PATHWAY CLINICAL GROUP

San Diego, California

A PATIENT GUIDE

What Trauma Therapy Actually Looks Like

Your window of tolerance, why nobody will ask you to relive it in the first session, and how the work is sequenced

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BEFORE YOU BEGIN

You are allowed to know what you are walking into

Most people who would benefit from trauma therapy wait a long time before starting it. Usually, the reason is not doubt about whether it works. It is a picture in the head of what the first session will be: sitting in a chair, being asked to describe the worst thing that has ever happened to you, in order and in detail, to a stranger who is taking notes.

That picture is not a mild exaggeration. It is close to the opposite of how the work is sequenced. What follows is a plain account of what a course of trauma therapy looks like from the inside — what the early sessions are for, what happens before anyone goes near a memory, what "processing" means in practice, and how much you have to say out loud, which is considerably less than almost everyone assumes.

You do not need a diagnosis to read this, and you do not need to have decided anything.

CLINICIAN'S NOTE •

People apologize to me in first sessions. They have the story queued up, they are braced to deliver it, and they are sorry that they cannot get it out.

I am not asking for it. Not that day, and often not for several weeks. What I need first is far more ordinary: how you are sleeping, what your days look like, what makes things worse, what has helped even slightly. That is not delicacy. The information required to plan treatment is not the story — it is what the story is currently doing to your life.

What surprises people most is that the decision about how much to say, and in what form, stays with you the whole way through. It is not something you earn later. It is how these treatments are built.

HOW TO USE THIS

Read it in any order. Skip whatever does not fit — your account of your own life outranks anything written here.

Nothing here adds up to a score, and none of it is a diagnosis. It describes a process, so you can decide whether to begin one.

IF YOU ARE NOT SAFE RIGHT NOW

If you are thinking about ending your life, call or text 988. It is free and staffed 24 hours a day. If you are in immediate danger, call 911.

If the danger is a person in your home, that comes first. There is help on the access page.

HOW COMMON THIS IS

Between 6 and 7 in 100 US adults meet criteria for PTSD at some point in their lives — roughly 1 in 10 women and 1 in 28 men, in the National Comorbidity Survey Replication. Many more carry trauma symptoms that never reach the diagnostic threshold and still cost them sleep, work, and closeness.

The figure matters for one reason. People who assume they are unusual tend to wait years before asking. Most of them did not need years.

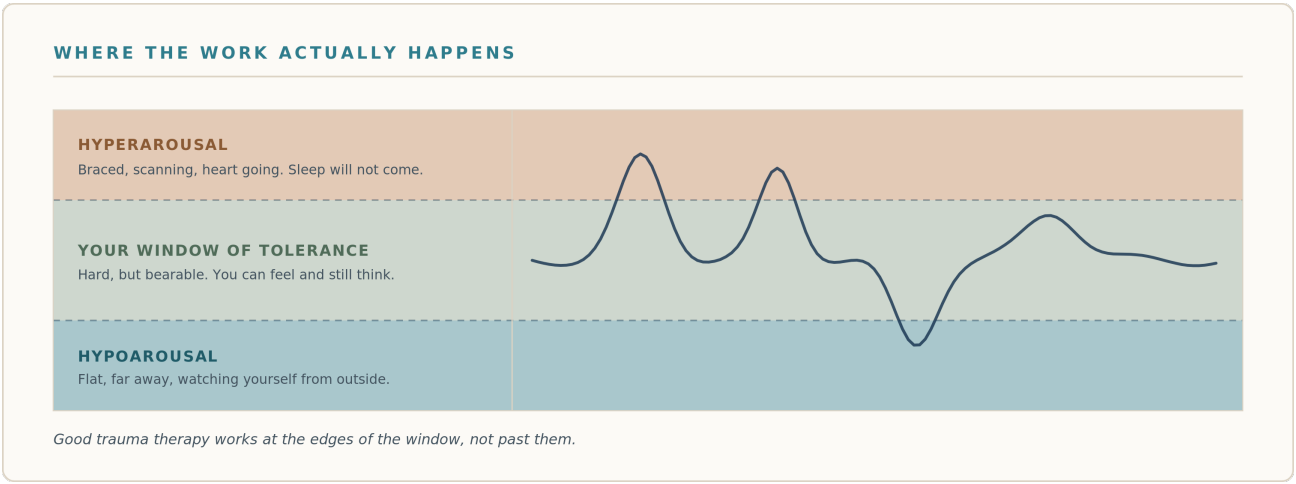
THE CENTRAL IDEA

The memory is not the problem. What your body does with it is.

