PRACTICE BRIEFS

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Posttraumatic Stress Disorder in Youth

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ABSTRACT: This practice brief provides a practitioner-focused overview of posttraumatic stress disorder (PTSD) in youth that includes a review of diagnostic criteria, prevalence patterns, developmentally responsive approaches to assessment, and the use of evidence supported interventions such as team-based care, psychological first aid, trauma-focused cognitive behavior therapy (CBT), cognitive processing therapy, and play-based approaches. We discuss considerations for related training and certification, as well as the importance of ethical and culturally informed practice.

Introduction

In the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., text rev.; *DSM-5*-TR; American Psychiatric Association [APA], 2022), posttraumatic stress disorder (PTSD) is defined as a mental health condition that can develop following exposure to life-threatening injury or death, often manifesting through intrusive symptoms, avoidance behaviors, negative changes in cognition and mood, and hyperarousal. For licensed professional counselors, competency in developmentally responsive evidence-based treatment is an ethical imperative. This brief examines the current landscape of PTSD in youth with practice-forward information for counselors.

Diagnostic Criteria and Core Features

PTSD is a pattern of characteristics that may emerge among individuals who have experienced, witnessed, or learned about a traumatic event (Criterion A; APA, 2022). Although many youth may return to typical developmental experiences following such events, others may experience the presence of intrusive dreams, dissociative reactions, or intense stress responses (Criterion B). It is also possible that youth may avoid experiences that remind them of the traumatic event (Criterion C), exhibit negative changes in cognition and mood (Criterion D), or demonstrate notable changes in arousal and reactivity regardless of whether the related stimuli are present (Criterion E). Among children ages 6 and younger, these symptoms may present differently given the emerging nature of cognitive and verbally expressive capabilities. Specifically, children ages 6 and under may not present with an immediate trauma response and the characteristics of symptoms domains such as intrusion and avoidance may be noted in activities such as play-based reenactment, social withdrawal, and markers of irritability including an exaggerated startle response and behavioral tantrums. Additionally, youth may manifest the symptoms of PTSD through flashbacks, expressions such as imaginary friends, or enacted imaginative play. The onset of PTSD symptoms may be delayed following exposure to a traumatic event; however, they must persist for more than 30 days to meet the diagnostic threshold for PTSD.

Prevalence

Exposure to a traumatic event does not causally portend the emergence of PTSD symptoms. Epidemiological reports provide weighted estimates of PTSD prevalence among youth that range from 6% to 21%, with gender prevalence rates reported among girls and older youth (APA, 2022; Mangelsdorf et al., 2024; Tamir et al., 2025). Pretraumatic risk and prognostic factors for developing PTSD are associated temperament, environmental characteristics, genetic vulnerabilities, and the salience of resilience promoting supports (APA, 2022). Schincariol et al. (2024) suggested that the key peritraumatic variables predicting the emergence of PTSD across U.S. and global samples include the severity and type of traumatic experiences, levels of caregiver distress, and the duration of exposure.

Assessment Strategies

Identifying the presence, severity, and impact of PTSD among youth is grounded in a comprehensive review that includes the child's trauma history, developmental context, medical history, social environment, risk and protective factors, and functional impairment. The aim for these interviews is to reach a bio-psycho-socio-cultural case formulation that is representative of the child's traumatic experience and related PTSD presentation, while also providing an impetus for responsive treatment planning and linking to related resources. Relevant trauma history data sources include child interview and observation, parent or significant collateral interview, medical records, childcare center or school reports, and Child Protective Services documentation, as applicable. Rather than consider the data from these reports in isolation, counselors are encouraged to process information into an integrated whole that represents an integrated representation among the elements.

Several standardized data collection tools are also available to characterize PTSD experiences among youth. For youth ages 7 and above, the Clinician-Administered PTSD Scale for *DSM-5* – Child and Adolescent Version (Pynoos et al., 2015) provides a 30-item structured interview that includes developmentally responsive items and picture response options to support diagnostic activities, treatment planning, and outcome measurement. Several self-report measures are also available including the Adverse Childhood Experiences Study Questionnaire (Felitti et al., 1998), the Child PTSD Symptom Scale for *DSM-5* (Foa et al., 2018), the Child and Adolescent Trauma Screen (Sachser et al., 2017), and the National Stressful Events Survey PTSD-Short Scale (LeBeau et al., 2014), available through the *DSM-5* emerging measures compendium. Standardized measures for children ages 6 and under include the PTSD Semi-Structured Interview and Observational Record for Infants and Young Children (Scheeringa et al., 2003), the UCLA PTSD Reaction Index for *DSM-5*: Age 6 and Younger (Steinberg et al., 2017), and the Preschool Inventory of Trauma Symptoms (Bollens & Fox, 2019).

