Australian Guidelines for the Prevention and Treatment of Acute Stress Disorder, Posttraumatic Stress Disorder, and Complex Posttraumatic Stress Disorder

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Summary of recommendations

Introduction (including guidance for use of MAGICApp)

Children and adolescents pre-incident preparedness

Children and adolescents within the first three months of exposure to a traumatic event

Early psychosocial prevention interventions for children

Conditional recommendation (against)

Individual psychological debriefing. For children and adolescents within the first three months after trauma exposure, we suggest providing information, emotional support, and practical assistance in preference to individual psychological debriefing.

Remark: Psychological debriefing aims to normalise reactions and promote emotional processing of the traumatic event through a structured process. The debriefing interventions are single-session and based on critical incident stress debriefing (CISD); individuals are asked to provide detailed facts about their traumatic experience, their thoughts, reactions, and symptoms before being provided with psychoeducation about symptoms and how to deal with them. The terms psychological debriefing and critical incident stress debriefing are often used interchangeably. The former describes a class of interventions delivered shortly following a trauma (usually between 24 and 72 hours) that aim to relieve distress and facilitate a rapid return to normal functioning, thereby mediating or avoiding long-term trauma symptoms. Psychological debriefing operates on the principles of ventilation (an opportunity to talk about the experience), normalisation of distress, and psychoeducation regarding potential symptoms. CISD, on the other hand, is a specific form of debriefing developed in the 1980s. It centres predominantly around group-based interventions for secondary victims such as emergency services personnel, rather than primary victims. While generally group-based, it also advocates individual (or one-on-one) interventions as an acceptable and expected variant. It relies heavily on processes of reconstruction of the traumatic event, ventilation, and normalisation, and includes a structured education component. Over time, CISD has been amalgamated within a framework of self-help activities and structured organisational processes, called critical incident stress management (CISM).

It should be noted that CISD and psychological debriefing differ from operational debriefing, a group process undertaken in high-risk industries to review a particular operation or activity. The aim of operational debriefing is to review the events and processes of the operation and to apply the lessons learnt to future events. Operational debriefing is considered good practice in high-risk industries as a method of improving service quality and is not a focus of these Guidelines.

Self-directed online psychoeducation for caregivers and children

RESEARCH RECOMMENDATION

For children and adolescents within the first three months after exposure to a potentially traumatic event, we suggest continuation of treatment as usual in preference to self-directed online psychoeducation for caregivers and children.

There is emerging evidence for self-directed online psychoeducation in caregivers and children following traumatic physical injury, and this could be used in a research context.

Remark: Psychoeducation provides individuals (in this context, caregivers and/or their children) with information about the reactions that commonly follow a trauma, when those reactions are consistent with a diagnosis of PTSD, and information about what maintains PTSD. The information is aimed at normalising and relieving trauma reactions by providing basic coping and resilience strategies. One study included psychoeducation more broadly with strategies such as (1) promoting adaptive cognitive appraisals, (2) decreasing excessive early avoidance coping, and (3) promoting use of social support. Psychoeducation for caregivers can include information regarding common child reactions to trauma, their likely time course, and how best they can assist their child’s emotional recovery (e.g., such as offer their child the opportunity to talk, not avoiding talking about the accident, and encouraging normal routine).
Self-directed online psychoeducation intervention for children only **RESEARCH RECOMMENDATION**

For children and adolescents within the first three months after exposure to a potentially traumatic event, we suggest continuation of treatment as usual in preference to self-directed online psychoeducation for children.

There is emerging evidence for self-directed online psychoeducation in children following an acute medical event, and this could be used in a research context.

Remark: Psychoeducation provides individuals (in this context, children) with information about the reactions that commonly follow a trauma, when those reactions are consistent with a diagnosis of PTSD, and information about what maintains PTSD. The information is aimed at normalising and relieving trauma reactions by providing basic coping and resilience strategies.

**Psychoeducation**

For children and adolescents within the first three months after exposure to a potentially traumatic event, there was insufficient evidence to make a recommendation on psychoeducation as a stand-alone intervention. However, psychoeducation should be routinely provided as part of usual care.

Remark: Psychoeducation provides individuals (in this context, children) with information about the reactions that commonly follow a trauma, when those reactions are consistent with a diagnosis of PTSD, and information about what maintains PTSD. The information is aimed at normalising and relieving trauma reactions by providing basic coping and resilience strategies.

Self-directed online psychoeducation for caregivers only

For children and adolescents within the first three months after exposure to a potentially traumatic event, there was insufficient evidence to make a recommendation on self-directed online psychoeducation for caregivers only.

Remark: Psychoeducation provides individuals with information about the reactions that commonly follow a trauma, when those reactions are consistent with a diagnosis of PTSD, and information about what maintains PTSD. The information is aimed at normalising and relieving trauma reactions by providing basic coping and resilience strategies.

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**Early psychosocial treatment interventions for children**

**Conditional recommendation**

**Child and Family Traumatic Stress Intervention (CFTSI)**

For children and adolescents within the first three months after trauma exposure where symptoms of PTSD are present, we suggest offering child and family traumatic stress intervention (CFTSI) in preference to supportive counselling.

Remark: The Child and Family Traumatic Stress Intervention (CFTSI) is a four-session caregiver-child model designed for early intervention and secondary prevention for children aged 7-17.\[19\] The CFTSI focusses on two PTSD risk factors of poor social or familial support and poor coping skills and aims to ameliorate these risks by (1) increasing communication between the affected child and their caregivers about feelings, symptoms and behaviors with the goal of increasing the caregivers' support of the child and (2) providing specific behavioural skills that are taught both to the caregiver and child to assist in coping with symptoms.

**Preventative interventions within a stepped care service model**

For children and adolescents within the first three months after exposure to a traumatic event where symptoms of PTSD are present, there was insufficient evidence to make a recommendation on preventative interventions within a stepped care service model.

Remark: Preventative interventions within a stepped care service model aim to matches each child's needs to appropriate levels of intervention, including psychoeducation for parents. This study evaluated the delivery and effectiveness of a targeted preventive pediatric intervention based on best practice recommendations and integrated within acute medical care.\[20\]
Brief trauma-focussed CBT For children and adolescents within the first three months after exposure to a traumatic event where symptoms of PTSD are present, there was insufficient evidence to make a recommendation on brief trauma-focussed CBT.

Remark: Trauma-focussed CBT is intended to help an individual come to terms with trauma through exposure to and emotional processing of memories of the event. This two session model of TF-CBT is delivered to children and caregivers. The intervention includes event reconstruction using drawing and toys, modification of unhelpful appraisals of the event, psychoeducation, and development of individual coping strategies.

Narrative Exposure Therapy (NET) For children and adolescents within the first three months after exposure to a traumatic event where symptoms of PTSD are present, there was insufficient evidence to make a recommendation on Narrative Exposure Therapy (NET).

Remark: NET allows PTSD sufferers to describe and develop a coherent, chronological, autobiographical narrative of their life that includes their traumatic experiences (a testimony). The therapist facilitates emotional processing through the use of cognitive-behavioural techniques. A modified version (KidNET) has been developed for children.

Early pharmacological interventions for children

Propranolol For children and adolescents within the first three months after exposure to a traumatic event where symptoms of PTSD are present, there was insufficient evidence to make a recommendation on propranolol.

Children and adolescents with clinically relevant post-traumatic stress symptoms

Psychological interventions for children and adolescents with PTSD

Strong recommendation

Trauma-focussed CBT for child For children and adolescents with symptoms of PTSD, we recommend trauma-focussed CBT.

Remark: Trauma-focussed CBT is intended to help an individual come to terms with trauma through exposure to and emotional processing of memories of the event. Trauma-focussed CBT for children is typically delivered by a trained practitioner to children or adolescents over six to 12 sessions, and more if clinically indicated. The intervention should be adapted to the child or young person's age or development. Trauma-focussed CBT generally includes psychoeducation about reactions to trauma, affect regulation skills, elaboration and processing of the trauma memories, processing of trauma-related emotions (such as shame, guilt, and anger), restructuring of unhelpful trauma-related thoughts and meanings for the individual and strategies to overcome avoidance.

Strong recommendation

Trauma-focussed CBT for caregiver and child For children and adolescents with symptoms of PTSD, we recommend trauma-focussed CBT for caregiver and child.

Remark: This is a trauma-focussed CBT intervention delivered to the child/adolescent and their caregiver. When possible, parents or caregivers are included throughout treatment to support the child or adolescent's practice and mastery of skills and to enhance positive parenting and parental support.
Conditional recommendation

**EMDR For children and adolescents with symptoms of PTSD, we suggest offering eye movement desensitisation and reprocessing (EMDR) where trauma-focussed CBT is unavailable or unacceptable.**

Remark: Eye Movement Desensitisation and Reprocessing (EMDR) was originally developed by Francine Shapiro to treat traumatic memories in adults with PTSD. For use with children, modifications of the EMDR protocol are made to adjust for child age and developmental level. For example, whenever needed, the eye movements can be replaced by tapping and face-figures can be used to assess the child's emotional state.

EMDR is a standardised, eight-phase, trauma-focussed therapy involving the use of bilateral physical stimulation (eye movements, taps, or tones). EMDR is based on the assumption that, during a traumatic event, overwhelming emotions or dissociative processes may interfere with information processing. This leads to the experience being stored in an ‘unprocessed’ way, disconnected from existing memory networks. In EMDR the person is asked to focus on the trauma-related imagery, and the associated thoughts, emotions, and body sensations while bilateral physical stimulation, such as moving their eyes back and forth, occurs. Processing targets may involve past events, present triggers and adaptive future functioning. It is proposed that this dual attention facilitates the processing of the traumatic memory into existing knowledge networks, although the precise mechanism involved is not known.

Group trauma-focussed CBT for child  **RESEARCH RECOMMENDATION**

For children and adolescents with symptoms of PTSD, we suggest doing trauma-focussed CBT in preference to group trauma-focussed CBT for child.

There is emerging evidence for group trauma-focussed CBT for child following exposure to traumatic events, and this could be used in a research context.

Remark: This is a CBT intervention with a trauma focus delivered in a group setting. The specific interventions included in the systematic review studies involve six to eight modules delivered by facilitators and include psychoeducation on trauma, dual attention tasks (such as knee tapping while thinking of traumatic events), controlled breathing, progressive muscle relaxation, identifying thoughts and feelings, reframing unhelpful thoughts, graded exposure techniques and trauma processing using artwork or sharing written trauma narratives with the group.

Individual and group trauma-focussed CBT for caregiver and child  **RESEARCH RECOMMENDATION**

For children and adolescents with symptoms of PTSD, we suggest doing trauma-focussed CBT in preference to individual and group trauma-focussed CBT for caregiver and child.

There is emerging evidence for Individual and group trauma-focussed CBT for caregiver and child following exposure to traumatic events, and this could be used in a research context.

Remark: A trauma-focussed CBT intervention with a combination of group sessions, caregiver education sessions, and individual sessions. Interventions include psychoeducation, relaxation training, cognitive restructuring, social problem solving, and trauma-focussed intervention strategies, including graded exposure and trauma processing using narrative techniques.
For children and adolescents with symptoms of PTSD we suggest continuation of treatment as usual in preference to parent-child relationship enhancement (play therapy).

There is emerging evidence for parent-child relationship enhancement (play therapy) for children with symptoms of PTSD and this could be used in a research context.

Remark: Child play interventions are guided by the unfolding child–caregiver interactions (if the parent is present in the session) and by the child's play with developmentally and culturally appropriate toys selected to elicit trauma play or enable children to communicate their thoughts and feelings. Regular child play sessions are interspersed with individual parent sessions.

For children and adolescents with symptoms of PTSD we suggest continuation of treatment as usual in preference to narrative exposure therapy for children (kidNET).

There is emerging evidence for kidNET following exposure to traumatic events, and this could be used in a research context.

Remark: KidNET is a modified version of narrative exposure therapy (NET) which has been developed for use with children. NET is a standardised short-term intervention adapted from testimony therapy (traditionally used with survivors of torture and civilian casualties of war), as well as from standard exposure approaches. It was originally developed both to treat survivors and to document human rights violations. In NET, the person is asked to develop and describe a narrative of their life from early childhood to present, focussing in detail on the traumatic events and elaborating on the associated thoughts and emotions. It is proposed that NET works in two ways: promoting habituation to traumatic memories through exposure, and reconstructing the individual's autobiographic memory.

For children and adolescents with symptoms of PTSD there was insufficient evidence to make a recommendation on trauma-focussed CBT for caregiver.

Remark: Trauma-focussed CBT for caregiver is a specific, phase-based model of CBT-T delivered to a child/adolescent caregiver. Caregivers are trained to serve as the child/adolescent's therapeutic agent. Caregivers are taught skills for responding to their child's behaviours and needs through modeling, gradual exposure and processing exercises. Caregivers are also trained in analysing their own behaviour in relation to their children and child management skills.

For children and adolescents with symptoms of PTSD there was insufficient evidence to make a recommendation on group trauma-focussed CBT for caregiver and child.

Non-directive counselling involves active, empathic listening to the patient who is usually provided with unconditional positive regard. The therapist helps the patient to explore and clarify issues, may provide advice, reflect and confirm appropriate reactions, and introduce problem-solving techniques.

For children and adolescents with symptoms of PTSD there was insufficient evidence to make a recommendation on group psychoeducation.

Remark: Group Psychoeducation provides individuals with information about traumatic stress reactions, PTSD and how to manage them in a group format.

For children and adolescents with symptoms of PTSD there was insufficient evidence to make a recommendation on family therapy.
Pharmacological interventions for children and adolescents with PTSD

Sertraline For children and adolescents with symptoms of PTSD there was insufficient evidence to make a recommendation on sertraline.

Remark: Sertraline, sold in Australia under the trade name Zoloft, is an antidepressant from the class of selective serotonin reuptake inhibitors (SSRIs).

Non-psychological and non-pharmacological treatments/interventions for children with PTSD

Mind-body skills group RESEARCH RECOMMENDATION

For children and adolescents with symptoms of PTSD we suggest continuation of treatment as usual in preference to mind-body skills group.

There is emerging evidence for mind-body skills group in refugee populations exposed to war-related traumatic events, and it could be used in a research context.

Remark: “Mind-body” techniques used in the studies in the systematic review include guided imagery, relaxation techniques, meditation, autogenic training, and biofeedback. In addition to these modalities, a variety of forms of self-expression may be offered, such as art therapy and written exercises. In refugee populations exposed to war-related traumatic events there is emerging evidence for the delivery of these mind-body techniques in small groups.

Trauma-focussed expressive art therapy For children and adolescents with symptoms of PTSD there was insufficient evidence to make a recommendation on trauma-focussed expressive art therapy.

Remark: In the treatment intervention used in this study, adolescent participants completed at least 13 collages or drawings and compiled them in a hand-made book format to express a narrative of their ‘life story’. The 16 session protocol on art and discussion topics focussed on enhancing the adolescent's capacity to monitor and regulate feelings of safety and danger, and to share trauma-related experiences and describe coping responses.

Adults pre-incident preparedness

Attention bias modification training (ABMT) RESEARCH RECOMMENDATION

For adults who are likely to be exposed to trauma, we suggest usual practice in preference to pre-incident attention bias modification training (ABMT).

There is emerging evidence for pre-incident ABMT in military populations and this could be used in a research context.

Remark: Attention bias modification training (ABMT) involves the delivery of brief (approximately 20 minute), computerised tasks. Attentional avoidance of negative information is encouraged through use of a modified dot-probe task where probes always appear in the location opposite negative stimuli. This procedure is designed to ‘train’ an individual’s attention away from or toward negative or threatening information. The immediate effects of ABMT appear to be most prominent when applied prior to exposure to a potentially traumatic event. ABMT has been delivered to soldiers immediately prior to combat deployment in order to attenuate the association between combat exposure and PTSD-related symptoms.
Attention control training **RESEARCH RECOMMENDATION**

For adults who are likely to be exposed to trauma, we suggest usual practice in preference to preincident attention control training.

There is emerging evidence for preincident attention control training and this could be used in a research context.

Remark: Attention control training uses the same format as ABMT but presents equal numbers of targets in the locations of threat and neutral attention stimuli (such as words). It is not designed to shift attention patterns (to favour neutral or threat stimuli) but rather to balance attention between neutral and threat stimuli.

Heart rate variability biofeedback (HRVB) **RESEARCH RECOMMENDATION**

For adults who are likely to be exposed to trauma, we suggest usual practice in preference to heart rate variability biofeedback (HRVB).

There is emerging evidence for heart rate variability biofeedback (HRVB) and this could be used in a research context.

Remark: Heart rate variability biofeedback (HRVB) is a form of cardiorespiratory intervention that consists of feeding back beat-by-beat heart rate data to the participant who tries to maximise respiratory sinus arrhythmia (RSA). RSA is the heart pattern that occurs when heart rate increases during inhalation and decreases during exhalation.

This intervention has been tested in the context of pre-combat deployment in order to prevent subsequent PTSD.

Mental Agility and Psychological Strength (MAPS) resilience training For adults who are likely to be exposed to trauma, there was insufficient evidence to make a recommendation on MAPS resilience training.

Remark: The Mental Agility and Psychological Strength (MAPS) training program aims to build knowledge and practical skills for psychological wellbeing and PTSD. It includes cognitive re-structuring, support seeking, and self-soothing or self-moderating through mindfulness and relaxation training.

Cognitive bias modification for interpretation (CBM-I) For adults who are likely to be exposed to trauma, there was insufficient evidence to make a recommendation on cognitive bias modification for interpretation (CBM-I).

Remark: CBM-I is a computer-based training that aims to promote less negative appraisal of post-event retrospection using software that presents emotionally ambiguous deployment-related scenarios in sentence format. The last word of each sentence is presented as a word fragment which the participant is asked to complete. These word fragments gradually increase the proportion of neutral or non-negative interpretations of the scenario.

Stress inoculation training (SIT) For adults who are likely to be exposed to trauma, there was insufficient evidence to make a recommendation on stress inoculation training (SIT).

Remark: Stress inoculation training (SIT) is a non-trauma-focussed anxiety management program that involves teaching coping skills to manage stress and anxiety (Meichenbaum, 1974). SIT consists of three phases. The first phase, conceptualization, includes education about stress, development of a collaborative relationship between the provider and the patient, and assessment and conceptualization of the stressors the patient is facing. The second phase, skill acquisition and rehearsal, includes teaching the patient coping skills that are tailored to the needs of the patient. These can include relaxation training, cognitive restructuring, problem-solving training, and positive self-statements. The final phase, application and follow-through, includes practicing coping skills and applying them to real life stressful situations through guided imagery, as well as relapse prevention (Meichenbaum & Deffenbacher, 1988).

These studies investigate the effectiveness of a predeployment SIT program of relaxation breathing to lessen the mental health consequences of combat stress.

**Adults within the first three months of a traumatic event**

**Single session early prevention interventions for adults**
Group 512 Psychological Intervention Model (Group 512 PIM) **RESEARCH RECOMMENDATION**

For adults within the first three months following exposure to a potentially traumatic event, we suggest usual practice in preference to Group 512 PIM.

There is emerging evidence for Group 512 PIM in Chinese military populations exposed to natural disaster and this could be used in a research context.

Remark: Group 512 PIM is an intervention tested on Chinese military rescuers and based on the standard principles of critical incident stress debriefing (CISD) developed by Mitchell (1983). Group 512 PIM involves four stages including introduction, discussing the facts, thoughts, reactions and symptoms related to the trauma followed by stress management tips. Group 512 PIM differs from standard CISD by including a final stage of cohesion training, where participants play games requiring team cooperation to foster military unit cohesion. This is a critical part of Group 512 PIM, as cohesion is thought to have protective effects in preventing stress.

**Conditional recommendation (against)**

Group psychological debriefing For adults within the first three months after trauma exposure, we suggest providing information, emotional support, and practical assistance in preference to group psychological debriefing.

Remark: Group psychological debriefing is a single-session, semi-structured intervention, applied shortly after exposure to a PTE, during which groups are guided through a seven-stage discussion soon after exposure to a severe stressor. Facts, thoughts and impressions are explored and education is provided on how to cope with possible stress reactions. Several methods of group debriefing have been proposed, most notably by Mitchell (1983) called Critical Incident Stress Debriefing (CISD). The goals of CISD following work-related exposure to a PTE are: (1) prevention and mitigation of the symptoms of traumatic stress and (2) promotion of recovery and acceleration of return to normal functioning.

The terms psychological debriefing and CISD are often used interchangeably. The former describes a class of interventions delivered shortly following a trauma (usually between 24 and 72 hours) that aim to relieve distress and facilitate a rapid return to normal functioning, thereby mediating or avoiding long-term psychopathology. Psychological debriefing operates on the principles of ventilation (an opportunity to talk about the experience), normalisation of distress, and psychoeducation regarding potential symptoms. CISD, on the other hand, is a specific form of debriefing developed in the 1980s which centres predominantly around group-based interventions for secondary victims such as emergency services personnel, rather than primary victims. While generally group-based, it also advocates individual (or one-on-one) interventions as an acceptable and expected variant. It relies heavily on processes of reconstruction of the traumatic event, ventilation, and normalisation, and includes a structured education component. Over time, CISD has been amalgamated within a framework of self-help activities and structured organisational processes, called critical incident stress management (CISM).

It should be noted that CISD and psychological debriefing differ from operational debriefing, a group process undertaken in high risk industries to review a particular operation or activity. The aim of operational debriefing is to review the events and processes of the operation and to apply the lessons learnt to future events. Operational debriefing is considered good practice in high risk industries as a method of improving service quality and is not a focus of these Guidelines.
Conditional recommendation (against)

Individual psychological debriefing
For adults within the first three months after trauma exposure, we suggest providing information, emotional support, and practical assistance in preference to individual psychological debriefing.

Remark: Individual psychological debriefing is the application of Critical Incident Stress Debriefing (CISD) in an individual setting. The intervention generally comprises an hour's debriefing combining a review of the traumatic experience, encouragement of emotional expression, and promotion of cognitive processing of the experience.

The terms psychological debriefing and CISD are often used interchangeably. The former describes a class of interventions delivered shortly following a trauma (usually between 24 and 72 hours) that aim to relieve distress and facilitate a rapid return to normal functioning, thereby mediating or avoiding long-term psychopathology. Psychological debriefing operates on the principles of ventilation (an opportunity to talk about the experience), normalisation of distress, and psychoeducation regarding potential symptoms. CISD, on the other hand, is a specific form of debriefing developed in the 1980s which centres predominantly around group-based interventions for secondary victims such as emergency services personnel, rather than primary victims. While generally group-based, it also advocates individual (or one-on-one) interventions as an acceptable and expected variant. It relies heavily on processes of reconstruction of the traumatic event, ventilation, and normalisation, and includes a structured education component. Over time, CISD has been amalgamated within a framework of self-help activities and structured organisational processes, called critical incident stress management (CISM).

It should be noted that CISD and psychological debriefing differ from operational debriefing, a group process undertaken in high risk industries to review a particular operation or activity. The aim of operational debriefing is to review the events and processes of the operation and to apply the lessons learnt to future events. Operational debriefing is considered good practice in high risk industries as a method of improving service quality and is not a focus of these Guidelines.

Eye Movement Desensitization and Reprocessing (EMDR) - single session
For adults within the first three months following exposure to a potentially traumatic event, there was insufficient evidence to make a recommendation on delivering a single session of EMDR.

Remark: Single session EMDR follows the EMDR Protocol for Recent Critical Incidents (EMDR-PRECI). EMDR-PRECI is a modified version of Shapiro's Recent Traumatic Events Protocol (R-TEP) which is specially designed for victims of recent traumatic events. EMDR-PRECI involves identifying the worst fragment of the client's trauma memory, followed by the remaining difficult fragments of the memory. Desensitising occurs by having the client focus on each memory fragment whilst simultaneously engaging in dual attention stimulation using eye movements, until all fragments have been processed and the client no longer experiences emotional, cognitive or somatic distress. In this study the EMDR sessions were delivered in the context of ER patients in a hospital.

Individual psychoeducation/self-help
For adults within the first three months following exposure to a potentially traumatic event, there was insufficient evidence to make a recommendation on individual psychoeducation/self-help.

Group stress management
For adults within the first three months following exposure to a potentially traumatic event, there was insufficient evidence to make a recommendation on group stress management.

Computerised visuospatial task
For adults within the first three months following exposure to a potentially traumatic event, there was insufficient evidence to make a recommendation on computerised visuospatial task.

Group education
For adults within the first three months following exposure to a potentially traumatic event, there was insufficient evidence to make a recommendation on group education.

Reassurance
For adults within the first three months following exposure to a potentially traumatic event, there was insufficient evidence to make a recommendation on reassurance.

Trauma-focused counselling
For adults within the first three months following exposure to a potentially traumatic event, there was insufficient evidence to make a recommendation on trauma-focused counselling.

Multiple session early prevention interventions for adults
Brief dyadic therapies RESEARCH RECOMMENDATION

For adults within the first three months following exposure to a potentially traumatic event, we suggest usual practice in preference to brief dyadic therapies.

There is emerging evidence for brief dyadic therapies and this could be used in a research context.

Remark: These are brief (e.g. two - three session) CBT-based therapies delivered dyadically with the aim of improving communication and fostering a shared approach to addressing psychological and practical difficulties. For example, brief dyadic therapy as described by Brunet and colleagues[186] aims to target social support process following trauma exposure, and involves elements of psychoeducation and motivational interviewing to enhance communication between the patient and their significant other. It involves two sessions, which aim to promote disclosure of thoughts and emotions relating to the trauma while attempting to reduce social constraints on disclosure and negative interactions between the dyad.186

Internet-based CBT RESEARCH RECOMMENDATION

For adults within the first three months following exposure to a potentially traumatic event, we suggest usual practice in preference to internet-based CBT.

There is emerging evidence for internet-based CBT and this could be used in a research context.

Remark: ‘Trauma TIPS’, an internet-based self-guided intervention, is based on CBT principles of psychoeducation, stress/relaxation techniques, and in vivo exposure. Trauma TIPS aims to decrease levels of distress and anxiety by providing information on successful coping, instructions and guidance for in vivo exposure, and stress management techniques.[199]

For adults within the first three months following exposure to a potentially traumatic event, there was insufficient evidence to make a recommendation on brief individual trauma processing therapy.

For adults within the first three months following exposure to a potentially traumatic event, there was insufficient evidence to make a recommendation on three step early intervention for mothers of infants born prematurely.

For adults within the first three months following exposure to a potentially traumatic event, there was insufficient evidence to make a recommendation on intensive care diaries.

For adults within the first three months following exposure to a potentially traumatic event, there was insufficient evidence to make a recommendation on brief Interpersonal Counselling.

For adults within the first three months following exposure to a potentially traumatic event, there was insufficient evidence to make a recommendation on collaborative care.

For adults within the first three months following exposure to a potentially traumatic event, there was insufficient evidence to make a recommendation on supported psychoeducational intervention.

For adults within the first three months following exposure to a potentially traumatic event, there was insufficient evidence to make a recommendation on telephone-based CBT.

For adults within the first three months following exposure to a potentially traumatic event, there was insufficient evidence to make a recommendation on communication facilitator in an intensive care setting.

