Which Therapy Does What?

How trauma therapies differ, and why fit matters more than force.

Austan Sloan • Recover-You

A note before you begin. This guide describes fifteen therapy approaches, including several that involve directly revisiting traumatic memories. Reading the descriptions is safe; the therapies themselves are not self-administered and shouldn't be. Nothing here is a recommendation for your situation. It's a map so you can ask better questions of the clinician you're working with.

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Not All Trauma Therapy Does the Same Thing

Trauma therapy is often treated as a single category. In reality, the approaches differ meaningfully in how they work, what they ask of you, and which part of your experience they target. Some focus on memory processing. Others work with beliefs, skills, body-based regulation, or nervous-system retraining.

That distinction matters, especially if you are accessing care through a public pathway like Alberta Health Services or Recovery Alberta. Therapist competence and therapeutic fit are not the same thing. A skilled clinician can still be working in a modality that does not suit your history or nervous system.

> *In trauma work, a sense of control is not a luxury. It is part of the mechanism.*

For people whose histories involved powerlessness, knowing what options exist means participating in your care rather than simply receiving it. That is not a small difference. This guide covers the modalities most commonly available in Alberta so you can see what actually exists, understand how they differ in practice rather than in description, and identify which approaches feel workable given where you are right now.

Some approaches are gentler entry points. Others are more intensive. Prolonged Exposure requires detailed, repeated verbal recounting. EMDR asks the client to bring traumatic material to mind but does not always require a full spoken narrative. ART generally uses less verbal retelling, although its evidence base is smaller. Those differences can matter in early recovery. Intensity should be judged with a clinician, not assumed from a modality's marketing.

Different jobs, with real overlap. CPT, EMDR, and Prolonged Exposure directly target PTSD and have the strongest guideline support. ART is promising but supported by fewer studies. CBT, DBT, and ACT may build skills, reduce avoidance, and improve daily functioning; some specialized forms also address trauma directly. Effective treatment is not a clean split between 'processing' and 'support.' It is matching the method, evidence, sequence, and clinician to the person in front of you.

This is not a ranking. There is no single best approach. Think of it as a map designed to give you realistic expectations, informed choice, and enough context to recognize what might actually fit.

A Personal Note on Fit, Timing, and What Gets Offered

My healing wasn't the result of one thing. Different approaches helped at different times and for different reasons. What that taught me is that we don't just store trauma differently. We respond to therapy differently too.

For years, I accepted at face value what treatment offered me, even with a quiet feeling that there was more to be done. I did not refuse deep trauma work. How could I? It was never on the table.

I had my share of Good Will Hunting moments with counsellors. I would open up, put everything out there, maybe break down, and hear, "It's not your fault." That was often the depth of it. Being witnessed mattered, but it was not trauma therapy. The problem was that those moments did not work on someone like me. Reassurance could not reach the part of me carrying the shame. Before "it's not your fault" could mean anything, I had to be capable of believing it. I know now that the shame had to loosen first.

When Accelerated Resolution Therapy was finally offered, it was the only trauma-processing option available to me. Based on conversations I had with AHS workers, I came away believing cost and access were part of why brief approaches like ART were easier to offer than therapies that may require many more sessions. That is my interpretation, not a claim about every program or funding decision.

What brought relief for me might overwhelm someone else. That does not make them weaker or less ready. Every nervous system has its own threshold, pace, and history. Sequence matters, but so does having a genuine choice of methods.

If you are cooperating fully with treatment and still feel that something is missing, listen to that feeling. Addiction can train us to ignore the inner voice that says do this or don't do that. We override it often enough that eventually we stop hearing it. You don't have to obey it blindly. Start by listening to what it is trying to say, then investigate.

> *You aren't failing at therapy. You may be recognizing that there is more work to do, or that the work you need has not yet been offered.*

Bilateral Stimulation / Eye-Movement Therapies

Structured approaches that pair trauma recall with bilateral stimulation (eye movements, taps, or tones) to help the brain reprocess stuck memory networks.

EMDR (Eye Movement Desensitization and Reprocessing)

Typical stage: Mid to late recovery. *Verbal: Moderate–High. Emotional: Moderate–High.*

What it is: A structured, evidence-based trauma therapy that uses bilateral stimulation, typically eye movements, while the client holds a traumatic memory in mind. It is widely considered a first-line treatment for PTSD.

How it works: Traumatic memories can remain emotionally raw when the brain has not fully integrated them. EMDR pairs memory recall with bilateral stimulation so those memories can be reprocessed with less emotional intensity. The exact mechanism is not fully established, but clinical research supports its ability to reduce distress and improve memory integration.

