PATHWAY CLINICAL GROUP

BEGINNING THERAPY

What to Expect in Your First Therapy Session

A clear, practical overview for starting therapy — you do not need to have everything figured out first.

Patient education resource · Pathway Clinical Group · San Diego, California · Reviewed August 2026

IF YOU NEED HELP RIGHT NOW

If you are thinking about harming yourself, cannot stay safe, or feel that your distress is urgent, do not wait for a scheduled appointment. Call or text 988 anytime to reach the Suicide & Crisis Lifeline — free, confidential, 24/7. You can also chat at 988lifeline.org. For a medical emergency or immediate danger, call 911.

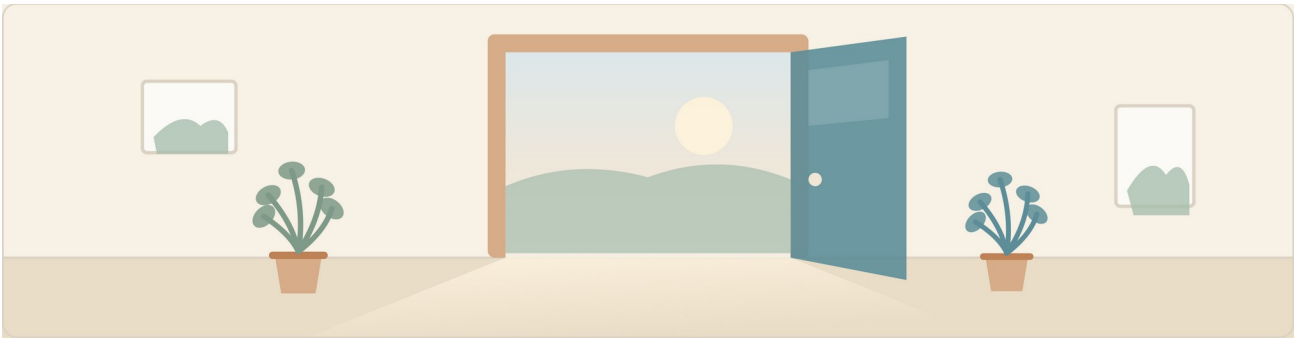
A routine first therapy session is not emergency care.

HOW TO USE THIS GUIDE

Read at your own pace. Pause where something feels relevant, note one observation, and bring it to a conversation with a licensed clinician. Nothing in this guide is a diagnosis, a score, or a substitute for individual care.

BEFORE YOU BEGIN

A clear place to begin

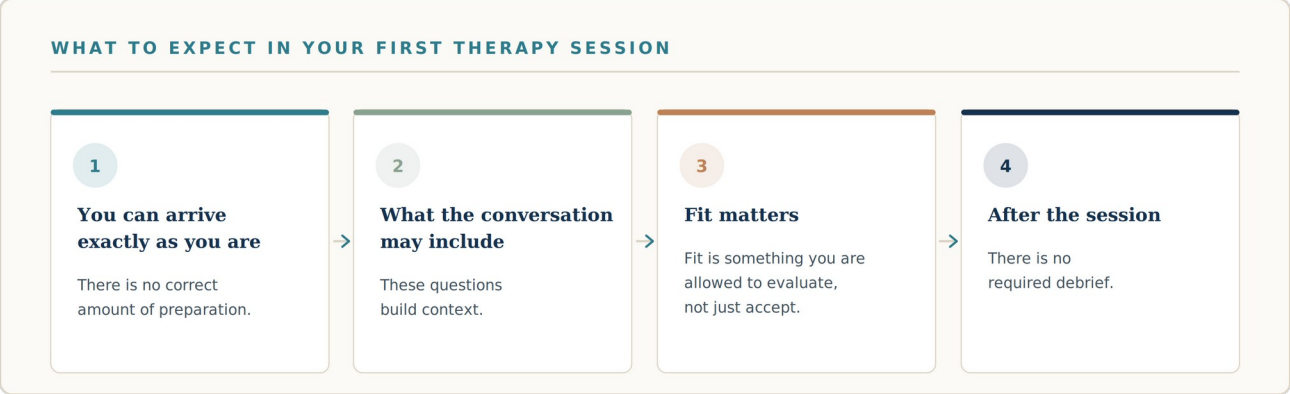


Starting therapy can bring relief, hesitation, hope, and uncertainty — often all at once. A first session is not a performance and not a complete account of your life. It is an early conversation about what has been difficult, what you hope might change, and whether working together feels workable.