For adults within the first three months following exposure to a potentially traumatic event, there was insufficient evidence to make a recommendation on nurse-led intensive care recovery program.
Early psychosocial treatment interventions for adults

**Strong recommendation**

Stepped/collaborative care For adults with PTSD symptoms in the first three months following trauma, we recommend a stepped/collaborative care model, in which individuals receive evidence-based care commensurate with the severity and complexity of their need.

Remark: A stepped care model recognises that not all those exposed to potentially traumatic events will develop a diagnosable disorder; many will experience only sub-threshold symptoms and others will not experience significant symptomatology at all. Stepped care aims to ensure that individuals receive care commensurate with the severity and complexity of their need. The approach involves ongoing monitoring of people who are more distressed and/or at heightened risk of poor psychological adjustment, with increasingly intensive interventions delivered as indicated. Interventions are generally CBT-based, but sometimes based on other psychological approaches (e.g. motivational interviewing) and may include components of case management and prescription of pharmacological intervention.

The collaborative care model by Zatzick and colleagues[267][268][269] is a stepped care model where injury patients are screened for high levels of PTSD symptoms. Those with risk factors are offered integrated care including pharmacotherapy, motivational interviewing targeting problematic alcohol use, and CBT targeting depression and PTSD symptoms. Elements of the treatment are provided in a stepped fashion such that those with greater ease of delivery such as psychoeducation and problem solving are given initially, followed later by more complex elements such as activity scheduling. Patient symptoms are repeatedly measured and higher-intensity care is initiated if the person requires it. The stepped care model proposed by O'Donnell and colleagues[259] aimed to address a comprehensive range of posttrauma psychopathology beyond PTSD. In a two-stage screening process, patients were screened for high risk symptoms of PTSD, depression and anxiety, and treated with an evidence-based modular CBT manual that allowed treatment to be tailored to the patient’s individual symptom-cluster profiles.

**Conditional recommendation**

Trauma-focussed CBT (TF-CBT) For adults with PTSD symptoms in the first three months following trauma, we suggest offering trauma-focussed CBT (includes prolonged exposure, cognitive processing therapy, cognitive therapy) in preference to doing nothing.

Remark: Trauma-focussed CBT is intended to help an individual come to terms with trauma through exposure to and emotional processing of memories of the event. This includes prolonged exposure, cognitive restructuring, cognitive processing therapy and cognitive therapy. Typically, TF-CBT involves homework and includes psycho-education, exposure work, cognitive work and more general relaxation/stress management; the relative contribution of these elements varies between different forms of TF-CBT.

**Conditional recommendation**

Brief EMDR For adults with PTSD symptoms in the first three months following trauma, we suggest offering brief Eye Movement Desensitisation and Reprocessing (EMDR) in preference to doing nothing.

Remark: Brief EMDR can range from one to three sessions and involves clients focusing on fragments of their trauma memory whilst simultaneously engaging in dual attention stimulation using eye movements.
Structured writing therapy **RESEARCH RECOMMENDATION**

For adults with PTSD symptoms in the first three months after exposure to a traumatic event, we recommend offering TF-CBT, PE, CT or Brief EMDR in preference to structured writing therapy.

There is emerging evidence for Structured writing therapy and this could be used in a research context.

Remark: Structured writing is a broad term that encompasses interventions that rely exclusively on writing assignments. Of the two studies that employed structured writing interventions, one study adapted their structured writing therapy program from the Interapy program, which is an internet-based 10-session structured writing intervention. The other study conducted by Bugg and colleagues adapted the Pennebaker (1988) writing paradigm, which requires participants to write about the feelings and emotions associated with their traumatic experience once a day for three consecutive days. Across these two studies, participants were individuals with ASD or PTSD who sustained a traumatic injury such as a traffic accident or a sexual or non-sexual assault.

Internet-based guided self-help **RESEARCH RECOMMENDATION**

For adults with PTSD symptoms in the first three months after exposure to a traumatic event, we recommend offering TF-CBT, PE, CT or Brief EMDR in preference to internet-based guided self-help.

There is emerging evidence for Internet-based guided self-help and it could be used in a research context.

Remark: Internet-based guided self-help uses internet-based programs to treat individuals with PTSD using CBT approaches. Use of the intervention is guided by a therapist. Patients receive guidance and feedback on homework assignments from the therapist.

Helping to Overcome PTSD through Empowerment (HOPE) **RESEARCH RECOMMENDATION**

For adults with PTSD symptoms in the first three months after exposure to a traumatic event, we recommend offering TF-CBT, PE, CT, or Brief EMDR in preference to Helping to Overcome PTSD through Empowerment (HOPE).

There is emerging evidence for HOPE and it could be used in a research context.

Remark: Helping to Overcome PTSD through Empowerment (HOPE) is a present-centred cognitive behavioural therapy and empowerment-based individual treatment created to address PTSD in the context of intimate partner violence (IPV) and the clinical challenges of residents of women's shelters who have ongoing safety issues. HOPE is informed by Herman's (1992) multistage model of recovery that views recovery from chronic trauma, including IPV, as occurring in three stages: (a) establishing safety, (b) remembrance and mourning, and (c) reconnection. HOPE incorporates many of the traditional components of CBT for PTSD (e.g., cognitive-restructuring, skill building) with a focus on helping women realistically appraise the degree of threat they are under and to learn how to manage their PTSD symptoms without increasing them or risking their safety. HOPE also incorporates empowerment strategies, helping women to identify aspects of their situation that are under their control and providing them with the skills (e.g., assertiveness with safety planning) that aim to empower them.

Behavioural activation For adults with PTSD symptoms in the first three months after exposure to a traumatic event, there was insufficient evidence to make a recommendation on behavioural activation.

Remark: Behavioural activation aims to help the individual to learn to manage negative feelings through activity planning. Core features of the intervention include psychoeducation, behavioural analysis, activity planning, goal identification, trouble shooting, homework and relapse prevention.

Supportive counselling For adults with PTSD symptoms in the first three months after exposure to a traumatic event, there was insufficient evidence to make a recommendation on supportive counselling.

Remark: SC involves active, empathic listening to the patient who is usually provided with unconditional positive regard. The therapist helps the patient to explore and clarify issues, may provide advice, reflect and confirm appropriate reactions, and introduce problem-solving techniques. SC has been used as a non-trauma focused control condition in several trials and focused attention to the index trauma event is usually avoided.
Computerised neurobehavioural training For adults with PTSD symptoms in the first three months after exposure to a traumatic event, there was insufficient evidence to make a recommendation on computerised neurobehavioural training.

Remark: Computerised Neurobehavioral Training aims to teach participants skills in order to improve neurocognitive functioning through an online program. Participants are encouraged to practice new skills through regular practice.

Nurse-led psychological intervention For adults with PTSD symptoms in the first three months after exposure to a traumatic event, there was insufficient evidence to make a recommendation on nurse-led psychological intervention.

Early pharmacological interventions for adults

Hydrocortisone RESEARCH RECOMMENDATION

For adults with PTSD symptoms in the first three months after exposure to a traumatic event, we recommend offering TF-CBT, PE, CT or Brief EMDR in preference to hydrocortisone.

There is emerging evidence for hydrocortisone and this could be used in a research context.

Remark: Hydrocortisone is the synthetic form of the adrenal gland-produced hormone cortisol. It has been used to try to bring about homeostasis (stability) to the hypothalamic-pituitary-adrenal axis by inhibiting further release of adrenaline and noradrenaline.

Docosahexaenoic acid For adults with PTSD symptoms in the first three months after exposure to a traumatic event, there was insufficient evidence to make a recommendation on docosahexaenoic acid.

Escitalopram For adults with PTSD symptoms in the first three months after exposure to a traumatic event, there was insufficient evidence to make a recommendation on escitalopram.

Oxytocin For adults with PTSD symptoms in the first three months after exposure to a traumatic event, there was insufficient evidence to make a recommendation on oxytocin.

Propranolol For adults with PTSD symptoms in the first three months after exposure to a traumatic event, there was insufficient evidence to make a recommendation on propranolol.

Gabapentin For adults with PTSD symptoms in the first three months after exposure to a traumatic event, there was insufficient evidence to make a recommendation on gabapentin.

Adults with clinically relevant post-traumatic stress symptoms

Psychological interventions for adults with PTSD

Strong recommendation

Cognitive processing therapy (CPT) For adults with PTSD, we recommend cognitive processing therapy (CPT).

Remark: Cognitive processing therapy (CPT) is a form of cognitive therapy refined specifically for the treatment of PTSD. CPT is a 12-session cognitive-behavioural manualised treatment for PTSD that systematically addresses key posttraumatic themes, including safety, trust, power and control, self-esteem and intimacy. The primary goal of treatment is to create more balanced, adaptive, multi-faceted trauma appraisals and beliefs (both looking back on the traumatic experience and in the present). Treatment helps the person to identify unhelpful thoughts and beliefs (‘stuck points’), challenge them, and replace them with rational alternatives in an adaptation of standard cognitive therapy approaches. It has a smaller exposure component than imaginal exposure therapy (restricted to writing an account of the experience). It also helps to address associated problems such as depression, guilt and anger.
Strong recommendation

Cognitive therapy (CT) For adults with PTSD, we recommend cognitive therapy (CT).

Remark: CT is a variant of trauma-focussed CBT in which the therapist and patient collaboratively develop an individualised version of Ehlers and Clark’s model of PTSD, which serves as the framework for therapy. Ehlers and Clark (2000) suggested that PTSD becomes persistent when individuals process the trauma in a way that leads to a sense of serious, current threat. The sense of threat is hypothesised to arise as a consequence of excessively negative appraisals of the trauma and/or its sequelae, and a disturbance of the autobiographical memory for the trauma which leads to involuntary re-experiencing of aspects of the trauma. The problem is maintained by unhelpful behavioral and cognitive strategies that are intended to control the symptoms and perceived threat. Accordingly, CT for PTSD aims to modify excessively negative appraisals, correct the autobiographical memory disturbance, and remove the problematic behavioural and cognitive strategies. CT is generally administered for 12 weekly treatment sessions (of 90 minutes for the initial sessions, and 60 minutes for the following sessions).

Strong recommendation

EMDR For adults with PTSD, we recommend eye movement desensitisation and reprocessing (EMDR).

Remark: Eye movement desensitisation and reprocessing (EMDR) is a standardised, eight-phase, trauma-focussed therapy involving the use of bilateral physical stimulation (eye movements, taps or tones). EMDR is based on the assumption that, during a traumatic event, overwhelming emotions or dissociative processes may interfere with information processing. This leads to the experience being stored in an ‘unprocessed’ way, disconnected from existing memory networks.

In EMDR the person is asked to focus on the trauma-related imagery, and the associated thoughts, emotions, and body sensations while bilateral physical stimulation, such as moving their eyes back and forth, occurs. Processing targets may involve past events, present triggers and adaptive future functioning. It is proposed that this dual attention facilitates the processing of the traumatic memory into existing knowledge networks, although the precise mechanism involved is not known.

Strong recommendation

Prolonged exposure (PE) For adults with PTSD we recommend prolonged exposure (PE).

Remark: Exposure therapy is long established as an effective treatment for a range of anxiety disorders. The key objective of exposure therapy is to help the person confront the object of their anxieties. A fundamental principle underlying the process of exposure is that of habituation, the notion that if people can be kept in contact with the anxiety-provoking stimulus for long enough, their anxiety will inevitably reduce. This may occur within an exposure session (within-session habituation) or across a series of sessions (between-session habituation). More contemporary models emphasise information processing as a key mechanism.

Prolonged Exposure is a manualised therapy (Foa, Hembree & Rothbaum, 2007). It consists of psychoeducation about common reactions to trauma, breathing retraining, in vivo exposure (approaching safe situations that patients avoided due to trauma-related fear), imagery exposure (repeated recounting of trauma memories during sessions and listening to recordings of the recounting made during therapy sessions), and processing (discussion of thoughts and feelings related to the exposure exercises).

Strong recommendation

Trauma-focussed CBT (TF-CBT) For adults with PTSD we recommend trauma-focussed CBT.

Remark: Trauma-focussed cognitive-behavioural therapy (TF-CBT) is a broad term that encompasses any treatment that employs the standard principles of CBT combined with some form of trauma processing. Generally, TF-CBT involves the integration of CBT principles with components of exposure therapy, including imaginal exposure and graded in vivo exposure. Across most studies from the systematic review that underpins these Guidelines, the typical format of TF-CBT involves psychoeducation, breathing/relaxation training (arousal reduction strategies), imaginal exposure, in vivo exposure, and cognitive restructuring.
Conditional recommendation

Guided internet-based trauma-focussed CBT For adults with PTSD where trauma-focussed cognitive behavioural therapies or EMDR are unavailable or unacceptable, we suggest guided internet-based trauma-focussed CBT.

Remark: Most internet-based interventions for PTSD commence with psychoeducation, and then present the rationale for CBT-based treatment. These programs incorporate cognitive techniques, with the aim of identifying and modifying unhelpful patterns of cognition. Usually, behavioural components are included; generally encompassing imaginal and in vivo exposure. Internet-based interventions vary in the level of therapist assistance provided. Guided internet-based programs can be delivered by a specialist therapist who provides input and feedback on homework, and encourages engagement with the program, or by a non-specialist mental health professional who intervenes to check on progress or provides input on demand, often by telephone or by email. An example of the latter is DESTRESS-PC, a variant of CBT and stress inoculation training designed for symptoms resulting from military trauma.

Conditional recommendation

Narrative exposure therapy (NET) For adults with PTSD where trauma is linked to genocide, civil conflict, torture, political detention or displacement, we suggest Narrative Exposure Therapy (NET).

Remark: NET allows PTSD sufferers to describe and develop a coherent, chronological, autobiographical narrative of their life that includes their traumatic experiences (a testimony). The therapist facilitates emotional processing through the use of cognitive-behavioural techniques.

Narrative exposure therapy (NET) is a standardised short-term intervention adapted from testimony therapy (traditionally used with survivors of torture and civilian casualties of war), as well as from mainstream exposure approaches. It was originally developed both to treat survivors and to document human rights violations. In NET, the person is asked to construct a narrative of their life from early childhood to present, focussing in detail on the traumatic events and elaborating on the associated thoughts and emotions. It is proposed that NET works in two ways: promoting habituation to traumatic memories through exposure, and reconstructing the individual’s autobiographic memory.

A number of RCTs have successfully been conducted in a variety of cultural settings, demonstrating NET’s applicability in both western and non-western countries.

Conditional recommendation

Present-centred therapy (PCT) For adults with PTSD where trauma-focussed cognitive behavioural therapies or EMDR are unavailable or unacceptable, we suggest present-centred therapy (PCT).

Remark: PCT is designed to target daily challenges that PTSD sufferers encounter as a result of their symptoms. It includes psychoeducation about the impact of PTSD symptoms, the development of effective strategies to deal with day-to-day challenges and homework to practice newly developed skills.

Present-centred therapy is a variant of supportive counselling. These approaches are often used as comparison conditions in randomised controlled trials. PCT is a non-trauma focussed manualised intervention designed to target daily challenges that PTSD sufferers encounter. It includes psychoeducation about the impact of PTSD symptoms, the development of effective strategies to deal with day-to-day challenges and homework to practice newly developed skills. Typically 10 group sessions of 90 minutes are delivered by therapists who help participants identify stressors and discuss them in a supportive, nondirective manner.
Conditional recommendation

Stress inoculation training (SIT) For adults with PTSD where trauma-focussed cognitive behavioural therapies or EMDR are unavailable or unacceptable, we suggest stress inoculation training (SIT).

Remark: The stress inoculation training (SIT) used in these studies is an anxiety management program for use with rape victims adapted from Veronen and Kilpatrick (1983). The nine sessions include breathing retraining, and ‘coping strategies’ such as muscle relaxation, thought stopping, cognitive restructuring and role play. [386]

Conditional recommendation

Trauma-focussed CBT (group) For adults with PTSD where individual trauma-focussed cognitive behavioural therapies or EMDR are unavailable or unacceptable, we suggest group trauma-focussed CBT.

Remark: Trauma-focussed CBT has been previously described as an early psychosocial treatment intervention for adults. In the group context, typically up to 16 sessions are delivered and run for 60-90 minutes each. Group interventions in the included studies encompass CPT [454][444]. Beck’s CBT and other protocols[371]. All treatment interventions require (to varying degrees) engagement with the traumatic memory, opportunities for cognitive restructuring, and skills aiming to reduce avoidance.

Couples trauma-focussed CBT RESEARCH RECOMMENDATION

For adults with PTSD we recommend offering TF-CBT, PE, CT, CPT or EMDR in preference to couples TF-CBT.

There is emerging evidence for couples TF-CBT and this could be used in a research context.

Remark: The relevant study delivered 15 sessions of manualised cognitive-behavioral conjoint therapy (CBCT) which is designed to treat PTSD and enhance intimate relationships in couples where one partner has been diagnosed with PTSD. [426]

Group and individual (combined) trauma-focussed CBT RESEARCH RECOMMENDATION

For adults with PTSD we recommend offering TF-CBT, PE, CT, CPT or EMDR in preference to group and individual (combined) TF-CBT.

There is emerging evidence for group and individual (combined) TF-CBT and this could be used in a research context.

Remark: The treatment intervention used in this study was CPT-SA, an adaptation of Resick and Schnicke’s (1993) cognitive processing therapy for rape victims. The intervention consisted of 17 weeks of a manual-based group and individual therapy, with participants attending a 90 minutes group each week and a 60 minute individual therapy session for the first nine weeks and the 17th week. [372]

Meta-cognitive therapy RESEARCH RECOMMENDATION

For adults with PTSD we recommend offering TF-CBT, PE, CT, CPT or EMDR in preference to meta-cognitive therapy.

There is emerging evidence for meta-cognitive therapy and this could be used in a research context.

Remark: Meta-cognitive therapy, a form of non-trauma focussed CBT, targets the disrupted thinking style characteristic of PTSD (threat monitoring, worry, and rumination) rather than focussing on trauma-processing. [462]
Non-trauma-focussed CBT (affect regulation) RESEARCH RECOMMENDATION

For adults with PTSD we recommend offering TF-CBT, PE, CT, CPT or EMDR in preference to non-trauma-focussed CBT (affect regulation).

There is emerging evidence for non-trauma-focussed CBT (affect regulation) and this could be used in a research context.

Remark: The non-trauma-focussed CBT interventions included in the systematic review use a variety of non-trauma focussed affect regulation techniques.\[466][391]

Reconsolidation of Traumatic Memories (RTM) RESEARCH RECOMMENDATION

For adults with PTSD we recommend offering TF-CBT, PE, CT, CPT or EMDR in preference to Reconsolidation of Traumatic Memories (RTM).

There is emerging evidence for RTM and this could be used in a research setting.

Remark: RTM is a brief intervention that involves activation of a traumatic memory. The participant’s trauma narrative is ended as soon as autonomic arousal is observed. A procedure follows that includes imagining a black and white movie of the event, dissociating from its content, and re-winding it when fully-associating over two seconds. This is designed to change the perspective from which the memory is recalled. RTM is administered in three sessions of up to 120 minutes each.\[459][396]

Single-session TF-CBT RESEARCH RECOMMENDATION

For adults with PTSD we recommend offering TF-CBT, PE, CT, CPT or EMDR in preference to single-session TF-CBT.

There is emerging evidence for single-session TF-CBT and it could be used in a research context.

Remark: These studies delivered a single session of modified behavioural treatment to earthquake survivors. The 60 minute treatment session focusses on reduction of fear and avoidance through exposure to simulated tremors in an earthquake simulator and self-exposure instructions.\[358][357]

Virtual Reality Therapy RESEARCH RECOMMENDATION

For adults with PTSD we recommend offering TF-CBT, CPT, or EMDR in preference to Virtual Reality Therapy.

There is emerging evidence for Virtual Reality Therapy and this could be used in a research context.

Remark: Virtual Reality therapies, such as virtual reality exposure (VRE\[441]) and VR-graded exposure therapy (VR-GET\[423]) are exposure therapies which integrate real-time computer graphics with other sensory input devices to immerse a participant in a virtual environment and facilitate the processing of memories associated with the traumatic event. Typically up to 12 graded sessions of virtual reality are administered, with the first session(s) focusing on psychoeducation and anxiety management techniques.

Written exposure therapy RESEARCH RECOMMENDATION

For adults with PTSD we recommend offering TF-CBT, PE, CT, CPT or EMDR in preference to written exposure therapy.

There is emerging evidence for written exposure therapy and this could be used in a research context.

Remark: Written exposure therapy is a brief trauma-focussed intervention of five, 30 minute sessions which include psychoeducation and confronting the trauma memory through the use of writing tasks. Participants are given scripted instructions to write about the same trauma memory each session.
Brief Eclectic Psychotherapy For adults with PTSD there was insufficient evidence to make a recommendation on Brief Eclectic Psychotherapy.

Remark: Brief Eclectic Psychotherapy draws on elements of TF-CBT and psychodynamic therapy, including the relationship between the patient and the therapist. It includes exposure to traumatic memories, therapeutic letter writing and consideration of how the individual has been affected by their experience(s). It usually ends with a farewell ritual.

Supportive counseling (SC) For adults with PTSD there was insufficient evidence to make a recommendation on supportive counseling.

Remark: SC involves active, empathic listening to the patient who is usually provided with unconditional positive regard. The therapist helps the patient to explore and clarify issues, may provide advice, reflect and confirm appropriate reactions, and introduce problem-solving techniques.

Psychodynamic therapy For adults with PTSD there was insufficient evidence to make a recommendation on psychodynamic therapy.

Remark: Psychodynamic therapy uses psychoanalytic theories and practices to help individuals understand and resolve their problems by increasing awareness of their inner world and its influences over current and past relationships.

Observed and experiential integration (OEI) For adults with PTSD there was insufficient evidence to make a recommendation on observed and experiential integration (OEI).

Remark: OEI involves alternately covering and uncovering the eyes ("switching") and the eyes tracking different locations in the visual field ("glitch-work") while experiencing a disturbing thought, feeling or memory. It also includes observation of differences between the two eyes' perceptions.

Relaxation training For adults with PTSD there was insufficient evidence to make a recommendation on Relaxation training.

Stabilising group treatment For adults with PTSD there was insufficient evidence to make a recommendation on stabilising group treatment.

Remark: Stabilizing group treatment is based on psycho-education and cognitive behavioural therapy. The program is based on Zlotnick's protocol [466] with additional sessions on assertiveness, bodily experiences and sexuality, distrust, guilt and shame, saying goodbye and future.

Group interpersonal therapy (IPT) For adults with PTSD there was insufficient evidence to make a recommendation on group interpersonal therapy (IPT).

Remark: IPT is an attachment-based treatment that focuses on current interpersonal problems and the resolution of these to improve symptoms.

Dialogical exposure therapy (DET) For adults with PTSD there was insufficient evidence to make a recommendation on dialogical exposure therapy (DET).

Remark: DET uses CBT techniques (with and without a trauma focus) and a Gestalt based exposure method (chair work) in a dialogical framework. Supported by the therapist, the individual enters into a dialogue with aspect of the traumatic experience.

Interpersonal therapy (IPT) For adults with PTSD there was insufficient evidence to make a recommendation on interpersonal therapy.

Remark: IPT is an attachment-based treatment that focuses on current interpersonal problems and the resolution of these to improve symptoms.

Acceptance and Commitment Therapy (ACT) For adults with PTSD there was insufficient evidence to make a recommendation on acceptance and commitment therapy (ACT).
Pharmacological interventions for adults with PTSD

Conditional recommendation

Selective Serotonin Reuptake Inhibitors (SSRIs) For adults with PTSD, we suggest SSRIs (sertraline, paroxetine, or fluoxetine) in circumstances where any of the following applies:

- The person is unwilling or not in a position to engage in or access recommended psychological therapy (TF-CBT, PE, CT, CPT or EMDR).
- The person has a comorbid condition or associated symptoms (e.g., clinically significant depression and high levels of dissociation) where SSRIs are indicated.
- The person's circumstances are not sufficiently stable to commence recommended psychological therapy (as a result, for example, of significant ongoing life stress such as domestic violence).
- The person has not gained significant benefit from recommended psychological therapy.
- There is a significant wait time before psychological treatment is available.

Remark: The most common approach to the pharmacological treatment of PTSD is through prescription of a selective serotonin reuptake inhibitor (SSRI). This class of drugs is widely prescribed for depression and anxiety and includes fluoxetine, paroxetine, and sertraline, each of which are conditionally recommended for use in the pharmacological treatment of PTSD.

Venlafaxine For adults with PTSD, we suggest venlafaxine in circumstances where any of the following applies:

- The person is unwilling or not in a position to engage in or access recommended psychological therapy (TF-CBT, PE, CT, CPT or EMDR).
- The person has a comorbid condition or associated symptoms (e.g., clinically significant depression and high levels of dissociation) where SNRIs are indicated.
- The person's circumstances are not sufficiently stable to commence recommended psychological therapy (as a result, for example, of significant ongoing life stress such as domestic violence).
- The person has not gained significant benefit from recommended psychological therapy.
- There is a significant wait time before psychological treatment is available.

Remark: Venlafaxine is an antidepressant from the Serotonin and Noradrenaline Reuptake Inhibitor (SNRI) class. Two studies included in the review suggest that venlafaxine is generally well tolerated and may be of benefit in the treatment of patients with PTSD.

Ketamine RESEARCH RECOMMENDATION

Where medication is indicated for the treatment of PTSD we suggest an SSRI or SNRI antidepressant. There is emerging evidence for the use of ketamine in the treatment of PTSD and it could be used in a research context.

Remark: Ketamine is an antagonist of the glutamate N-methyl-D-aspartate (NMDA) receptor.

Quetiapine RESEARCH RECOMMENDATION

Where medication is indicated for the treatment of PTSD we suggest an SSRI or SNRI antidepressant. There is emerging evidence for the use of quetiapine in the treatment of PTSD and it could be used in a research context.

Remark: Quetiapine is an atypical antipsychotic that is used for individuals with significant agitation.

Mirtazapine For adults with PTSD there was insufficient evidence to make a recommendation on mirtazapine.

Amitriptyline For adults with PTSD there was insufficient evidence to make a recommendation on amitriptyline.
Impiramine. For adults with PTSD there was insufficient evidence to make a recommendation on imipramine.

Brofaromine. For adults with PTSD there was insufficient evidence to make a recommendation on brofaromine.

Phenelzine. For adults with PTSD there was insufficient evidence to make a recommendation on phenelzine.

Olanzapine. For adults with PTSD there was insufficient evidence to make a recommendation on olanzapine.

Divalproex. For adults with PTSD there was insufficient evidence to make a recommendation on divalproex.

Lamotrigine. For adults with PTSD there was insufficient evidence to make a recommendation on lamotrigine.

Tiagabine. For adults with PTSD there was insufficient evidence to make a recommendation on tiagabine.

Topiramate. For adults with PTSD there was insufficient evidence to make a recommendation on topiramate.

Ganaxolone. For adults with PTSD there was insufficient evidence to make a recommendation on ganaxolone.

Neurokinin-1 antagonist. For adults with PTSD there was insufficient evidence to make a recommendation on neurokinin-1 antagonist.

### Non-psychological and non-pharmacological interventions for adults with PTSD

**Acupuncture** RESEARCH RECOMMENDATION

For adults with PTSD we recommend offering TF-CBT, PE, CT, CPT or EMDR in preference to acupuncture.

There is emerging evidence for acupuncture and this could be used in a research context.

