PATIENT GUIDE · VIRTUAL PSYCHIATRY PRACTICE

After Trauma
What actually helps

A plain-language guide to the treatments that have the strongest evidence behind them — what they involve, what to expect, and how to find them in British Columbia.

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If something frightening, overwhelming, or life-threatening has happened to you, your mind and body will react. That reaction is not a character flaw and it is not permanent. Most people recover. For those who don't recover on their own, we have treatments that work well — and we know quite a lot about which ones work best.

This guide covers what the research actually shows. It is not a substitute for an assessment, and it won't tell you which treatment is right for you. What it will do is let you walk into an appointment already knowing the landscape, so the conversation can start further along.

SECTION 01

The conditions this covers

Four different responses to difficult events. They overlap, and they are treated differently.

CONDITION	WHAT IT LOOKS LIKE
Post-traumatic stress disorder (PTSD)	Lasting more than a month after a traumatic event. Unwanted memories, flashbacks, or nightmares. Avoiding reminders. Feeling constantly on guard. Changes in how you see yourself, other people, or the world.
Acute stress disorder	The same kinds of symptoms, but in the first days to weeks after the event. Many people who have this recover without treatment.
Adjustment disorder	A strong reaction to a difficult life stressor — a job loss, a diagnosis, a separation, a move — that is out of proportion to what you'd expect, or is getting in the way of daily life.
Prolonged grief disorder	Grief after a death that stays intense and disabling beyond about a year, with persistent yearning or preoccupation with the person who died. This is different from ordinary grief, which also hurts but changes shape over time.

AN IMPORTANT POINT ABOUT TIMING

In the first weeks after a traumatic event, difficult symptoms are normal and expected. Most people improve without any formal treatment. Support, safety, sleep, and practical help matter more in this window than therapy does. If symptoms are still significant at about one month, that is the point to be assessed.

SECTION 02

The main finding: therapy comes first

Across every major clinical guideline, a specific kind of talking therapy is the first-choice treatment for PTSD — ahead of medication.

This is the clearest message in the evidence, and it surprises people. The therapies that work are not general supportive counselling. They are structured, time-limited treatments built specifically for trauma, usually delivered one-on-one over roughly eight to fifteen sessions, following a manual.

In 2023 the largest clinical guideline review of PTSD treatment took the additional step of recommending these therapies over medication, because the improvement is larger and lasts longer after treatment ends.

THE THREE WITH THE STRONGEST EVIDENCE

01 **Cognitive Processing Therapy (CPT)**

Focuses on the conclusions you drew from what happened — about safety, trust, blame, control. You examine those beliefs directly and test whether they hold up. Involves writing and structured worksheets.

02 **Prolonged Exposure (PE)**

You revisit the memory in a controlled, repeated, and supported way, and gradually re-approach situations you've been avoiding. The avoidance is what keeps PTSD going; this treatment works by reversing it.

03 **Eye Movement Desensitization and Reprocessing (EMDR)**

You hold the memory in mind while following a repeated side-to-side eye movement or another rhythmic cue. Why the eye movements help is still debated. That the treatment works is not — it performs as well as the others in head-to-head trials.

These three do not clearly beat one another. Choosing between them comes down to what fits you — how you like to work, what you can tolerate, and honestly, which one you can actually get an appointment for.

IF THOSE DON'T FIT

- **Written Exposure Therapy** — five sessions of structured writing. In a direct comparison it worked as well as a twelve-session treatment, and far fewer people dropped out. A reasonable option if a long course feels impossible.
- **Present-Centered Therapy** — focuses on current problems and coping rather than revisiting the trauma. Less effective than the trauma-focused treatments, but genuinely helpful, and a real option if you are not willing or ready to go into the memory.
- **Skills-first approaches** — if emotions feel completely unmanageable, some people do a block of emotion-regulation skills work before trauma processing.

> Being told you need to "be stable first" for years before anyone will treat the trauma is a common experience. Experts genuinely disagree about how much preparation complex cases need, but a growing body of evidence shows the standard trauma-focused treatments still work well for many people with complicated histories. Complexity is a reason to plan carefully, and rarely a reason to wait indefinitely.

SECTION 03

What therapy actually feels like

Honest expectations, because knowing this in advance is one of the things that helps people finish.

It may get harder before it gets easier.

Approaching a memory you've been avoiding is uncomfortable by design. A temporary increase in distress in the early sessions is common and is not a sign the treatment is failing.

A lot of people stop early — and that's worth planning around.