You do not need a tidy story to begin. "I am not sure where to start, but I know something needs attention" is a complete opening. Keep what is useful here and skip what is not.

WHAT TENDS TO BE ON PEOPLE'S MINDS BEFOREHAND

- Whether the clinician will think the problem is "too small" or "too much"
- How much of the story needs to be told in the first hour
- Whether saying something out loud will make it feel more real
- What happens if the fit is wrong, or if a topic feels too hard to raise yet



BY THE NUMBERS

In 2024, 14.0% of U.S. adults — about 1 in 7 — received counseling or therapy from a mental health professional in the past 12 months, and 19.3% took medication for their mental health (CDC/NCHS Data Brief No. 564). Seeking therapy is common, and needing support is not a sign of weakness. At the same time, if what you are experiencing feels severe or unsafe, that deserves prompt attention rather than reassurance — see "When to reach out" later in this guide.

NOT ABOUT BLAME

If you have put off starting therapy, or a past attempt did not stick, that is not a failing to account for. Cost, insurance coverage, availability, and difficulty finding the right clinician are among the barriers people commonly report when they want care and do not receive it (SAMHSA national survey data). These are practical obstacles, not character flaws.

THE SHORT VERSION

What a first session is — and isn’t

A first session is an intake conversation, not a test and not a long-term commitment. Its job is narrow: to help you and a clinician get oriented to what is going on and decide together whether working together makes sense. It is not where your whole history must be organized, and it is not your only chance to say something the right way.

You will usually be asked to review and sign consent and privacy forms. These describe fees, cancellation policies, and how your information is handled. Signing them does not obligate you to continue — you can end therapy or change clinicians at any point.

THREE THINGS TO HOLD ONTO

- A first session does not permanently decide your care. If your visit is billed to insurance, your clinician may need to record a working (provisional) diagnosis for the claim — a starting point that can be revised as they learn more. You can ask what was recorded and why.
- You can ask questions, slow down, or say that a topic is not ready yet.

- Fit is something you are allowed to evaluate, not just accept.

YOUR PRIVACY — AND ITS LIMITS

What you discuss in therapy is generally private and protected by federal health privacy rules (APA: confidentiality in psychotherapy; HHS: notice of privacy practices). There are narrow legal exceptions — for example suspected abuse or neglect of a child or vulnerable adult, a serious risk of harm to you or to an identifiable other person, or a valid court order (duty-to-warn overview). Exact rules vary by state. Ask your clinician to walk you through their privacy policy at the first session — it is a normal question.

PART 1 OF 4

You can arrive exactly as you are

Walking into a first session, it is common to feel that you should have a clearer story than you do, or a problem that feels "worthy" enough to bring. There is no correct amount of preparation.

Clinicians open a first session in different ways — some review paperwork first, some ask "what brings you in today" right away, some spend the first few minutes helping you settle. None of these is the wrong way to start. If you arrive empty-handed and unsure where to begin, that is still enough.

WHAT THIS CAN LOOK LIKE

- Bringing written notes, or a single sentence you rehearsed in the car
- Not knowing where to start, and saying so out loud
- Feeling nervous, and being unsure whether that is worth mentioning
- Wondering whether what is bothering you is "enough" to justify being there

ABOUT THE PAPERWORK

Intake forms typically ask about safety, current medications, allergies, and an emergency contact, and include a privacy notice and consent form. This is standard for any first visit, not a sign that something specific has been flagged about you. If a question is unclear, ask why it is being asked.