A traumatic memory behaves differently from an ordinary one. Ordinary memories stay put when you are not using them, and they come back with a sense of pastness attached — while you are remembering, you know that you are remembering. Traumatic memories often lose that tag. They arrive uninvited, in fragments, carrying the full physical charge of the original moment, and the body reacts as though the event were current.

This is why "just stop thinking about it" fails so reliably. It is also why talking about it more does not automatically help. The aim of treatment is not to erase the memory, and not to make you unmoved by it. It is to give the memory back its pastness, so that remembering becomes something you do rather than something that happens to you.

Everything else in this guide follows from that one point. The sequencing, the pacing, the choices you keep about disclosure — all of it exists to hold you in the state where that shift is possible.



The window of tolerance: the range of arousal in which you can feel something difficult and still think clearly.

Much of trauma therapy is the work of widening it.

THREE THINGS TO HOLD ONTO

NOTICE

Your symptoms are not evidence that something is wrong with you. They are what a threat-detection system does after it has been correctly triggered.

UNDERSTAND

Recovery does not require reliving anything. It requires being able to approach the memory without leaving the window.

CHOOSE

You set the pace. A therapist who overrides that is not being thorough. They are working badly, and you can say so.

THE SHAPE OF A COURSE

Three phases, and how long each really takes

Nearly every model of trauma treatment in use today is a version of the same three-part sequence, first described by Pierre Janet more than a century ago: steady the system, work through the memory, then rebuild the life around it. Different schools use different names, and the International Society for Traumatic Stress Studies still organises its complex-trauma guidance this way.

The phases are a sequence, not a staircase. People move back and forth between them, and the boundaries in practice are blurry.

The number people most want is how long. For structured, well-tested protocols, a full course usually runs between 8 and 16 weekly sessions. That is a real course of treatment with a real endpoint, not an open-ended arrangement. Where trauma is long-running and began early, the work often takes longer — but longer means months, not the indefinite commitment people brace for.

WHEN THIS GUIDE IS NOT THE RIGHT MAP

Some things need a different response than the one described here, and working through this guide alone will delay it. Come back to the next page, or raise it with a clinician directly, if any of the following are true:

- You are still in the situation. Ongoing danger is not a phase-one problem — it is a safety problem, and it comes first.
- You are regularly losing time, or finding evidence of hours you cannot account for.
- You are drinking or using in order to sleep or to stop remembering.
- You are thinking about ending your life, or you cannot be confident of keeping yourself safe.

You do not have to tell the whole story to ask for help. "Something happened and I am not doing well" is a complete sentence, and it is enough to start with.

SECTION 1 OF 6

Your window of tolerance

Everyone has a band of arousal inside which they can function — awake enough to engage, calm enough to think. Inside that band you can be upset and still reason, still hear someone else, still choose what to do next. Trauma narrows the band. What used to be a wide, forgiving range becomes a strip, and ordinary pressure now tips you out of it in one direction or the other.

Above the window is hyperarousal: heart going, muscles set, scanning for the thing that is about to go wrong. Below it is hyperarousal, which gets discussed far less and matters just as much — flat, distant, moving through the day behind glass. Both are the same system doing its job too well.

WHAT THIS CAN LOOK LIKE

- Going from level to furious with almost nothing in between, then not recognizing yourself an hour later.
- Falling asleep without much trouble and waking at three, fully alert, most nights.
- Watching yourself have a conversation from somewhere slightly behind your own head.
- Arriving home and not being able to account for the drive.
- Feeling nothing at all at a funeral, and being frightened by that.

CLINICIAN'S NOTE •

People arrive worried about the top of the window. The anger, the startle, the racing heart — those announce themselves, and they are embarrassing in front of other people.

Almost nobody arrives worried about the bottom. But shutting down is more often what ends a relationship, because from the outside it does not look like distress. It looks like indifference. Partners describe it as being left, and the person doing it usually has no idea it is visible at all.

If you recognize the lower band more than the upper one, that is worth saying out loud early. It changes what we work on first.

TRY THIS

NOTICE

For one week, note only which direction you went — up or down — and what happened just before. Not why. Just the direction.

UNDERSTAND

A narrow window is not a permanent setting. It is the current calibration of a system that has been running hot, and calibration moves.

CHOOSE

Pick one reliable way back — cold water, walking, a phone call. The same one every time, so it works when you cannot think.