Roughly a third of people leave these treatments before finishing — about 34% in cognitive processing therapy and 29% in prolonged exposure across pooled trials, and higher in everyday clinic settings. That is a well-documented problem, not a personal failing. It is also partly fixable: meeting twice a week instead of weekly cuts drop-out substantially, and intensive formats that compress treatment into a shorter block do even better. If you are worried about being able to stick with it, say so at the start and ask about these options.

There is homework.

These treatments involve practice between sessions. That practice is where much of the change happens.

Video sessions work.

Delivered by secure video, these treatments perform as well as in-person. If distance or travel is the barrier, it doesn't have to be.

SECTION 04

Medication: what it does and doesn't do

Medication is a real option — it is simply not the first one for PTSD.

Antidepressants do help PTSD. The honest description is that the benefit is moderate: they reduce symptoms for many people, but fewer than expected reach full remission on medication alone. That is why therapy leads.

Medication makes good sense when trauma-focused therapy isn't available or has a long wait, when you don't want to do it, when depression is a major part of the picture, or alongside therapy when symptoms are severe.

WHERE MEDICATION IS USUALLY STARTED

A small number of antidepressants have the strongest evidence in PTSD — sertraline, paroxetine, and venlafaxine among them. Two of these are formally approved in Canada for this use. Give any of them a fair trial: eight to twelve weeks at a proper dose before deciding it hasn't worked. If it does work, staying on it for at least a year reduces the chance of relapse.

NIGHTMARES

A blood-pressure medication called prazosin is sometimes used specifically for trauma nightmares. The evidence is genuinely mixed — early studies were positive, and the largest study was not. It remains worth trying for some people,

started at a low dose and increased slowly. Alongside it, a therapy called Imagery Rehearsal Therapy, where you rewrite the nightmare while awake, is effective and often overlooked — the sleep medicine field endorses it, though the strictest PTSD guideline review considered the evidence still insufficient.

WHERE CAUTION IS WARRANTED

- **Sedative anti-anxiety medications** (the benzodiazepine group — lorazepam, clonazepam and similar) are specifically recommended against in PTSD. They don't treat the core problem, they carry dependence risk, and there is evidence they make trauma-focused therapy work less well. If they were started for you in a crisis, that is understandable — but they are usually worth coming off, slowly and with support.
- **Cannabis** is widely used for PTSD symptoms and is recommended against in the current guidelines. It commonly helps sleep in the short term while worsening the overall picture.
- **Alcohol** — the same pattern, more so.
- **Antipsychotic medications added on** are not recommended as a routine next step. They may be appropriate in specific severe situations, with monitoring.

TREATMENTS YOU MAY HAVE READ ABOUT

MDMA-assisted therapy received wide coverage. In August 2024 the US regulator declined to approve it and asked for another trial, citing problems with how the studies were run — the advisory panel voted 2 to 9 against the treatment being effective, and 1 to 10 against its benefits outweighing its risks. It is not an approved treatment in Canada or the US, and that had not changed as of 2026. **Psilocybin and other psychedelics, ketamine, and brain stimulation approaches** are all under study for PTSD; none currently has enough evidence to be a standard treatment. Ketamine does have a role in treatment-resistant depression, which is a different question.

SECTION 05

The things around the treatment

These are not a substitute for treatment. They meaningfully change how well it goes.

Sleep

Sleep problems that persist after other symptoms improve predict relapse. Insomnia is treatable in its own right, and cognitive behavioural therapy for insomnia works well alongside trauma treatment.

People

Social support is one of the strongest predictors of recovery in the research. Not a large network — a few people who respond well when you tell them something hard. It is also worth knowing that critical or dismissive responses from close people measurably slow recovery.

Family involvement

Bringing a partner or family member into a session or two, so they understand what the treatment involves, tends to improve the odds of finishing it. Well-meaning people often help you avoid things, which works against the treatment.

Work

Returning to meaningful activity helps, and it usually goes better with adjustments than without. Being sent back into the setting where the trauma happened, before treatment, generally does not go well.