CLINICIAN'S NOTE (A CLINICIAN'S OBSERVATION, NOT RESEARCH)

Most people rehearse an opening line on the drive over, then say something completely different once they sit down. A first session is closer to a conversation finding its footing than a presentation being delivered. People who apologize for "not having a real problem" are rarely right about that — if something has been taking up space in your life long enough to bring you here, that is reason enough.

NOTICE

What is the one sentence you would use if you only had one?

UNDERSTAND

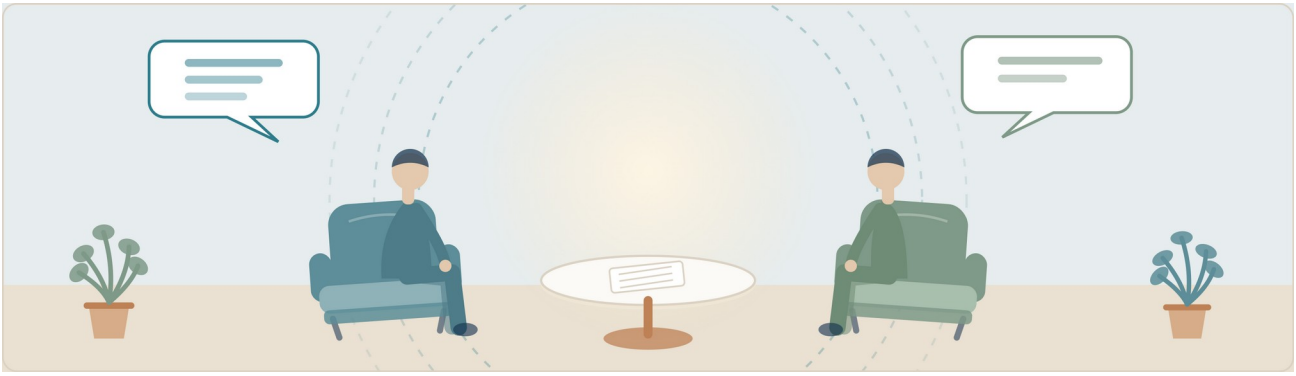
Preparation is not a requirement. Clarity is something the conversation builds.

CHOOSE

Decide what you want to name first, and let the rest follow.

PART 2 OF 4

What the conversation may include



A clinician will typically ask what brought you in, along with relevant history, relationships, work or school, sleep, and physical health, and what you would like to be different. These questions build context. They are not a test and they are not aimed at assigning a quick label.

Not every question will feel relevant, and it is fine to say so. Clinicians ask broadly early on because context makes later conversations more useful, not because every thread will matter equally to your care.

WHAT THIS CAN LOOK LIKE

- Questions about sleep, appetite, energy, or physical symptoms
- Questions about family history or past experiences with therapy
- A chance to ask why a particular question matters
- Being invited to say "I would rather come back to that" about anything

PHYSICAL SYMPTOMS DESERVE A MEDICAL LOOK TOO

Some medical conditions can cause fatigue, sleep or appetite changes, low mood, or trouble concentrating that closely resemble a mental health concern — for example an underactive thyroid (NIDDK) or iron-deficiency anemia (NHLBI). If changes in sleep, energy, weight, heart rate, or appetite appeared before or alongside the emotional ones, mention this to your primary care clinician as well as your therapist.

A medical check-up and starting therapy can happen at the same time — you do not need to delay mental health care while waiting for test results. Seek urgent medical care for symptoms such as chest pain, severe shortness of breath, fainting, or a sudden severe change in how you are thinking or behaving.

CLINICIAN'S NOTE (A CLINICIAN'S OBSERVATION, NOT RESEARCH)

When people describe fatigue, appetite change, or a racing heart alongside anxiety or low mood, I usually ask when they last saw their physician. That is not a delay tactic — it is part of getting the plan right early.

NOTICE

What is the physical symptom you almost did not mention?

