

Practical information

Treatment of post-traumatic stress disorder

Phase 2: Reprocessing trauma

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 reprocessing phase ?

The aim of Phase 2 of PTSD treatment is to **directly address traumatic memories and the resulting emotional reactions**. This phase should enable the patient to **desensitise the traumatic memories, regulate the associated emotions and transform the resulting negative beliefs**.



Goals

- To reduce the emotional burden associated with memories
- To integrate memories into a coherent autobiographical recollection
- To reduce symptoms (flashbacks, avoidance, nightmares, etc.)
- To change the dysfunctional beliefs associated with the event ("I'm in danger", "it's my fault", etc.)

Managed by whom?



The reprocessing phase can be carried out by several qualified professionals, provided that they are trained in supporting post-traumatic stress disorder:

- Clinical psychologists
- Psychiatrists
- Psychotherapists certified in approaches adapted to trauma (TF-CBT, EMDR, etc.)

The treatment phase requires:

- **reliable recognised clinical training**
- **proficiency in emotional regulation, identifying dissociation and reprocessing techniques**
- **the capacity to adapt the method to the patient's psychological stability**

Clinical supervision is recommended, especially for complex cases.

Duration



The duration of this phase can vary depending on a number of factors: the type(s) of trauma, the therapy used and the patient's reaction. It can last from several weeks to several months or several years.

PTSD

4 to 12 sessions

Complex PTSD

several months to over a year

In case of dissociation, avoidance or relapses

slow progression, a possible return to stabilization

Prerequisites

- The patient has developed the **capacity to regulate their emotions**
- They can tolerate moderate activation **without major dissociation**
- They are able to **return to the here and now**
- Internal and external resources **are available** to them
- They explicitly agree to come to grips **with memories**
- They manage **cravings** and **consumption**

✗ Do not access too early: risk of re-traumatisation

Things to monitor and prevent



- **Dissociation, freezing, emotional avoidance**
- **Relapsing into self-destructive beliefs**
- **Reactivation after the session:** ensure that tools are available to calm the patient
- **Suicide risk or endangerment**



What therapy ?

International guidelines

TF-CBT	PE	CPT	EMDR	NET	WET
12 to 25 sessions	10 sessions	12 sessions	3 to 12 sessions	4 to 12 sessions	5 sessions
12 to 25 sessions	5 to 10 weeks	6 to 12 weeks	1 to 20 weeks	4 to 12 weeks	5 weeks
60 to 90 min / session	60 to 90 min / session	60 min / session	60 to 90 min / session	90 to 120 min / session	45 min / session
Repeated exposure in the imagination and in vivo + restructuration	Repeated exposure in the imagination and in vivo + debriefing	Restructuration of post-traumatic beliefs	desensitization and reprocessing by eye movements or tappings	Chronological and integrative life story	Repeated exposure by writing
Cohen, Mannarino & Deblinger (2006) (in children)	Foa, Hembree, Rothbaum & Rauch (2019)	Resick, Monson & Chard (2024)	Shapiro (2018)	Schauer, Neuner & Elbert (2024)	Sloan & Marx (2025)
Very high*	Very high*	Very high*	Very high*	High*	High*

- **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

*Level of evidence

- **Level 1: very high**
 - highly recommended
- **Level 2: high to moderate**
 - recommended, but with caution
- **Level 3: average**
 - supported by initial data, but requires further validation
- **Level 4: low**
 - to be considered as experimental

Key elements of these therapies

➤ Choice of target event or memory

- Either the most disturbing
- Or a manageable memory to start with (graded exposure)

➤ Controlled memory activation

- By imagination, verbally, through drawing, writing and/or movement
- Controlled activation (do not overwhelm)

➤ Desensitisation/reprocessing

- By exposure, cognitive or physical re-encoding
- Reducing emotional and sensory burden

➤ Cognitive restructuring

- Identifying beliefs resulting from the trauma ("I am in danger", "I am guilty")
- Introducing more realistic alternative beliefs ("I survived", "I am no longer in danger")

➤ Re-grounding in the present

- Ensuring that the patient is back in the here and now
- Re-mobilising resources if necessary

Note: there are other therapies, either emerging or for which science has not yet determined the level of efficacy. This does not mean that they do not work, but rather that research is still underway to assess their effectiveness.

Use of tracking tools (e.g : SUD, questionnaires)

Benchmarks for moving on to phase 3

- The targeted memories no longer have an emotional burden
- Negative beliefs have been changed
- The patient can remember without dissociating
- A reorganisation of the life narrative has emerged
- Acute symptoms have clearly lessened

Key points

- This phase is the heart of therapeutic work
- It requires solid grounding (through phase 1)
- Exposure is not passively 'reliving' but rather taking back power over the memory.
- Work is carried out at an adapted pace, and is sometimes non-linear
- The aim is integration, not erasure
- Training in one of the recommended therapies is advised