May be most suitable when:

— Trauma memories are clearly identifiable (single events or specific themes)

— You experience intrusive memories, flashbacks, or strong emotional reactions
— You can tolerate recalling aspects of the trauma verbally
— You want a time-limited, structured approach

Important considerations:

— Requires adequate stabilization before processing begins, particularly for complex trauma or active addiction
— For C-PTSD or developmental trauma, preparation can take months. This is not necessarily a delay; it is often essential work.
— Can feel emotionally intense early in processing
— Requires a trained and certified clinician; quality of delivery varies

Accelerated Resolution Therapy (ART)

Typical stage: Early to mid recovery. *Verbal: Low–Moderate. Emotional: Moderate.*

What it is: A trauma therapy derived from EMDR that uses eye movements to reprocess traumatic memories, but with significantly less verbal retelling. Most protocols are completed in one to five sessions.

How it works: ART uses eye movements alongside voluntary image replacement. The client intentionally substitutes distressing imagery with neutral or self-chosen images. This targets both the emotional charge and the sensory representation of the memory without requiring the client to narrate the trauma aloud.

May be most suitable when:

— Verbal retelling feels overwhelming or re-traumatizing
— You want trauma resolution with less narrative exposure
— You have complex trauma but limited tolerance for emotional flooding
— Early recovery or high shame makes disclosure difficult

Important considerations:

— Fewer trained clinicians than EMDR, though availability is growing in Alberta
— Research base is developing; less standardized than EMDR
— Still requires emotional safety and basic stabilization
— Image replacement can also shift self-perception from trauma-defined toward a more resilient internal narrative

Brainspotting

Typical stage: Early to mid recovery. *Verbal: Low. Emotional: Low–Moderate.*

What it is: A therapy developed from EMDR in which a client focuses on an eye position while attending to internal experience. Practitioners call these positions 'brainspots.' The method is used clinically, but it is not currently recommended as a first-line PTSD treatment and has very limited controlled evidence.

How it is proposed to work: practitioners use the phrase 'where you look affects how you feel' and hold an eye position while the client attends to sensations and emotions. Claims that this accesses a brainspot, discharges stored trauma, or specifically targets the subcortical nervous system have not been established by neuroscience. Any benefit may come from focused attention, exposure, therapeutic support, expectation, or other factors still being studied.

May be most suitable when:

— Trauma feels held in the body rather than in identifiable memories
— EMDR or ART feels too activating or verbally demanding
— Trauma is preverbal or developmental
— You want deep processing with minimal storytelling

Important considerations:

— Fewer trained therapists than EMDR, though growing rapidly in Alberta
— Particularly well-suited to preverbal or developmental trauma
— Often used alongside other modalities rather than as a standalone protocol

Exposure-Based Trauma Therapies

Approaches that reduce trauma symptoms by systematically confronting avoided memories, sensations, and situations. The nervous system relearns safety through experience rather than avoidance.

Prolonged Exposure (PE)

Typical stage: Mid to late recovery. *Verbal: High. Emotional: High.*

What it is: A highly structured, evidence-based therapy for PTSD that reduces symptoms through repeated, controlled exposure to trauma memories and avoided situations. Among the most extensively researched treatments for PTSD, with strong outcomes for event-based trauma.

How it works: PE operates on the principle that avoidance maintains PTSD. Treatment involves two core components: imaginal exposure (narrating the trauma aloud, in first person and present tense, repeatedly across sessions) and in vivo exposure (gradually approaching avoided real-world situations). Through repeated, safe contact with the avoided material, the nervous system learns that the memory is no longer a present-tense threat.

May be most suitable when:

— PTSD symptoms are driven primarily by avoidance and fear conditioning
— You are emotionally stable enough to tolerate sustained distress
— Trauma is event-based rather than developmental or relational
— You want a protocol-driven, extensively evidence-supported approach

Important considerations:

— Emotionally demanding, with higher dropout rates than some other modalities
— Less flexible for complex, relational, or attachment-based trauma
— Not appropriate during early sobriety or periods of severe dysregulation
— Requires a stable therapeutic relationship and clear informed consent before beginning

Cognitive-Based Approaches (Some Trauma-Focused)

Approaches that work primarily with thoughts, beliefs, interpretations, and behavioral patterns. Some directly target trauma-related meanings. Others are better understood as support therapies that build awareness, coping, and psychological flexibility around trauma-related symptoms.