UNDERSTAND

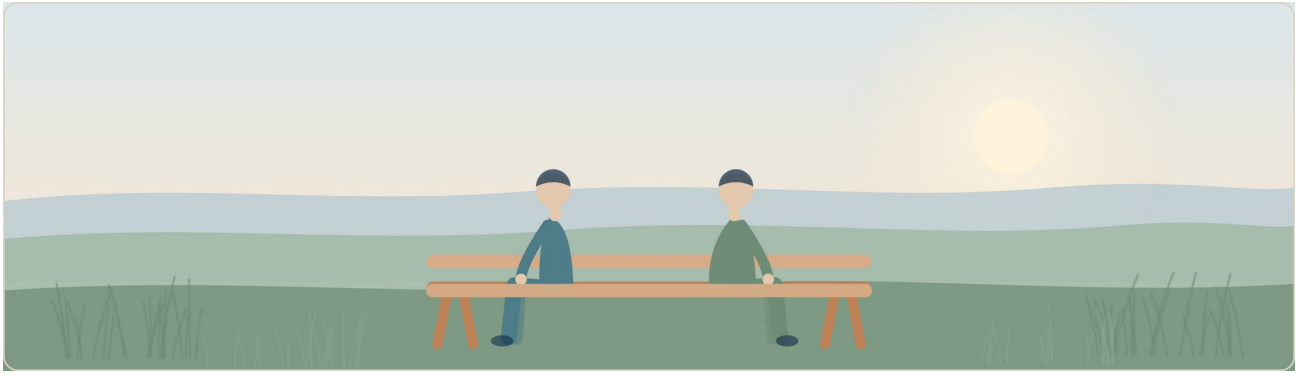
Context-building questions are not judgment — they are how a clinician avoids guessing.

CHOOSE

Decide one topic you want to make sure gets covered today.

PART 3 OF 4

Fit matters



A first session is also a chance to notice the working relationship itself — not only what is being discussed, but how it feels to be in the room. The quality of that working relationship is one of the more consistent predictors of how therapy goes, across different approaches.

Fit is not only about personality. It also includes practical things: session length, availability, cost, whether telehealth or in-person suits you better, and whether a clinician's areas of focus match what you are bringing. All of these are fair to ask about directly, in the first session or before it.

WHAT THIS CAN LOOK LIKE

- Noticing whether you feel rushed, judged, or genuinely heard
- Wondering whether the clinician's style — direct, gentle, structured, exploratory — matches what you need
- Feeling unsure and wanting a second opinion or a different clinician
- Not returning after a first session, and not owing anyone an explanation for that

IT IS FINE TO ASK AROUND

Many practices offer a brief phone consultation before a first full session, though this is not universal and policies differ. Ask when you call whether a short consultation is available, how long it lasts, and whether there is a charge. Questions worth asking are outlined by the American Psychological Association), including whether the clinician is licensed in your state and what experience they have with your concern.

WHAT THE RESEARCH SAYS ABOUT NOT RETURNING

In one large study of adults starting outpatient psychotherapy, 34% did not return for a second visit within 45 days — and not returning was not always a poor outcome. Some people who did not return reported the highest levels of improvement (Olfson et al., Psychiatric Services). Broader reviews of psychotherapy dropout report an average closer to about 20%, with estimates varying by how "dropout" is defined (Swift & Greenberg meta-analysis). There is also evidence that some people benefit meaningfully from a single session (systematic review).

What matters is noticing why. If it is fit, look for someone else. If the discomfort is about something the fit made easier to avoid, that is worth naming too — even just to yourself.

NOTICE

Did today feel like being understood, or like being processed?

UNDERSTAND

A mismatch in style is not a verdict on whether therapy can help you.

CHOOSE

If it is not fit, name what specifically felt off before trying again elsewhere.

PART 4 OF 4

After the session

You may leave feeling lighter, tired, unsettled, or some combination that is hard to name. These are ordinary responses to talking about something real for the first time.

There is no required debrief. Some evidence-based approaches, such as cognitive behavioral therapy, do include agreed between-session practice, and research suggests that completing it is associated with better outcomes (meta-analysis of homework and outcomes). If practice tasks are part of your plan, your clinician should explain them and agree on them with you. If you simply want a bridge between sessions, a few lines in a notes app when something comes up are enough — they do not need to be organized.