Remark: Acupuncture involves the insertion of fine needles at specific points on the body (acupressure points) to reduce symptoms of PTSD.

**Mindfulness-based stress reduction (MBSR)** RESEARCH RECOMMENDATION

For adults with PTSD we recommend offering TF-CBT, PE, CT, CPT or EMDR in preference to mindfulness-based stress reduction (MBSR).

There is emerging evidence for MBSR and it could be used in a research context.

Remark: Therapeutic applications of mindfulness are commonly called mindfulness-based interventions (MBIs). The first MBI, Mindfulness-Based Stress Reduction (MBSR), was developed in 1979 by Professor Jon Kabat-Zinn from the University of Massachusetts Medical Centre. The original intent of MBSR was to help outpatients attending a stress reduction clinic to relieve the suffering associated with stress, pain, and illness. Since then, other programs based on the foundational and structural approach of MBSR have been developed. MBSR is a program that uses a variety of techniques to cultivate the state of mindfulness (i.e., nonjudgmental present-moment awareness; Kabat–Zinn, 1994). It is typically delivered in a series of weekly 2.5-hour group meetings in the context of a day-long retreat. Mindfulness training delivered via telehealth (2 sessions in person and 6 by telephone) showed a positive effect for veterans when compared with psychoeducation. This brief treatment was based on MBSR principles but was delivered in individual sessions and did not include the full program.
Neurofeedback  **RESEARCH RECOMMENDATION**

For adults with PTSD we recommend offering TF-CBT, PE, CT, CPT or EMDR in preference to neurofeedback.

There is emerging evidence for neurofeedback and it could be used in a research context.

Remark: Neurofeedback involves real-time displays of brain activity that are used to help individuals train (self-regulate) their brain activity. In neurofeedback training, neural activity is recorded from scalp electrodes and fed back to participants in a readily understood, visual format (such as simple computer games). Neurofeedback training is hypothesised to help individuals with PTSD acquire self-regulation skills by stabilising EEG activity, thereby improving focus and attention.[585]

Physical exercise  **RESEARCH RECOMMENDATION**

For adults with PTSD we recommend offering TF-CBT, PE, CT, CPT or EMDR in preference to physical exercise. There is emerging evidence for physical exercise and it could be used in a research context.

Remark: The physical exercise consisted of a 12-week intervention with a weekly supervised exercise session, two unsupervised home-based exercise sessions, and a walking program facilitated by the provision of a pedometer and exercise diary.[581] In the integrated exercise study, veteran participants attended three one hour group sessions each week for 12 weeks, for a total of 36 sessions.[573] Exercise sessions included aerobic exercise, strength training with weights and resistance bands, and yoga movements and poses presented within a framework of mindfulness principles.

Repetitive Transcranial Magnetic Stimulation (rTMS)  **RESEARCH RECOMMENDATION**

For adults with PTSD we recommend offering TF-CBT, PE, CT, CPT or EMDR in preference to repetitive transcranial magnetic stimulation (rTMS).

There is emerging evidence for rTMS and this could be used in a research context.

Remark: Repetitive TMS (rTMS) is a non-invasive procedure that involves the application of electrical current pulses, induced by a strong pulsating electromagnetic field. Electromagnetic energy passes through the scalp and skull without inducing pain or injury. rTMS aims to stimulate nerve cells in targeted areas of the brain which can lead to an increase or decrease in brain activity in specific regions. It is thought that the dorsolateral prefrontal cortex may be implicated in PTSD symptoms, and that interventions such as rTMS that can target this area of the brain might ameliorate symptoms of PTSD.

Transcendental Meditation (TM)  **RESEARCH RECOMMENDATION**

For adults with PTSD we recommend offering TF-CBT, PE, CT, CPT or EMDR in preference to transcendental meditation (TM).

There is emerging evidence for Transcendental Meditation and this could be used in a research context.

Remark: TM is a specific type of silent meditation developed by Maharishi Mahesh Yogi that involves repetition of a sound (a mantra) to facilitate a settled state of restful alertness. TM differs from mindfulness practice in that mindfulness involves focusing on the present moment in a specifically recommended way, whereas TM is taught as the effortless thinking of a mantra without concentration or contemplation.

Yoga  **RESEARCH RECOMMENDATION**

For adults with PTSD we recommend offering TF-CBT, PE, CT, CPT or EMDR in preference to yoga.

There is emerging evidence for yoga and it could be used in a research context.

Remark: Yoga is a mind-body practice that typically combines physical postures, regulation of the breath, and techniques to cultivate attention. The emphasis on each of these factors varies according to the type of practice. The studies providing evidence for yoga are largely pilot studies. The populations studied include veterans and women, with the types of yoga investigated including Sudarshan Kriya (SKY) yoga,[592][583] Kripalu,[576][580] and trauma-informed yoga.[584]
Mantram repetition For adults with PTSD there was insufficient evidence to make a recommendation on mantram repetition.

Remark: Mantram repetition involves repeating a holy word(s) or phrase(s).

Group music therapy For adults with PTSD there was insufficient evidence to make a recommendation on group music therapy.

Remark: Group music therapy includes a combination of active and receptive musical activities with percussion instruments that emphasizes improvisation. Instrumental support is provided by music therapists.

Nature adventure therapy For adults with PTSD there was insufficient evidence to make a recommendation on nature adventure therapy.

Remark: Nature adventure therapy is a group-based rehabilitation intervention based upon the theoretical framework of experiential learning. It uses activity-based interventions such as sailing, to provide opportunity for personal growth.

Somatic experiencing For adults with PTSD there was insufficient evidence to make a recommendation on somatic experiencing.

Remark: Somatic Experiencing involves a focus on perceived body sensations and to learn how to regulate these with the aim of resolving symptoms.

Saikokaishikankyo For adults with PTSD there was insufficient evidence to make a recommendation on Saikokaishikankyo.

Remark: This is a traditional Japanese herbal medicine.

Attentional bias modification For adults with PTSD there was insufficient evidence to make a recommendation on attentional bias modification.

Remark: ABM is a treatment designed for the management of anxiety disorders based on the finding that patients with anxiety disorders selectively attend to threatening information. It involves computer-based training to keep attention away from threatening information.

Hypnotherapy For adults with PTSD there was insufficient evidence to make a recommendation on hypnotherapy.

Remark: Hypnotherapy uses hypnosis to induce an altered state of consciousness before undertaking therapeutic work.

Electroacupuncture For adults with PTSD there was insufficient evidence to make a recommendation on electroacupuncture.

Remark: Electroacupuncture combines traditional Chinese acupuncture with modern electrotherapy. Acupuncture points are stimulated via needles connected to electrodes that deliver a continuous 100Hz wave.

Stellate Ganglion Block (SGB) For adults with PTSD there was insufficient evidence to make a recommendation on stellate ganglion block (SGB).

Remark: The stellate ganglion is a structure in the sympathetic chain commonly found at the level of the seventh cervical vertebra. Injecting local anesthetic around the stellate ganglion (stellate ganglion block [SGB]) has been shown to inhibit both efferent sympathetic effects and visceral pain fibers to the upper extremity and face. The SGB is now commonly used for the treatment of hypersympathetic activity influencing the upper extremity, such as Raynaud phenomena, or in sympathetically maintained pain as observed in complex regional pain syndrome.

Development of the Guidelines
Introduction (including guidance for use of MAGICApp)

Introduction to the Guidelines

The Guidelines have been designed to be used by: a) the range of general and mental health practitioners planning and providing treatment across clinical settings; b) people affected by trauma making decisions about their treatment; and c) funding bodies making service purchasing decisions. The intended outcome of the Guidelines is increased recognition of ASD, PTSD, and CPTSD, increased uptake of evidence-based care, and ultimately, better outcomes for people affected by trauma.

Importantly, the Guidelines are intended to guide practice rather than be used prescriptively. Each person’s unique circumstances and their overall mental health care needs must be considered. The Guidelines do not substitute for the knowledge and skill of competent individual practitioners and are designed to guide appropriate interventions in the context of each person’s unique circumstances and their overall mental health care needs. Practitioners should be enabled to interpret and implement treatment recommendations in the context of good clinical judgement, not as rigid rules.

The Guidelines were developed by a team of Australia's leading trauma experts, a methodologist, specialist practitioners working with people affected by trauma, and individuals with lived experience of trauma, supported by the Phoenix Australia project team. Recommendations were based on best practice evidence found through a systematic review of the Australian and international trauma literature. The recommendations and evidence are contained in this online platform, while the supporting chapters are available on the Guidelines website.

The supporting chapters are as follows:

Chapter 1 Introduction provides an overview of the Guidelines development process and details their objectives and scope.

Chapter 2 Trauma and Trauma Reactions provides background information on trauma and trauma reactions.

Chapter 3 General Considerations when Working with Children and Adolescents outlines key issues for younger people with PTSD.

Chapter 4 Interventions presents descriptions of all of the interventions in the Guidelines on which strong, conditional, or research recommendations were made.

Chapter 5 Methodology provides an overview of the systematic review of evidence that underpins the Guideline treatment recommendations. In the main, that Chapter is reproduced below in ‘Methodology’.

Chapter 6 Treatment Recommendations presents the Guideline treatment recommendations alongside issues for consideration in implementation.

Chapter 7 Complex PTSD provides a narrative review of the disorder, including a discussion of conceptual, diagnostic, assessment, management and treatment issues.

Chapter 8 Economic Considerations highlights the economic impact of PTSD. PTSD has been found to be associated with greater individual disability than other mental or physical disorders, and have higher healthcare costs than depression and anxiety.

Chapter 9 Specific Populations and Trauma Types provides guidance on issues to be considered when applying the Guidelines to particular populations who develop PTSD following trauma, and to particular trauma types.

The special populations covered in Chapter 9 are:

- Aboriginal and Torres Strait Islander peoples
- Refugees and asylum seekers
- Military and ex-military personnel
- Emergency services personnel
- Older people with PTSD.

The categories of traumatic event covered in the chapter are:

- Motor vehicle accidents
- Crime
- Sexual assault
- Natural disasters
- Terrorism
- Interpersonal violence

Guidance for use of MAGICApp

MagicApp works in ‘layers’, with the first layer outlining the recommendation (and description of the intervention) and the second layer setting out the basis for the recommendation.

Recommendations are made for or against a treatment option, with the strength of the recommendation as strong (clinicians should provide the intervention to all or almost all people in all or almost all circumstances), conditional (clinicians should provide the
intervention to most people, but not all), or as insufficient evidence to make a recommendation. These areas that require further research are noted as research recommendations.

The basis for the recommendation is set out in tabs located under each recommendation. These are as follows:

**Research evidence**: The study details, overall effect estimates and detailed description of the certainty of the evidence criteria ratings for each outcome, that support each recommendation. The Grading of Recommendations, Assessment, Development and Evaluations (GRADE) system was used to assess the certainty of the evidence and inform the recommendation strength. The GRADE rating system is described in Chapter 5 - Methodology.

**Evidence to decision**: Captures key information relating to the benefits and harms of the intervention, certainty of the evidence, values and preferences of the target population, resources and other considerations.

The forest plots for the meta-analysis that inform each comparison, and risk of bias assessments for each included study are linked in the certainty of evidence section of the key info tab.

Where harms have been reported in any study informing a recommendation, these are detailed in the benefits and harms section of the key info tab.

The following cut-offs were used to define clinical importance:

- For interventions delivered within 3 months of exposure to trauma, SMD >0.5 for treatment comparisons and SMD >0.2 for prevention comparisons for continuous outcomes and RR <0.8 or >1.20 for binary outcomes.
- For interventions delivered 3 or more months post-trauma, SMD >0.8 for waitlist comparisons, SMD >0.5 for treatment attention control comparisons, SMD >0.4 for placebo control comparisons and SMD >0.2 for active treatment control comparisons for continuous outcomes and RR <0.65 for binary outcomes.
- For pre-incident preparedness interventions SMD > 0.2

NOTE: where multiple comparisons inform a recommendation, the comparison in which the experimental intervention is compared to waitlist or treatment as usual was considered to be the most critical comparison and the certainty of evidence for this comparison inform the overall GRADE certainty of evidence ratings for the body of evidence in this section. Comparisons of interventions with other treatments were included to inform recommendations.

**Rationale**: Description of how the Guideline Development Group synthesised the above elements with expert opinion and clinical expertise in order to agree upon the the current recommendation direction and strength.

**References**: Provides the full citations for the interactive references used in the meta-analyses used to make each recommendation, and the associated meta-analysis forest plots.

Please note that some tabs, such as Practical Information, and Adaptation, have not been populated.

These Guidelines provide recommendations on the best interventions for children, adolescents and adults who have been exposed to potentially traumatic events as well as those who have developed acute stress disorder (ASD) or posttraumatic stress disorder (PTSD). The Guidelines also recognise the new diagnosis of complex posttraumatic stress disorder (CPTSD) in the World Health Organisation's 11th revision of the International Classification of Diseases (ICD-11). Chapter 7 focuses on this new diagnosis and management and treatment issues.

**Publication Approval**

These guideline recommendations were approved by the Chief Executive Officer of the National Health and Medical Research Council (NHMRC) on 23 June 2020 under Section 14A of the National Health and Medical Research Council Act 1992. In approving the guideline recommendations the NHMRC considers that they meet the NHMRC standard for clinical practice guidelines. This approval is valid for a period of five years.

NHMRC is satisfied that the guideline recommendations are systematically derived, based on identification and synthesis of the best available scientific evidence and are developed for health professionals practising in an Australian health care setting.
This publication reflects the views of the authors and not necessarily the views of the Australian Government.

**Funding**
Phoenix Australia gratefully acknowledges the financial assistance provided by the Australian Government (Departments of Health and Veterans' Affairs). The development of the final recommendations has not been influenced by the views or interests of the funding bodies.

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**Citation**
Children and adolescents pre-incident preparedness

This was included in the systematic review of the literature but no studies were identified.
Children and adolescents within the first three months of exposure to a traumatic event

Early psychosocial prevention interventions for children

“For children and adolescents within the first three months of a traumatic event, do psychosocial interventions when compared to intervention as usual, waiting list or no intervention, result in a clinically important reduction/prevention of symptoms?”

Individual psychological debriefing

<table>
<thead>
<tr>
<th>Conditional recommendation (against)</th>
</tr>
</thead>
<tbody>
<tr>
<td>For children and adolescents within the first three months after trauma exposure, we suggest providing information, emotional support, and practical assistance in preference to individual psychological debriefing.</td>
</tr>
</tbody>
</table>

Psychological debriefing aims to normalise reactions and promote emotional processing of the traumatic event through a structured process. The debriefing interventions are single-session and based on critical incident stress debriefing (CISD); individuals are asked to provide detailed facts about their traumatic experience, their thoughts, reactions and symptoms before being provided with psychoeducation about symptoms and how to deal with them. The terms psychological debriefing and critical incident stress debriefing are often used interchangeably. The former describes a class of interventions delivered shortly following a trauma (usually between 24 and 72 hours) that aim to relieve distress and facilitate a rapid return to normal functioning, thereby mediating or avoiding long-term trauma symptoms. Psychological debriefing operates on the principles of ventilation (an opportunity to talk about the experience), normalisation of distress, and psychoeducation regarding potential symptoms. CISD, on the other hand, is a specific form of debriefing developed in the 1980s. It centres predominantly around group-based interventions for secondary victims such as emergency services personnel, rather than primary victims. While generally group-based, it also advocates individual (or one-on-one) interventions as an acceptable and expected variant. It relies heavily on processes of reconstruction of the traumatic event, ventilation, and normalisation, and includes a structured education component. Over time, CISD has been amalgamated within a framework of self-help activities and structured organisational processes, called critical incident stress management (CISM).

It should be noted that CISD and psychological debriefing differ from operational debriefing, a group process undertaken in high risk industries to review a particular operation or activity. The aim of operational debriefing is to review the events and processes of the operation and to apply the lessons learnt to future events. Operational debriefing is considered good practice in high risk industries as a method of improving service quality and is not a focus of these Guidelines.

Evidence To Decision

**Benefits and harms**

Evidence from 2 RCTs [10][11] suggests that individual psychological debriefing has no clinically important benefit and a trend toward increased PTSD symptom severity in children aged 7-18 who received medical treatment after a motor vehicle accident, relative to neutral discussion or usual care.

**Certainty of the Evidence**

Certainty of the evidence is MODERATE due to serious imprecision (low number of participants).

The evidence analyses and risk of bias assessments for this intervention can be found [here](#).

**Preference and values**

Unfortunately there is no intervention that is supported by the literature on what care should be provided to children and adolescents exposed to a potentially traumatic event. We recognise that parents value quality care for children and will likely seek advice on what they should do in these circumstances. For those parents who seek advice, rather than just advising not to use psychological debriefing, we suggest providing information, emotional support and practical assistance, consistent with the set of interventions collectively referred to as psychological first aid.
We also recognise that some parents will not seek care for children and adolescents exposed to a potentially traumatic event, but will rely on their own resources and natural recovery.

**Rationale**

Individual psychological debriefing has not been found to be effective in preventing PTSD in children and young people aged 7-18 following motor vehicle accident. Further, the evidence suggests that it may cause harm for some (there was a trend toward increased PTSD symptom severity in the treatment group). Although the population was quite specific in these studies, when combined with evidence that psychological debriefing confers no benefit and may cause harm in adults, the Guideline Development Group felt that it was appropriate to suggest that individual psychological debriefing not be provided. Instead, children and adolescents should be offered comfort, information, emotional support and practical assistance.

We also recognise that some parents will not seek care for children and adolescents exposed to a potentially traumatic event, but will rely on their own resources and natural recovery.

**Resources and other considerations**

The content of information provided to assist children following traumatic events, should be of high quality and tailored to the traumatic event type and the target audience. Information given following traumatic events may include: a) information about likely outcomes (most frequently positive); b) reinforcement of existing and new positive coping; c) advice on avenues for seeking further assistance if required; and d) possible indicators of a need for further assistance.

Information following traumatic events may also include a recognition of the role of, and impact on, caregivers, siblings and teachers.

The provision of information, emotional support and practical assistance should be provided in a developmentally appropriate way depending on the age and developmental stage of the child.

This support may require specific resourcing depending on the context of the potentially traumatic event. For example in a disaster setting, significant additional resources may be required whereas in incidents involving a single child or small number of children, this support could reasonably be provided by caregivers, teachers or usual treating practitioners (e.g., family doctor).

Clinicians should be aware of the potential for parents’ own distress or other factors to compromise their capacity to provide a protective/buffering function for the child.

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**Clinical Question/ PICO**

| Population: | Children and adolescents within the first three months post traumatic event |
| Intervention: | Individual psychological debriefing |
| Comparator: | Waitlist/ usual care |

<table>
<thead>
<tr>
<th>Outcome / Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain Text Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity 3 months</td>
<td>Lower better Based on data from: 231 patients in 2 studies. (Randomized controlled)</td>
<td></td>
<td></td>
<td>Moderate Due to serious imprecision</td>
<td>Individual psychological debriefing probably has no effect or may increase PTSD symptom severity slightly</td>
</tr>
</tbody>
</table>

**Plain text summary**

1. **Inconsistency:** No serious. **Indirectness:** No serious. **Imprecision:** Serious. Low number of patients (n=231). Publication
Bias: No serious.

Self-directed online psychoeducation for caregivers and children

**RESEARCH RECOMMENDATION**

For children and adolescents within the first three months after exposure to a potentially traumatic event, we suggest continuation of treatment as usual in preference to self-directed online psychoeducation for caregivers and children.

There is emerging evidence for self-directed online psychoeducation in caregivers and children following traumatic physical injury, and this could be used in a research context.

Psychoeducation provides individuals (in this context, caregivers and/or their children) with information about the reactions that commonly follow a trauma, when those reactions are consistent with a diagnosis of PTSD, and information about what maintains PTSD. The information is aimed at normalising and relieving trauma reactions by providing basic coping and resilience strategies. One study included psychoeducation more broadly with strategies such as (1) promoting adaptive cognitive appraisals, (2) decreasing excessive early avoidance coping, and (3) promoting use of social support. Psychoeducation for caregivers can include information regarding common child reactions to trauma, their likely time course, and how best they can assist their child's emotional recovery (e.g., such as offer their child the opportunity to talk, not avoiding talking about the accident, and encouraging normal routine).

**Evidence To Decision**

**Benefits and harms**

Evidence from a single RCT suggests a clinically important benefit on self-rated PTSD symptom severity at 4-6 weeks post-trauma from a self-administered online psychoeducation intervention for children aged 7-16 who had experienced an unintentional injury and an information booklet for their parents [9].

**Certainty of the Evidence**

The certainty of the evidence is LOW due to serious risk of bias, and serious imprecision

The evidence analyses and risk of bias assessments for this intervention can be found here

**Preference and values**

**Resources and other considerations**

**Rationale**

On the basis of research to date, there is not enough evidence to recommend the use of this self-directed online psychoeducation intervention for children, combined with information for caregivers. The evidence is limited to a single trial in a specific population of children following accidental injury which showed a benefit on PTSD symptom severity. In light of this study's promising findings and the absence of harm to participants, together with the potential reach of online treatment for those who would not otherwise have access to treatment due to geographical or financial barriers, the Guideline Development Group agreed that the intervention warranted further research in a range of child and adolescent trauma populations.
Clinical Question/ PICO

Population: Children and adolescents within the first three months post traumatic event
Intervention: Self-directed online psychoeducation for caregivers and children
Comparator: Waitlist/ usual care

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity 3 months</td>
<td>Lower better Based on data from: 56 patients in 1 studies. (Randomized controlled)</td>
<td>Comparator: Waitlist/ treatment usual care</td>
<td>Intervention: Self-directed online psychoeducation for caregivers and children</td>
<td>Low Due to serious risk of bias, Due to serious imprecision</td>
<td>Self-directed online psychoeducation for caregivers and children may decrease PTSD symptom severity</td>
</tr>
</tbody>
</table>

1. **Risk of Bias**: Serious. Due to significant group differences at baseline, completer analysis. **Inconsistency**: No serious. **Indirectness**: No serious. **Imprecision**: Serious. Low number of patients (n=56), wide confidence intervals (CIs include important benefit and unimportant benefit). **Publication bias**: No serious.

Self-directed online psychoeducation intervention for children only

**RESEARCH RECOMMENDATION**

For children and adolescents within the first three months after exposure to a potentially traumatic event, we suggest continuation of treatment as usual in preference to self-directed online psychoeducation for children.

There is emerging evidence for self-directed online psychoeducation in children following an acute medical event, and this could be used in a research context.

*Psychoeducation provides individuals (in this context, children) with information about the reactions that commonly follow a trauma, when those reactions are consistent with a diagnosis of PTSD, and information about what maintains PTSD. The information is aimed at normalising and relieving trauma reactions by providing basic coping and resilience strategies.*

Evidence To Decision

**Benefits and harms**

Evidence from a single RCT [13] suggests benefit on self-rated PTSD symptom severity from an online game-format intervention “Coping Coach” in children age 8 to 12 years, admitted to hospital for acute medical events.

No harms were reported in this study

**Certainty of the Evidence**

Certainty of the evidence was LOW due to serious risk of bias and serious imprecision.

The evidence analyses and risk of bias assessments for this intervention can be found [here](#).
Rationale

On the basis of research to date, there is not enough evidence to recommend the use of this self-directed online psychoeducation intervention for children. The evidence is limited to a single trial in a specific population of children aged 8-12 years following medical emergency events which showed a benefit on PTSD symptom severity. In light of these promising findings and the absence of harm to participants, together with the potential reach of online treatment for those who would not otherwise have access to treatment due to geographical or financial barriers, the Guideline Development Group agreed that the intervention warranted further research in a range of child trauma populations.

Clinical Question/ PICO

| Population: | Children and adolescents within the first three months post traumatic event |
| Intervention: | Self-directed online psychoeducation intervention for children only |
| Comparator: | Waitlist/ treatment as usual |

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator Waitlist/ treatment as usual</th>
<th>Intervention Self-directed online psychoeducation intervention for children</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better Based on data from: 72 patients in 1 studies. (Randomized controlled)</td>
<td>Difference: SMD 0.63 lower (CI 95% 1.1 lower — 0.15 lower)</td>
<td>Low Due to serious risk of bias, Due to serious imprecision 1</td>
<td>Self-directed online psychoeducation intervention may decrease PTSD symptom severity</td>
<td></td>
</tr>
</tbody>
</table>

1. **Risk of Bias: Serious.** Due to significant group differences at baseline, Incomplete data and/or large loss to follow up (high differential attrition). **Inconsistency: No serious. Indirectness: No serious. Imprecision: Serious.** Low number of patients (n=72), Wide confidence intervals (CIs include important benefit and unimportant benefit). **Publication bias: No serious.**

Psychoeducation

For children and adolescents within the first three months after exposure to a potentially traumatic event, there was insufficient evidence to make a recommendation on psychoeducation as a stand-alone intervention. However, psychoeducation should be routinely provided as part of usual care.

*Psychoeducation provides individuals (in this context, children) with information about the reactions that commonly follow a trauma, when those reactions are consistent with a diagnosis of PTSD, and information about what maintains PTSD. The information is aimed at normalising and relieving trauma reactions by providing basic coping and resilience strategies.*
Self-directed online psychoeducation for caregivers only

For children and adolescents within the first three months after exposure to a potentially traumatic event, there was insufficient evidence to make a recommendation on self-directed online psychoeducation for caregivers only.

Psychoeducation provides individuals with information about the reactions that commonly follow a trauma, when those reactions are consistent with a diagnosis of PTSD, and information about what maintains PTSD. The information is aimed at normalising and relieving trauma reactions by providing basic coping and resilience strategies.

Clinical Question/ PICO

**Population:** Children and adolescents within the first three months post traumatic event  
**Intervention:** Self-directed online psychoeducation for caregivers only  
**Comparator:** Waitlist/ usual care

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity 3 months</td>
<td>Lower better based on data from: 100 patients in 1 studies. (Randomized controlled)</td>
<td>Comparator: Waitlist/ usual care</td>
<td>Intervention: Self-directed online psychoeducation for caregivers only</td>
<td>Certainty: Very low Due to serious risk of bias, Due to very serious imprecision 1</td>
<td>We are uncertain whether self-directed online psychoeducation for caregivers only increases or decreases</td>
</tr>
</tbody>
</table>

1. Risk of Bias: Serious. Incomplete data and/or large loss to follow up, Inadequate concealment of allocation during randomization process, resulting in potential for selection bias, Due to significant group differences at baseline.  
Inconsistency: No serious.  
Indirectness: No serious.  
Imprecision: Very serious. Low number of patients (n=56), Wide confidence intervals (CIs include important benefit and important benefit).  
Publication bias: No serious.
Early psychosocial treatment interventions for children

“For children and adolescents within the first three months of a traumatic event, do psychosocial interventions when compared to intervention as usual, waiting list or no intervention, result in a clinically important reduction/prevention of symptoms?”

**Conditional recommendation**

For children and adolescents within the first three months after trauma exposure where symptoms of PTSD are present, we suggest offering child and family traumatic stress intervention (CFTSI) in preference to supportive counselling.

The Child and Family Traumatic Stress Intervention (CFTSI) is a four-session caregiver-child model designed for early intervention and secondary prevention for children aged 7-17.[19] The CFTSI focuses on two PTSD risk factors of poor social or familial support and poor coping skills and aims to ameliorate these risks by (1) increasing communication between the affected child and their caregivers about feelings, symptoms and behaviors with the goal of increasing the caregivers’ support of the child and (2) providing specific behavioural skills that are taught both to the caregiver and child to assist in coping with symptoms.