Cognitive Processing Therapy (CPT)

Typical stage: Mid recovery. *Verbal: Moderate. Emotional: Low–Moderate.*

What it is: A structured, trauma-focused cognitive therapy that examines and restructures beliefs formed in response to trauma. Considered a first-line treatment for PTSD, particularly where shame, guilt, or self-blame are prominent.

How it works: CPT targets "stuck points," meaning distorted beliefs about safety, trust, power, esteem, and intimacy that formed during or after trauma and continue to shape emotion and behaviour. Through structured writing and Socratic questioning, clients examine those beliefs and develop more balanced interpretations. Unlike exposure-based therapies, its primary mechanism is cognitive rather than emotional habituation.

May be most suitable when:

— Trauma has led to persistent shame, guilt, or self-blame
— You are analytical and respond well to structured frameworks
— You want to understand how trauma shaped your current beliefs
— You can engage with written reflection between sessions

Important considerations:

— Less physiologically activating than exposure-based therapies, but can be cognitively demanding
— Socratic questioning of long-held beliefs about self, blame, or safety can feel confronting
— Less effective when trauma is primarily somatic or preverbal, where cognitive restructuring doesn't reach the stored material

Trauma-Focused CBT (TF-CBT)

Typical stage: Early to mid recovery. *Verbal: Moderate. Emotional: Moderate.*

What it is: A structured, phase-based trauma therapy originally designed for children and adolescents with trauma histories, sometimes adapted for adults. Combines psychoeducation, coping skill development, gradual trauma exposure, and cognitive restructuring within a safety-oriented framework.

How it works: TF-CBT follows the PRACTICE framework: Psychoeducation, Relaxation, Affective modulation, Cognitive coping, Trauma narration and processing, In vivo mastery, Conjoint sessions, and Enhancing safety. For youth, a parallel caregiver track is standard. The sequence places stabilization before direct trauma processing.

May be most suitable when:

— Trauma occurred in childhood
— Emotional regulation skills are underdeveloped
— Structure and pacing are needed before deeper processing
— Caregiver or support involvement is possible (for youth)

Important considerations:

— Less commonly offered to adults; designed and validated primarily for youth
— More directive than exploratory and may feel constraining for adults with complex presentations
— Not designed for deep attachment or identity-level trauma

Cognitive Behavioral Therapy (CBT)

Typical stage: Early recovery. *Verbal: Moderate. Emotional: Low.*

What it is: A broad, evidence-based therapy focused on identifying and modifying the relationship between thoughts, emotions, and behaviors. One of the most widely available therapies in Alberta's public system.

How it works: CBT teaches skills to identify cognitive distortions, interrupt automatic thought-behaviour cycles, and build healthier response patterns. In a trauma context, it can address avoidance, negative self-beliefs, and anxiety-driven behaviour without directly processing trauma memories.

May be most suitable when:

— Trauma symptoms overlap with anxiety, depression, or addiction
— You want practical, skill-based tools with predictable structure
— You are early in recovery and need stabilization before deeper work
— Emotional reactivity is high and needs to be reduced first

Important considerations:

— Does not directly process trauma memories
— Can feel reductive or invalidating when used as the primary treatment for complex trauma
— Most effective as a stabilization foundation paired with trauma-specific work

Parts-Based / Internal Systems Therapies

Approaches that treat symptoms as protective strategies rather than flaws. Instead of fighting your reactions, you learn what they are protecting and build an internal relationship that reduces shame and restores choice.

Internal Family Systems (IFS)

Typical stage: Mid to late recovery. *Verbal: Moderate. Emotional: Low–Moderate.*

What it is: A non-pathologizing therapy that views the mind as a system of distinct "parts." Each carries its own perspective, role, and protective function shaped by past experience. IFS proposes a core "Self" that can relate to these parts with curiosity and compassion rather than shame or conflict.

How it works: IFS distinguishes between exiles, which carry pain or shame; managers, which suppress exiles to maintain function; and firefighters, which react impulsively when exiles break through. Addiction, self-harm, and dissociation can be understood as firefighter responses. Therapy develops access to Self so the wounded parts can be approached and eventually unburdened. The goal is internal integration rather than symptom suppression.

May be most suitable when:

— Trauma is relational or developmental
— You experience inner conflict, self-criticism, or compulsive behaviors
— Addiction or self-protective behaviors have functioned as emotional management
— You want a compassion-based framework for understanding your responses

Important considerations:

— Less externally structured than CBT or EMDR, but the model itself provides a clear internal framework that most clients find stabilizing
— Can feel abstract initially; understanding deepens with time and practice
— Depth increases gradually because protective parts may resist early work until trust is established
— Not all clinicians who reference IFS are fully trained; depth of training varies significantly

Skills, Stabilization & Flexibility Therapies

Approaches focused on safety, regulation, daily functioning, and behavioural flexibility. They are often essential in early recovery or periods of high distress because they reduce crisis behaviours and build the stability needed for deeper trauma work.