WHAT THIS CAN LOOK LIKE

- Feeling drained and wanting quiet time before the next thing on your calendar
- Noticing a thought or memory surface later that did not come up in session
- Replaying what you said and second-guessing how it came across
- Feeling unexpectedly relieved, even if nothing was "solved"

IF YOU ARE NOT SURE WHETHER TO CONTINUE

A second session does not require you to already know. It is common not to feel clear after one conversation, and uncertainty this early is ordinary rather than a warning sign. Because the working relationship is closely tied to how therapy goes (alliance meta-analysis), it is worth paying attention over the first few sessions — and saying directly if something feels off.

CLINICIAN'S NOTE (A CLINICIAN'S OBSERVATION, NOT RESEARCH)

The most common thing I hear at a second session is some version of "I thought about our conversation more than I expected to." That is not a sign anything went wrong — a first session often loosens something that keeps working quietly in the background.

NOTICE

What feeling showed up in the hours after, if any?

UNDERSTAND

Aftereffects, even uncomfortable ones, are information — not a verdict on whether to continue.

CHOOSE

Write down one question or observation to bring to the next conversation.

PUTTING IT TOGETHER

What good care involves

The sections above describe the shape of a first session. This part pulls the through-line together, plus two things any guide like this owes you plainly: what to expect from good care afterward, and where medication fits.

- A clinician who explains their approach and reasoning when asked
- Regular, explicit check-ins about whether the current approach is helping
- Room to change what you are working on as things become clearer
- A plan you understand, even in rough, first-pass form
- Honesty about what a clinician does not specialize in, and a referral when someone else would fit better
- Clear information about fees, cancellation policies, and privacy

Therapy is a well-studied treatment with good evidence behind several approaches, but no clinician can promise a specific result or timeline. If several months pass with no meaningful change, that is a reasonable thing to raise directly — see NIMH: Psychotherapies and APA: Understanding psychotherapy.

ABOUT MEDICATION

This guide focuses on therapy; that is not a position for or against medication. Most psychologists do not prescribe — in a small number of U.S. states, specially trained psychologists can (APA Services: prescriptive authority). Medication decisions belong with a prescriber, such as a psychiatrist, primary care clinician, or nurse practitioner. A therapist and a prescriber can, and often do, work together.

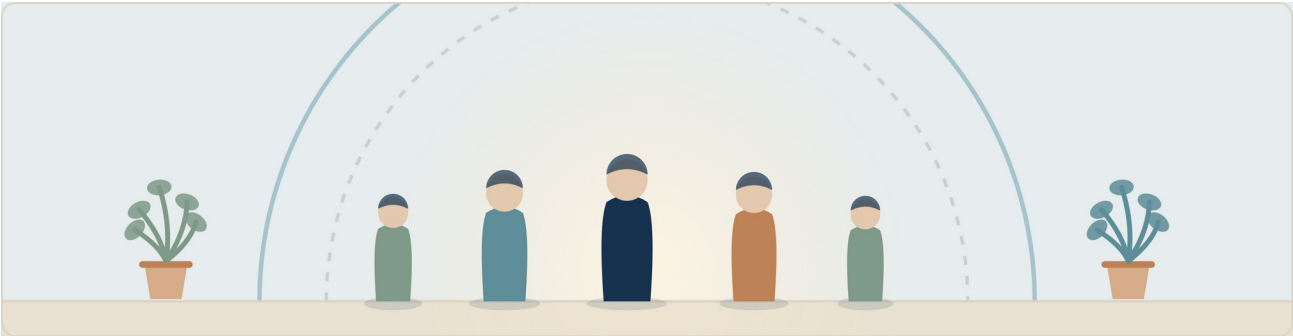
Worth asking a prescriber: what benefit is expected, which side effects are common, how long a fair trial takes before judging whether it is working, and what stopping should look like if you ever choose to.