Evidence To Decision

**Benefits and harms**

Evidence from a single RCT [19] suggests clinically important benefits of Child and Family Traumatic Stress Intervention (CFTSI) relative to a supportive intervention including psychoeducation and relaxation on reducing self-rated PTSD symptom severity.

No harms were reported in this study.

**Certainty of the Evidence**

1. **Risk of Bias:** Serious. Incomplete data and/or large loss to follow up. **Inconsistency:** No serious. **Indirectness:** No serious. **Imprecision:** Very serious. Low number of patient (n=100), Wide confidence intervals (CI's include important harm and benefit). **Publication bias:** No serious.
Rationale

The Guideline Development Group made a conditional recommendation for the use of CFTSI, in preference to supportive counselling despite low certainty of the evidence. Drawing on their clinical expertise, the group judged the intervention unlikely to pose a risk and likely to provide some clinical benefit for children and adolescents with symptoms of PTSD.

Certainty of the evidence is LOW due to serious risk of bias and serious imprecision

The evidence analyses and risk of bias assessments for this intervention can be found here

Preference and values

Children and their caregivers will likely value information about the intervention, including its aim, content, duration and mode of delivery, expectations during the intervention and that recovery is more likely if the individual stays engaged with treatment.

Resources and other considerations

This approach is not well disseminated and therefore it is not likely to be available widely in Australia. This approach is for school-aged children only.

Clinical Question/ PICO

<table>
<thead>
<tr>
<th>Population</th>
<th>Intervention</th>
<th>Comparator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children and adolescents within the first three months post traumatic event</td>
<td>Child and Family Traumatic Stress Intervention (CFTSI)</td>
<td>Supportive care</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator Supportive care</th>
<th>Intervention Child and Family Traumatic Stress Intervention (CFTSI)</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better Based on data from: 106 patients in 1 studies. (Randomized controlled)</td>
<td></td>
<td></td>
<td>Low Due to serious risk of bias, Due to serious imprecision 1</td>
<td>Child and family traumatic stress intervention (CFTSI) may decrease PTSD symptom severity</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Difference: SMD 0.68 lower ( CI 95% 1.07 lower — 0.29 lower )</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. **Risk of Bias: Serious.** Inadequate/lack of blinding of outcome assessors, resulting in potential for detection bias. **Inconsistency: No serious. Indirectness: No serious. Imprecision: Serious.** Low number of patients (n=106). Wide confidence intervals (CI includes important and unimportant benefit). **Publication bias: No serious.**
Preventative interventions within a stepped care service model

For children and adolescents within the first three months after exposure to a traumatic event where symptoms of PTSD are present, there was insufficient evidence to make a recommendation on preventative interventions within a stepped care service model.

Preventative interventions within a stepped care service model aim to match each child’s needs to appropriate levels of intervention, including psychoeducation for parents. This study evaluated the delivery and effectiveness of a targeted preventive pediatric intervention based on best practice recommendations and integrated within acute medical care.[20]

Clinical Question/ PICO

| Population: | Children and adolescents within the first three months post traumatic event |
| Intervention: | Stepped preventative care intervention |
| Comparator: | Waitlist/ treatment as usual |

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator Waitlist/ treatment as usual</th>
<th>Intervention Stepped preventative care intervention</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity 3 months</td>
<td>Lower better Based on data from: 64 patients in 1 studies. (Randomized controlled)</td>
<td>Difference: SMD 0.34 higher (CI 95% 0.16 lower – 0.84 higher)</td>
<td>Low Due to serious risk of bias, Due to serious imprecision 1</td>
<td>Stepped preventative care intervention may increase PTSD symptom severity slightly</td>
<td></td>
</tr>
</tbody>
</table>

1. Risk of Bias: Serious. Due to significant group differences at baseline (in gender and recent mental health treatment). Inconsistency: No serious. Indirectness: No serious. Imprecision: Serious. Low number of patients (n=64), Wide confidence intervals (CI includes important harm and unimportant benefit). Publication bias: No serious.

Brief trauma-focussed CBT

For children and adolescents within the first three months after exposure to a traumatic event where symptoms of PTSD are present, there was insufficient evidence to make a recommendation on brief trauma-focussed CBT.

Trauma-focussed CBT is intended to help an individual come to terms with trauma through exposure to and emotional processing of memories of the event. This two session model of TF-CBT is delivered to children and caregivers. The intervention includes event reconstruction using drawing and toys, modification of unhelpful appraisals of the event, psychoeducation, and development of individual coping strategies.

Clinical Question/ PICO

| Population: | Children and adolescents within the first three months post traumatic event |
| Intervention: | Brief trauma-focused CBT |
| Comparator: | Waitlist/ treatment as usual |
Narrative Exposure Therapy (NET)

For children and adolescents within the first three months after exposure to a traumatic event where symptoms of PTSD are present, there was insufficient evidence to make a recommendation on Narrative Exposure Therapy (NET).

NET allows PTSD sufferers to describe and develop a coherent, chronological, autobiographical narrative of their life that includes their traumatic experiences (a testimony). The therapist facilitates emotional processing through the use of cognitive-behavioural techniques. A modified version (KidNET) has been developed for children.

Clinical Question/ PICO

**Population:** Children and adolescents within the first three months post traumatic event  
**Intervention:** Trauma-focused CBT (NET)  
**Comparator:** Meditation

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence</th>
<th>Plain text summary</th>
</tr>
</thead>
</table>
| PTSD symptom severity 3 months | Lower better Based on data from: 31 patients in 1 studies. (Randomized controlled) | Meditation | Trauma-focused CBT (NET) | Very low Due to very serious imprecision, Due to serious indirectness | There may be little or no difference between NET and meditation on PTSD symptom severity. 

1. **Risk of Bias:** No serious. Incomplete data and/or large loss to follow up. **Inconsistency:** No serious. **Indirectness:** No serious. **Imprecision:** Very serious. Low number of patients (n= 31), Wide confidence intervals (CIs include important benefit and important harm). **Publication bias:** No serious.
Early pharmacological interventions for children

“For children and adolescents within the first three months of a traumatic event, do pharmacological interventions when compared to placebo result in a clinically important reduction/prevention of symptoms, or presence of disorder?”

Propranolol

For children and adolescents within the first three months after exposure to a traumatic event where symptoms of PTSD are present, there was insufficient evidence to make a recommendation on propranolol.

Evidence To Decision

Preference and values

Resources and other considerations

Clinical Question/ PICO

| Population: | Children and adolescents within the first three months post traumatic event |
| Intervention: | Propranolol |
| Comparator: | Placebo |

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator Placebo</th>
<th>Intervention Propranolol</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity 3 months</td>
<td>Lower better Based on data from: 20 patients in 1 studies. (Randomized controlled)</td>
<td></td>
<td>Difference: SMD 0.04 higher ( CI 95% 0.84 lower — 0.92 higher )</td>
<td>Low Due to very serious imprecision 1</td>
<td>Propranolol may have little or no difference on PTSD symptom severity</td>
</tr>
</tbody>
</table>

1. Inconsistency: No serious. Indirectness: No serious. Imprecision: Very serious. Low number of patients (n= 20), Wide confidence intervals (CIs include important benefit and important harm). Publication bias: No serious.
Children and adolescents with clinically relevant post-traumatic stress symptoms

Psychological interventions for children and adolescents with PTSD

“For children and adolescents with clinically relevant post-traumatic stress symptoms, do psychological treatments when compared to treatment as usual, waiting list or no treatment, result in clinically important reduction/prevention of symptoms?”

Trauma-focussed CBT for child

**Strong recommendation**

For children and adolescents with symptoms of PTSD, we recommend trauma-focussed CBT.

*Trauma-focussed CBT is intended to help an individual come to terms with trauma through exposure to and emotional processing of memories of the event. Trauma-focussed CBT for children is typically delivered by a trained practitioner to children or adolescents over six to 12 sessions, and more if clinically indicated. The intervention should be adapted to the child or young person’s age or development. Trauma-focussed CBT generally includes psychoeducation about reactions to trauma, affect regulation skills, elaboration and processing of the trauma memories, processing of trauma-related emotions (such as shame, guilt, and anger), restructuring of unhelpful trauma-related thoughts and meanings for the individual and strategies to overcome avoidance.*

Evidence To Decision

**Benefits and harms**

Evidence from 15 RCTs [51][52][56][60][61][63][71][74][78][82][83][85][86][88][95][96] suggests large clinically important benefits of CBT-T (child) on PTSD symptomology in children and adolescents relative to waitlist or usual care.

Evidence from 6 RCTs [56][68][69][70][89][90] suggest large clinically important benefits of CBT-T (child) on PTSD symptomology relative to non-directive counselling.

Evidence from a single RCT [80] suggests small clinically important benefits of CBT-T (child) relative to psychoeducation.

Evidence from 2 RCTs [61][73] suggests that EMDR has a greater clinically important benefit on PTSD symptom severity than CBT-T (child).

Moderate quality evidence from 2 RCTs [62][78] suggests that CBT-T for caregiver and child has a slightly greater clinically unimportant benefit on PTSD symptom severity than TF-CBT for child only.

Low quality evidence from a single RCT [62] suggest no difference between CBT-T for caregiver only and CBT-T for child only on PTSD symptom severity.

No harms were reported in these studies

**Certainty of the Evidence**

Overall certainty of the evidence was **MODERATE**

Certainty of evidence for CBT-T (child) vs waitlist/usual care was **MODERATE** due to serious risk of bias

The evidence analyses and risk of bias assessments for this intervention can be found [here](#)

Certainty of evidence for CBT-T (child) vs non-directive counselling was **LOW** due to serious imprecision and serious risk of
Rationale

The Guideline development group considered the evidence that trauma-focussed CBT is effective in reducing PTSD symptom severity in children and adolescents relative to waitlist or treatment as usual and relative to non-directive counselling and psychoeducation. The benefits have been shown in a diverse range of children and adolescents from Western countries as well as China, Jordan, Iran, Thailand, South Africa and Mexico. They also include a broad range of trauma types including incarcerated adolescents, girls in child welfare, girls involved in delinquency, street children in Mexico, Chinese youths who lost parents in an

bias.

The evidence analyses and risk of bias assessments for this intervention can be found here

Certainty of evidence for CBT-T (child) vs psychoeducation was LOW due to serious risk of bias, and serious imprecision.

The evidence analyses and risk of bias assessments for this intervention can be found here

Certainty of evidence for CBT-T (child) vs EMDR was LOW due to serious risk of bias, and serious imprecision.

The evidence analyses and risk of bias assessments for this intervention can be found here

Certainty of evidence for CBT-T (child) vs CBT-T (caregiver and child) was MODERATE due to serious imprecision.

The evidence analyses and risk of bias assessments for this intervention can be found here

Certainty of evidence for CBT-T (child) vs CBT-T (caregiver) was LOW due to very serious imprecision.

The evidence analyses and risk of bias assessments for this intervention can be found here

Preference and values

Most caregivers would choose trauma-focussed CBT for children given the benefits and no reported harms. The treatment should be delivered by appropriately trained and qualified practitioners with ongoing supervision.

Children and their caregivers will likely value information about the intervention, its aim, content, duration and mode of delivery, expectations during the intervention and that recovery is more likely if the child stays engaged with treatment. Children and their caregivers may have various preferences regarding intensity and pace of treatment. Given the concept of the child talking about their trauma is of concern to some parents, an initial parent-only therapy information session is advised. During that session it may be helpful to let the parents know that a temporary increase in symptoms at the commencement of treatment is not uncommon and is not a cause for concern.

Patient preferences - including experience with any previous treatment - should determine the choice between TF-CBT for child and TF-CBT for child and caregiver as both interventions are recommended.

Resources and other considerations

It is important that those delivering TF-CBT for children are appropriately trained with an understanding of child development and family functioning so that the psychotherapy can be delivered in a developmentally sensitive way. Access to specialist service providers with evidence based training is limited in some areas. However, there is high quality online training available for TF-CBT, as well as face-to-face training. Ideally a manualised approach would be used.

Most of the evidence for trauma-focussed CBT comes from children aged over 7 years; delivery of the intervention to children younger than this needs to be adapted to the age and developmental stage of the child.

Rationale

The Guideline development group considered the evidence that trauma-focussed CBT is effective in reducing PTSD symptom severity in children and adolescents relative to waitlist or treatment as usual and relative to non-directive counselling and psychoeducation. The benefits have been shown in a diverse range of children and adolescents from Western countries as well as China, Jordan, Iran, Thailand, South Africa and Mexico. They also include a broad range of trauma types including incarcerated adolescents, girls in child welfare, girls involved in delinquency, street children in Mexico, Chinese youths who lost parents in an
earthquake, survivors of the tsunami in Thailand, sexually abused children and adolescents, war exposed adolescents, former child soldiers, and war-affected Congolese girls. This leads to confidence that the intervention will be helpful in most circumstances.

The Guideline Development Group noted that limited evidence showed no benefit of trauma-focussed CBT relative to EMDR. However, the Group agreed that the breadth and strength of the evidence base for TF-CBT was considerably greater than that of EMDR, and that a strong recommendation for TF-CBT was justified while a conditional recommendation was most appropriate for EMDR at this stage in the absence of adequate evidence scope.

The Guideline Development Group noted the statistically significant but clinically unimportant trend indicating that CBT-T for caregiver and child was more effective than CBT-T for child alone. The Group agreed that as both CBT-T for caregiver and child and CBT-T for child alone had strong evidence for benefits, both forms of the intervention be strongly recommended and the option to include caregivers in treatment should be offered to patients in clinical practice where appropriate based on patient preference and clinicians judgment of the individual cases.

Given the breadth of culture and trauma type represented in the studies, the Guideline Development Group was confident in making a strong recommendation for the use of trauma focussed CBT for children. The group did note, however, the absence of children and adolescents of Aboriginal and Torres Strait Islander background and those from a refugee or asylum seeker background in studies to date. Our confidence in the applicability of the findings to these groups is less certain but in the absence of alternative evidence-based treatments, trauma focussed CBT is still recommended. Research with these populations should be prioritised.

The group also noted that only one study (Scheeringa et al. 2011) included pre-school aged children. In the absence of a strong body of evidence for the treatment of PTSD in pre-school age children specifically, trauma focussed CBT adapted to the developmental stage of the child is still recommended.

**Clinical Question/ PICO**

| Population: | Children and adolescents with clinically relevant post-traumatic stress symptoms |
| Interventions: | Trauma-focused CBT for child |
| Comparator: | Waitlist/ treatment as usual |

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better</td>
<td>Difference: SMD 1.46 lower (CI 95% 1.94 lower – 0.99 lower)</td>
<td>Moderate Due to serious risk of bias</td>
<td>Trauma-focused CBT for child decreases PTSD symptom severity</td>
<td></td>
</tr>
</tbody>
</table>

1. **Risk of Bias**: **Serious**. Inadequate of blinding of participants and personnel, resulting in potential for performance bias in 1 study. Incomplete data and large loss to follow up in 1 study. Inadequate sequence generation/ generation of comparable groups, resulting in potential for selection bias in 1 study. Inadequate concealment of allocation during randomization process, resulting in potential for selection bias in 1 study. **Inconsistency**: **No serious**. The magnitude of statistical heterogeneity was high, with $I^2 = 85\%$ however inconsistency is almost completely between very large, large and moderate effects and is therefore not important. **Indirectness**: **No serious**. **Imprecision**: **No serious**. **Publication bias**: **No serious**.
Clinical Question/ PICO

Population: Children and adolescents with clinically relevant post-traumatic stress symptoms
Intervention: Trauma-focused CBT for child
Comparator: Non-directive counselling

Outcome | Study results and measurements | Comparator | Intervention | Certainty of the Evidence (Quality of evidence) | Plain text summary
--- | --- | --- | --- | --- | ---
PTSD symptom severity | Lower better | Non-directive counselling | Trauma-focused CBT for child | Low | Trauma-focused CBT for child may be more effective than non-directive counselling for decreasing PTSD symptom severity

1. **Risk of Bias: Serious.** Inadequate/lack of blinding of outcome assessors, resulting in potential for detection bias, incomplete data and/or large loss to follow up. **Inconsistency: No serious. Indirectness: No serious. Imprecision: Serious.** Low number of patients (n=239). **Publication bias: No serious.**

Clinical Question/ PICO

Population: Children and adolescents with clinically relevant post-traumatic stress symptoms
Intervention: Trauma-focused CBT for child
Comparator: Psychoeducation

Outcome | Study results and measurements | Comparator | Intervention | Certainty of the Evidence (Quality of evidence) | Plain text summary
--- | --- | --- | --- | --- | ---
PTSD symptom severity | Lower better | Psychoeducation | Trauma-focused CBT for child | Low | Trauma-focused CBT for child may be more effective than psychoeducation in decreasing PTSD symptom severity

1. **Risk of Bias: Serious.** Inadequate/lack of blinding of outcome assessors, resulting in potential for detection bias, incomplete data and large loss to follow up. **Inconsistency: No serious. Indirectness: No serious. Imprecision: Serious.** Low number of patients (n=127). Wide confidence intervals (CI includes important benefit and unimportant benefit).

Clinical Question/ PICO

Population: Children and adolescents with clinically relevant post-traumatic stress symptoms
Intervention: Trauma-focused CBT for child
Comparator: EMDR
1. **Risk of Bias**: Serious. Inadequate concealment of allocation during randomization process, resulting in potential for selection bias. **Inconsistency**: No serious. **Indirectness**: No serious. **Imprecision**: Serious. Low number of patients (n=99), wide confidence intervals (CI includes unimportant benefit and important harm).

**Clinical Question/ PICO**

- **Population**: Children and adolescents with clinically relevant post-traumatic stress symptoms
- **Intervention**: Trauma-focused CBT for caregiver
- **Comparator**: Trauma-focused CBT for child

**Outcome Timeframe** | Study results and measurements | Comparator | Intervention | Certainty of the Evidence | Plain text summary
--- | --- | --- | --- | --- | ---
PTSD symptom severity | Lower better Based on data from: 99 patients in 2 studies. (Randomized controlled) | EMDR | Trauma-focused CBT for child | Low Due to serious risk of bias. Due to serious imprecision 1 | EMDR may be more effective than CBT-T for decreasing PTSD symptom severity

**Plain Text Summary**

- **Difference**: SMD 0.3 higher (CI 95% 0.1 lower — 0.7 higher)
- **Certainty of the Evidence**: Low

PTSD symptom severity

1. **Imprecision**: Very serious. Low number of patients (n=46), wide confidence intervals (CI includes important benefit and important harm).

**Clinical Question/ PICO**

- **Population**: Children and adolescents with clinically relevant post-traumatic stress symptoms
- **Intervention**: Trauma-focused CBT for caregiver and child
- **Comparator**: Trauma-focused CBT for child

**Outcome Timeframe** | Study results and measurements | Comparator | Intervention | Certainty of the Evidence | Plain text summary
--- | --- | --- | --- | --- | ---
PTSD symptom severity | Lower better Based on data from: 46 patients in 1 studies. (Randomized controlled) | Trauma-focused CBT for child | Trauma-focused CBT for caregiver | Low Due to very serious imprecision 1 | There may be little or no difference between CBT-T for caregiver and CBT-T for child for PTSD symptom severity

**Plain Text Summary**

- **Difference**: SMD 0.09 lower (CI 95% 0.49 lower — 0.67 higher)
- **Certainty of the Evidence**: Low

**Moderate**

CBT-T for caregiver and
1. **Inconsistency:** No serious. **Indirectness:** No serious. **Imprecision:** Serious. Low number of patients (n=70), Wide confidence intervals (CIs include important benefit and unimportant harm). **Publication bias:** No serious.

**Trauma-focussed CBT for caregiver and child**

**Strong recommendation**

For children and adolescents with symptoms of PTSD, we recommend trauma-focussed CBT for caregiver and child.

This is a trauma-focussed CBT intervention delivered to the child/adolescent and their caregiver. When possible, parents or caregivers are included throughout treatment to support the child or adolescent's practice and mastery of skills and to enhance positive parenting and parental support.

**Evidence To Decision**

**Benefits and harms**

Evidence from 7 RCTs suggests large clinically important benefit of CBT-T for caregiver and child relative to waitlist or usual care [54][63][62][72][75][78][84][93], and evidence from 4 RCTs suggest a small clinically important benefit relative to non-directive counselling [57][59] and CBT-T for child only [62][78].

Evidence from a single RCT (n=53) suggests no important difference between CBT-T for caregiver and child and stepped care CBT-T for caregiver and child [92].

Evidence from a single RCT (n=48) suggests no important difference between CBT-T for caregiver and child and EMDR [65].

No harms were reported in these studies.

**Certainty of the Evidence**

Overall certainty of the evidence for Trauma-focused CBT for caregiver and child is MODERATE

Certainty for Trauma-focused CBT for caregiver and child vs waitlist/treatment as usual was MODERATE due to serious imprecision.

The evidence analyses and risk of bias assessments for this intervention can be found [here](#).

Certainty for Trauma-focused CBT for caregiver and child vs non-directive counselling was LOW due to serious risk of bias, and serious imprecision.
The Guideline development group considered the evidence that trauma-focused CBT for caregiver and child is effective in reducing PTSD symptom severity in children and adolescents relative to waitlist or treatment as usual, non-directive counselling of TF-CBT for child only. The benefits have been shown in young people with mixed trauma types, including sexual abuse, and have been conducted in both western and non-western countries. This leads to confidence that the intervention will be helpful in most circumstances.

The group did note, however, the absence of children and adolescents of Aboriginal and Torres Strait Islander background and those from a refugee or asylum seeker background in studies to date. Our confidence in the applicability of the findings to these groups is less certain but in the absence of alternative evidence-based treatments, trauma focussed CBT for caregiver and child is still recommended. Research with these populations should be prioritised.

The group also noted that only one study (Salloum et al. 2016) included pre-school aged children. In the absence of a strong evidence base, it is recommended that research with this age group be prioritised.

Certainty for Trauma-focused CBT for caregiver and child vs EMDR was VERY LOW due to serious risk of bias, and very serious imprecision.

Certainty for Trauma-focused CBT for caregiver and child vs Trauma-focused CBT for child was MODERATE due to serious imprecision.

Certainty for Trauma-focused CBT for caregiver and child vs stepped care trauma-focused CBT for caregiver and child was VERY LOW due to serious risk of bias, and very serious imprecision.

Preference and values
Most caregivers would choose trauma-focussed CBT for caregiver and child given the benefits and no reported harms.

Children and their caregivers will likely value information about the intervention, its aim, content, duration and mode of delivery, expectations during the intervention and that recovery is more likely if the child stays engaged with treatment. Children and their caregivers may have various preferences regarding intensity and pace of treatment. Given the concept of the child talking about their trauma is of concern to some parents, an initial parent-only therapy information session is advised. During that session it may be helpful to let the parents know that a temporary increase in symptoms at the commencement of treatment is not uncommon and is not a cause for concern.

Patient preferences - including experience with any previous treatment - should determine the choice between TF-CBT for child and TF-CBT for child and caregiver as both interventions are recommended.

Resources and other considerations
It is important that those delivering TF-CBT for child are appropriately trained with an understanding of child development and family functioning so that the psychotherapy can be delivered in a developmentally sensitive way. Access to specialist service providers with evidence based training is limited in some areas. However, there is high quality online training available for TF-CBT, as well as face-to-face training. Ideally a manualised approach would be used.

Most of the evidence for trauma-focussed CBT comes from children aged over 7 years; delivery of the intervention to children younger than this needs to be adapted to the age and developmental stage of the child.

Rationale
The Guideline development group considered the evidence that trauma focussed CBT for caregiver and child is effective in reducing PTSD symptom severity in children and adolescents relative to waitlist or treatment as usual, non-directive counselling of TF-CBT for child only. The benefits have been shown in young people with mixed trauma types, including sexual abuse, and have been conducted in both western and non-western countries. This leads to confidence that the intervention will be helpful in most circumstances.

The group did note, however, the absence of children and adolescents of Aboriginal and Torres Strait Islander background and those from a refugee or asylum seeker background in studies to date. Our confidence in the applicability of the findings to these groups is less certain but in the absence of alternative evidence-based treatments, trauma focussed CBT for caregiver and child is still recommended. Research with these populations should be prioritised.

The group also noted that only one study (Salloum et al. 2016) included pre-school aged children. In the absence of a strong
body of evidence for the treatment of PTSD in pre-school age children specifically, trauma focussed CBT for caregiver and child, adapted to the developmental stage of the child is still recommended.

The Guideline Development Group noted the statistically significant but clinically unimportant trend indicating that CBT-T for caregiver and child was more effective than CBT-T for child alone. The Group agreed that as both CBT-T for caregiver and child and CBT-T for child alone had strong evidence for benefits, both forms of the intervention be strongly recommended and the option to include caregivers in treatment should be offered to patients in clinical practice where appropriate based on patient preference and clinicians judgment of the individual cases.

### Clinical Question/ PICO

<table>
<thead>
<tr>
<th>Population:</th>
<th>Children and adolescents with clinically relevant post-traumatic stress symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention:</td>
<td>Trauma-focused CBT for caregiver and child</td>
</tr>
<tr>
<td>Comparator:</td>
<td>Waitlist/ treatment as usual</td>
</tr>
</tbody>
</table>

### Outcome

<table>
<thead>
<tr>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better</td>
<td>Trauma-focused CBT for caregiver and child</td>
<td>Moderate Due to serious imprecision</td>
<td>CBT-T for caregiver and child probably decreases PTSD symptom severity</td>
</tr>
</tbody>
</table>

1. **Risk of Bias:** No serious. Inadequate/lack of blinding of outcome assessors, resulting in potential for detection bias in 1 study. Incomplete data and/or large loss to follow up in 2 studies. **Inconsistency:** No serious. The magnitude of statistical heterogeneity was high, with $I^2 = 52\%$ however inconsistency is mostly between studies with very high, high and moderate effects and therefore not important. **Indirectness:** No serious. **Imprecision:** Serious. Wide confidence intervals (CI includes important benefit and unimportant benefit). **Publication bias:** No serious.
1. **Risk of Bias:** Serious. Large loss to follow up, Missing intention-to-treat analysis. **Inconsistency:** No serious. **Indirectness:** No serious. **Imprecision:** Serious. Low number of patients (n=206), Wide confidence intervals (CIs include important benefit and unimportant benefit). **Publication bias:** No serious.

**Clinical Question/ PICO**

**Population:** Children and adolescents with clinically relevant post-traumatic stress symptoms  
**Intervention:** Trauma-focused CBT for caregiver and child  
**Comparator:** EMDR

### Outcome | Study results and measurements | Comparator | Intervention | Certainty of the Evidence | Plain text summary
--- | --- | --- | --- | --- | ---
PTSD symptom severity | Lower better  
Based on data from: 206 patients in 2 studies.  
(Randomized controlled) | Non-directive counselling | Trauma-focused CBT for caregiver and child | Low  
Due to serious risk of bias, Due to serious imprecision | CBT-T for caregiver and child may be more effective than non-directive counselling for decreasing PTSD symptom severity

**Difference:** SMD 0.37 lower  
( CI 95% 0.64 lower — 0.09 lower )

1. **Risk of Bias:** Serious. Due to inconsistencies between protocol and study measures, only 1/3 of enrolment target reached. **Inconsistency:** No serious. **Indirectness:** No serious. **Imprecision:** Very serious. Low number of patients (n=48), Wide confidence intervals (CI includes important benefit and important harm). **Publication bias:** No serious.