SECTION 06

Getting help in British Columbia

RESOURCE	WHAT IT OFFERS
Your family doctor or nurse practitioner	The usual starting point. They can begin treatment, and they are the route to a psychiatric referral.
BounceBack BC	Free cognitive behavioural therapy program from the Canadian Mental Health Association, ages 13 and up, province-wide, no waitlist. The online program (bouncebackonline.ca) and the video series (bouncebackvideo.ca, access code bbtodaybc) are open to anyone. The telephone coaching stream can be started by you, but you'll need to name a family doctor, nurse practitioner, or counsellor who stays clinically responsible for your care. **This program is designed for mild-to-moderate low mood, anxiety, stress, and worry — not for PTSD.** It can help with those symptoms while you wait for trauma-specific treatment. 1-866-639-0522 · bouncebackbc.ca
Foundry	Free, confidential mental health services for ages 12-24 and their caregivers, in person at Foundry centres and virtually through the Foundry BC app. No referral needed. There are around 20 centres across BC, including one in Kelowna, with more opening. foundrybc.ca
Crime Victim Assistance Program	If your trauma came from a violent crime committed in BC, this provincial program can fund counselling — for victims, immediate family, and some witnesses. Apply through the BC government website, or call 1-866-660-3888. VictimLink BC (1-800-563-0808) can help you find a victim service worker to assist with the application.
Low- and no-cost counselling	The province funds community organizations to provide free or low-cost counselling across BC, with trauma among the most common reasons people come. Availability varies by community and depends on funding that is renewed periodically — worth asking your doctor what is currently running near you.
WorkSafeBC	If the trauma occurred at work, a psychological injury claim may cover treatment — this is open to any worker. Some occupations also have presumptive coverage, meaning the work connection is assumed rather than argued: first responders, correctional officers, dispatchers, nurses and care aides, and — since June 2024 — social workers, shelter and transition-house workers, victim-service and harm-reduction workers, respiratory therapists, coroners, parole and probation officers, community-integration specialists, and withdrawal-management workers. If a claim is accepted, WorkSafeBC funds trauma-focused therapy through its own network of contracted providers — one of the few routes in BC where this treatment is publicly paid for.
Interior Health mental health & substance use	Community mental health services across the Interior, including Kelowna. Call **310-6478** (no area code) to reach your local centre — you can refer yourself, or your doctor can refer you. For substance use, Access Central offers same-day screening at 1-866-777-1103.
Registered psychologists and clinical counsellors	Where most CPT, PE, and EMDR is actually delivered in BC, usually private-pay or through extended benefits. Funded routes do exist — WorkSafeBC for eligible claims, the Crime Victim Assistance Program, and health authority mental health teams. Ask any therapist directly whether they are trained in one of these specific treatments; that question matters more than the general credential.

IF YOU ARE IN CRISIS

If you are in immediate danger, call **911**.

988 — Suicide Crisis Helpline, call or text, available across Canada, 24/7.
310-6789 — BC Mental Health Support Line, no area code needed, 24/7.
1-800-784-2433 — BC Suicide Prevention and Intervention line, 24/7.
1-888-353-2273 — Interior Crisis Line Network, for Kelowna and the Interior, 24/7.
1-800-588-8717 — KUU-US Crisis Line, Indigenous-specific support, 24/7.

Reaching out during a hard hour is a reasonable thing to do, and these lines exist for exactly that.

SECTION 07

Questions worth asking

Bring these to your appointment.

- Is the therapy you're recommending one of the trauma-focused treatments, or is it general counselling? Both have a place — it helps to know which one this is.
- Are you trained in CPT, PE, or EMDR specifically?
- Roughly how many sessions, and how often? Could we meet twice a week?
- If medication is being suggested — what is it meant to do, how long before we'll know if it's working, and how long would I stay on it?
- What do we do if this doesn't work? What's the next step?
- How will we measure whether I'm actually improving?

> That last question is worth insisting on. Trauma treatment is one of the areas of medicine where progress can be tracked with a short questionnaire, repeated over time. Being able to see change on paper is useful when it doesn't yet feel like change.

IF YOU REMEMBER SIX THINGS

1. In the first weeks after a traumatic event, distress is normal. Most people recover without treatment. The one-month mark is when to be assessed.
2. For PTSD, a trauma-focused talking therapy — CPT, Prolonged Exposure, or EMDR — is the first-choice treatment, ahead of medication.
3. Ask directly whether a therapist is trained in one of those three. It matters more than the general credential.
4. Medication helps and is a legitimate choice, particularly when therapy isn't available or depression is a large part of the picture. Give it eight to twelve weeks.
5. Sedative anti-anxiety medications and cannabis are recommended against in PTSD, even though both can feel like they help in the short term.
6. Ask how progress will be measured, and look at the numbers over time.

About this guide. Prepared by Dr. Marie Claire Bourque, MD, FRCPC, a psychiatrist in virtual practice in British Columbia. It summarizes recommendations from the major current clinical practice guidelines for trauma- and stressor-related disorders, including the VA/DoD guideline (2023), the American Psychological Association guideline (2017), the International Society for Traumatic Stress Studies guidelines (2019), NICE guideline NG116 (2018), and World Health Organization guidance. Reviewed August 2026.

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