Treatment Approaches

Foundational counselor education programs, including those accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2024), address human development, cultural diversity, and counseling practice across the lifespan. However, foundational training alone is not sufficient to deliver specialized care for youth who experience the symptoms of PTSD. Counselors are encouraged to seek post-degree training, certification, and supervised practice that builds upon the rigor of their core knowledge base. This pursuit requires professional discernment for the benefit of the clients served, clinical and school-based counselors, as well as counselor educators and supervisors.

To date, no intervention has been identified as the optimal approach to treating all youth experiencing all types of traumatic experiences. However, across the 30+ treatments, interventions, and practices identified by the National Child Traumatic Stress Network as bearing some degree of evidentiary support treating PTSD, four characteristics tend to be represented within the majority of approaches to treating PTSD with youth: (a) education about trauma responses, (b) engagement with non-offending family members or other collaterals, (c) linking to community resources and supports, and (d) targeted symptom recovery through the development of adaptive cognitive and behavioral coping skills. This underscores the importance of team-based care and integrated care in supporting whole-child recovery.

Team-Based Care

Trauma systems therapy (TST; Saxe et al., 2016) is an integrative case management and counseling strategy intended to support making changes in the child's environment to reduce the cuing of survival states, increasing emotional regulation, and supporting interdisciplinary care across the ecology of development. Implementation of TST occurs across three sequential phases (safety-focused treatment; regulation-focused treatment; beyond trauma treatment) with a duration ranging from 4–12 months. Primary studies of TST have provided evidentiary support for treatment adherence, resource access, and reductions of PTSD symptoms (Ellis et al., 2013; Saxe et al., 2012).

Early Intervention

Psychological first aid (PFA; Brymer et al., 2006) is an evidence-based modular approach for reducing the initial distress associated with disaster or terrorism events and promoting immediate and long-term coping. The eight core actions (contact and engagement; safety and comfort; stabilization; information gathering; practice assistance; connection with social support; information on coping; linking with collaborative services) can be implemented with youth and their families to rapidly identify immediate concerns, needs, and resources that inform short-term supportive responses. A review of 12 studies by Hermosilla et al. (2023) found promising evidence supporting the use of PFA to reduce the onset of PTSD and promote experiences of safety, connectedness, and control among youth.

Trauma-Informed Intervention

Trauma-focused cognitive behavior therapy (TF-CBT; Cohen et al., 2017) is a components-based approach to treating PTSD symptoms associated with a wide range of trauma types.TF-CBT typically includes between 8 and 16 sessions focusing on intervention with youth and their caregivers across a core set of skills training and cognitive processing modules:

- psychoeducation and parent training;
- relaxation training;
- affective modulation and expression;
- cognitive coping and processing of traumatic memories;
- developing a trauma narrative;
- activities that promote in vivo mastery of trauma reminders;
- conjoint child-parent sessions; and
- enhancing future safety.

A review of 34 studies by Lenz and Hollenbaugh (2026) found evidence supporting the differential effectiveness of TF-CBT when compared to no treatment and alternative interventions for decreasing the symptoms of PTSD and co-occurring depression.

Growing evidence supports the emergence of developmentally adapted cognitive processing therapy (DA-CPT; Resnick, 2024). DA-CPT typically includes 12 sessions focusing intervention with adolescents within cognitive processing domain modules:

- psychoeducation;
- identification of stuck points;
- writing an impact statement;
- abc & challenging questions worksheets;
- identification of patterns of problematic thinking; and
- optional authoring of a trauma narrative

Stuck points generally center around themes of safety, trust, power/control, esteem, and intimacy. Variations with the original CPT model include the inclusion of safe caregivers, peer support, and

developmentally appropriate language and worksheet formats for youth. Preliminary support for DA-CPT was presented by Rosner et al. (2019) through a randomized control trial which showed adolescents with abuse-related PTSD benefitted significantly more from DA-CPT than from a wait-list condition; these findings were confirmed in a subsequent analysis by Steil et al. (2022), demonstrating long-term benefit.

Integrating Play into Therapies

Play is a natural means for youth to explore psychological life, including the meaning and impact of traumatic experiences (Aliannezhadi, 2025). Thus, counselors should consider the degree that integrating play into the treatment of trauma symptoms is clinically prudent. If not used as a primary or adjuvant strategy for promoting development and recovery, play-based activities may be helpful during the initial phases of establishing rapport and developing a working alliance, to facilitate engagement, and support the assessment of relational dynamics and intrapersonal experiences (Kottman & Ashby, 2024). Modalities of interest that have at least a modest degree of empirical support include child-centered play therapy, Adlerian play therapy, virtual-reality play therapy, and Theraplay-based approaches (Rodriguez, 2025).

