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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

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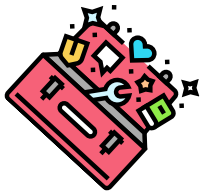
Phase 1 - Stabilization



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 i**dentify 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.

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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 retraumatisation and to ensure that the patient is ready to gradually face the traumatic memories.

Recommended by :

- ISTSS (2020)
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- Phoenix (2020)
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Stabilization → **Reprocessing** → **Integration**

Whatis 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 retraumatisation**

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**

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Phase 2: Reprocessing trauma

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 behavorial 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

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.

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

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

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Treatment of post-traumatic stress disorder
Phase 3 - Integration

Why a phased treatment?

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Recommended by :

- ISTSS (2020)
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Stabilization → **Reprocessing** → **Integration**

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

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

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.)

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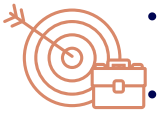
Phase 3 - Integration

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, 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)

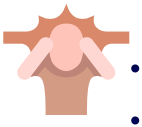
Strengthening interpersonal relationships

- 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 behavorial 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.