Important safety point: do not start, stop, skip, or change the dose of a psychiatric medication without talking to your prescriber first — some medications need to be tapered (NIMH: Mental health medications).

PRACTICAL MATTERS

Cost and access

Cost and logistics are real barriers, not a sign you are not serious about getting help. A few routes worth knowing about:



- **Insurance.** Federal parity law requires many plans that cover mental health care to apply cost-sharing and visit limits no more restrictively than for medical or surgical care. Parity does not guarantee that therapy is covered, that your preferred clinician is in-network, or that no cost applies (U.S. Department of Labor). Ask your plan what is covered, what your share of the cost is, and how out-of-network reimbursement works.
- **Employee Assistance Program (EAP).** If your workplace offers one, this is a confidential, employer-paid benefit that usually covers a limited number of short-term counseling sessions at no cost to you. The number of sessions and what happens afterward vary by employer — ask your HR department or the EAP line.
- **Sliding-scale fees.** Many clinicians and community clinics set fees based on income, and federally qualified health centers offer discounts based on ability to pay (SAMHSA: free and low-cost treatment). Ask about this when you call to schedule.
- **Community mental health centers and 211.** Dial 2-1-1 for local community services, including low-cost mental health care. In many areas you can also text your ZIP code to 898211, though texting is not available everywhere and hours vary by local center — check 211.org or the federal directory at FindTreatment.gov.
- **Group therapy.** Usually less expensive per session than individual therapy, and research comparing the two formats generally finds broadly similar results for many common concerns (format comparison research). Findings are not identical for every condition, so ask which format fits what you are working on.
- **Guided self-help programs and workbooks.** Evidence-based options can be a reasonable starting point while you look for a longer-term fit. They are not a substitute for care if symptoms are severe.

None of these options require you to already know what kind of therapy you need. A receptionist, an intake coordinator, or 211 can help point you in the right direction once you have made contact — the first call does not have to be the informed one.

COST IS NEVER A GATE IN A CRISIS

If you are in crisis, the 988 Suicide & Crisis Lifeline and many local crisis lines are free and confidential regardless of insurance or ability to pay.

A NOTE ON FAMILY AND CULTURE

Parts of this guide assume one person making a private decision. That is not how everyone relates to care. In many families and communities, involving a parent, partner, elder, or faith leader in the decision to seek therapy is a value, not a sign of dependence, and it does not make the choice any less yours. If that is true for you, the more useful question may not be "should I go alone" but "who do I want with me in this, and how do I want to describe what I am doing."

A SIMPLE NEXT STEP

When to reach out

This is general guidance, not a diagnostic tool. Only a licensed clinician can assess your situation. If you are unsure, it is reasonable to ask.

CONSIDER CONTACTING A LICENSED CLINICIAN IF

- Low mood, worry, irritability, or numbness has lasted a few weeks or longer
- Sleep, appetite, concentration, or energy have changed and are not returning to normal
- Work, school, relationships, or daily routines are being affected
- You are using alcohol, cannabis, or other substances more than you want to in order to cope
- Strategies that used to help are no longer helping
- Something happened that you have not been able to talk about with anyone