The Right Training versus The Right-Now Training

Not all post-degree training opportunities are created equal, so it is imperative that counselors be thoughtful consumers of the training objectives, content, and processes. A quality training or certification program should reflect current, evidence-based approaches to trauma treatment with youth; be facilitated by clinicians who are both well-credentialed and clinically experienced; and be offered through reputable professional organizations such as the American Counseling Association (ACA) or the National Board for Certified Counselors (NBCC). When counselors intend to deliver services in person, they should prioritize in-person or hybrid training, as the parallel processes imbued within the relational and developmental nuances of working with traumatized youth can be supported through direct observation and live supervision. Similarly, it may be clinically pragmatic for practitioners who deliver trauma services using telehealth platforms to complete training and supervision using similar mediums of interaction. In either case, ongoing consultation with an experienced professional with a specialization in youth who are experiencing PTSD is an additional hallmark of quality professional development. Counselors are cautioned against paid-for and on-demand credentials that require minimal clinical investment, as well as training content generated by artificial intelligence tools. Such trainings have not undergone the peer review or empirical validation necessary to constitute evidence-based education.

Cultural and Ethical Considerations

The *ACA Code of Ethics* (2014) requires counselors to practice within their boundaries of competence, a standard especially salient when serving vulnerable populations such as youth who are diagnosed with PTSD (Standard C.2.a). Counselors without prior specialized training are ethically obligated to seek consultation, pursue relevant training, or refer to a colleague with appropriate expertise. The *ACA Code of Ethics* further directs counselors to engage in continuing education to support competence (Standard C.2.f) and to ensure that supervisors hold credentials congruent with the area of supervision. Counselors working with minors must also be trained in the consent and confidentiality standards unique to the youth population. Given the documented correlations between youth development of PTSD and contributing factors such as child sex trafficking, bullying and domestic violence, specialized competencies are also necessary (Interiano-Shiverdecker et al., 2023).

State and Federal Legal Considerations

Counselors should consult their state licensure board's administrative codes regarding training requirements for working with specialized populations, including traumatized youth. At the federal level, the

RISE from Trauma Act aims to mitigate the impact of trauma on children through expansion of trauma-informed training and workforce development (RISE from Trauma Act, 2021). Additionally, under the Individuals with Disabilities Education Act (IDEA, 2004), PTSD may qualify a student for special-education services under the emotional disturbance category when the condition adversely affects educational performance, underscoring the importance of trauma training for school-based counselors and educators.

Cultural Context

In recent years, counselors have been called to consider historical and intergenerational patterns such as slavery, colonization and forced migration, poverty, and systemic oppression, and their impacts on trauma. Additionally, populations at greater risk to adverse experiences are shaped by long-term disruptions to family systems, parenting practices, attachment, and chronic stress (Lee et al., 2023; Menakem, 2017). Thus, it is imperative for counselors to raise their awareness of the ways that youth experiencing PTSD may be perceived across individual, community, and societal levels, and provide culturally responsive care that aligns with the client's cultural values, beliefs, and context while retaining the core therapeutic principles.

For example, counselors who view development solely through a Western-centric framework may wrongly label common trauma responses such as academic disengagement, irritability and rage, mistrust of authority, and survival-based behaviors as oppositional or pathological (Bassford et al., 2025; Fehrenback et al., 2022). Additionally, youth living in communities experiencing oppression may experience racialized stress and identity conflict, leading to hypervigilance as an adaptive response. As a result, PTSD may be underdiagnosed, or symptom expressions may be misdiagnosed as being better accounted for by externalizing disorders such as oppositional defiant disorder or conduct disorder (Knefel et al., 2023). When combined with the other phenomena such as the adultification of youth, risk for deleterious experiences such as disproportionate restraint, seclusion, and involuntary medication administration become more probable (Daniels et al., 2023).

In response, counselors are called to embrace a position of cultural humility when providing client care to reduce the risks of retraumatization, misdiagnosis, and ethical issues related to counselor competence. Culturally responsive PTSD treatment requires not only developing a client-informed cultural awareness, but also the use of related assessment and engagement practices and adjustments to the therapeutic process (Naeem et al., 2024). These processes inherently require collaboration with caretakers, families, and communities, as well as the inclusion of empowerment-focused strategies, identity-affirming interventions, and collective healing practices to address individual and systemic barriers (Malott et al., 2025).

Conclusion

The treatment of PTSD in youth requires both competency and relational sensitivity from professional counselors. As the evidence base continues to evolve, diagnostic criteria, assessment practices, and treatment modalities have also changed over time. Although there are several treatment modalities available for consideration based on counselors' population and setting characteristics, the importance of quality training and supervision cannot be overstated. Ethical considerations have expanded to include technology-integrated care, and the value of cultural humility has deepened to include understanding of concepts such as intergenerational trauma experiences in youth. Counselors are uniquely positioned within the broader space of mental health professions to provide accessible evidence-based support to youth with PTSD in agency, private practice, and school-based settings.

Resources

- *ACA Code of Ethics,* American Counseling Association

- Multicultural and Social Justice Counseling Competencies, Association for Multicultural Counseling and Development
- 2024 CACREP Standards, Council for Accreditation of Counseling and Related Educational Programs
- Child Measures of Trauma and PTSD, National Center for PTSD
- RISE from Trauma Act, S.3461 – 119th Congress
- The National Child Traumatic Stress Network
- IDEA: Individuals with Disabilities Education Act, U.S. Department of Education

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