

EDITORIAL

Editorial: Scaling Up Trauma-Focused Treatment for Youth: From Recognition to Real-World Impact

Irma M. Hein^{a,*}, MD, PhD 

 ver the past decades, posttraumatic stress disorder (PTSD) has become firmly established as a prevalent and consequential condition in children and adolescents, with recognition evolving alongside advances in developmentally informed assessment and treatment. As exposure to potentially traumatic events is widespread, and as trauma-related problems operate as a transdiagnostic driver of psychopathology, the need for effective and scalable trauma-focused care has become a health imperative. In this context, the large-scale observational study featured in this issue provides compelling real-world evidence that Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) can be delivered with both fidelity and flexibility across diverse routine care settings, achieving outcomes comparable to those reported in clinical trials. At the same time, the persistence of residual symptoms in a substantial minority of youth underscores the need for continued refinement of interventions, stepped-care approaches, and systematic trauma screening. Together, these findings shift the field beyond questions of efficacy toward the crucial challenge of organizing and sustaining trauma-focused mental health services at the scale required to meaningfully improve developmental trajectories for trauma-exposed youth.

Although trauma-related symptoms in young people had long been observed, PTSD was initially conceptualized as an adult disorder, informed largely by studies of war veterans and adult survivors of violence.¹ Subsequent developmental research has demonstrated that children and adolescents can develop clinically significant and persistent posttraumatic stress responses, often expressed in age-specific ways that differ from adult presentations. The gradual inclusion of developmentally sensitive PTSD criteria in the *DSM* has marked an important shift in the recognition of PTSD in children and adolescents, reinforcing the notion that trauma-related psychopathology during childhood and adolescence is both prevalent and consequential. In 1994, the *DSM-IV* included

developmental specifications for children and adolescents, whereas the *DSM-5* provides the most developmentally informed criteria, including a subtype for children aged 6 years and under.^{2,3} This recognition has catalyzed advances in assessment, treatment development, and prevention, while simultaneously highlighting the responsibility of child and adolescent mental health services to respond effectively to trauma exposure early in the life course.

The current study by Braathu *et al.*, presented in this issue, makes an important contribution to this evolving field by moving beyond questions of efficacy of trauma treatment in youth to address implementation at scale.⁴ TF-CBT is among the most empirically supported treatments for youth with PTSD, yet much of the evidence base stems from controlled trials that do not reflect routine clinical practice. The current large-scale observational study addresses this gap by examining how TF-CBT is delivered across diverse outpatient settings; how clinicians adapt the model to patient characteristics such as age (6-18 years) and symptom complexity (including complex PTSD); and whether these adaptations are associated with outcomes. By analyzing 25,000 treatment sessions, the authors provide rare and compelling data demonstrating that TF-CBT can be implemented with fidelity and flexibility across an entire national mental health care system, yielding outcomes broadly comparable to those observed in randomized controlled trials. At the same time, there remains clear room for improvement. The substantial proportion of youth with residual symptoms after treatment, with 22% still meeting criteria for probable PTSD, indicates that further refinement of existing interventions, or the development of alternative or stepped-care approaches, may be necessary for those who do not adequately respond to first-line trauma-focused treatments. However, the outcomes represent a critical step forward for the field of implementation science in youth trauma care.

The significance of these findings must be understood in the context of the widespread exposure to potentially

traumatic events (PTEs) among children and adolescents. Population-based studies consistently show that the majority of youth (80%) experience at least one PTE before adulthood, with a substantial minority exposed to multiple and interpersonal PTEs.⁵ Although many children show resilience, a significant proportion (12%-20%) develop clinically meaningful posttraumatic stress symptoms, particularly following chronic or interpersonal trauma.⁶ Importantly, trauma exposure is not confined to specialized populations but cuts across socioeconomic, cultural, and diagnostic boundaries. As a result, trauma-related problems should be considered a major public health issue rather than an exceptional clinical problem. Child and adolescent mental health services that do not systematically account for exposure to PTEs risks overlooking a fundamental determinant of emotional and behavioral functioning in youth.

Within clinical populations, PTSD and subthreshold posttraumatic stress symptoms frequently co-occur with a wide range of psychiatric disorders, including depression, anxiety disorders, and high-risk behaviors such as self-harm and suicidality.⁷ Growing evidence suggests that exposure to PTEs and the development of trauma-related symptoms often act as transdiagnostic mechanisms, contributing to greater symptom severity, poorer treatment response, and increased chronicity when left unaddressed.^{8,9} Yet PTSD remains under-recognized in routine care, particularly when youth present with complex or mixed symptom profiles. This underscores the importance of systematic trauma screening and assessment in child and adolescent mental health services. The use of brief, validated instruments such as the Child and Adolescent Trauma Screener can support earlier identification and subsequently more accurate case formulation, thereby facilitating timely referral to trauma-focused treatment pathways.^{10,11}

Over the last 2 decades, a range of trauma-focused psychotherapies for youth has been developed and evaluated, including TF-CBT and Eye Movement Desensitization and Reprocessing.¹² Despite differences in theoretical orientation, these treatments share a core set of evidence-based components, such as psychoeducation, skills for affect regulation, gradual trauma processing, cognitive restructuring, and caregiver involvement.¹³ In TF-CBT, these elements are integrated within a structured yet adaptable framework, making it particularly well suited for dissemination in real-world settings.¹⁴ The current study highlights how clinicians naturally tailor the balance of these components: for example, emphasizing stabilization and caregiver involvement for younger children, or

increasing trauma processing for youth with complex PTSD, while adhering to the underlying treatment principles.⁴ From an implementation perspective, this capacity for flexible fidelity is a major strength, enabling TF-CBT to meet the heterogeneous needs of clinical populations without diluting its therapeutic potency.

Perhaps the most consequential implication of this work lies in its relevance for large-scale service planning. As trauma-informed screening improves, and as awareness of trauma-related psychopathology grows, mental health services must be prepared for a substantial increase in the number of children and adolescents identified as needing trauma-focused care. Without scalable, implementable interventions, this recognition could prompt an inadequate response from services that are already under strain and lack the necessary resources or expertise. The present findings provide encouraging evidence that TF-CBT can be implemented broadly, with acceptable completion rates and meaningful clinical improvement, across diverse community settings. Investing in the dissemination and sustained implementation of such treatments has the potential to yield far-reaching benefits. Early and effective treatment of PTSD not only alleviates individual suffering but also reduces long-term mental health burden, educational disruption, and societal costs associated with untreated trauma and stalled developmental progress in young people.¹⁵

From this perspective, the detection of trauma-related problems and the scaling up of trauma-focused care are not merely clinical imperatives, but societal ones. The challenge ahead is no longer whether we can treat trauma effectively, but whether we have the capacity and willingness to organize care systems on a scale that matches the mental health needs of children and families.

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^aAmsterdam University Medical Center, Amsterdam, the Netherlands

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*Correspondence to Irma M. Hein, MD, PhD, Amsterdam University Medical Center, and Levvel, Meibergdreef 5, 1105 AZ Amsterdam, the Netherlands; e-mail: i.hein@levvel.nl

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