

PRACTICE BRIEFS



Posttraumatic Stress Disorder

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ABSTRACT: Posttraumatic stress disorder (PTSD) is a mental health disorder developing after trauma events, involving intense stress, and leading to persistent intrusive memories, avoidance of reminders, negative changes in thinking/mood, and heightened arousal. Cognitive processing therapy is a structured trauma focused therapy that helps PTSD clients modify unhelpful beliefs about trauma. Prolonged exposure emphasizes in-vivo, imaginal, and narrative exposure to the traumatic event, with a focus on related memories, feelings, and narratives of the situation. Counselors can collaborate with other professionals and community services to reduce the stigma that may keep clients from seeking help and to expand availability of services.

Introduction

The *International Classification of Diseases* (11th ed.; *ICD-11*) defines posttraumatic stress disorder (PTSD) as a syndrome arising after an extremely threatening or horrific event, characterized by a specific set of core symptoms (re-experiencing, avoidance, sense of current threat; WHO, 2024). The stress response ranges from everyday stressors to which individuals recuperate quickly to intense or chronic stressors that disrupt mental and physical functioning (Ivey et al., 2024; Krupnik, 2020). PTSD is a mental health disorder that develops after trauma events, involving intense stress and leading to persistent intrusive memories, avoidance of reminders, negative changes in thinking/mood (e.g., detachment, guilt, fear), and heightened arousal (e.g., irritability, hypervigilance, sleep issues; American Psychiatric Association [APA], 2022).

Exposure may occur through directly experiencing an event, witnessing an event, learning that an event occurred to a close family member or friend, or repeated or extreme exposure to aversive details of traumatic events. PTSD is diagnosed after a month or longer duration of symptoms causing significant personal distress and impairing functioning. Events that elicit a traumatic stress response can disrupt life, produce neurobiological changes (in brain and stress systems), and alter immune functioning (Bremner & Wittbrodt, 2020). These changes can remain and carry on in the body, further impacting brain, mental, and social functioning (Laricchiuta et al., 2023; Van der Kolk, 2014).

Symptoms typically appear within three months of the trauma, but may appear later and persist for a long time (American Psychiatric Association, 2025). Diagnosis requires one re-experiencing symptom, one avoidance symptom, two symptoms reflecting negative alterations in cognition or mood, and two symptoms reflecting alterations in arousal or reactivity (Brewin et al., 2025). Symptoms also must be unrelated to medication, substance use, or other illnesses. Similar symptomatology with less than one-month duration is diagnosed as acute stress disorder (ASD; American Psychiatric Association, 2025).

Epidemiologic research shows that PTSD is more likely to develop following interpersonal and intentional trauma, including rape, sexual assault, bullying, childhood abuse and neglect, intimate partner

violence, torture, and combat exposure, whereas lower rates are associated with unintentional events such as accidents, natural disasters, and witnessing injury or death.

PTSD can occur at any age. The average age of onset is early 20s. Applicable criteria and symptom numbering are different for children 6 years of age or younger, but these traumas may be carried through life, often resulting in illness and mental disorders. The Adverse Life Experiences Scale can be used to identify or discuss childhood experiences (Hawes et al., 2021).

Prevalence

Most people experience a traumatic event at some point in their lives. Typically, they experience a reaction to the event but recover over time. Lifetime prevalence among U.S. adults is 6-8% and annual prevalence is about 5% (NIMH, 2023). Prevalence is higher among women (8%; men, 4%) and U.S. military personnel (7%). Prevalence is also higher for emergency responders, refugees, American Indian/Alaska Natives, lower-income individuals, individuals with heavy substance use, individuals with a past suicide attempt, LGBTQIA+ individual, and women with prior military sexual trauma (Schein et al., 2021).

Assessment Strategies

The following are examples of commonly used interviews and self-report measures or inventories.