**Clinical Question/ PICO**

**Population:** Children and adolescents with clinically relevant post-traumatic stress symptoms  
**Intervention:** Trauma-focused CBT for caregiver and child  
**Comparator:** Trauma-focused CBT for child

### Outcome | Study results and measurements | Comparator | Intervention | Certainty of the Evidence | Plain text summary
--- | --- | --- | --- | --- | ---
PTSD symptom severity | Lower better  
Based on data from: 48 patients in 1 studies.  
(Randomized controlled) | EMDR | Trauma-focused CBT for caregiver and child | Very low  
Due to serious risk of bias, Due to very serious imprecision | We are uncertain if there is any difference between CBT-T for caregiver and child and EMDR in decreasing PTSD symptom severity

**Difference:** SMD 0.05 higher  
( CI 95% 0.52 lower — 0.62 higher )
<table>
<thead>
<tr>
<th>Outcome</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better Based on data from: 70 patients in 2 studies. (Randomized controlled)</td>
<td>Trauma-focused CBT for child</td>
<td>Trauma-focused CBT for caregiver and child</td>
<td>Moderate Due to serious imprecision</td>
<td>CBT-T for caregiver and child is probably more effective than CBT-T for child alone in decreasing PTSD symptom severity</td>
</tr>
</tbody>
</table>

1. **Inconsistency:** No serious. **Indirectness:** No serious. **Imprecision:** Serious. Low number of patients (n=70), Wide confidence intervals (CIs include important benefit and unimportant harm). **Publication bias:** No serious.

**Clinical Question/ PICO**

**Population:** Children and adolescents with clinically relevant post-traumatic stress symptoms  
**Intervention:** Trauma-focused CBT for caregiver and child  
**Comparator:** Stepped care trauma-focused CBT for caregiver and child

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better Based on data from: 53 patients in 1 studies. (Randomized controlled)</td>
<td>Stepped care trauma-focused CBT for caregiver and child</td>
<td>Trauma-focused CBT for caregiver and child</td>
<td>Very low Due to serious risk of bias, Due to very serious imprecision</td>
<td>There may be no difference between CBT-T for caregiver and child and stepped care CBT-T for caregiver and child on PTSD symptom severity</td>
</tr>
</tbody>
</table>

1. **Risk of Bias:** Serious. Due to differences at baseline. **Inconsistency:** No serious. **Indirectness:** No serious. **Imprecision:** Very serious. Low number of patients (n=53), Wide confidence intervals (CIs include important benefit and important harm). **Publication bias:** No serious.
EMDR

Conditional recommendation

For children and adolescents with symptoms of PTSD, we suggest offering eye movement desensitisation and reprocessing (EMDR) where trauma-focused CBT is unavailable or unacceptable.

Eye Movement Desensitisation and Reprocessing (EMDR) was originally developed by Francine Shapiro to treat traumatic memories in adults with PTSD. For use with children, modifications of the EMDR protocol are made to adjust for child age and developmental level. For example, whenever needed, the eye movements can be replaced by tapping and face-figures can be used to assess the child’s emotional state.

EMDR is a standardised, eight-phase, trauma-focused therapy involving the use of bilateral physical stimulation (eye movements, taps, or tones). EMDR is based on the assumption that, during a traumatic event, overwhelming emotions or dissociative processes may interfere with information processing. This leads to the experience being stored in an ‘unprocessed’ way, disconnected from existing memory networks. In EMDR the person is asked to focus on the trauma-related imagery, and the associated thoughts, emotions, and body sensations while bilateral physical stimulation, such as moving their eyes back and forth, occurs. Processing targets may involve past events, present triggers and adaptive future functioning. It is proposed that this dual attention facilitates the processing of the traumatic memory into existing knowledge networks, although the precise mechanism involved is not known.

Evidence To Decision

Benefits and harms

Evidence from 4 RCTs suggests a moderate, clinically unimportant benefit of EMDR for PTSD symptom severity post treatment relative to waitlist or usual care. Two of these studies show strong clinically important benefit ([55][61], n=93). Another study suggests a small unimportant benefit ([50], n=33) and a small study by Soberman 2002 ([97], n=21) suggests very small unimportant harm.

Evidence from 2 RCTs ([61][73], n=99) suggests EMDR to be more beneficial than CBT-T for children for reducing PTSD symptom severity.

Evidence from 1 RCT ([65], n=48) suggests no important difference between EMDR and CBT-T for caregiver and child on PTSD symptom severity.

Certainty of the Evidence

Overall certainty of the evidence was LOW.

Certainty of evidence for EMDR vs waitlist/treatment as usual was LOW due to serious imprecision, and serious inconsistency.

The evidence analyses and risk of bias assessments for this intervention can be found here

Certainty of evidence for EMDR vs trauma-focused CBT for child was LOW due to serious risk of bias, and serious imprecision.

The evidence analyses and risk of bias assessments for this intervention can be found here

Preference and values

Given possible benefits of EMDR on PTSD symptoms in children older than 7 years, caregivers are likely to consider EMDR if their child does not benefit from, or engage with, trauma-focussed CBT or if it is not available.

Children and their caregivers will likely value information about the intervention, including its aim, content, duration and
mode of delivery, expectations during the intervention and that recovery is more likely if the individual stays engaged with treatment. Children and their caregivers may have various preferences regarding intensity and pace of treatment.

Resources and other considerations

Delivery of EMDR is restricted to practitioners who have undertaken accredited training. This may limit the availability of EMDR in the community. The delivery of EMDR should be based on a validated manual (only available for practitioners through EMDR-training) and delivered by practitioners trained to deliver EMDR for PTSD in children. When working with children, EMDR practitioners should also be trained in child development and family functioning in order to deliver the psychotherapy in a developmentally sensitive way.

Rationale

The Guideline Development Group considered the limited evidence and the absence of a clinically important benefit for EMDR for children and adolescents with PTSD relative to usual care. The Guideline Development Group also noted the evidence suggesting a greater benefit from EMDR than TF-CBT on PTSD symptom severity. The Group agreed that in light of the stronger evidence base for TF-CBT, a weaker recommendation for EMDR was warranted. The Guideline Development Group recommends that EMDR be offered when TF-CBT is unavailable or unacceptable.

Clinical Question/ PICO

| Population: | Children and adolescents with clinically relevant post-traumatic stress symptoms |
| Intervention: | Trauma-focused CBT for child |
| Comparator: | EMDR |

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator EMDR</th>
<th>Intervention Trauma-focused CBT for child</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better Based on data from: 99 patients in 2 studies. (Randomized controlled)</td>
<td>Difference: SMD 0.3 higher ( CI 95% 0.1 lower — 0.7 higher )</td>
<td>Low Due to serious risk of bias, Due to serious imprecision</td>
<td>EMDR may be more effective than CBT-T for decreasing PTSD symptom severity</td>
<td></td>
</tr>
</tbody>
</table>

1. Risk of Bias: Serious. Inadequate concealment of allocation during randomization process, resulting in potential for selection bias. Inconsistency: No serious. Indirectness: No serious. Imprecision: Serious. Low number of patients (n=99), Wide confidence intervals (CI includes unimportant benefit and important harm).

Clinical Question/ PICO

| Population: | Children and adolescents with clinically relevant post-traumatic stress symptoms |
| Intervention: | Eye Movement Desensitization and Reprocessing (EMDR) |
| Comparator: | Waitlist/ treatment as usual |
RESEARCH RECOMMENDATION

For children and adolescents with symptoms of PTSD, we suggest doing trauma-focussed CBT in preference to group trauma-focussed CBT for child.

There is emerging evidence for group trauma-focussed CBT for child following exposure to traumatic events, and this could be used in a research context.

This is a CBT intervention with a trauma focus delivered in a group setting. The specific interventions included in the systematic review studies involve six to eight modules delivered by facilitators and include psychoeducation on trauma, dual attention tasks (such as knee tapping while thinking of traumatic events), controlled breathing, progressive muscle relaxation, identifying thoughts and feelings, reframing unhelpful thoughts, graded exposure techniques and trauma processing using artwork or sharing written trauma narratives with the group.

Evidence To Decision

Benefits and harms

Evidence from 2 RCTs [87][98] suggests a large clinically important benefit of Group CBT-T for PTSD symptom severity relative to usual care in children who have been exposed to trauma.

Evidence from a single RCT [86] suggests no important difference between Group CBT-T for child and a group resilience-based intervention (child friendly spaces) in Congolese youth exposed to multiple traumas.

Certainty of the Evidence

Overall certainty of evidence for group trauma-focused CBT for child was LOW.

Certainty of evidence for group trauma-focused CBT for child vs waitlist/treatment as usual was LOW due to serious risk of bias, and serious imprecision.
The evidence analyses and risk of bias assessments for this intervention can be found [here](#).

Certainty of evidence for group trauma-focused CBT for child vs group resilience building intervention was LOW due to very serious imprecision.

The evidence analyses and risk of bias assessments for this intervention can be found [here](#).

### Resources and other considerations

#### Rationale

The results of two randomised controlled trials have shown benefit of group TF-CBT for reducing PTSD symptom severity in children and adolescents with PTSD. There is not enough evidence to recommend this treatment yet but given the promising results and the potential for group based treatment to increase the accessibility of TF-CBT for those who are unable to access individual treatment, the Guideline Development Group considered that further research into group-based TF-CBT for children and adolescents was warranted.

#### Clinical Question/ PICO

| Population: | Children and adolescents with clinically relevant post-traumatic stress symptoms |
| Intervention: | Group trauma-focused CBT for child |
| Comparator: | Waitlist/ treatment as usual |

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better</td>
<td>Waitlist/ treatment as usual</td>
<td>Group trauma-focused CBT for child</td>
<td>Low Due to serious risk of bias, Due to serious imprecision</td>
<td>Group trauma-focused CBT for child probably decreases PTSD symptom severity</td>
</tr>
</tbody>
</table>

1. **Risk of Bias: Serious**, Inadequate/lack of blinding of outcome assessors, resulting in potential for detection bias.
2. **Inconsistency: No serious**, **Indirectness: No serious**, **Imprecision: Serious**, Low number of patients (n=216), Wide confidence intervals (CI includes important benefit and unimportant benefit). **Publication bias: No serious.**
Individual and group trauma-focused CBT for caregiver and child

RESEARCH RECOMMENDATION

For children and adolescents with symptoms of PTSD, we suggest doing trauma-focused CBT in preference to individual and group trauma-focused CBT for caregiver and child.

There is emerging evidence for Individual and group trauma-focused CBT for caregiver and child following exposure to traumatic events, and this could be used in a research context.

A trauma-focused CBT intervention with a combination of group sessions, caregiver education sessions, and individual sessions. Interventions include psychoeducation, relaxation training, cognitive restructuring, social problem solving, and trauma-focused intervention strategies, including graded exposure and trauma processing using narrative techniques.

Evidence To Decision

Benefits and harms

Evidence from a single RCT [79] suggests a large clinically important benefit from an individual and group CBT-T intervention for children in grades 1-5 and caregivers ("Bounce Back program") for reducing PTSD symptom severity in children who have been exposed to trauma.

No harms were reported in this study

Certainty of the Evidence

Certainty of the evidence was MODERATE due to serious imprecision

The evidence analyses and risk of bias assessments for this intervention can be found here

Rationale

The Guideline Development Group noted the large clinically important benefit of a school based individual and group TF-CBT for caregivers and children for PTSD symptom severity. The Group noted the limited evidence base of a single RCT for this
intervention and agreed that there is not yet enough evidence to recommend this intervention but given the promising results and the potential for such an intervention to increase access to care, the Guideline Development Group recommended that further research into a school-based individual and group TF-CBT intervention for caregivers and children is warranted.

Clinical Question/ PICO

**Population:** Children and adolescents with clinically relevant post-traumatic stress symptoms  
**Intervention:** Individual and group trauma-focused CBT for caregiver and child  
**Comparator:** Waitlist/ treatment as usual

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
</table>
| PTSD symptom severity | Lower better  
Based on data from: 71 patients in 1 studies.  
(Randomized controlled) | Waitlist/ treatment as usual | Individual and group trauma-focused CBT for caregiver and child | Moderate  
Due to serious imprecision | Individual and group trauma-focused CBT for caregiver and child probably decreases PTSD symptom severity |

1. **Inconsistency:** No serious.  
**Indirectness:** No serious.  
**Imprecision:** Serious.  
Low number of patients (n=71), Wide confidence intervals (CI's include important benefit and unimportant benefit).  
**Publication bias:** No serious.

Parent-child relationship enhancement (play therapy)

**RESEARCH RECOMMENDATION**

For children and adolescents with symptoms of PTSD we suggest continuation of treatment as usual in preference to parent-child relationship enhancement (play therapy).

There is emerging evidence for parent-child relationship enhancement (play therapy) for children with symptoms with PTSD and this could be used in a research context.

*Child play interventions are guided by the unfolding child–caregiver interactions (if the parent is present in the session) and by the child’s play with developmentally and culturally appropriate toys selected to elicit trauma play or enable children to communicate their thoughts and feelings. Regular child play sessions are interspersed with individual parent sessions.*

**Evidence To Decision**

**Benefits and harms**

Evidence from a single RCT ([81], n=65) suggests a large clinically important benefit of play therapy relative to case management plus individual treatment for parent.  
Evidence from a single small RCT ([94], n=26) showed no important difference between play therapy and CBT-T for caregiver and child.

There were no harms reported in these studies
Certainty of the Evidence

Overall certainty of evidence for parent-child relationship enhancement (play therapy) was MODERATE

Certainty of evidence for parent-child relationship enhancement (play therapy) vs case management plus individual treatment for parent was MODERATE due to serious imprecision.

The evidence analyses and risk of bias assessments for this intervention can be found here

Certainty of evidence for parent-child relationship enhancement (play therapy) vs trauma-focused CBT for caregiver and child was VERY LOW due to serious risk of bias, and very serious imprecision

The evidence analyses and risk of bias assessments for this intervention can be found here

Rationale

The Guideline Development Group noted that two studies showed clinically important benefit of parent-child relationship enhancement (play therapy) for children with symptoms of PTSD, and has no associated harm. The Group noted that the evidence is limited in breadth in terms of the study populations which included refugees and children exposed to marital violence. Although the Guideline Development Group noted that it is widely accepted to be good practice to work with families and children's carers in the context of trauma, the Group recommended that further research with a broader range of trauma types is needed before a stronger recommendation can be made to offer this specific intervention.

Clinical Question/ PICO

| Population: | Children and adolescents with clinically relevant post-traumatic stress symptoms |
| Intervention: | Parent-child relationship enhancement (play therapy) |
| Comparator: | Case management plus individual treatment for parent |

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSTD symptom severity</td>
<td>Lower better Based on data from: 65 patients in 1 studies. (Randomized controlled)</td>
<td>Difference: SMD 0.95 lower ( CI 95% 1.47 lower — 0.44 lower )</td>
<td>Moderate Due to serious imprecision 1</td>
<td>Play therapy probably decreases PSTD symptom severity</td>
<td></td>
</tr>
</tbody>
</table>

1. Inconsistency: No serious. Indirectness: No serious. Imprecision: Serious. Low number of patients (n=65). Publication bias: No serious.
Narrative Exposure Therapy for children (kidNET)

**RESEARCH RECOMMENDATION**

For children and adolescents with symptoms of PTSD we suggest continuation of treatment as usual in preference to narrative exposure therapy for children (kidNET).

There is emerging evidence for kidNET following exposure to traumatic events, and this could be used in a research context.

KidNET is a modified version of narrative exposure therapy (NET) which has been developed for use with children. NET is a standardised short-term intervention adapted from testimony therapy (traditionally used with survivors of torture and civilian casualties of war), as well as from standard exposure approaches. It was originally developed both to treat survivors and to document human rights violations. In NET, the person is asked to develop and describe a narrative of their life from early childhood to present, focussing in detail on the traumatic events and elaborating on the associated thoughts and emotions. It is proposed that NET works in two ways: promoting habituation to traumatic memories through exposure, and reconstructing the individual’s autobiographic memory.

**Evidence To Decision**

**Benefits and harms**

Evidence from 2 RCTs suggests a large, clinically important benefit from kidNET for PTSD symptom severity in former child soldiers [66] and traumatised refugees [91].

Evidence from a single RCT suggests no important difference between kidNET and non-directive counselling for PTSD symptom severity in former child soldiers aged 12-25 years [66].

**Certainty of the Evidence**

Overall certainty of evidence for Narrative Exposure Therapy for children (kidNET) was LOW.

Certainty of evidence for Narrative Exposure Therapy for children (kidNET) vs waitlist/treatment as usual was LOW due to serious imprecision, and serious inconsistency.

The evidence analyses and risk of bias assessments for this intervention can be found [here](#).
Rationale

The Guidelines development group noted large clinically important benefits on PTSD symptom severity in two trials of kidNET - Narrative Exposure Therapy for children. The Group noted the limited breadth of the evidence with studies conducted with refugee children and former child soldiers. The Guideline Development Group agreed that while the results are promising and no harms have been associated with the intervention, there is not yet sufficient evidence to make a treatment recommendation. Given the promising results in these specific trauma populations, the Guideline Development Group recommended that investment in further research is warranted.

Clinical Question/ PICO

| Population: | Children and adolescents with clinically relevant post-traumatic stress symptoms |
| Intervention: | kidNET |
| Comparator: | Waitlist/ treatment as usual |

Outcome Timeframe | Study results and measurements | Comparator Waitlist/ treatment as usual | Intervention kidNET | Certainty of the Evidence (Quality of evidence) | Plain text summary |
<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better Based on data from: 79 patients in 2 studies. (Randomized controlled)</td>
<td>Difference: SMD <strong>1.1 lower</strong> ( CI 95% 2.51 lower — 0.32 higher )</td>
<td></td>
<td>Low Due to serious imprecision. Due to serious inconsistency.</td>
<td>KidNET may improve PTSD symptom severity</td>
</tr>
</tbody>
</table>

1. **Risk of Bias: No serious.** Treatments were carried out by intensively trained local lay counselors. **Inconsistency: Serious.** The magnitude of statistical heterogeneity was high, with $I^2: 85\%$. Some of this may be due to differences at baseline between studies in PTSD severity, mean age and suicide ideation. **Indirectness: No serious. Imprecision: Serious.** Low number of patients ($n=79$), Wide confidence intervals (CI includes important benefit and unimportant harm). **Publication bias: No serious.**
For children and adolescents with symptoms of PTSD there was insufficient evidence to make a recommendation on trauma-focussed CBT for caregiver.

Trauma-focused CBT for caregiver

For children and adolescents with symptoms of PTSD there was insufficient evidence to make a recommendation on trauma-focussed CBT for caregiver.

**Clinical Question/ PICO**

**Population:** Children and adolescents with clinically relevant post-traumatic stress symptoms  
**Intervention:** Trauma-focused CBT for caregiver  
**Comparator:** Waitlist/ treatment as usual

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better</td>
<td>KidNET</td>
<td>Trauma-focused CBT for caregiver</td>
<td>Low</td>
<td>Due to very serious imprecision ¹</td>
</tr>
<tr>
<td></td>
<td>Based on data from: 50 patients in 1 studies. (Randomized controlled)</td>
<td></td>
<td>Difference: SMD 0.16 lower ( CI 95% 0.72 lower — 0.4 higher )</td>
<td></td>
<td>There is probably little or no difference between the effectiveness of kidNET and Non-directive counselling on PTSD symptom severity</td>
</tr>
</tbody>
</table>

1. **Imprecision:** Very serious. Low number of patients (n=44), Wide confidence intervals (CI includes important benefit and no effect).
Clinical Question/ PICO

**Population:** Children and adolescents with clinically relevant post-traumatic stress symptoms

**Intervention:** Trauma-focused CBT for caregiver

**Comparator:** Trauma-focused CBT for child

### PTSD symptom severity

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better Based on data from: 44 patients in 1 studies. (Randomized controlled)</td>
<td>Trauma-focused CBT for child</td>
<td>Trauma-focused CBT for caregiver</td>
<td>Low</td>
<td>Trauma-focused CBT for caregiver and child may be more beneficial than CBT-T for caregiver only for PTSD symptom severity</td>
</tr>
</tbody>
</table>

1. **Imprecision:** Very serious. Low number of patients (n=44), Wide confidence intervals (CI includes unimportant harm and important harm).

### Group trauma-focussed CBT for caregiver and child

For children and adolescents with symptoms of PTSD there was insufficient evidence to make a recommendation on group trauma-focussed CBT for caregiver and child.

#### Clinical Question/ PICO

**Population:** Children and adolescents with clinically relevant post-traumatic stress symptoms
Non-directive counselling

For children and adolescents with symptoms of PTSD there was insufficient evidence to make a recommendation on non-directive counselling.

Non-directive counselling involves active, empathic listening to the patient who is usually provided with unconditional positive regard. The therapist helps the patient to explore and clarify issues, may provide advice, reflect and confirm appropriate reactions, and introduce problem-solving techniques.

Clinical Question/ PICO

| Population: | Children and adolescents with clinically relevant post-traumatic stress symptoms |
| Intervention: | Non-directive counselling |
| Comparator: | Waitlist/ treatment as usual |

### Outcome Timeframe

<table>
<thead>
<tr>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better Based on data from: 74 patients in 2 studies. (Randomized controlled)</td>
<td>Difference: SMD 0.29 lower ( CI 95% 0.75 lower — 0.18 higher )</td>
<td>Moderate Due to serious imprecision ¹</td>
<td>Non-directive counseling probably decreases PTSD symptom severity slightly</td>
</tr>
</tbody>
</table>

#### Risk of Bias

1. Risk of Bias: No serious. Treatments were carried out by intensively trained local lay counselors; . Inconsistency: No serious. Indirectness: No serious. Imprecision: Serious. Low number of patients (n=74). Publication bias: No serious.
Group psychoeducation

For children and adolescents with symptoms of PTSD there was insufficient evidence to make a recommendation on group psychoeducation.

*Group Psychoeducation provides individuals with information about traumatic stress reactions, PTSD and how to manage them in a group format.*

Clinical Question/ PICO

**Population:** Children and adolescents with clinically relevant post-traumatic stress symptoms  
**Intervention:** Group psychoeducation  
**Comparator:** Waitlist/treatment as usual

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator Waitlist/treatment as usual</th>
<th>Intervention Group psychoeducation</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
</table>
| PTSD symptom severity | Lower better  
Based on data from: 166 patients in 1 studies.  
(Randomized controlled) | Difference: SMD 1.3 lower  
( CI 95% 1.64 lower — 0.96 lower ) | | Very low  
Due to serious imprecision, Due to serious risk of bias, Due to serious indirectness | We are uncertain whether group psychoeducation increases or decreases PTSD symptom severity |

1. **Risk of Bias:** Serious, due to local volunteers conducted data collection.  
   **Inconsistency:** No serious.  
   **Indirectness:** Serious.  
   Differences between the population of interest and those studied; Children exposed to 2004 Sri Lankan tsunami.  
   **Imprecision:** Serious. Low number of patients (n=166).  
   **Publication bias:** No serious.

Family therapy

For children and adolescents with symptoms of PTSD there was insufficient evidence to make a recommendation on family therapy.

Clinical Question/ PICO

**Population:** Children and adolescents with clinically relevant post-traumatic stress symptoms  
**Intervention:** Family therapy  
**Comparator:** Waitlist/treatment as usual

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator Waitlist/treatment as usual</th>
<th>Intervention Family therapy</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom</td>
<td>Low</td>
<td></td>
<td></td>
<td>Family therapy may</td>
<td></td>
</tr>
</tbody>
</table>

Australian Guidelines for the Prevention and Treatment of Acute Stress Disorder, Posttraumatic Stress Disorder, and Complex Posttraumatic Stress
Pharmacological interventions for children and adolescents with PTSD

“For children and adolescents with clinically relevant post-traumatic stress symptoms, do pharmacological treatments when compared to placebo, result in clinically important reduction/prevention of symptoms?”

Note: There is further discussion of pharmacological treatments for children in the ‘Pharmacotherapy for children and adolescents’ section in Chapter 7 (Treatment recommendations) of the supporting chapters (hyperlink to be inserted once Guideline approved by NHMRC).

Sertraline

For children and adolescents with symptoms of PTSD there was insufficient evidence to make a recommendation on sertraline.

Sertraline, sold in Australia under the trade name Zoloft, is an antidepressant from the class of selective serotonin reuptake inhibitors (SSRIs).

Clinical Question/ PICO

Population: Children and adolescents with clinically relevant post-traumatic stress symptoms

Intervention: Sertraline

Comparator: Placebo

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator Placebo</th>
<th>Intervention Sertraline</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>severity</td>
<td>Lower better</td>
<td></td>
<td></td>
<td>Due to serious risk of bias, Due to serious imprecision</td>
<td>decrease PTSD symptom severity slightly</td>
</tr>
</tbody>
</table>

Sertraline may increase PTSD symptom severity slightly

1. Risk of Bias: Serious. Incomplete data and/or large loss to follow up- Higher attrition in intervention and 7.5% of sertraline arm discontinued due to adverse events. Trial was stopped for futility. Inconsistency: No serious. Indirectness: No serious. Imprecision: Serious. Low number of patients (n=129).
Non-psychological and non-pharmacological treatments/interventions for children with PTSD

“For children and adolescents with clinically relevant post-traumatic stress symptoms, do non-psychological and non-pharmacological treatments/interventions when compared to treatment as usual, waiting list or no treatment, result in clinically important reduction/prevention of symptoms?”

Mind-body skills group

RESEARCH RECOMMENDATION

For children and adolescents with symptoms of PTSD we suggest continuation of treatment as usual in preference to mind-body skills group.

There is emerging evidence for mind-body skills group in refugee populations exposed to war-related traumatic events, and it could be used in a research context.

“Mind-body” techniques used in the studies in the systematic review include guided imagery, relaxation techniques, meditation, autogenic training, and biofeedback. In addition to these modalities, a variety of forms of self-expression may be offered, such as art therapy and written exercises. In refugee populations exposed to war-related traumatic events there is emerging evidence for the delivery of these mind-body techniques in small groups.

Evidence To Decision

Benefits and harms

Evidence from a single RCT [103] suggests large clinically important benefit of Mind body skills group in 14-18 year old Kosovar adolescents who witnessed war, on self-rated PTSD symptom severity relative to waitlist.

Certainty of the Evidence

The certainty in the evidence is LOW due to serious imprecision and serious risk of bias.

The evidence analyses and risk of bias assessments for this intervention can be found here

Rationale

The Guideline Development Group noted the large clinically important benefit of a mind-body skills group intervention on PTSD symptom severity in adolescents with PTSD following exposure to the war in Kosovo. The group noted that while results suggest a large benefit and no harms, they are based on a single RCT and, as such, it would be premature to make a treatment recommendation. Given the promising results in this specific trauma population, the Guideline Development Group recommended that further research is warranted.

Clinical Question/ PICO

Population: Children and adolescents with clinically relevant post-traumatic stress symptoms
### Trauma-focussed expressive art therapy

For children and adolescents with symptoms of PTSD there was insufficient evidence to make a recommendation on trauma-focussed expressive art therapy.