Dialectical Behavior Therapy (DBT)

Typical stage: Early recovery. *Verbal: Low–Moderate. Emotional: Low.*

What it is: A structured, skills-based therapy originally developed for chronic suicidality and severe emotional dysregulation. Widely used for trauma presentations involving self-harm, addiction, impulsivity, or intense interpersonal instability.

How it works: DBT balances acceptance and change through four skill modules: distress tolerance (managing crisis without making it worse), emotion regulation (understanding and modifying emotional responses), interpersonal effectiveness (communicating needs while maintaining relationships), and mindfulness (observing experience without automatic reactivity). Full DBT includes individual therapy, group skills training, phone coaching, and therapist consultation.

May be most suitable when:

— Emotions escalate quickly into impulsive or harmful action
— Self-harm, suicidality, or addiction are active concerns
— Trauma processing feels unsafe or premature
— Interpersonal instability is significantly impairing daily functioning

Important considerations:

— Does not directly process trauma memories
— Skills require consistent practice; passive engagement produces limited results
— Full DBT is time-intensive; many programs offer DBT-informed or skills-only versions, which are less comprehensive
— Best understood as a stabilization foundation rather than a complete trauma treatment

Acceptance and Commitment Therapy (ACT)

Typical stage: Early to mid recovery. *Verbal: Moderate. Emotional: Low–Moderate.*

What it is: A therapy focused on psychological flexibility: the ability to remain present and act according to personal values even when difficult thoughts and emotions arise.

How it works: ACT targets experiential avoidance, the tendency to suppress, escape, or control internal experiences. Using acceptance, defusion, present-moment awareness, and values clarification, ACT helps clients move toward meaningful behaviour rather than away from distress. Defusion changes your relationship to thoughts rather than their content. The goal is not to eliminate difficult thoughts or feelings, but to reduce their control over behaviour.

May be most suitable when:

— Avoidance, including addiction, emotional shutdown, or overwork, is a dominant pattern
— You feel internally overwhelmed despite appearing functional
— You want to reconnect with values and direction, not just manage symptoms
— Rigid thinking patterns are maintaining distress

Important considerations:

— Does not directly process trauma memories
— Concepts like defusion and acceptance can feel abstract without concrete application
— Most effective alongside trauma-focused or somatic work rather than as a standalone treatment

Body-Based / Nervous System Approaches

Bottom-up approaches that work directly with the nervous system rather than memory or cognition. They are often used as a foundation, helping the body stabilize so cognitive or memory-based work becomes safer and more effective.

Somatic Therapy (General)

Typical stage: Early to mid recovery. *Verbal: Low. Emotional: Low–Moderate.*

What it is: An umbrella term for therapies that address trauma through bodily sensations, movement, and physiological states rather than narrative recall. Includes approaches such as Somatic Experiencing, Sensorimotor Psychotherapy, and body-oriented trauma therapy.

How it works: These approaches understand trauma as incomplete survival responses held in the body. Patterns of activation, bracing, collapse, or disconnection can persist after the threat has passed. Rather than recounting events, the work focuses on tracking sensations, completing interrupted movement responses, and restoring regulation through the body.

May be most suitable when:

— Trauma is preverbal, chronic, or without clear narrative
— You feel disconnected from your body or numb
— Talk-based therapy has had limited impact
— Symptoms are primarily physical, such as chronic tension, pain, fatigue, or shutdown

Important considerations:

Somatic Experiencing (SE)

Typical stage: Early to mid recovery. *Verbal: Low. Emotional: Low.*

What it is: A body-focused therapy developed by Peter Levine. Its model emphasizes tracking sensation, approaching activation in small amounts, and restoring a sense of control. Levine drew inspiration from animal responses to threat, but the claim that wild animals avoid trauma because they discharge survival energy is a theory, not an established explanation of human PTSD.

How it works: SE uses gradual, moment-to-moment attention to bodily sensations. The client tracks activation while the nervous system is guided toward a measured release of stored survival energy, without requiring detailed retelling or emotional flooding. Pendulation, moving between activation and relative safety, is central to the method.