Clinician Administered PTSD Scale for DSM-5

Clinician Administered PTSD Scale for DSM-5 (CAPS-5; Weathers et al., 2013) is a 30-item structured interview that corresponds to the DSM-5 criteria for PTSD. It can be used to assess symptoms over the past week, month, or lifetime. CAPS identifies traumatic stressors experienced via The Life Events Checklist (LEC). Administration takes 45–60 minutes. The version for children and adolescents (7 year and older) is the CAPS-CA-5 (Weathers et al., 2018; Marx et al., 2022).

The PTSD Symptom Scale–Interview

The PTSD Symptom Scale–Interview (PSS-I-5; Foa et al., 2016b) is a 24-question interview developed to assess *DSM-5* criteria for PTSD. It measures frequency and intensity of the 20 *DSM-5* PTSD symptoms. It includes four additional items evaluate onset, duration, distress, and interference caused by symptoms. Administration takes 20–30 minutes.

Structured Clinical Interview for the *DSM-5*

Structured Clinical Interview for the *DSM-5* (SCID) is a semi-structured interview for making the major *DSM-5* diagnoses. There are various versions. SCID is broken down into separate modules corresponding to categories of diagnoses. PTSD is diagnosed using the corresponding module. There is no reliability or validity data for the SCID-5. Administration takes 30–180 minutes, depending on version used.

The Structured Interview for PTSD

The Structured Interview for PTSD (SI-SIP; Davidson, 2002) assesses *DSM-5* criteria for PTSD. The interview consists of 19 items, including two measuring survival and behavioral guilt. Administration takes 20–30 minutes.

International Trauma Interview

International Trauma Interview (ITI; Roberts et al., 2025) is a free semi-structured clinician interview that assesses for *ICD-11* PTSD and complex PTSD (CPTSD). The ITI is available in multiple languages. Administration takes 60–120 minutes.

The Posttraumatic Stress Diagnostic Scale

The Posttraumatic Stress Diagnostic Scale (PDS-5; Foa et al., 2016a) is a 24-item self-report measure designed to assess all 20 *DSM-5* PTSD symptoms and includes four additional items about distress and interference of symptoms and their onset and duration. Administration takes 10–15 minutes.

Mississippi Scale for Combat-Related PTSD

Mississippi Scale for Combat-Related PTSD (MISS or M-PTSD) is a 35-item self-report measure that assesses combat-related PTSD in veterans. Administration takes 10 minutes (Bhattarai et al., 2020).

SPAN Self-Report Screen

SPAN Self-Report Screen (Davidson, 2002) is a four-item self-report screen that assesses startle, physically upset by reminders, anger, and numbness symptoms. Administration takes two minutes.

International Trauma Questionnaire

International Trauma Questionnaire (ITQ; Cloitre et al., 2018) is a free 18-item self-report measure to assess *ICD-11* PTSD and complex PTSD (CPTSD). The questionnaire has been validated across international population, Administration takes 3–5 minutes (Redican et al., 2021).

Treatment Approaches

The following interventions are effective for PTSD (American Psychological Association, 2025; National Institute for Health and Care Excellence, 2018; U.S. Department of Veterans Affairs, 2025). The use of psychotherapy is indicated over pharmacotherapy when both are available (U.S. Department of Veterans Affairs & U.S. Department of Defense, 2023).

Cognitive Behavior Therapy

Cognitive behavior therapy (CBT) is a short-term, structured therapy focusing on the relationship between thoughts, feelings and behaviors. Its goal is to identify areas of intervention to reduce challenges and symptoms clients are experiencing. Their basic assumption is that changes in one of those domains can lead to changes in the others (Beck, 2023; Curtiss et al., 2021).

Trauma-Focused Cognitive Behavior Therapy

Trauma-focused cognitive behavior therapy (TF-CBT) is a specialized, structured, short-term protocol specifically designed for children (3–18) dealing with trauma (Cohen et al., 2024). Different than the more flexible and individual CBT treatment, TF-CBT involves caregiver involvement and trauma-specific techniques. Furthermore, CBT is used in the treatment of a variety of disorders and ages, whereas TF-CBT is used specifically to treat PTSD, trauma-related depression, and behavioral problems stemming from trauma for 3–18 year old individuals (Lee & Lang, 2024).