**Clinical Question/ PICO**

- **Population:** Children and adolescents with clinically relevant post-traumatic stress symptoms
- **Intervention:** Trauma-focused expressive art therapy
- **Comparator:** Waitlist/ treatment as usual

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Based on data from: 29 patients in 1 studies. (Randomized controlled)</td>
<td>Comparator: Waitlist/ treatment as usual</td>
<td>Intervention: Trauma-focused expressive art therapy</td>
<td>Low</td>
<td>Trauma-focused expressive art therapy may decrease PTSD symptom severity</td>
</tr>
</tbody>
</table>

1. **Risk of Bias:** Serious. Inadequate/lack of blinding of participants and personnel, resulting in potential for performance bias. **Inconsistency:** No serious. **Indirectness:** No serious. **Imprecision:** Serious. Low number of patients (n=77). **Publication bias:** No serious.

**PTSD symptom severity**

- **Comparator:** Waitlist/ treatment as usual
- **Intervention:** Trauma-focused expressive art therapy
- **Certainty of the Evidence:** Low
- **Imprecision:** Due to serious risk of bias, Due to serious imprecision

**Difference:** SMD 1.52 lower (CI 95% 2.03 lower — 1.01 lower)

**Mind-body skills group may decrease PTSD symptom severity**

1. **Inconsistency:** No serious. **Indirectness:** No serious. **Imprecision:** Very serious. Low number of patients (n=29), Wide confidence intervals (CI includes important benefit and unimportant benefit). **Publication bias:** No serious.
Adults pre-incident preparedness
Attention bias modification training (ABMT)

**RESEARCH RECOMMENDATION**

For adults who are likely to be exposed to trauma, we suggest usual practice in preference to pre-incident attention bias modification training (ABMT).

There is emerging evidence for pre-incident ABMT in military populations and this could be used in a research context.

Attention bias modification training (ABMT) involves the delivery of brief (approximately 20 minute), computerised tasks. Attentional avoidance of negative information is encouraged through use of a modified dot-probe task where probes always appear in the location opposite negative stimuli. This procedure is designed to 'train' an individual’s attention away from or toward negative or threatening information. The immediate effects of ABMT appear to be most prominent when applied prior to exposure to a potentially traumatic event. ABMT has been delivered to soldiers immediately prior to combat deployment in order to attenuate the association between combat exposure and PTSD-related symptoms.

**Evidence To Decision**

**Benefits and harms**

Evidence from a single RCT suggests clinically important benefit of 4 sessions of predeployment ABMT relative to no training control on PTSD diagnosis in Israeli soldiers, and a clinically unimportant benefit on PTSD symptom severity [125].

Evidence suggests a clinically important benefit of 4 sessions of ABMT on PTSD diagnosis relative to attention control training (ACT) [125] but no difference in effect on PTSD symptom severity between ABMT and ACT after either a single session [126] or 4 sessions [125].

**Certainty of the Evidence**

Overall certainty of evidence for Attention bias modification training (ABMT) was LOW for PTSD diagnosis, and MODERATE for PTSD symptom severity.

Certainty of evidence for Attention bias modification training (ABMT) vs no training control was LOW due to very serious imprecision for PTSD diagnosis, and MODERATE due to serious imprecision for PTSD symptom severity.

The evidence analyses and risk of bias assessments for this intervention can be found here for PTSD diagnosis, and here for PTSD symptom severity.

Certainty of evidence for Attention bias modification training (ABMT) vs Attention Control Training (ACT) was LOW due to very serious imprecision for PTSD diagnosis, and LOW due to very serious imprecision for PTSD symptom severity.

The evidence analyses and risk of bias assessments for this intervention can be found here for PTSD diagnosis, and here for PTSD symptom severity.

Certainty of evidence for Single session Attention bias modification training (ABMT) vs Attention Control Training (ACT) was LOW due to serious imprecision, and serious risk of bias for PTSD symptom severity.

The evidence analyses and risk of bias assessments for this intervention can be found here.

**Rationale**

The Guideline Development Group noted the reduced risk of developing PTSD in Israeli soldiers delivered four 10-minute sessions of Attention Bias Modification Training (ABMT) prior to combat exposure. The group recommended that while this is a potentially very important finding, given limited evidence in general for pre-incident preparedness and the very specific context of the single available study, further research is needed before a recommendation in favour of the intervention can be made.
Clinical Question/ PICO

Population: Adults
Intervention: Attention bias modification training (ABMT)
Comparator: No training control

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD diagnosis</td>
<td>Relative risk 0.32 (CI 95% 0.1 — 0.97) Based on data from 360 patients in 1 studies. (Randomized controlled)</td>
<td>No training control</td>
<td>Attention bias modification training (ABMT) 68 per 1000 22 per 1000 Difference: 46 fewer per 1000 (CI 95% 61 fewer — 2 fewer)</td>
<td>Low Due to very serious imprecision ¹</td>
<td>Attention bias modification may decrease PTSD diagnosis</td>
</tr>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better Based on data from: 308 patients in 1 studies. (Randomized controlled)</td>
<td></td>
<td></td>
<td>Moderate Due to serious imprecision ²</td>
<td>Attention bias modification probably has little or no difference on PTSD symptom severity</td>
</tr>
</tbody>
</table>

1. **Inconsistency:** No serious. **Indirectness:** No serious. **Imprecision:** Very serious. Low number of patients, Wide confidence intervals. **Publication bias:** No serious.
2. **Inconsistency:** No serious. **Indirectness:** No serious. **Imprecision:** Serious. Only data from one study. **Publication bias:** No serious.

Clinical Question/ PICO

Population: Adults
Intervention: Attention bias modification training (ABMT)
Comparator: Attention Control Training (ACT)

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD diagnosis</td>
<td>Relative risk 0.56 (CI 95% 0.17 — 1.88) Based on data from 364 patients in 1 studies. (Randomized controlled)</td>
<td>Attention Control Training (ACT) 39 per 1000</td>
<td>Attention bias modification training (ABMT) 22 per 1000 Difference: 17 fewer per 1000 (CI 95% 32 fewer — 34 more)</td>
<td>Low Due to very serious imprecision ¹</td>
<td>Attention bias modification (ABMT) may be more effective than ACT in decreasing PTSD diagnosis</td>
</tr>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better</td>
<td></td>
<td></td>
<td>Low Due to very</td>
<td>There may be little or no difference between</td>
</tr>
</tbody>
</table>

Difference: SMD 0.15 lower (CI 95% 0.37 lower — 0.08 higher)
Attention control training

**Clinical Question/ PICO**

**Population:** Adults  
**Intervention:** Single session Attention Bias Modification Training (ABMT)  
**Comparator:** Attention Control Training (ACT)

**Outcome Timeframe** | **Study results and measurements** | **Comparator Attention Control Training (ACT)** | **Intervention Attention bias modification (ABMT)** | **Certainty of the Evidence (Quality of evidence)** | **Plain text summary**  
--- | --- | --- | --- | --- | ---  
PTSD symptom severity | Lower better  
Based on data from: 99 patients in 1 studies.  
(Randomized controlled) | Difference: **SMD 0.19 higher**  
( CI 95% 0.2 lower — 0.59 higher ) | Low  
Due to serious imprecision, Due to serious risk of bias  
1 | There may be little or no difference between single session ABMT and ACT on PTSD symptom severity

1. **Risk of Bias:** Serious. Incomplete data and/or large loss to follow up, no. of participant randomised to each arm not reported. Inconsistency: No serious. Indirectness: No serious. Imprecision: Serious. Only data from one study. Publication bias: No serious.

**Attention control training**

**RESEARCH RECOMMENDATION**

For adults who are likely to be exposed to trauma, we suggest usual practice in preference to preincident attention control training.

There is emerging evidence for preincident attention control training and this could be used in a research context.

Attention control training uses the same format as ABMT but presents equal numbers of targets in the locations of threat and neutral attention stimuli (such as words). It is not designed to shift attention patterns (to favour neutral or threat stimuli) but rather to balance attention between neutral and threat stimuli.
Evidence To Decision

Benefits and harms
Evidence from a single RCT [125] suggests clinical important benefit of 4 sessions of predeployment attention control training for Israeli soldiers relative to no training on PTSD diagnosis and clinically unimportant benefit on PTSD symptom severity.

Evidence suggests attention control training is not as effective as ABMT on PTSD diagnosis [125] and suggests no difference in effect on PTSD symptom severity between ABMT and attention control training after either a single session [126] or 4 sessions [125].

Certainty of the Evidence
Overall certainty of evidence for Attention control training was LOW for PTSD diagnosis, and MODERATE for PTSD symptom severity.

Certainty of evidence for Attention control training vs no training control was LOW due to very serious imprecision for PTSD diagnosis, and MODERATE due to serious imprecision for PTSD symptom severity.

The evidence analyses and risk of bias assessments for this intervention can be found here for PTSD diagnosis, and here for PTSD symptom severity.

Certainty of evidence for Attention control training vs Attention bias modification Training (AMBT) was LOW due to very serious imprecision for PTSD diagnosis, and LOW due to very serious imprecision for PTSD symptom severity.

The evidence analyses and risk of bias assessments for this intervention can be found here for PTSD diagnosis, and here for PTSD symptom severity.

Certainty of evidence for Attention control training vs Single session Attention Bias Modification Training (ABMT) was LOW due to serious imprecision, and serious risk of bias for PTSD symptom severity.

The evidence analyses and risk of bias assessments for this intervention can be found here.

Rationale
The Guideline Development Group noted the reduced risk of developing PTSD in Israeli soldiers delivered four 10-minute sessions of Attention Control Training prior to combat exposure, albeit with lower clinical effect than Attention Bias Modification Training (ABMT). The group recommended that while this is a potentially very important finding, given limited evidence in general for pre-incident preparedness and the very specific context of the single available study, further research is needed before a recommendation in favour of the intervention can be made.

Clinical Question/ PICO

<table>
<thead>
<tr>
<th>Population:</th>
<th>Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention:</td>
<td>Attention bias modification training (ABMT)</td>
</tr>
<tr>
<td>Comparator:</td>
<td>Attention Control Training (ACT)</td>
</tr>
</tbody>
</table>
### PTSD diagnosis

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Attention Control Training (ACT)</td>
<td>Attention bias modification (ABMT)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PTSD diagnosis</td>
<td>Relative risk 0.56 (CI 95% 0.17 — 1.88) Based on data from 364 patients in 1 studies. (Randomized controlled)</td>
<td>39 per 1000</td>
<td>22 per 1000</td>
<td>Low Due to very serious imprecision</td>
<td>Attention bias modification (ABMT) may be more effective than ACT in decreasing PTSD diagnosis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Difference: <strong>17 fewer</strong> per 1000 (CI 95% 32 fewer — 34 more)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better Based on data from: 297 patients in 1 studies. (Randomized controlled)</td>
<td>Difference: <strong>SMD 0.02 higher</strong> (CI 95% 0.21 lower — 0.25 higher)</td>
<td></td>
<td></td>
<td>There may be little or no difference between Attention bias modification and Attention control training on PTSD symptom severity</td>
</tr>
</tbody>
</table>

1. **Inconsistency:** No serious. **Indirectness:** No serious. **Imprecision:** Very serious. Wide confidence intervals, Low number of patients. **Publication bias:** No serious.

2. **Inconsistency:** No serious. **Indirectness:** No serious. **Imprecision:** Very serious. Low number of patients, Wide confidence intervals. **Publication bias:** No serious.

---

### Clinical Question/ PICO

**Population:** Adults  
**Intervention:** Attention Control Training (ACT)  
**Comparator:** No training control

### PTSD diagnosis

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>No training control</td>
<td>Attention Control Training (ACT)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PTSD diagnosis</td>
<td>Relative risk 0.57 (CI 95% 0.23 — 1.42) Based on data from 356 patients in 1 studies. (Randomized controlled)</td>
<td>68 per 1000</td>
<td>39 per 1000</td>
<td>Low Due to very serious imprecision</td>
<td>Attention control training (ACT) may decrease PTSD diagnosis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Difference: <strong>29 fewer</strong> per 1000 (CI 95% 52 fewer — 29 more)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better Based on data from: 297 patients in 1 studies. (Randomized controlled)</td>
<td>Difference: <strong>SMD 0.16 lower</strong> (CI 95% 0.39 lower — 0.07 higher)</td>
<td></td>
<td></td>
<td>There is probably little or no difference between Attention control training and no training control on PTSD symptom severity</td>
</tr>
</tbody>
</table>

1. **Inconsistency:** No serious. **Indirectness:** No serious. **Imprecision:** Very serious. Wide confidence intervals, Low number of patients. **Publication bias:** No serious.

2. **Inconsistency:** No serious. **Indirectness:** No serious. **Imprecision:** Serious. Low number of patients. **Publication bias:** No serious.
### Clinical Question/ PICO

<table>
<thead>
<tr>
<th>Population</th>
<th>Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention</td>
<td>Single session Attention Bias Modification Training (ABMT)</td>
</tr>
<tr>
<td>Comparator</td>
<td>Attention Control Training (ACT)</td>
</tr>
</tbody>
</table>

### Outcome Table

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator Attention Control Training (ACT)</th>
<th>Intervention Single session Attention Bias Modification Training (ABMT)</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better Based on data from: 99 patients in 1 studies. (Randomized controlled)</td>
<td>Difference: SMD 0.19 higher ( CI 95% 0.2 lower — 0.59 higher )</td>
<td>Low Due to serious imprecision, Due to serious risk of bias ¹</td>
<td>There may be little or no difference between single session ABMT and ACT on PTSD symptom severity</td>
<td></td>
</tr>
</tbody>
</table>

1. **Risk of Bias:** Serious. Incomplete data and/or large loss to follow up, no. of participant randomised to each arm not reported. **Inconsistency:** No serious. **Indirectness:** No serious. **Imprecision:** Serious. Only data from one study. **Publication bias:** No serious.

### Heart rate variability biofeedback (HRVB)

#### RESEARCH RECOMMENDATION

For adults who are likely to be exposed to trauma, we suggest usual practice in preference to heart rate variability biofeedback (HRVB).

There is emerging evidence for heart rate variability biofeedback (HRVB) and this could be used in a research context.

**Heart rate variability biofeedback (HRVB) is a form of cardiorespiratory intervention that consists of feeding back beat-by-beat heart rate data to the participant who tries to maximise respiratory sinus arrhythmia (RSA). RSA is the heart pattern that occurs when heart rate increases during inhalation and decreases during exhalation.**

*This intervention has been tested in the context of pre-combat deployment in order to prevent subsequent PTSD.*

### Evidence To Decision

#### Benefits and harms

Evidence from a single RCT of U.S. soldiers suggest clinically important benefit of HRVB on PTSD diagnosis, and clinically important benefit on PTSD symptom severity, relative to controls who received no extra training [123].

Evidence from this study suggests clinically important benefit of HRVB relative to cognitive bias modification for interpretation (CBM-I) on PTSD diagnosis and no important difference in PTSD symptom severity.

#### Certainty of the Evidence

Certainty of evidence for heart rate variability biofeedback vs control was LOW for PTSD symptom severity due to serious risk of bias and serious imprecision, and VERY LOW for PTSD diagnosis due to serious risk of bias and very serious imprecision.
The evidence analyses and risk of bias assessments for this intervention can be found here for PTSD diagnosis, and here for PTSD symptom severity.

Certainty of evidence for heart rate variability biofeedback vs Cognitive bias modification for interpretation was LOW for PTSD symptom severity due to serious risk of bias and serious imprecision, and LOW for PTSD diagnosis due to serious risk of bias and serious imprecision.

The evidence analyses and risk of bias assessments for this intervention can be found here for PTSD diagnosis, and here for PTSD symptom severity.

Resources and other considerations

Soldiers in this study reported multiple challenges related to iPod use in a combat zone. Restrictions on iPod use in deployment settings may limit feasibility of this intervention.

Rationale

The Guideline Development Group noted that a single RCT has examined the effectiveness of heart rate variability biofeedback (HRVB) as a PTSD preventative intervention delivered to US soldiers pre-deployment. The Group noted that while the study found no clinically important benefit overall, it was found to benefit the subgroup of older soldiers. As the intervention was found to be acceptable and feasible pre-deployment, and conferred benefit on a subgroup of participants, the Guideline Development Group recommended that further research is undertaken.

Clinical Question/ PICO

| Population: | Adults |
| Intervention: | Heart rate variability biofeedback (HRVB) |
| Comparator: | Control |

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator Control</th>
<th>Intervention Heart rate variability biofeedback (HRVB)</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD diagnosis</td>
<td></td>
<td>Relative risk 0.33 (CI 95% 0.07 — 1.47) Based on data from 227 patients in 1 studies. (Randomized controlled)</td>
<td></td>
<td>67 per 1000</td>
<td>Very low Due to serious risk of bias, Due to very serious imprecision 1</td>
<td>We are uncertain whether heart rate variability biofeedback (HRVB) increases or decreases PTSD diagnosis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Difference: 45 fewer per 1000 ( CI 95% 62 fewer — 31 more )</td>
<td></td>
<td>22 per 1000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PTSD symptom severity</td>
<td></td>
<td>Lower better Based on data from: 227 patients in 1 studies. (Randomized controlled)</td>
<td></td>
<td>Difference: SMD 0.23 lower ( CI 95% 0.49 lower — 0.04 higher )</td>
<td>Low Due to serious imprecision, Due to serious risk of bias 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Heart rate variability biofeedback (HRVB) may decrease PTSD symptom severity</td>
<td></td>
</tr>
</tbody>
</table>

1. Risk of Bias: Serious. Incomplete data and/or large loss to follow up, due to differences at baseline, issues with iPad use, adherence not monitored, Incomplete data and/or large loss to follow up. Inconsistency: No serious. Indirectness: No serious.
Imprecision: Very serious. Wide confidence intervals (CI includes important benefit and important harm), Low number of events (11). Publication bias: No serious.

2. Risk of Bias: Serious. Incomplete data and/or large loss to follow up, due to differences at baseline, issues with iPad use, adherence not monitored, Incomplete data and/or large loss to follow up. Inconsistency: No serious. Indirectness: No serious. Imprecision: Serious. Low number of patients (n=227), Wide confidence intervals (CI includes important benefit and unimportant harm). Publication bias: No serious.

Mental Agility and Psychological Strength (MAPS) resilience training

For adults who are likely to be exposed to trauma, there was insufficient evidence to make a recommendation on MAPS resilience training.

The Mental Agility and Psychological Strength (MAPS) training program aims to build knowledge and practical skills for psychological wellbeing and PTSD. It includes cognitive re-structuring, support seeking, and self-soothing or self-moderating through mindfulness and relaxation training.

Clinical Question/ PICO

| Population: | Adults |
| Intervention: | MAPS resilience training |
| Comparator: | Training as usual (TAU) |

Clinical Question/ PICO

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator Training as usual (TAU)</th>
<th>Intervention MAPS resilience training</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better Based on data from: 61 patients in 1 studies. (Randomized controlled)</td>
<td>Comparator Training as usual (TAU)</td>
<td>Intervention MAPS resilience training</td>
<td>Certainty of the Evidence (Quality of evidence)</td>
<td>Plain text summary</td>
</tr>
</tbody>
</table>

1. Inconsistency: No serious. Indirectness: No serious. Imprecision: Serious. Only data from one study, Low number of patients. Publication bias: No serious.

Cognitive bias modification for interpretation (CBM-I)

For adults who are likely to be exposed to trauma, there was insufficient evidence to make a recommendation on cognitive bias modification for interpretation (CBM-I).

CBM-I is a computer-based training that aims to promote less negative appraisal of post-event retrospection using software that presents emotionally ambiguous deployment-related scenarios in sentence format. The last word of each sentence is presented as a word fragment which the participant is asked to complete. These word fragments gradually increase the proportion of neutral or non-negative interpretations of the scenario.
### Clinical Question/ PICO

**Population:** Adults  
**Intervention:** Heart rate variability biofeedback (HRVB)  
**Comparator:** Cognitive bias modification for interpretation (CBM-I)

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator Cognitive bias modification for interpretation (CBM-I)</th>
<th>Intervention Heart rate variability biofeedback (HRVB)</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PTSD diagnosis</strong></td>
<td>Relative risk 0.35 (CI 95% 0.07 — 1.74) Based on data from 172 patients in 1 studies. (Randomized controlled)</td>
<td><strong>63</strong> per 1000 Difference: <strong>41 fewer</strong> per 1000 (CI 95% 59 fewer — 47 more)</td>
<td><strong>22</strong> per 1000</td>
<td>Low Due to serious imprecision, Due to serious risk of bias</td>
<td>Heart rate variability biofeedback (HRVB) may be more beneficial than CBM-I for decreasing PTSD diagnosis</td>
</tr>
<tr>
<td><strong>PTSD symptom severity</strong></td>
<td>Lower better Based on data from: 172 patients in 1 studies. (Randomized controlled)</td>
<td>Difference: <strong>SMD 0.06 lower</strong> (CI 95% 0.36 lower — 0.24 higher)</td>
<td></td>
<td>Low Due to serious imprecision, Due to serious risk of bias</td>
<td>There may be little or no difference between HRVB and CBM-I on PTSD symptom severity</td>
</tr>
</tbody>
</table>

1. **Risk of Bias:** Serious. Incomplete data and/or large loss to follow up, due to differences at baseline, issues with iPad use, adherence not monitored, Incomplete data and/or large loss to follow up. Inconsistency: No serious. Indirectness: No serious. Imprecision: Serious. Only data from one study. Publication bias: No serious.

2. **Risk of Bias:** Serious. Incomplete data and/or large loss to follow up, due to differences at baseline, issues with iPad use, adherence not monitored, Incomplete data and/or large loss to follow up. Inconsistency: No serious. Indirectness: No serious. Imprecision: Serious. Only data from one study. Publication bias: No serious.

### Clinical Question/ PICO

**Population:** Adults  
**Intervention:** Cognitive bias modification for interpretation (CBM-I)  
**Comparator:** Control

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator Control</th>
<th>Intervention Cognitive bias modification for interpretation (CBM-I)</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PTSD diagnosis</strong></td>
<td>Relative risk 0.94 (CI 95% 0.33 — 2.7) Based on data from 215 patients in 1 studies. (Randomized controlled)</td>
<td><strong>67</strong> per 1000 Difference: <strong>4 fewer</strong> per 1000 (CI 95% 45 fewer — 114 more)</td>
<td><strong>63</strong> per 1000</td>
<td>Low Due to serious imprecision, Due to serious risk of bias</td>
<td>There may be little or no difference between CBM-I and control on PTSD diagnosis</td>
</tr>
<tr>
<td><strong>PTSD symptom severity</strong></td>
<td>Lower better Based on data from: 215</td>
<td>Difference: <strong>SMD 0.16 lower</strong> (CI 95% 0.44 lower — 0.12 higher)</td>
<td></td>
<td>Low Due to serious imprecision, Due</td>
<td>There may be little or no difference between CBM-I and control on PTSD</td>
</tr>
</tbody>
</table>
Stress inoculation training (SIT)

For adults who are likely to be exposed to trauma, there was insufficient evidence to make a recommendation on stress inoculation training (SIT).

Stress inoculation training (SIT) is a non-trauma-focussed anxiety management program that involves teaching coping skills to manage stress and anxiety (Meichenbaum, 1974). SIT consists of three phases. The first phase, conceptualization, includes education about stress, development of a collaborative relationship between the provider and the patient, and assessment and conceptualization of the stressors the patient is facing. The second phase, skill acquisition and rehearsal, includes teaching the patient coping skills that are tailored to the needs of the patient. These can include relaxation training, cognitive restructuring, problem-solving training, and positive self-statements. The final phase, application and follow-through, includes practicing coping skills and applying them to real life stressful situations through guided imagery, as well as relapse prevention (Meichenbaum & Deffenbacher, 1988).

These studies investigate the effectiveness of a predeployment SIT program of relaxation breathing to lessen the mental health consequences of combat stress.

Clinical Question/ PICO

<table>
<thead>
<tr>
<th>Population:</th>
<th>Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention:</td>
<td>Stress inoculation training (SIT)</td>
</tr>
<tr>
<td>Comparator:</td>
<td>Control</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD diagnosis</td>
<td>Relative risk 0.95 (CI 95% 0.35 — 2.52) Based on data from 454 patients in 2 studies. (Randomized controlled)</td>
<td>Control</td>
<td>Stress inoculation training (SIT)</td>
<td>Very low Due to serious risk of bias, Due to serious indirectness, Due to very serious imprecision</td>
<td>Very low We are uncertain whether stress inoculation training (SIT) increases or decreases PTSD diagnosis</td>
</tr>
<tr>
<td>PTSD symptom</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Risk of Bias: Serious. Incomplete data and/or large loss to follow up, due to differences at baseline, issues with iPad use, adherence not monitored, Incomplete data and/or large loss to follow up. Inconsistency: No serious. Indirectness: No serious. Imprecision: Serious. Only data from one study. Publication bias: No serious.

2. Risk of Bias: Serious. Incomplete data and/or large loss to follow up, due to differences at baseline, issues with iPad use, adherence not monitored, Incomplete data and/or large loss to follow up. Inconsistency: No serious. Indirectness: No serious. Imprecision: Serious. Only data from one study. Publication bias: No serious.
<table>
<thead>
<tr>
<th>Outcome</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>severity</td>
<td>Lower better Based on data from: 267 patients in 1 studies. (Randomized controlled)</td>
<td>Control</td>
<td>Stress inoculation training (SIT)</td>
<td>(Quality of evidence)</td>
<td>is a difference between SIT and control on PTSD symptom severity</td>
</tr>
</tbody>
</table>

1. **Risk of Bias: Serious.** Incomplete data and large loss to follow up, no. of participant randomised to each arm not reported. Contamination between group- control reported using SIT, Selective outcome reporting. **Indirectness: Serious.** Differences between the population of interest and those studied, Soldiers that were randomised were never deployed due to a change in military operations in 1 study. **Imprecision: Very serious.** Wide confidence intervals.

2. **Risk of Bias: Serious.** Incomplete data and large loss to follow up, no. of participant randomised to each arm not reported. Contamination between group- control reported using SIT. **Inconsistency: No serious.** **Indirectness: Serious.** Differences between the population of interest and those studied, Soldiers that were randomised were never deployed due to a change in military operations. **Imprecision: Serious.** Only data from one study. **Publication bias: No serious.**

Due to serious imprecision, Due to serious risk of bias, Due to serious indirectness ²

Difference: **SMD 0.01 higher**

( CI 95% 0.23 lower — 0.25 higher )

Based on data from: 267 patients in 1 studies. (Randomized controlled)
Adults within the first three months of a traumatic event

Single session early prevention interventions for adults

“For adults within the first three months of a traumatic event, do psychosocial interventions when compared to intervention as usual, waiting list or no intervention, result in clinically important reduction/prevention of symptoms or presence of disorder?”

Group 512 Psychological Intervention Model (Group 512 PIM)

RESEARCH RECOMMENDATION

For adults within the first three months following exposure to a potentially traumatic event, we suggest usual practice in preference to Group 512 PIM.

There is emerging evidence for Group 512 PIM in Chinese military populations exposed to natural disaster and this could be used in a research context.