SECTION 2 OF 6

What actually happens in the first sessions

The opening sessions are an assessment. Their purpose is to work out what is going on, what else might be going on, and which treatment fits — not to get the story on the record. A good assessment is mostly about the present: your sleep, your concentration, what you have stopped doing, who is still in your life, what you have already tried.

Somewhere in there you will be asked, in general terms, what kind of thing happened and roughly when. General terms genuinely means general terms. "A car accident four years ago" or "things at home when I was a child" is enough information to plan around. You are not being tested on detail, and nothing is being withheld from you if the follow-up questions do not come.

WHAT THIS CAN LOOK LIKE

- Questionnaires, often the PCL-5, which you fill in yourself and which gives a number to track over time.
- Questions about drinking, sleep, head injuries, and medication — screening, not judgement.
- A conversation about goals that are about your life rather than your symptoms: sleeping through, driving again, being present with your kids.
- An explanation of which treatment is being proposed and why, with room to ask what the alternatives are.

CLINICIAN'S NOTE •

Occasionally someone does tell me everything in the first hour. It pours out, and afterwards they feel wrung out and strangely exposed, and sometimes they do not come back.

I have learned to slow that down, and people are often puzzled by it. It can read as a lack of interest. It is the opposite. Telling the whole story to someone you met forty minutes ago, before either of us knows how to bring you back down afterwards, is not therapy — it is an uncontrolled exposure with nobody minding the exit. If your last therapy went that way and left you worse, that was a sequencing failure. It is not evidence that you cannot do this work.

TRY THIS

NOTICE

Write down what you want back, not what you want gone. It is a more useful answer to the goals question, and harder to think of on the spot.

UNDERSTAND

Assessment is not a gate you have to pass. It is the part where the clinician earns the right to propose something specific.

CHOOSE

You may ask what the plan is, how long it runs, and what happens if it is not working. A clear answer is a reasonable expectation.

SECTION 3 OF 6

Steadying comes first — but not for as long as you think

Phase one has a narrow job: make sure that when something difficult comes up, you have a way back. That means learning what your own early warning signs are, having two or three things that reliably bring your arousal down, and sorting out whatever is currently making everything harder — usually sleep, sometimes alcohol, sometimes an untreated medical problem.

There is a real risk at this stage, and it is worth naming. Some people spend years in phase one. Coping skills are pleasant to work on; they produce a feeling of progress, and they never require anyone to go near the difficult part. Meanwhile, the symptoms do not shift, because skills manage a memory rather than change it.

WHAT THIS CAN LOOK LIKE

- Paced breathing or grounding, practiced when you are calm so it is available when you are not.
- Fixing sleep first, because almost nothing else improves reliably while sleep is broken.
- Mapping your own signals — jaw, shoulders, the sudden urge to leave the room.
- Deciding together, out loud, when phase two starts, rather than letting it drift.

CLINICIAN'S NOTE •

The honest position on this phase is that the evidence for a long one is thinner than its popularity suggests. A 2021 randomized trial in Psych Open took adults with PTSD from childhood abuse — the group most often told they need extensive preparation — and gave half of them eight sessions of skills training before trauma-focused work, and the other half the trauma-focused work straight away. There was no significant difference between the groups at any point. Just under 70% no longer met criteria for PTSD afterwards, in both conditions.

IF YOU ARE STILL IN IT

None of this applies while the danger is current. If someone in your home is hurting you, frightening you, or controlling what you do, processing the past is the wrong task and can make you less safe. Safety planning comes first, and it is specialized work. The National Domestic Violence Hotline is 1-800-799-7233, or text START to 88788. Tell your therapist. It changes the plan entirely, and it is not something to work around.

SECTION 4 OF 6

What "processing" actually means

Processing is the phase people are most afraid of and know least about. It does not mean narrating the event until you are numb to it, and it is not catharsis. In practice, it means bringing the memory to mind under conditions where your body can finally register that the danger is over — and then staying with it long enough for that information to land.

What that looks like depends on the treatment. In cognitive processing therapy, most of the time is spent on the conclusions you drew afterward, not the event: that you should have known, that you let it happen, that you cannot trust your own judgment now. In EMDR, you hold the memory in mind briefly while doing something that occupies attention, usually following the therapist's hand, in short sets with talking in between. With prolonged exposure, you approach the memory and the avoided situations, in an agreed order that you help build.