Cognitive Processing Therapy

Cognitive processing therapy (CPT) is a structured trauma-focused therapy that helps PTSD clients modify unhelpful beliefs (i.e., “stuck points”) about trauma. The reevaluation of the trauma’s meaning can lead to new understandings and the reduction of symptoms. The reevaluation can also lead to learning of ways to cope with triggers and other stressors that are different and more effective than avoidance (Resick et al., 2024; Sager et al., 2025; Sandanapitchai & Nixon, 2025).

Prolonged Exposure

Prolonged exposure (PE) therapy emphasizes in-vivo, imaginal, and narrative (oral and/or written) exposure to the traumatic event. PE uses a gradual approach to the trauma-experience, with a focus on related memories, feelings, and narratives of the situation (Rubenstein et al., 2024).

Cognitive Therapy

Cognitive therapy (CT) emphasizes cognitive restructuring (i.e., challenging automatic negative beliefs connected to the traumatic event) of beliefs about safety or trust. The goal is to interrupt pessimistic thoughts and negative behaviors affecting daily life (American Psychological Association, 2025).

Eye-Movement Desensitization and Reprocessing

Eye-movement desensitization and reprocessing (EMDR) combines an exposure component (e.g., holding a distressing traumatic memory), a cognitive component (e.g., identifying a negative cognition), and a bilateral stimulation (e.g., eye movements). All of which are associated with reductions on the intensity of the memory and emotions associated with the trauma (de Jongh et al., 2024; Seok & Kim, 2024; Villegas-Ortega et al., 2026).

Bottom-up, Body-Based Therapies

Therapies like somatic experiencing (SE), sensorimotor psychotherapy, internal family systems (IFS), and others (e.g., yoga therapy, biofeedback, and trauma-sensitive mindfulness), target the autonomic nervous system and somatic memories rather than relying solely on cognitive recall. These approaches improve emotional regulation, reduce trauma-related hyperarousal, and help process implicit, body-based trauma through mindfulness and physical sensation (Fisher, 2011). These therapies are particularly beneficial when top-down, cognitive therapies have failed, as they address the physical manifestation of trauma and help reconnect individuals with their bodies in a safe, controlled manner (Kuhfuß et al., 2021; Nicholson et al., 2025).

Additional Treatment Options

Other therapeutic options include psychoeducation, group therapy, and supportive services for family and caregivers, hypnosis, relaxation techniques, imagery rehearsal therapy, neurofeedback, spiritual support, psychosocial rehabilitation, and complementary and alternative medicine (CAM) approaches. They may be used as adjunctive treatments to facilitate a relaxation response, reduce hyperarousal symptoms, increase engagement in care, and address co-morbid conditions such as pain control and sleep disturbances (Burback et al., 2025; Cushing & Braun, 2018 ;U.S. Department of Veterans Affairs, n.d.).

Medications

Clients seeking medication should be referred to a psychiatrist or primary care physician for a comprehensive evaluation and prescription management. Medication decisions should follow an individualized, patient-centered (precision medicine) approach, as effectiveness and tolerability vary across individuals. Evidence-supported medications for PTSD include selective serotonin reuptake inhibitors (SSRIs), such as fluoxetine (Prozac), paroxetine (Paxil), and sertraline (Zoloft), which can reduce symptom clusters including re-experiencing, avoidance, and hyperarousal. The serotonin-norepinephrine reuptake inhibitor (SNRI) venlafaxine (Effexor) is also supported by evidence and is commonly used to target anxiety and depressive symptoms associated with PTSD. Benzodiazepines are not recommended for PTSD, as they have not been shown to improve core symptoms and may cause significant adverse effects with long-term use (American Psychological Association, 2025; National Center for PTSD, 2025).

Cultural and Ethical Considerations

Race, ethnicity, and broader cultural identities (e.g., gender, disability, nationality) play an important role in the likelihood of developing PTSD and seeking treatment. In many cultures, individuals are more likely to report physical or somatic symptoms, instead of emotional distress. Intrusive experiences may be interpreted as dreams or visions and symptoms of hyperarousal may be attributed to unrelated causes. Their cultural norms may favor avoidance strategies over directly acknowledging trauma, which can reduce interest in trauma-focused treatment (Ceja et al., 2022; Patel & Hall, 2021).