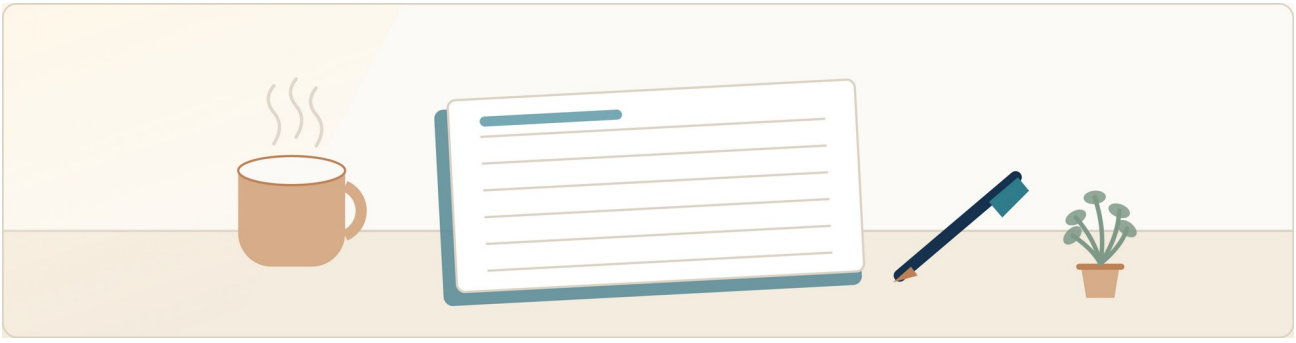
SEEK URGENT OR EMERGENCY CARE IF

- You are thinking about suicide or harming yourself, or you cannot keep yourself safe — call or text 988, or call 911 if you are in immediate danger
- You are unable to care for yourself — not eating, not sleeping for days, or unable to leave your home
- You are experiencing new confusion, hearing or seeing things others do not, or a marked change in behavior, unusually high energy, or racing thoughts with little need for sleep
- You have a sudden severe physical symptom such as chest pain, severe shortness of breath, or fainting

If symptoms are severe enough that you are missing work or cannot care for yourself, say that directly when you call a clinic and ask about an expedited evaluation or a higher level of care rather than waiting for a routine intake appointment. You do not need to have the whole story ready to ask for help faster.

One small, realistic step

You do not need to work through this whole guide at once. One specific observation can be enough to make the next conversation more useful.



What am I noticing?

Name one pattern, question, or moment that feels important.

What might help?

Choose one small support, experiment, or conversation to try.

Who can I involve?

A trusted person, clinician, or service that could help you continue.

WHEN TO SEEK HELP RIGHT NOW

988 — Suicide & Crisis Lifeline. Call or text 988, 24/7, free and confidential. Chat at 988lifeline.org. If you are Deaf or hard of hearing and use American Sign Language, you can reach a signing counselor by calling 988 from a videophone; TTY users can dial 711 then 988 (988 accessibility services).

911 — for a medical emergency or immediate danger.

988 en español — call 988 and press 2, or text AYUDA to 988.

211 — dial 2-1-1 for local community services, including low-cost mental health care (211.org).

SAMHSA National Helpline — 1-800-662-HELP (4357), free and confidential, 24/7 (samhsa.gov/find-support).

A routine first therapy session is not emergency care.

SOURCES AND SUPPORT

Where this information comes from

This guide draws on U.S. federal health agency sources, peer-reviewed research, and professional guidance to support a thoughtful conversation — not to replace individual assessment or care. Written information cannot account for your full history, health, relationships, culture, or current safety needs.

SELECTED SOURCES

- Centers for Disease Control and Prevention / NCHS. Mental Health Treatment Among Adults: United States, 2024 (Data Brief No. 564, June 2026)
- National Institute of Mental Health. Psychotherapies and Mental Health Medications
- American Psychological Association. Understanding psychotherapy, How do I find a good therapist?, Confidentiality in psychotherapy
- Substance Abuse and Mental Health Services Administration. Find Support, Free or low-cost treatment, FindTreatment.gov
- U.S. Department of Labor (EBSA). Mental Health and Substance Use Disorder Parity; CMS MHPAEA overview
- U.S. Department of Health and Human Services. HIPAA notices of privacy practices
- National Institute of Diabetes and Digestive and Kidney Diseases. Hypothyroidism (underactive thyroid)
- National Heart, Lung, and Blood Institute. Iron-deficiency anemia
- Olfson M, et al. Is dropout after a first psychotherapy visit always a bad outcome? Psychiatric Services, 2012.
- Swift JK, Greenberg RP. Premature discontinuation in adult psychotherapy: a meta-analysis (669 studies).
- Flückiger C, et al. The alliance in adult psychotherapy: a meta-analytic synthesis

- Kazantzis N, et al. Homework compliance and therapy outcomes: an updated meta-analysis
- Federal Communications Commission. 988 ASL direct video calling service

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