WHAT THIS CAN LOOK LIKE

- Sessions that feel like work rather than like disaster — tiring, specific, and finite.
- Homework between sessions, which is a large part of why these treatments work.
- Noticing partway through that you can bring the memory up on purpose and put it down again.
- A stretch of feeling worse before feeling better, usually early, usually brief.

CLINICIAN'S NOTE •

That last point deserves a straight answer, because people ask and are often given a reassuring non-answer.

Yes, symptoms sometimes rise before they fall. Across studies, somewhere between one in ten and one in five people show a measurable worsening at some stage — and, notably, those people are no more likely to drop out than anyone else. Dropout across evidence-based PTSD treatments averages around 18%, which is unremarkable compared with therapy for other conditions.

What I tell people is this: a hard week is expected and is planned for. A month of getting steadily worse is not, and it is information — about the pacing, or the fit of the treatment, or something in the assessment we missed. That is a conversation to have out loud with your therapist, not a verdict on you.

TRY THIS

NOTICE

Track something concrete week to week — hours slept, places gone, arguments avoided. Symptom change is easier to see in behavior than in mood.

UNDERSTAND

The goal is not to stop caring about what happened. It is for the memory to stop setting off the alarm as though it were news.

CHOOSE

Agree in advance what the last ten minutes of a session are for. Every session should end with you back inside the window.

SECTION 5 OF 6

You decide how much to say, and in what form

This is the part most worth knowing before you start, because it is the assumption that keeps people out of treatment for years — the belief that recovery requires a full spoken account of what happened, delivered to another person.

It does not. Cognitive processing therapy originally included a written account of the event. A patient can choose to write one, and some do, but the standard protocol no longer requires it. A 2025 meta-analytic review in the Journal of Anxiety Disorders compared the two versions across trials and found no significant difference in effect size or in the number of people who dropped out. EMDR needs even less: you are not required to describe the memory aloud at all, only to hold it in mind. Prolonged exposure does involve recounting, which is precisely why it is one option among several rather than the only one.

WHAT THIS CAN LOOK LIKE

- Saying "there is a part I am not ready to talk about yet" and having that respected as clinical information rather than resistance.
- Choosing a treatment on the basis of how much disclosure it asks for, which is a legitimate reason to choose one.
- Working on a memory without naming what happened in it out loud.
- Being told, before you agree to anything, what a given treatment will actually ask of you.

CLINICIAN'S NOTE •

I want to be exact here, because vagueness on this point costs people years.

You will not be made to describe anything. Not by me, and not by any therapist working competently. If the version of treatment on offer requires more disclosure than you are willing to give, that is a reason to change the treatment, not a reason to conclude you are not ready. There is more than one route through, and their outcomes are broadly comparable.

The thing people fear most about therapy turns out to be optional. It is worth saying plainly, because almost nobody is told.

IF TALKING OUTSIDE THE FAMILY IS NOT A NEUTRAL ACT

In many families and communities, describing what happened at home to an outsider is not simply difficult — it is a breach of something that matters, and the cost of it is real and falls on you, not on your therapist. That is not a symptom to be treated, and a clinician who treats it as one is misreading you.

The question that survives translation is narrower: is there a version of this work you could do that does not require you to hand over the whole account? Usually there is. Ask for it directly.

SECTION 6 OF 6

What the end of treatment looks like

The third phase gets the least attention and is often the part people are least prepared for. Symptoms have eased, and what is left is a life that was organized around avoiding things. The job now is to put attention back into work, people, plans, and the ordinary appetites that got crowded out while everything went into managing.

This phase is frequently unglamorous and occasionally flat. People expect relief and find something closer to disorientation — a set of hours that used to be filled with vigilance, and no clear idea what goes there instead.

WHAT THIS CAN LOOK LIKE

- Realizing you have not checked the locks twice in a fortnight and cannot remember when that stopped.
- Grief arriving late, once there is enough room for it.
- Having to decide what you actually want, having not had the space to want much for a long time.
- The memory still being sad, or still making you angry, without hijacking the day.

CLINICIAN'S NOTE •

Recovery is more anticlimactic than people expect, and I think it is worth warning them. Nobody has the moment where the memory dissolves. What happens is subtler: you notice, weeks after the fact, that something you used to avoid has quietly gone back to being ordinary.

The other thing worth saying is that finishing does not mean never again. Anniversaries, a similar event in the news, a smell in a car park — these can knock a person sideways months later. That is not relapse and it does not undo the work. It usually means a session or two, not another course.