Ongoing social and cultural stressors also contribute to trauma, producing effects that may persist across generations. Race-based and systemic induced trauma (e.g., cultural, intergenerational trauma) produces neurobiological changes in the human genome that can be transmitted from one generation to the next, further complicating the impact of cultural and intergenerational trauma (Cacace & Summers, 2025; Cunningham et al., 2021; Chou et al., 2024; Fortuna et al., 2022; Walker et al., 2022).

Many client experiences are deeply rooted in societal dysfunction, harassment, inequity, and oppression. Specialized trauma care increasingly emphasizes treatments that address cultural, race, and intergenerational trauma conceptualization and management of PTSD. Psychotherapeutic interventions must be sensitive to the cultural and historical context of the client, aiming to improve treatment outcomes and minimize the risk of retraumatization.

Advocacy

Counselors should advocate for greater access to effective therapies and help clients understand why these work and what to expect. They can collaborate with other professionals and community services to reduce the stigma that may keep clients from seeking help and to expand availability of these services (McGuffin et al., 2021).

Conducting public awareness campaigns (e.g., social media, community events) that emphasize PTSD as a treatable condition and encourage seeking help can benefit clients and families. Conducting such campaigns within institutions like the military or police might support organizational changes reducing stigma, increasing services, and reframing help-seeking as a sign of strength rather than a career risk (McGuffin et al., 2021).

Current perspectives suggest the use of a multiculturally humble approach and a conceptualization that removes the “pathology” description. PTSD can be understood as a response to extreme events or social environments (Ivey et al., 2023, 2024). Many of the issues that clients experience are deeply involved with societal dysfunction, harassment, inequities, and oppression, that can be conceptualized as cultural or intergenerational trauma.

Conclusion

Current research underscores the high prevalence and the significant progress made in the treatment of PTSD. This practice brief offers clinical guidelines to describe, diagnose, and treat PTSD. The integration of updated clinical guidelines and modernized assessment scales supports the delivery of personalized care for individuals affected by trauma. Current trauma-focused therapies have demonstrated effectiveness in reducing symptoms and improving outcomes, while ongoing research continues to refine treatment protocols and diagnostic tools. Culturally sensitive, trauma-focused perspectives further expand the applicability and effectiveness of current treatments. Continued interdisciplinary collaboration and culturally sensitive research are essential for advancing the field and addressing the complex needs of those living with PTSD.

Resources

- [Disaster Mental Health Counseling: A Guide to Preparing](#), American Counseling Association
- [Disaster Counseling](#), American Counseling Association
- [Disaster Mental Health in the Age of COVID-19](#), American Counseling Association
- [Posttraumatic Stress Disorder in Youth](#), American Counseling Association
- [Postpartum Posttraumatic Stress Disorder](#), American Counseling Association
- [6B40 Posttraumatic Stress Disorder, ICD-11](#)
- [6B41 Complex Posttraumatic Stress Disorder, ICD-11](#)
- [PTSD](#), Medscape
- [PTSD \(NG116\)](#), National Institute for Health and Care Excellence
- [PTSD](#), National Institute of Mental Health
- [National Center for PTSD](#), U.S. Department of Veterans Affairs
- [PTSD and DSM-5](#), U.S. Department of Veterans Affairs
- [Post-Traumatic Stress Disorder](#), World Health Organization
- [Posttraumatic Stress Disorder \(PTSD\): Psychological Interventions – Adults](#), World Health Organization
- [Posttraumatic stress disorder \(PTSD\): Psychological interventions – children and adolescents](#), World Health Organization
- [How Common Is PTSD in Adults?](#), National Center for PTSD

