused on the development of affective and interpersonal regulation skills
- **ACT** : acceptance and commitment therapy

Key points

- Phase 3 is the end of the therapeutic process, where the emphasis is on reintegration, rebuilding self-concept and preparing for the future. It is essential to ensure that patients sustainably adapt to life after trauma by consolidating coping strategies and building resilience.
- It requires flexibility, firm grounding in reality, and a deep understanding of inner transformations.
- It is essential to prevent relapses and to durably integrate what has been learnt.
- Phase 3 is a springboard to recovery. It is an individual, non-linear process that continues after the formal end of therapy and during which the person regains a sense of control over their life and redefines their identity beyond the trauma.