Group 512 PIM is an intervention tested on Chinese military rescuers and based on the standard principles of critical incident stress debriefing (CISD) developed by Mitchell (1983). Group 512 PIM involves four stages including introduction, discussing the facts, thoughts, reactions and symptoms related to the trauma followed by stress management tips. Group 512 PIM differs from standard CISD by including a final stage of cohesion training, where participants play games requiring team cooperation to foster military unit cohesion. This is a critical part of Group 512 PIM, as cohesion is thought to have protective effects in preventing stress.\(^\text{[163]}\)

Evidence To Decision

Benefits and harms

Evidence from a single RCT suggests clinically important benefit of Group 512 PIM debriefing of Chinese military rescuers after an earthquake relative to no debriefing or group debriefing on PTSD symptom severity \(^\text{[163]}\).

Certainty of the Evidence

Overall certainty of evidence for Group 512 PIM was LOW

Certainty of evidence for Group 512 PIM vs waitlist/treatment as usual was LOW due to serious risk of bias, and serious indirectness.

The evidence analyses and risk of bias assessments for this intervention can be found \(\text{here}\).

Certainty of evidence for Group 512 PIM vs Group debriefing was LOW due to serious risk of bias, and serious indirectness.

The evidence analyses and risk of bias assessments for this intervention can be found \(\text{here}\).

Rationale

The Guideline Development Group noted that Group 512 PIM has been tested in a single RCT with Chinese military rescuers following an earthquake and showed a clinically important benefit. The Group discussed the uncertainty in the acceptability of the intervention, which combines group debriefing with cohesion building activities such as playing games which need team cooperation, with participants “asked to tell in private or shout in public the words they most want to say”, to workers in an Australian context. The Guideline Development Group recommended that further research was warranted.

Clinical Question/ PICO

Population: Adults within the first three months post traumatic event
Intervention: Group 512 PIM
Comparator: Waitlist/treatment as usual

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better</td>
<td>Waitlist/treatment as usual</td>
<td>Group 512 PIM</td>
<td>Low</td>
<td>Group 512 PIM may decrease PTSD symptom severity</td>
</tr>
</tbody>
</table>

1. Risk of Bias: Serious. Moderate loss to follow up, Missing intention-to-treat analysis. Inconsistency: No serious. Indirectness: Serious. Differences between the population of interest and those studied; Chinese soldiers undergoing rescue after earthquake. Differences between the intervention/comparator of interest and those studied; Intervention includes components that may not be transferable to other cultures. Imprecision: No serious.

Clinical Question/ PICO
Population: Adults within the first three months post traumatic event
Intervention: Group 512 PIM
Comparator: Group debriefing

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity 3-6 months</td>
<td>Lower better</td>
<td>Group debriefing</td>
<td>Group 512 PIM</td>
<td>Low</td>
<td>Group 512 PM may be more effective than group debriefing in decreasing PTSD symptom severity</td>
</tr>
</tbody>
</table>

1. Risk of Bias: Serious. Moderate loss to follow up, Missing intention-to-treat analysis. Inconsistency: No serious. Indirectness: Serious. Differences between the intervention/comparator of interest and those studied; Intervention includes components that may not be transferable to other cultures. Differences between the population of interest and those studied; Chinese soldiers undergoing rescue after earthquake. Imprecision: No serious. Publication bias: No serious.
Group psychological debriefing

Conditional recommendation (against)

For adults within the first three months after trauma exposure, we suggest providing information, emotional support, and practical assistance in preference to group psychological debriefing.

Group psychological debriefing is a single-session, semi-structured intervention, applied shortly after exposure to a PTE, during which groups are guided through a seven-stage discussion soon after exposure to a severe stressor. Facts, thoughts and impressions are explored and education is provided on how to cope with possible stress reactions. Several methods of group debriefing have been proposed, most notably by Mitchell (1983) called Critical Incident Stress Debriefing (CISD). The goals of CISD following work-related exposure to a PTE are: (1) prevention and mitigation of the symptoms of traumatic stress and (2) promotion of recovery and acceleration of return to normal functioning.

The terms psychological debriefing and CISD are often used interchangeably. The former describes a class of interventions delivered shortly following a trauma (usually between 24 and 72 hours) that aim to relieve distress and facilitate a rapid return to normal functioning, thereby mediating or avoiding long-term psychopathology. Psychological debriefing operates on the principles of ventilation (an opportunity to talk about the experience), normalisation of distress, and psychoeducation regarding potential symptoms. CISD, on the other hand, is a specific form of debriefing developed in the 1980s which centres predominantly around group-based interventions for secondary victims such as emergency services personnel, rather than primary victims. While generally group-based, it also advocates individual (or one-on-one) interventions as an acceptable and expected variant. It relies heavily on processes of reconstruction of the traumatic event, ventilation, and normalisation, and includes a structured education component. Over time, CISD has been amalgamated within a framework of self-help activities and structured organisational processes, called critical incident stress management (CISM).

It should be noted that CISD and psychological debriefing differ from operational debriefing, a group process undertaken in high risk industries to review a particular operation or activity. The aim of operational debriefing is to review the events and processes of the operation and to apply the lessons learnt to future events. Operational debriefing is considered good practice in high risk industries as a method of improving service quality and is not a focus of these Guidelines.

Evidence To Decision

Benefits and harms

Evidence from 3 RCTs suggests that Group debriefing has no effect on PTSD symptom severity [163][159][144].

Certainty of the Evidence

The certainty of the evidence is MODERATE due to serious risk of bias.

The evidence analyses and risk of bias assessments for this intervention can be found here

Preference and values

Although no longer considered best practice, group psychological debriefing is still widely used in many occupational settings. This can be valued by work groups as an organisational acknowledgement of the difficult event they have experienced.

Unfortunately, there is no intervention that is supported by the literature on what care should be provided to adults exposed to a potentially traumatic event. However, we recognise that both organisations and individuals value quality care and will likely seek advice on what they should do in these circumstances. Rather than just advising not to use psychological debriefing, we suggest providing information, emotional support and practical assistance, consistent with the set of interventions collectively referred to as psychological first aid. These interventions are likely to help and importantly, do no harm.

Adults exposed to a potentially traumatic event who wish to discuss the experience, and demonstrate a capacity to tolerate associated distress, should be supported in doing so. In doing this the practitioner should keep in mind the potential adverse
effects of excessive ventilation in those who are very distressed.

We also recognise that some people will not seek care but will rely on their own resources and natural recovery.

**Rationale**

The Guideline Development Group noted the non-significant effect of group psychological debriefing on PTSD severity. This evidence alone would have led to no recommendation, but the Guideline Development Group also considered the broader evidence of increased PTSD diagnosis following individual debriefing, which shares several features with group debriefing. In light of this potential harm, the Group agreed that a conditional recommendation against the use of group debriefing was appropriate.

---

**Clinical Question/ PICO**

**Population:** Adults within the first three months post-traumatic event

**Intervention:** Group debriefing

**Comparator:** Waitlist/ treatment as usual

---

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator Waitlist/ treatment as usual</th>
<th>Intervention Group debriefing</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity 3-6 months</td>
<td>Lower better Based on data from 1,184 patients in 3 studies. (Randomized controlled)</td>
<td></td>
<td>Difference: SMD 0.09 lower (CI 95% 0.2 lower — 0.03 higher)</td>
<td>Moderate Due to serious risk of bias</td>
<td>Group debriefing probably has little or no effect on PTSD symptom severity</td>
</tr>
</tbody>
</table>

1. **Risk of Bias:** **Serious.** Incomplete data and/or large loss to follow up, Missing intention-to-treat analysis, Inadequate concealment of allocation during randomization process, resulting in potential for selection bias. **Inconsistency:** **No serious.** **Indirectness:** **No serious.** **Imprecision:** **No serious.** N=1184. Publication bias: **No serious.**
Individual psychological debriefing

**Conditional recommendation (against)**

For adults within the first three months after trauma exposure, we suggest providing information, emotional support, and practical assistance in preference to individual psychological debriefing.

*Individual psychological debriefing* is the application of Critical Incident Stress Debriefing (CISD) in an individual setting. The intervention generally comprises an hour’s debriefing combining a review of the traumatic experience, encouragement of emotional expression, and promotion of cognitive processing of the experience.

The terms psychological debriefing and CISD are often used interchangeably. The former describes a class of interventions delivered shortly following a trauma (usually between 24 and 72 hours) that aim to relieve distress and facilitate a rapid return to normal functioning, thereby mediating or avoiding long-term psychopathology. Psychological debriefing operates on the principles of ventilation (an opportunity to talk about the experience), normalisation of distress, and psychoeducation regarding potential symptoms. CISD, on the other hand, is a specific form of debriefing developed in the 1980s which centres predominantly around group-based interventions for secondary victims such as emergency services personnel, rather than primary victims. While generally group-based, it also advocates individual (or one-on-one) interventions as an acceptable and expected variant. It relies heavily on processes of reconstruction of the traumatic event, ventilation, and normalisation, and includes a structured education component. Over time, CISD has been amalgamated within a framework of self-help activities and structured organisational processes, called critical incident stress management (CISM).

It should be noted that CISD and psychological debriefing differ from operational debriefing, a group process undertaken in high risk industries to review a particular operation or activity. The aim of operational debriefing is to review the events and processes of the operation and to apply the lessons learnt to future events. Operational debriefing is considered good practice in high risk industries as a method of improving service quality and is not a focus of these Guidelines.

Evidence To Decision

**Benefits and harms**

Evidence from 3 RCTs suggests that individual debriefing may slightly increase PTSD diagnosis [145][148][156].

Evidence from 5 RCTs suggests that individual debriefing has no effect on PTSD symptom severity [145][148][151][155][156].

**Certainty of the Evidence**

Overall certainty of the evidence is LOW

Certainty of evidence is LOW due to serious risk of bias and serious imprecision for PTSD symptom severity

The evidence analyses and risk of bias assessments for this intervention can be found here

Certainty of evidence is VERY LOW due to serious risk of bias and very serious imprecision for PTSD diagnosis

The evidence analyses and risk of bias assessments for this intervention can be found here

**Preference and values**

Unfortunately there is no intervention that is supported by the literature on what care should be provided to adults exposed to a potentially traumatic event. We recognise that people value quality care and will likely seek advice on what they should do in these circumstances. For this reason, rather than just advising not to use psychological debriefing, we suggest providing information, emotional support and practical assistance, consistent with the set of interventions collectively referred to as psychological first aid. These interventions are likely to help and do no harm.

Adults exposed to a potentially traumatic event who wish to discuss the experience, and demonstrate a capacity to tolerate associated distress, should be supported in doing so. In doing this the practitioner should keep in mind the potential adverse
effects of excessive ventilation in those who are very distressed.

We also recognise that some people will not seek care but will rely on their own resources and natural remission.

### Resources and other considerations

The provision of information, emotional support and practical assistance may require specific resourcing depending on the context of the potentially traumatic event. For example in a disaster setting significant additional resources may be required whereas in incidents involving an individual this support could reasonably be provided by usual social supports or treating practitioners (e.g., family doctor), or in a workplace context, by welfare staff or appropriately trained managers or supervisors.

### Rationale

The Guideline Development Group noted the evidence showed an increase in the risk of PTSD diagnosis following individual debriefing. The Group discussed that any indication of an intervention being associated with patient harm should taken very seriously and on this basis, the Guideline Development Group agreed to make a conditional recommendation against the use of individual debriefing despite low certainty of evidence.

### Clinical Question/ PICO

<table>
<thead>
<tr>
<th>Population:</th>
<th>Adults within the first three months post-traumatic event</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention:</td>
<td>Individual debriefing</td>
</tr>
<tr>
<td>Comparator:</td>
<td>Waitlist/ treatment as usual</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator Waitlist/ treatment as usual</th>
<th>Intervention Individual debriefing</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD diagnosis 3-6 months</td>
<td>Relative risk 1.12 (CI 95% 0.78 – 1.59) Based on data from 278 patients in 3 studies. (Randomized controlled)</td>
<td>287 per 1000</td>
<td>321 per 1000</td>
<td>Very low Due to serious risk of bias, Due to very serious imprecision ¹</td>
<td>We are uncertain whether individual debriefing increases or decreases PTSD diagnosis</td>
</tr>
<tr>
<td>PTSD symptom severity 3-6 months</td>
<td>Lower better Based on data from: 358 patients in 5 studies. (Randomized controlled)</td>
<td>Difference: SMD 0.09 higher (CI 95% 0.12 lower – 0.3 higher)</td>
<td></td>
<td>Low Due to serious risk of bias, Due to serious imprecision ²</td>
<td>Individual debriefing may have little or no effect on PTSD symptom severity</td>
</tr>
</tbody>
</table>

1. **Risk of Bias: Serious.** Inadequate concealment of allocation during randomization process, resulting in potential for selection bias, Inadequate/lack of blinding of outcome assessors, resulting in potential for detection bias, Incomplete data and/or large loss to follow up. **Inconsistency: No serious. Indirectness: No serious. Imprecision: Very serious.** Low number of patients (events = 87), Wide confidence intervals (CI include important benefit and important harm). **Publication bias: No serious.**
2. **Risk of Bias: Serious.** Inadequate concealment of allocation during randomization process, resulting in potential for selection bias. Inadequate/lack of blinding of outcome assessors, resulting in potential for detection bias. Incomplete data and/or large loss to follow up. Missing intention-to-treat analysis. **Inconsistency: No serious. Indirectness: No serious. Imprecision: Serious.** Wide confidence intervals including unimportant benefit and important harm. **Publication bias: No serious.**

Eye Movement Desensitization and Reprocessing (EMDR) - single session

For adults within the first three months following exposure to a potentially traumatic event, there was insufficient evidence to make a recommendation on delivering a single session of EMDR.

*Single session EMDR follows the EMDR Protocol for Recent Critical Incidents (EMDR-PRECI). EMDR-PRECI is a modified version of Shapiro’s Recent Traumatic Events Protocol (R-TEP) [162] which is specially designed for victims of recent traumatic events. EMDR-PRECI involves identifying the worst fragment of the client’s trauma memory, followed by the remaining difficult fragments of the memory. Desensitising occurs by having the client focus on each memory fragment whilst simultaneously engaging in dual attention stimulation using eye movements, until all fragments have been processed and the client no longer experiences emotional, cognitive or somatic distress. In this study the EMDR sessions were delivered in the context of ER patients in a hospital.[150]*

Evidence To Decision

**Benefits and harms**

Evidence from 1 RCT [150] suggests a clinically important benefit of a single session of EMDR relative to wait list or usual care for PTSD diagnosis.

Evidence from 1 RCT [150] suggests a clinically important benefit of EMDR relative to reassurance for PTSD diagnosis.

No harms were reported in this study.

**Certainty of the Evidence**

Overall certainty of evidence for single session EMDR is VERY LOW.

Certainty of evidence for single session EMDR vs waitlist is VERY LOW due to serious risk of bias and very serious imprecision for PTSD diagnosis.

Certainty of evidence for single session EMDR vs reassurance is VERY LOW due to serious risk of bias and very serious imprecision for PTSD diagnosis.

**Preference and values**

Most individuals would value a single session of EMDR given the potential benefit and no reported harms. The treatment should be delivered by appropriately trained and qualified practitioners with ongoing supervision.

When discussing this treatment option, information should be provided about the proposed intervention, including its aim, content, duration and mode of delivery.

Patient preferences will influence whether this treatment is appropriate.

**Resources and other considerations**
There may be accessibility issues in the delivery of single session EMDR which should be based on a validated protocol (only available for practitioners through EMDR-training) and delivered by trained practitioners.

Access to psychological treatments can be slow to procure and those patients less committed to obtaining help can get lost in the process. Many GPs struggle with Medicare's process of ATAPs and Better Access and triage of these services through the Primary Health Networks to mental health professionals they deem most suitable, without being able to easily refer directly to the professional of the GP’s choosing. Increased clarity regarding which psychologists are offering which therapies would make referrals from GPs more relevant and useful for the patient's condition.

Clinical Question/ PICO

Population: Adults within the first three months post-traumatic event
Intervention: EMDR
Comparator: Waitlist/ treatment as usual

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
</table>
| PTSD diagnosis 3-6 months | Relative risk 0.16 (CI 95% 0.02 — 1.2) Based on data from 71 patients in 1 studies. (Randomized controlled) | Waitlist/ treatment as usual | EMDR | Very low
Due to serious risk of bias, Due to very serious imprecision | We are uncertain whether EMDR increases or decreases PTSD diagnosis |

1. **Risk of Bias: Serious.** Inadequate concealment of allocation during randomization process, resulting in potential for selection bias, Moderate loss to follow up. **Inconsistency: No serious. Indirectness: No serious. Imprecision: Very serious.** Low number of events (events = 8), Wide confidence intervals (CI includes important benefit and unimportant harm). **Publication bias: No serious.**

Clinical Question/ PICO

Population: Adults within the first three months post traumatic event
Intervention: EMDR
Comparator: Reassurance
Individual psychoeducation/self-help

For adults within the first three months following exposure to a potentially traumatic event, there was insufficient evidence to make a recommendation on individual psychoeducation/self-help.

Clinical Question/ PICO

Population: Adults within the first three months post-traumatic event
Intervention: Individual psychoeducation/self-help
Comparator: Waitlist/ treatment as usual

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD diagnosis 3-6 months</td>
<td>Relative risk 0.19 (CI 95% 0.02 – 1.47) Based on data from 72 patients in 1 studies. (Randomized controlled)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comparator Reassurance</td>
<td></td>
<td></td>
<td>158 per 1000</td>
<td></td>
<td>Very low Due to serious risk of bias, Due to very serious imprecision</td>
</tr>
<tr>
<td>Intervention EMDR</td>
<td></td>
<td></td>
<td>30 per 1000</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Difference: 128 fewer per 1000 ( CI 95% 155 fewer – 74 more )</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>We are uncertain whether EMDR increases or decreases PTSD diagnosis</td>
</tr>
</tbody>
</table>

1. **Risk of Bias: Serious.** Inadequate concealment of allocation during randomization process, resulting in potential for selection bias, Moderate loss to follow up. **Inconsistency: No serious. Indirectness: No serious. Imprecision: Very serious.** Low number of events (events = 7), Wide confidence intervals (CI's include important benefit and important harm). **Publication bias: No serious.**

**Individual psychoeducation/self-help**

For adults within the first three months following exposure to a potentially traumatic event, there was insufficient evidence to make a recommendation on individual psychoeducation/self-help.

Clinical Question/ PICO

Population: Adults within the first three months post-traumatic event
Intervention: Individual psychoeducation/self-help
Comparator: Waitlist/ treatment as usual

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD diagnosis 3-6 months</td>
<td>Relative risk 1.7 (CI 95% 0.85 – 3.39) Based on data from 142 patients in 1 studies. (Randomized controlled)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comparator</td>
<td></td>
<td>Waitlist/ treatment as usual</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>149 per 1000</td>
<td></td>
<td>Low Due to very serious imprecision</td>
</tr>
<tr>
<td>Intervention</td>
<td></td>
<td>Individual psychoeducation/self-help</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>253 per 1000</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Difference: 104 more per 1000 ( CI 95% 22 fewer – 356 more )</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Individual psychoeducation/self-help may increase PTSD diagnosis</td>
</tr>
</tbody>
</table>

1. **Inconsistency: No serious. Indirectness: No serious. Imprecision: Very serious.** Low number of events (events = 29), Wide confidence intervals (CI includes unimportant benefit and important harm). **Publication bias: No serious.**

2. **Inconsistency: No serious. Indirectness: No serious. Imprecision: Serious.** Low number of patients (n=272), Wide confidence intervals (CI's include important benefit and unimportant harm). **Publication bias: No serious.**
Group stress management

For adults within the first three months following exposure to a potentially traumatic event, there was insufficient evidence to make a recommendation on group stress management.

Clinical Question/ PICO

**Population:** Adults within the first three months post traumatic event

**Intervention:** Group stress management

**Comparator:** Waitlist/ treatment as usual

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator Waitlist/ treatment as usual</th>
<th>Intervention Group stress management</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better Based on data from: 411 patients in 1 studies. (Randomized controlled)</td>
<td>Difference: <strong>SMD 0.08 lower</strong> (CI 95% 0.28 lower — 0.11 higher)</td>
<td>Low Due to serious risk of bias, Due to serious imprecision 1</td>
<td>Group stress management may have little or no effect on PTSD symptom severity</td>
<td></td>
</tr>
</tbody>
</table>

1. **Risk of Bias:** Serious. Inadequate concealment of allocation during randomization process, resulting in potential for selection bias. Incomplete data and/or large loss to follow up, resulting in attrition bias. **Inconsistency:** No serious. **Indirectness:** No serious. **Imprecision:** Serious. Wide confidence intervals (CI’s include important benefit and unimportant harm). **Publication bias:** No serious.

Computerised visuospatial task

For adults within the first three months following exposure to a potentially traumatic event, there was insufficient evidence to make a recommendation on computerised visuospatial task.

Clinical Question/ PICO

**Population:** Adults within the first three months post traumatic event

**Intervention:** Computerised visuospatial task

**Comparator:** Waitlist/ treatment as usual

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator Waitlist/ treatment as usual</th>
<th>Intervention Computerised visuospatial task</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD diagnosis</td>
<td>Relative risk 0.58 (CI 95% 0.13 — 2.6) Based on data from 127 patients in 2 studies. (Randomized controlled)</td>
<td>164 per 1000</td>
<td>92 per 1000</td>
<td>Very low Due to serious risk of bias, Due to serious inconsistency. Due to very high imprecision.</td>
<td>We are uncertain whether computerised visuospatial task increases or decreases PTSD diagnosis</td>
</tr>
</tbody>
</table>

**Difference:** **72 fewer** per 1000 (CI 95% 130 fewer — 74 more)
<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better Based on data from: 127 patients in 2 studies. (Randomized controlled)</td>
<td>Comparator Waitlist/ treatment as usual</td>
<td>Intervention Computerised visuospatial task</td>
<td>Very low Due to very serious imprecision</td>
<td>We are uncertain whether computerised visuospatial task increases or decreases PTSD symptom severity</td>
</tr>
</tbody>
</table>

**Clinical Question/ PICO**

**Population:** Adults within the first three months post traumatic event  
**Intervention:** Group education  
**Comparator:** Waitlist/ treatment as usual

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better Based on data from: 47 patients in 1 studies. (Randomized controlled)</td>
<td>Comparator Waitlist/ treatment as usual</td>
<td>Intervention Group education</td>
<td>Very low Due to serious risk of bias, Due to very serious imprecision</td>
<td>We are uncertain whether group education improves or worsens PTSD symptom severity</td>
</tr>
</tbody>
</table>

1. **Risk of Bias:** Serious. Inadequate/lack of blinding of outcome assessors, resulting in potential for detection bias.  
   **Inconsistency:** Serious. The magnitude of statistical heterogeneity was high, with $I^2 = 53\%$.  
   **Indirectness:** No serious.  
   **Imprecision:** Very serious. Low number of events (events = 16), Wide confidence intervals (CI includes important benefit and important harm).  
   **Publication bias:** No serious.  

We are uncertain whether computerised visuospatial task increases or decreases PTSD symptom severity.

---

**Group education**

For adults within the first three months following exposure to a potentially traumatic event, there was insufficient evidence to make a recommendation on group education.
Reassurance

For adults within the first three months following exposure to a potentially traumatic event, there was insufficient evidence to make a recommendation on reassurance.

Clinical Question/ PICO

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD diagnosis</td>
<td>Relative risk 0.83 (CI 95% 0.31 – 2.25) Based on data from 75 patients in 1 studies. (Randomized controlled)</td>
<td>Comparator Waitlist/ treatment as usual</td>
<td>Intervention Reassurance</td>
<td>Very low Due to serious risk of bias, Due to very serious imprecision</td>
<td>We are uncertain whether reassurance increases or decreases PTSD diagnosis</td>
</tr>
</tbody>
</table>

1. Risk of Bias: Serious. Incomplete data and/or large loss to follow up, Missing intention-to-treat analysis, Inadequate concealment of allocation during randomization process, resulting in potential for selection bias. Inconsistency: No serious. Indirectness: No serious. Imprecision: Very serious. Low number of events (n=75), Wide confidence intervals (CI includes important benefit and important harm). Publication bias: No serious.

Trauma-focussed counselling

For adults within the first three months following exposure to a potentially traumatic event, there was insufficient evidence to make a recommendation on trauma-focussed counselling.

Clinical Question/ PICO

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD diagnosis</td>
<td>Relative risk 2.84 (CI 95% 0.12 – 68.86) Based on data from 183 patients in 1 studies. (Randomized controlled)</td>
<td>Comparator Heart stress counselling</td>
<td>Intervention Trauma-focused counselling</td>
<td>Low Due to very serious imprecision</td>
<td>Trauma-focused counselling may be less beneficial than heart stress counselling for PTSD diagnosis</td>
</tr>
</tbody>
</table>

1
Multiple session early prevention interventions for adults

“For adults within the first three months of a traumatic event, do psychosocial interventions when compared to intervention as usual, waiting list or no intervention, result in a clinically important reduction/prevention of symptoms, or presence of disorder?”

Brief dyadic therapies

**RESEARCH RECOMMENDATION**

For adults within the first three months following exposure to a potentially traumatic event, we suggest usual practice in preference to brief dyadic therapies.

There is emerging evidence for brief dyadic therapies and this could be used in a research context.

These are brief (e.g. two - three session) CBT-based therapies delivered dyadically with the aim of improving communication and fostering a shared approach to addressing psychological and practical difficulties. For example, brief dyadic therapy as described by Brunet and colleagues[186] aims to target social support process following trauma exposure, and involves elements of psychoeducation and motivational interviewing to enhance communication between the patient and their significant other. It involves two sessions, which aim to promote disclosure of thoughts and emotions relating to the trauma while attempting to reduce social constraints on disclosure and negative interactions between the dyad[186].

**Evidence To Decision**

**Benefits and harms**

Evidence from 2 RCTs [186][196] suggests small, clinically important benefit of brief dyadic therapy on PTSD symptom severity for adults within the first three months of a traumatic event.

**Certainty of the Evidence**

Certainty of the evidence is LOW due to serious risk of bias and serious imprecision

The evidence analyses and risk of bias assessments for this intervention can be found [here](#).

**Rationale**

The Guideline Development Group noted the small clinical benefit shown in two trials of brief dyadic therapy on PTSD symptom severity with no associated harm. The Group agreed that the body of evidence was too limited to make a recommendation in favour of brief dyadic therapy but they recommended that this intervention warranted further research.
Clinical Question/ PICO

Population: Adults in the first three months post traumatic event
Intervention: Brief dyadic therapies
Comparator: Waitlist/ treatment as usual

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity 3-6 months</td>
<td>Lower better Based on data from: 103 patients in 2 studies. (Randomized controlled)</td>
<td>Waitlist/ treatment as usual</td>
<td>Brief dyadic therapies</td>
<td>Low Due to serious imprecision, Due to serious risk of bias</td>
<td>Brief dyadic therapies probably decreases PTSD symptom severity</td>
</tr>
</tbody>
</table>

1. **Risk of Bias:** Serious. Incomplete data and/or large loss to follow up, Missing intention-to-treat analysis. **Inconsistency:** No serious. **Indirectness:** No serious. **Imprecision:** Serious. Low number of patients (n=103), Wide confidence intervals (CIs include important benefit and unimportant benefit). **Publication bias:** No serious.

Internet-based CBT

**RESEARCH RECOMMENDATION**

For adults within the first three months following exposure to a potentially traumatic event, we suggest usual practice in preference to internet-based CBT.