TRY THIS

NOTICE

Make a list of what you stopped doing. Not to tackle it, only to see it. Most people are surprised by the length.

UNDERSTAND

Feeling adrift once the symptoms lift is common and does not mean the work failed. There is simply space where there was not any.

CHOOSE

Put one thing back on purpose this month. Something small and specific, chosen because you want it rather than to prove a point.

BEFORE YOU ASSUME THIS IS THE RIGHT TREATMENT

Seven things that need a different answer

Trauma symptoms overlap with several other conditions, and a few of those need something other than trauma processing — sometimes first, sometimes instead. This page exists so you can raise the possibility yourself. Nothing here rules trauma therapy out; each one changes the order of operations, which is exactly the kind of thing that is easier to sort out at the start than six months in.

Ongoing danger. If the harm is current — an abusive partner, an unsafe home, an active threat — hypervigilance is not a symptom to reduce. It is accurate. *Safety planning first; processing later.*

Significant dissociation. Regularly losing time, finding evidence of hours you cannot account for, or feeling that more than one part of you responds to things differently. *Say so before starting; it changes pacing and sometimes the whole approach.*

Substance use as regulation. Drinking or using to get to sleep, to stop remembering, or to get through a specific time of day. This is common, and it is not a moral failure, but processing on top of it tends to destabilize. *Concurrent or prior treatment; ask about integrated care.*

Bipolar disorder or psychosis. A history of periods of elevated mood, greatly reduced need for sleep, or experiences others could not verify. Trauma and these conditions co-occur often, and treating only one goes badly. *Needs a psychiatric assessment, not only a trauma one.*

Medical causes and mimics. Head injury, obstructive sleep apnea driving the nightmares and the exhaustion, thyroid problems, medication effects. Any of these can produce the whole picture on its own. *See a physician first; ruling out the body is not a detour.*

Intrusive thoughts that are OCD. Unwanted thoughts that are not memories, that horrify you, and that you neutralize with checking, reassurance, or mental rituals. These are frequently mistaken for flashbacks. *Exposure and response prevention, not trauma processing.*

Grief after a death. Bereavement is not PTSD, though it can be traumatic and the two can sit together. Persistent, disabling grief past roughly a year has its own treatment. *Ask specifically about prolonged grief disorder.*

> RAISING IT IS NOT OVERSTEPPING
>
> If you recognize something on this page, bring it up. You will not be told you are self-diagnosing. Clinicians rely on this information and cannot always see it from where they sit — several of these are things only you would know about. You do not have to tell the whole story to ask the question.

PUTTING IT TOGETHER

What the evidence supports, and what it does not promise

WHAT THE SYMPTOMS WERE DOING FOR YOU

THE STRATEGY	WHAT IT PROTECTED	WHAT IT COSTS NOW
Avoidance	Kept you clear of what once meant danger	The map of safe places keeps shrinking
Staying alert	Caught trouble early, back when that mattered	Rest never quite arrives
Numbing	Turned down feeling you could not afford	Good things come through muted too
Keeping quiet	Spared you disbelief, blame, or pity	Nobody can help with what they cannot see

None of this is a character flaw. It is what a nervous system does to keep you going.

Each of these was a solution to a real problem. The trouble is that they outlast the conditions that made them sensible.

THIS IS NOT ABOUT BLAME

Understanding where a pattern came from is a different activity from deciding whose fault it is. Most of the people in these stories were working inside constraints you could not see at the time. You can hold what happened as serious and real without needing a verdict on anyone — and trauma work generally goes better once the search for one is set down.

WHERE THE EVIDENCE IS STRONGEST

Both the American Psychological Association guideline and the 2023 VA and Department of Defense guideline recommend trauma-focused psychotherapy as first-line treatment, and the VA/DoD guideline recommends psychotherapy over medication where both are available, because the improvement is larger and lasts longer. Cognitive processing therapy, prolonged exposure, and EMDR are named most consistently.

The honest limit: these treatments help most people and cure nobody reliably. In a large trial of US veterans, between 28% and 40% of those who completed a full course no longer met criteria for PTSD afterward, and civilian samples generally do better. Response is defined differently across studies, so headline figures are a range rather than a promise. A first course that does not work is information about fit, not a verdict on you.

GETTING TO TREATMENT

If cost or availability is the obstacle

A guide that builds up your motivation and then names one private practice has done half the job. Trauma treatment is not evenly available, and the routes below are real ones that people use.