May be most suitable when:

— You experience freeze, chronic shutdown, or persistent anxiety
— Trauma feels held in the body rather than in memory or narrative
— Gentle, carefully paced processing is needed

Important considerations:

— Progress is often subtle and cumulative rather than immediately felt
— Focuses on regulation and nervous-system resilience rather than symptom elimination
— Requires patience and willingness to work at a slow pace

Neurofeedback

Typical stage: Early recovery. *Verbal: Very Low. Emotional: Low.*

What it is: A non-invasive, brain-based intervention that uses real-time EEG feedback to train the brain toward more regulated and stable activity patterns. It is not psychotherapy; it targets neurophysiological dysregulation associated with trauma symptoms.

How it works in practice: sensors measure electrical brain activity while visual or audio feedback changes in real time. The client learns, through feedback and practice, to alter aspects of that signal. Small trials suggest possible benefit for PTSD, but protocols vary and major guidelines do not currently place neurofeedback alongside first-line treatments. Claims that it directly retrains a dysregulated brain are ahead of the evidence.

May be most suitable when:

— Symptoms are severe, treatment-resistant, or physiologically entrenched
— Sleep disruption, attention difficulties, or emotional volatility are prominent
— Talk-based or exposure therapy feels inaccessible or ineffective

Important considerations:

— Addresses physiological regulation ("hardware") but does not process meaning, belief, or narrative ("software"); it is best paired with psychotherapy
— Significant cost and access barriers; limited availability in public care
— Requires multiple sessions to produce durable change

Trauma-Informed Yoga

Typical stage: Early recovery. *Verbal: Very Low. Emotional: Low.*

What it is: A body-based practice adapted from traditional yoga to prioritize felt safety, interoceptive awareness, and personal choice rather than performance, alignment, or achievement. It was developed in part through research on trauma and the body at the Trauma Center in Boston.

How it works: Trauma-informed yoga uses gentle movement, breath, and invitation-based language to help clients reconnect with bodily sensations without threat. By restoring a sense of agency over physical experience, it directly counters the helplessness and disconnection that trauma leaves behind. Repetitive, predictable sequences also help regulate the nervous system over time.

May be most suitable when:

— You feel disconnected from or unsafe in your body
— Hypervigilance, shutdown, or chronic tension is present

— You want a low-barrier, non-verbal entry point

Important considerations:

— Adjunctive rather than a standalone trauma treatment
— Instructor training in trauma-informed practice matters significantly; standard yoga instruction is not equivalent
— Effects are cumulative; consistency over time is required

Sensorimotor Psychotherapy

Typical stage: Early to mid recovery. *Verbal: Low. Emotional: Low–Moderate.*

What it is: A body-oriented psychotherapy developed by Pat Ogden that integrates somatic awareness with attachment theory and trauma treatment. It uses posture, movement, gesture, and physical sensation as primary entry points rather than relying on narrative.

How it works: Sensorimotor Psychotherapy tracks physical expressions of trauma such as collapsed posture, bracing, restricted movement, or habitual gestures. These may represent learned protective patterns and embodied experience. The method works with sensation and movement while integrating cognitive and emotional processing. Claims that it accesses material verbal approaches cannot reach have not been established.

May be most suitable when:

— Trauma feels stored in physical patterns rather than memory or narrative
— Traditional talk therapy has not addressed somatic or physical symptoms
— You want a body-first, bottom-up processing approach

Important considerations:

— Available through a number of Calgary and Edmonton therapists
— Integrates well with SE and other somatic or regulation-focused approaches
— Progress can feel subtle initially; effects tend to deepen over time
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— Knowing what these approaches are is one thing.
— Finding a practitioner who uses them and understands both trauma and addiction is another matter. The trauma therapy directory filters by modality and location so you can search for the approaches you have just read about.

Before You Go

If one thing carries out of this, let it be the distinction between stabilization and processing. They are both real therapy. They do different jobs. Knowing which one you're currently receiving tells you a great deal about why you may or may not be feeling movement.

The other useful takeaway is that the intensity columns matter. If verbal retelling is the part you can't face, that rules some approaches in and others out, and it is a completely legitimate basis for choosing. Wanting a gentler entry point is not avoidance. For a nervous system that isn't stabilized yet, it's the correct clinical call.

None of these should be attempted alone. That isn't a formality: several of them deliberately raise activation in order to reprocess it, and that requires someone trained in the room to keep it inside a window you can tolerate.

Take this to your next appointment and ask two questions: which of these am I actually doing, and what would need to be true before I could do one of the others? A good clinician will welcome both.

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Sources & Further Reading

These sources cover the treatment guidelines that rank these approaches, the evidence behind the individual modalities, and the phase-based sequencing argument that runs through this guide.

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