Assessments

- [Clinician-Administered PTSD Scale for DSM-5 \(CAPS-5\)](#), U.S. Department of Veterans Affairs
- [Clinician-Administered PTSD Scale for DSM-5 - Child/Adolescent Version \(CAPS-CA-5\)](#), U.S. Department of Veterans Affairs
- [PTSD Symptom Scale - Interview for DSM-5 \(PSS-I-5\)](#), U.S. Department of Veterans Affairs
- [The Structured Clinical Interview for DSM-5](#), American Psychiatric Association Publishing
- [Structured Interview for PTSD \(SI-PTSD\)](#), U.S. Department of Veterans Affairs
- [International Trauma Interview \(ITI\)](#), U.S. Department of Veterans Affairs
- [Posttraumatic Diagnostic Scale \(PDS-5\)](#), U.S. Department of Veterans Affairs
- [PTSD Checklist for DSM-5 \(PCL-5\)](#), U.S. Department of Veterans Affairs
- [PTSD Checklist for DSM-5 \(PCL-5, 2023 Version Instrument\)](#), National Center for PTSD
- [Mississippi Scale for Combat-Related PTSD](#), U.S. Department of Veterans Affairs
- [SPAN Self-Report Screen](#), U.S. Department of Veterans Affairs
- [International Trauma Questionnaire \(ITQ\)](#), U.S. Department of Veterans Affairs

Treatment Approaches

- [Cognitive Behavioral Therapy \(CBT\)](#), American Psychological Association
- [Beck Institute](#)
- [REBT Network](#)
- [The International Association of Cognitive Behavioral Therapy \(IACBT\)](#)
- [Trauma-Focused Cognitive Behavioral Therapy](#), National Child Traumatic Stress Network
- [Trauma-Focused Cognitive Behavioral Therapy \(TF-CBT\): AT-A-GLANCE](#), National Child Traumatic Stress Network
- [A Course For Trauma-Focused Cognitive-Behavioral Therapy \(TF-CBT\)](#), TF-CBTWeb2.0

- [A Web-Based Learning Course for Cognitive Processing Therapy](#), CPTWeb2.0
- [Cognitive Processing Therapy \(CPT\)](#), American Psychological Association
- [Cognitive Processing Therapy for Post Traumatic Stress Disorder](#)
- [Cognitive Processing Therapy for PTSD](#), U.S. Department of Veterans Affairs
- [Prolonged Exposure](#), American Psychological Association
- [Prolonged Exposure for PTSD](#), U.S. Department of Veterans Affairs
- [Online Training on Prolonged Exposure \(PE\) Therapy](#), PEWeb
- [Cognitive Therapy \(CT\)](#), American Psychological Association
- [Eye Movement Desensitization and Reprocessing \(EMDR\) Therapy](#), American Psychological Association
- [Eye Movement Desensitization and Reprocessing \(EMDR\) for PTSD](#), U.S. Department of Veterans Affairs
- [Sensorimotor Psychotherapy: Body Centered Healing for Trauma](#), Sensorimotor Psychotherapy Institute
- [Resources](#), Somatic Experiencing International (SEI)
- [What Is Internal Family Systems?](#), Internal Family Systems
- [Trauma & Stress-Related Disorders](#), American Counseling Association
- [APA Clinical Practice Guideline for the Treatment of Posttraumatic Stress Disorder \(PTSD\) in Adults](#), American Psychological Association
- [Practice Guideline for the Treatment of Patients with Acute Stress Disorder and Posttraumatic Stress Disorder](#), American Psychological Association
- [Rape, Abuse & Incest National Network \(RAINN\)](#)
- [Trauma and Violence](#), Substance Abuse and Mental Health Services Administration
- [Trauma-Informed Approaches and Programs](#), Substance Abuse and Mental Health Services Administration
- [Child Trauma](#), Substance Abuse and Mental Health Services Administration
- [Overview of Psychotherapy for PTSD](#), U.S. Department of Veterans Affairs
- [Understanding PTSD Treatment](#), U.S. Department of Veterans Affairs
- [Clinical Practice Guidelines](#), U.S. Department of Veterans Affairs
- [Medications for PTSD](#), American Psychological Association
- [Medications](#), U.S. Department of Veterans Affairs
- [Resources on Race-Based Trauma](#), National Child Traumatic Stress Network
- [Racial Trauma](#), Mental Health America
- [Racial Trauma](#), U.S. Department of Veterans Affairs

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