ROUTES WORTH TRYING

- Insurance, including out-of-network. Many plans reimburse a share of out-of-network therapy against a superbill. It is worth calling the number on your card and asking what the out-of-network mental health benefit actually is — the answer is frequently better than people assume.
- Sliding scale. Many practices, including this one, hold a number of reduced-fee places. They are rarely advertised. Ask directly; it is a normal question, and nobody is offended by it.
- Community mental health. Dial 211 for local services anywhere in the US, including counties across San Diego. This is also the route for housing, food, and legal help, which are often the more urgent problem.
- Group therapy. Substantially cheaper per session, and for trauma specifically it addresses the isolation directly rather than incidentally.
- Guided self-help. Structured programs with some clinician contact have reasonable evidence and can bridge a waitlist rather than replacing treatment.
- Veterans. VA care includes CPT, PE, and EMDR at no cost to eligible veterans, and the Vet Center network offers counseling without enrollment in VA healthcare.

FOUR QUESTIONS WORTH ASKING ON A FIRST CALL

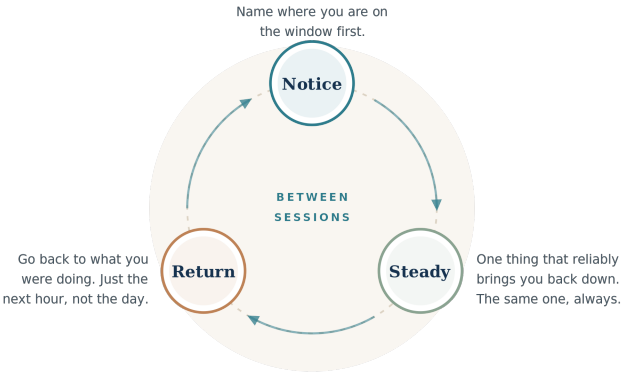
- Which trauma treatments do you actually deliver, and have you been trained in them? A specific answer — CPT, prolonged exposure, EMDR — is a better sign than "I work with trauma."
- Roughly how many sessions does that usually run? Anyone offering these protocols should be able to give you a range.
- How much of it involves describing what happened out loud? You are allowed to choose partly on this basis.
- What is the fee, is there a reduced-fee place, and will you provide a superbill for out-of-network reimbursement?

COST IS NOT A GATE IN A CRISIS

Emergency mental health care does not require insurance, money, or documentation. If you are in danger, call 988 or 911 and sort the rest out afterwards. Nobody will be turned away from a crisis line for inability to pay, and no one will ask you for the story before helping you.

SOMETHING TO DO WITH THIS

A rhythm for the weeks in between



Not a coping strategy so much as a habit of returning. The point is the loop, not any one step in it.

Where I go first

Up or down — which edge do I leave the window through?

My reliable way back

One thing that works when I cannot think clearly.

What I want returned

One thing I stopped doing that I would like back.

WHEN TO REACH OUT

LEVEL 1 OF 3

Worth raising

- Sleep or focus slipping
- Avoiding more places or people
- Flatter than you used to be

Bring it to your next session

LEVEL 2 OF 3

Worth moving on

- Missing work, pulling away
- Drinking or using more to sleep
- Losing time, or feeling unreal

Book something this week

LEVEL 3 OF 3

Do not wait

- Thoughts of ending your life
- You are not safe where you live
- You cannot keep yourself safe

Call or text 988 now

This is a gradient, not a test. You do not have to reach the third card to deserve help.

A gradient, not a threshold. Most people wait longer than they needed to.

ONE SENTENCE IS ENOUGH TO START WITH

If you decide to make the call, you do not need an account prepared, a diagnosis, or a clear sense of whether what happened to you counts. "Something happened and I am not doing well" gets you an appointment. The rest is what the appointment is for.

REFERENCE

Sources, and where to go next

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IF YOU NEED HELP NOW

988 Suicide & Crisis Lifeline — call or text, 24/7. Chat at 988lifeline.org. Videophone available for ASL users. Veterans, press 1.

911 Medical emergency or immediate danger.

211 Local community services — counselling, housing, food, legal help.

1-800-799-7233 National Domestic Violence Hotline, 24/7. Text START to 88788, or chat at thehotline.org.

This guide is general education, not medical or psychological advice, and reading it does not create a clinician–patient relationship. It is not a diagnostic instrument and nothing in it produces a score. If anything, here conflicts with guidance from a clinician who knows your history, follow theirs.