There is emerging evidence for internet-based CBT and this could be used in a research context.

Trauma TIPS, an internet-based self-guided intervention, is based on CBT principles of psychoeducation, stress/relaxation techniques, and in vivo exposure. Trauma TIPS aims to decrease levels of distress and anxiety by providing information on successful coping, instructions and guidance for in vivo exposure, and stress management techniques.¹⁹⁹

Evidence To Decision

**Benefits and harms**

Evidence from a single study (¹⁹⁹) suggests a small, clinically important benefit of internet-based CBT on PTSD diagnosis and symptom severity in adults in the first 3 months following serious injury.

**Certainty of the Evidence**

Overall certainty of the evidence is LOW due to serious imprecision.

Certainty of the evidence LOW due to very serious imprecision for PTSD symptom severity.

The evidence analyses and risk of bias assessments for this intervention can be found here.
Rationale

The Guideline Development Group noted the small benefit of an internet-based CBT on PTSD diagnosis and symptom severity, with no associated harms. The Group noted that the evidence consists of a single study of injury survivors and so the extent to which the results can be generalised to all adults in the first 3 months following trauma is not known. The Guideline Development Group agreed that there is not yet enough evidence to make a recommendation in favour of internet-based CBT. The Group noted the potential for this intervention to increase the availability of treatment for individuals who are unable to access face-to-face treatment due to availability, access, or cost, barriers and the Group, therefore, recommend further research into internet-based CBT in other populations and trauma types.

Clinical Question/ PICO

| Population: | Adults in the first three months post traumatic event |
| Intervention: | Guided internet-based CBT |
| Comparator: | Waitlist/ treatment as usual |

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator Waitlist/ treatment as usual</th>
<th>Intervention Guided internet-based CBT</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD diagnosis 3-6 months</td>
<td>Relative risk 0.5 (CI 95% 0.18 — 1.45) Based on data from 185 patients in 1 studies. (Randomized controlled)</td>
<td>102 per 1000</td>
<td>51 per 1000</td>
<td>Low Due to very serious imprecision</td>
<td>Internet-based CBT may improve PTSD diagnosis</td>
</tr>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better Based on data from: 300 patients in 1 studies. (Randomized controlled)</td>
<td>Difference: 51 fewer per 1000 (CI 95% 84 fewer — 46 more)</td>
<td>Difference: SMD 0.27 lower (CI 95% 0.5 lower — 0.04 lower)</td>
<td>Moderate Due to serious imprecision</td>
<td>Guided internet-based CBT probably decreases PTSD symptom severity</td>
</tr>
</tbody>
</table>

1. Inconsistency: No serious. Indirectness: No serious. Imprecision: Very serious. Low number of events (events = 14), Wide confidence intervals (CI includes important benefit and important harm). Publication bias: No serious.
2. Imprecision: Serious. Low number of patients (n=300), CI includes important benefit and unimportant benefit.

Brief individual trauma processing therapy

For adults within the first three months following exposure to a potentially traumatic event, there was insufficient evidence to make a recommendation on brief individual trauma processing therapy.
Clinical Question/ PICO

Population: Adults in the first three months post traumatic event
Intervention: Brief individual trauma processing therapy
Comparator: Supportive listening

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator Supportive listening</th>
<th>Intervention Brief individual trauma processing therapy</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD diagnosis 3-6 months</td>
<td>Relative risk 0.55 (CI 95% 0.36 — 0.85) Based on data from 315 patients in 3 studies. (Randomized controlled)</td>
<td>206 per 1000</td>
<td>113 per 1000</td>
<td>Low Due to serious imprecision, Due to serious risk of bias</td>
<td>Brief individual trauma processing therapy may decrease PTSD diagnosis</td>
</tr>
<tr>
<td>PTSD symptom severity 3-6 months</td>
<td>Lower better Based on data from: 329 patients in 3 studies. (Randomized controlled)</td>
<td>Difference: 93 fewer per 1000 ( CI 95% 132 fewer — 31 fewer )</td>
<td>Difference: SMD 0.04 lower ( CI 95% 0.41 lower — 0.49 higher )</td>
<td>Very low Due to serious risk of bias, Due to serious inconsistency, Due to very serious imprecision</td>
<td>We are uncertain whether brief individual trauma processing therapy improves or worsen PTSD symptom severity</td>
</tr>
</tbody>
</table>

1. **Risk of Bias: Serious.** Incomplete data and/or large loss to follow up, Missing intention-to-treat analysis, Inadequate sequence generation/ generation of comparable groups, resulting in potential for selection bias. Inconsistency: No serious. Indirectness: No serious. Imprecision: Serious. Low number of events (events = 65), Wide confidence intervals (CI includes important and unimportant benefit). Publication bias: No serious.

2. **Risk of Bias: Serious.** Inadequate sequence generation/ generation of comparable groups, resulting in potential for selection bias, Missing intention-to-treat analysis. Inconsistency: Serious. The magnitude of statistical heterogeneity was high, with I^2:72%. Indirectness: No serious. Imprecision: Very serious. Low number of patients (n=127), Wide confidence intervals (CI’s include important benefit and important harm). Publication bias: No serious.

Clinical Question/ PICO

Population: Adults in the first three months post traumatic event
Intervention: Brief individual trauma processing therapy
Comparator: Supportive listening

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator Supportive listening</th>
<th>Intervention Brief individual trauma processing therapy</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity 3-6 months</td>
<td>Lower better Based on data from: 51 patients in 2 studies.</td>
<td>Difference: SMD 0.54 lower ( CI 95% 1.42 lower — 0.34 higher )</td>
<td>Very low Due to serious risk of bias, Due to serious</td>
<td>We are uncertain whether there is a difference between brief individual trauma</td>
<td></td>
</tr>
</tbody>
</table>

Australian Guidelines for the Prevention and Treatment of Acute Stress Disorder, Posttraumatic Stress Disorder, and Complex Posttraumatic Stress

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Three step early intervention for mothers of infants born prematurely

For adults within the first three months following exposure to a potentially traumatic event, there was insufficient evidence to make a recommendation on three step early intervention for mothers of infants born prematurely.

Clinical Question/ PICO

<table>
<thead>
<tr>
<th>Population:</th>
<th>Adults in the first three months post traumatic event</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention:</td>
<td>Three step early intervention for mothers of infants born prematurely</td>
</tr>
<tr>
<td>Comparator:</td>
<td>Waitlist/ treatment as usual</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator Supportive listening</th>
<th>Intervention Brief individual trauma processing therapy</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better</td>
<td>Based on data from: 55 patients in 1 studies. (Randomized controlled)</td>
<td>Difference: SMD 0.08 lower (CI 95% 0.61 lower — 0.45 higher)</td>
<td>Very low Due to serious risk of bias, Due to very serious imprecision ¹</td>
<td>We are uncertain whether three step early intervention for mothers premature infants improves or worsens PTSD symptom severity</td>
</tr>
</tbody>
</table>

1. Risk of Bias: Serious. Incomplete data and/or large loss to follow up. Inconsistency: No serious. Indirectness: No serious. Imprecision: Very serious. Low number of patients (N=55), Wide confidence intervals (CI includes important benefit and important harm). Publication bias: No serious.
Intensive care diaries

For adults within the first three months following exposure to a potentially traumatic event, there was insufficient evidence to make a recommendation on intensive care diaries.

Clinical Question/ PICO

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator Waitlist/ treatment as usual</th>
<th>Intervention Intensive care diaries</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD diagnosis</td>
<td>Relative risk 0.38 (CI 95% 0.17 — 0.82) Based on data from 322 patients in 1 studies. (Randomized controlled)</td>
<td>131 per 1000</td>
<td>50 per 1000</td>
<td>Very low Due to serious risk of bias, Due to very serious imprecision 1</td>
<td>We are uncertain whether intensive care diaries increases or decreases PTSD diagnosis</td>
</tr>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better Based on data from: 322 patients in 1 studies. (Randomized controlled)</td>
<td>Difference: SMD 0 lower ( CI 95% 0.22 lower — 0.22 higher )</td>
<td></td>
<td>Very low Due to serious risk of bias, Due to very serious imprecision 2</td>
<td>We are uncertain whether intensive care diaries increases or decreases PTSD symptom severity</td>
</tr>
</tbody>
</table>

1. **Risk of Bias: Serious.** Inadequate/lack of blinding of outcome assessors, resulting in potential for detection bias, Inconsistent data and/or large loss to follow up, Missing intention-to-treat analysis, due to more females in the control arm. **Inconsistency: No serious. Indirectness: No serious. Imprecision: Very serious.** Low number of patients events (events = 29), Wide confidence intervals (CI includes important benefit and unimportant benefit). **Publication bias: No serious.**

2. **Risk of Bias: Serious.** Inadequate/lack of blinding of outcome assessors, resulting in potential for detection bias, Inconsistent data and/or large loss to follow up, Missing intention-to-treat analysis, due to more females in the control arm. **Inconsistency: No serious. Indirectness: No serious. Imprecision: Very serious.** Low number of patients (n= 322), Wide confidence intervals (CI includes important benefit and important harm). **Publication bias: No serious.**

**Brief Interpersonal Counselling**

For adults within the first three months following exposure to a potentially traumatic event, there was insufficient evidence to make a recommendation on brief IPT.

Clinical Question/ PICO

<table>
<thead>
<tr>
<th>Population:</th>
<th>Adults in the first three months post traumatic event</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention:</td>
<td>Brief Interpersonal Counselling</td>
</tr>
<tr>
<td>Comparator:</td>
<td>Waitlist/ treatment as usual</td>
</tr>
</tbody>
</table>
1. **Risk of Bias:** **Very serious.** Incomplete data and/or large loss to follow up: presented data for those who completed the IPT intervention (52.9%) of those allocated to this arm, although the participant flowchart suggests that 92.2% of those randomised to IPT completed the 3 month assessment and 90.2% completed the 6 month assessment. **Inconsistency:** No serious. **Indirectness:** No serious. **Imprecision:** Very serious. Low number of events (events = 7), Wide confidence intervals (CI includes important benefit and important harm). **Publication bias:** No serious.

2. **Risk of Bias:** **Very serious.** Incomplete data and/or large loss to follow up: presented data for those who completed the IPT intervention (52.9%) of those allocated to this arm, although the participant flowchart suggests that 92.2% of those randomised to IPT completed the 3 month assessment and 90.2% completed the 6 month assessment. **Inconsistency:** No serious. **Indirectness:** No serious. **Imprecision:** Very serious. Low number of patients (n=58), Wide confidence intervals (CI includes important benefit and important harm). **Publication bias:** No serious.

**Clinical Question/ PICO**

**Population:** Adults in the first three months post traumatic event  
**Intervention:** Collaborative care  
**Comparator:** Waitlist/ treatment as usual

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator Waitlist/ treatment as usual</th>
<th>Intervention Collaborative care</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
</table>
| PTSD diagnosis 3-6 months | Relative risk 0.39 (CI 95% 0.1 – 1.58)  
Based on data from 26 patients in 1 studies. | 429 per 1000 | 167 per 1000 | Very low  
Due to serious risk of bias, Due to very serious | We are uncertain whether collaborative care increases or decreases PTSD |

**PTSD diagnosis**

Relative risk 1.53  
( CI 95% 0.38 – 6.24)  
Based on data from 58 patients in 1 studies. (Randomized controlled)

97 per 1000  
Difference: **51 more** per 1000  
( CI 95% 60 fewer – 508 more )  
Very low  
Due to very serious risk of bias, Due to very serious imprecision  
We are uncertain whether brief interpersonal counselling increases or decreases PTSD diagnosis

**PTSD symptom severity 3-6 months**

Lower better  
Based on data from: 58 patients in 1 studies. (Randomized controlled)

Difference: **SMD 0.1 higher**  
( CI 95% 0.42 lower – 0.61 higher )  
Very low  
Due to very serious risk of bias, Due to very serious imprecision  
We are uncertain whether brief interpersonal counselling increases or decreases PTSD symptom severity

**Collaborative care**

For adults within the first three months following exposure to a potentially traumatic event, there was insufficient evidence to make a recommendation on collaborative care.
For adults within the first three months following exposure to a potentially traumatic event, there was insufficient evidence to make a recommendation on supported psychoeducational intervention.

### Clinical Question/ PICO

<table>
<thead>
<tr>
<th>Population</th>
<th>Adults in the first three months post traumatic event</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention</td>
<td>Supported psychoeducational intervention</td>
</tr>
<tr>
<td>Comparator</td>
<td>Waitlist/ treatment as usual</td>
</tr>
</tbody>
</table>

### Outcome Timeframe: PTSD symptom severity 3-6 months

<table>
<thead>
<tr>
<th>Comparator</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supported psychoeducational intervention</td>
<td>Supported psychoeducational intervention</td>
</tr>
</tbody>
</table>

#### Certainty of the Evidence (Quality of evidence)

1. **Risk of Bias:** Serious. Due to compromised continuity of care, intervention unmanualised resulting in likely marked variability in implementation. **Inconsistency:** No serious. **Indirectness:** No serious. **Imprecision:** Very serious. Low number of events (events = 8), Wide confidence intervals (CI includes important benefit and important harm). **Publication bias:** No serious.

2. **Risk of Bias:** Serious. Due to compromised continuity of care, intervention unmanualised resulting in likely marked variability in implementation. **Inconsistency:** No serious. **Indirectness:** No serious. **Imprecision:** Very serious. Low number of patients (n=26), Wide confidence intervals CI includes important benefit and important harm. **Publication bias:** No serious.

### Summary

<table>
<thead>
<tr>
<th>Metric</th>
<th>Effect Size (95% CI)</th>
<th>Certainty of Evidence (Quality of Evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difference: 262 fewer per 1000</td>
<td>(CI 95% 386 fewer — 249 more)</td>
<td>imprecision 1</td>
<td>We are uncertain whether supported psychoeducational intervention increases or decreases PTSD symptom severity</td>
</tr>
<tr>
<td>Difference: SMD 0.41 higher</td>
<td>(CI 95% 0.37 lower — 1.19 higher)</td>
<td>Very low</td>
<td></td>
</tr>
</tbody>
</table>

**Supported psychoeducational intervention**

**Clinical Question/ PICO**

**Population:** Adults in the first three months post traumatic event  
**Intervention:** Supported psychoeducational intervention  
**Comparator:** Waitlist/ treatment as usual  

1. **Risk of Bias:** Serious. Incomplete data and/or large loss to follow up: Outcome data were assessed on an ITT basis and involved all parent–child pairs randomly assigned and providing follow-up data. However, outcome data was only available for 17 (77.8%) of the intervention group and 6 (66.6%) of the TAU group. **Inconsistency:** No serious. **Indirectness:** Serious.
Differences between the population of interest and those studied; parents of children in ICU. **Imprecision: Very serious.** Low number of patients (n=23), Wide confidence intervals (CI includes important benefit and important harm).

### Telephone-based CBT

For adults within the first three months following exposure to a potentially traumatic event, there was insufficient evidence to make a recommendation on telephone-based CBT.

#### Clinical Question/ PICO

| Population: | Adults in the first three months post traumatic event |
| Intervention: | Telephone-based CBT |
| Comparator: | Waitlist/ treatment as usual |

#### Outcome Timeframe | Study results and measurements | Comparator Waitlist/ treatment as usual | Intervention Telephone-based CBT | Certainty of the Evidence (Quality of evidence) | Plain text summary
--- | --- | --- | --- | --- | ---
PTSD symptom severity | Lower better Based on data from: 185 patients in 1 studies. (Randomized controlled) | Difference: **SMD 0.08 lower** ( CI 95% 0.37 lower — 0.21 higher ) | Very low Due to serious indirectness, Due to very serious imprecision | We are uncertain whether telephone-based CBT increases or decreases PTSD symptom severity

1. **Inconsistency: No serious. Indirectness: Serious.** Differences between the intervention/comparator of interest and those studied, intervention was tailored to coping with the effects Implantable Cardioverter Defibrillator. **Imprecision: Very serious.** Low number of patients (n=185), Wide confidence intervals (CI include important benefit and important harm). **Publication bias: No serious.**

#### Clinical Question/ PICO

| Population: | Adults in the first three months post traumatic event |
| Intervention: | Telephone + Internet-based CBT |
| Comparator: | Critical illness educational intervention |
### Communication facilitator in an intensive care setting

For adults within the first three months following exposure to a potentially traumatic event, there was insufficient evidence to make a recommendation on communication facilitator in an intensive care setting.

#### Clinical Question/ PICO

- **Population:** Adults in the first three months post traumatic event
- **Intervention:** Communication facilitator in an intensive care setting
- **Comparator:** Waitlist/ treatment as usual

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity 3-6 months</td>
<td>Lower better Based on data from: 168 patients in 1 studies. (Randomized controlled)</td>
<td>Waitlist/ treatment as usual</td>
<td>Communication facilitator in an intensive care setting</td>
<td>Low Due to serious risk of bias, Due to serious imprecision 1</td>
<td>Communication facilitator in an intensive care setting may have little or no effect on PTSD symptom severity</td>
</tr>
<tr>
<td><strong>Differences:</strong> SMD 0.11 lower ( CI 95% 0.41 lower — 0.19 higher )</td>
<td><strong>Low</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. **Risk of Bias: Serious.** Large loss to follow up. **Inconsistency: No serious. Indirectness: No serious. Imprecision: Serious.** Low number of patients (n=168), Wide confidence intervals (CI includes important benefit and unimportant harm). **Publication bias: No serious.**

### Nurse-led intensive care recovery program

For adults within the first three months following exposure to a potentially traumatic event, there was insufficient evidence to make a recommendation on nurse-led intensive care recovery program.
Clinical Question/ PICO

Population: Adults within the first three months post traumatic event
Intervention: Nurse-led intensive care recovery program
Comparator: WL/TAU

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator WL/TAU</th>
<th>Intervention Nurse-led intensive care recovery program</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better Based on data from: 215 patients in 1 studies. (Randomized controlled)</td>
<td></td>
<td></td>
<td>Very low Due to serious risk of bias, Due to very serious imprecision, Due to serious indirectness</td>
<td>We are uncertain whether nurse-led intensive care recovery program increases or decreases PTSD symptom severity</td>
</tr>
</tbody>
</table>

1. Risk of Bias: Serious. Incomplete data . Inconsistency: No serious. Indirectness: Serious. Differences between the population of interest and those studied (ICU pt.s on mechanical ventilation). Imprecision: Very serious. Low number of patients. Wide confidence intervals (include important benefit and harm). Publication bias: No serious.

Early psychosocial treatment interventions for adults

“*For adults within the first three months of a traumatic event, do psychosocial interventions when compared to intervention as usual, waiting list or no intervention, result in a clinically important reduction/prevention of symptoms, or presence of disorder?*”

Stepped/collaborative care

For adults with PTSD symptoms in the first three months following trauma, we recommend a stepped/collaborative care model, in which individuals receive evidence-based care commensurate with the severity and complexity of their need.

A stepped care model recognises that not all those exposed to potentially traumatic events will develop a diagnosable disorder; many will experience only sub-threshold symptoms and others will not experience significant symptomatology at all. Stepped care aims to ensure that individuals receive care commensurate with the severity and complexity of their need. The approach involves ongoing monitoring of people who are more distressed and/or at heightened risk of poor psychological adjustment, with increasingly intensive interventions delivered as indicated. Interventions are generally CBT-based, but sometimes based on other psychological approaches (e.g. motivational interviewing) and may include components of case management and prescription of pharmacological intervention.

The collaborative care model by Zatzick and colleagues\[267]\[268]\[269] is a stepped care model where injury patients are screened for high levels of PTSD symptoms. Those with risk factors are offered integrated care including pharmacotherapy, motivational interviewing targeting problematic alcohol use, and CBT targeting depression and PTSD symptoms. Elements of the treatment are provided in a stepped fashion such that those with greater ease of delivery such as psychoeducation and problem solving are given initially, followed later by more complex elements such as activity scheduling. Patient symptoms are repeatedly measured and higher-intensity care is initiated if the person requires it. The stepped care model proposed by O’Donnell and colleagues\[259]\ aimed to address a comprehensive range of posttrauma psychopathology beyond PTSD. In a two-stage screening process, patients were screened for high risk symptoms of PTSD, depression and anxiety, and treated with an evidence-based modular CBT manual that allowed treatment to be tailored to the patient’s individual symptom-cluster profiles.
Evidence To Decision

Benefits and harms
Evidence from 4 RCTs [259][267][268][269] suggests a small unimportant benefit on symptom severity and a clinically important benefit of a stepped/collaborative care model on PTSD diagnosis in adults within 3 months of trauma exposure.

Certainty of the Evidence
Overall certainty of the evidence was MODERATE

Certainty of evidence for a stepped care model was MODERATE due to serious imprecision for PTSD symptom severity.

The evidence analyses and risk of bias assessments for this intervention can be found here

Certainty of evidence for a stepped care model was LOW due to very serious imprecision for PTSD diagnosis.

The evidence analyses and risk of bias assessments for this intervention can be found here

Preference and values
Most patients would value a stepped care approach in which each level of care is evidence based, and the level of care provided is matched with their need.

Resources and other considerations
In Australia, the principle of stepped care has been adopted nationally and is an explicit policy of the Primary Health Network (PHN) initiative. The implementation of stepped care, however, can be challenging. It requires monitoring of patient symptoms, targeting of those patients who require escalation of care, and connected systems which can provide continuity of care across different practitioners.

In mental health the application of stepped care can be particularly challenging. The guideline development group observed that there is organisational and systemic demarcation between acute preventative and early intervention care and stepped up intermediate and higher level care that does not facilitate a stepped or collaborative care process. It was considered that overall prioritisation is given to physical versus mental health care in spite of the overwhelming evidence for an integrated and interdisciplinary care approach.

A systems level change to mental health models of care that includes care coordination across time would be required to fully implement this recommendation. This may be challenging from a health policy and resourcing perspective.

Rationale
The Guideline Development Group considered the fact that a stepped care model is regarded as best practice in the field and is highly valued by patients. They agreed that it is a pragmatic approach to patient care that maximises the use of scare resources for the benefit of the greatest number and therefore, the Group agreed to make a strong recommendation for the use of a model of stepped care in which the care that is provided at each level is evidence based, despite the mixed certainty of evidence and strength of effect across outcomes.

Clinical Question/ PICO

Population: Adults within the first three months post-traumatic event
### Trauma-focused CBT (TF-CBT)

#### Conditional recommendation

For adults with PTSD symptoms in the first three months following trauma, we suggest offering trauma-focused CBT (includes prolonged exposure, cognitive processing therapy, cognitive therapy) in preference to doing nothing. 

*Trauma-focused CBT is intended to help an individual come to terms with trauma through exposure to and emotional processing of memories of the event. This includes prolonged exposure, cognitive restructuring, cognitive processing therapy and cognitive therapy. Typically, TF-CBT involves homework and includes psycho-education, exposure work, cognitive work and more general relaxation/stress management; the relative contribution of these elements varies between different forms of TF-CBT.*

#### Evidence To Decision

**Benefits and harms**

Evidence from 16 RCTs suggests a clinically important benefit of TF-CBT on PTSD symptom severity and diagnosis, relative to WL/TAU [241][246][250][251][260][262][263][264], supportive counselling [242][243][244][245][252][257][258], and relaxation [249].
Evidence from a single RCT [264] suggests that TFCBT was not as effective as structured writing therapy in reducing PTSD diagnosis but showed similar benefit on symptom severity.

Evidence from a subgroup analysis of brief PE-based interventions [242][243][244][245][251][252] suggest clinically important benefit on PTSD diagnosis and symptom severity relative to supportive counselling.

Evidence from a subgroup analysis of brief CPT-based interventions suggest a clinically important effect on PTSD diagnosis [257] and unimportant benefit on PTSD symptom severity [257][258] relative to supportive counselling.

**Certainty of the Evidence**

Overall certainty of evidence for Trauma-focused CBT was LOW

Certainty of evidence for Trauma-focused CBT vs waitlist/treatment as usual was LOW due to serious risk of bias, and serious imprecision for PTSD symptom severity, and VERY LOW due to serious risk of bias, serious inconsistency, and serious imprecision for PTSD diagnosis.

The evidence analyses and risk of bias assessments for this intervention can be found here for PTSD symptom severity, and here for PTSD diagnosis

Certainty of evidence for Trauma-focused CBT vs Supportive counselling was LOW due to serious risk of bias, and serious imprecision for PTSD symptom severity, and VERY LOW due to serious risk of bias, serious inconsistency, and serious imprecision for PTSD diagnosis.

The evidence analyses and risk of bias assessments for this intervention can be found here for PTSD symptom severity, and here for PTSD diagnosis

Certainty of evidence for Brief prolonged exposure-based interventions vs supportive counselling was LOW due to serious risk of bias, and serious imprecision for PTSD symptom severity and VERY LOW due to serious risk of bias, serious inconsistency, and serious imprecision for PTSD diagnosis.

The evidence analyses and risk of bias assessments for this intervention can be found here for PTSD symptom severity, and here for PTSD diagnosis

Certainty of evidence for Brief CPT-based interventions vs Supportive counselling was LOW due to serious risk of bias, and serious imprecision for PTSD symptom severity, and VERY LOW due to serious risk of bias, and serious imprecision for PTSD diagnosis.

The evidence analyses and risk of bias assessments for this intervention can be found here for PTSD symptom severity, and here for PTSD diagnosis

Certainty of evidence for Trauma-focused CBT vs relaxation was VERY LOW due to serious risk of bias, and serious imprecision for PTSD symptom severity and VERY LOW due to serious risk of bias, and very serious imprecision for PTSD diagnosis.

The evidence analyses and risk of bias assessments for this intervention can be found here for PTSD symptom severity, and here for PTSD diagnosis

Certainty of evidence for Trauma-focused CBT vs Structured writing therapy was VERY LOW due to serious risk of bias, and very serious imprecision for PTSD symptom severity, and VERY LOW due to serious risk of bias, and very serious imprecision for PTSD diagnosis.

The evidence analyses and risk of bias assessments for this intervention can be found here for PTSD symptom severity, and here for PTSD diagnosis
The Guideline Development Group considered the evidence showing benefits of trauma-focussed CBT for adults with PTSD symptoms within the first three months of exposure to a potentially traumatic event relative to waitlist or usual treatment, supportive counselling and relaxation. The Group considered evidence for clinically important benefits across subgroup analyses of brief interventions relative to supportive counselling. The group noted the low to very low certainty of evidence across the body of evidence.

The Guideline Development Group noted the weak evidence from a single study indicating that structured writing therapy was more effective than CBT-T for PTSD prevention and judged it inappropriate to amend the recommendation based on this study due to the very low certainty of this evidence.

The Group agreed to make a conditional recommendation that CBT-T should be offered to adults with symptoms of PTSD within the first three months of trauma may involve one or a combination of approaches including prolonged exposure, cognitive processing therapy and cognitive therapy. Patients would value information about each treatment in order to make an informed choice between them. Patient preferences and the availability of each treatment are likely to guide selection of TF-CBT vs EMDR, which are both conditionally recommended treatments for adults with PTSD symptoms in the first three months after exposure to a traumatic event.

Based on the evidence gathered through real world effectiveness trials of trauma focused treatments, a proportion of patients may be expected to drop out of treatment. Adequate preparation including providing a rationale for treatment and a realistic preview of what treatment will involve is likely to minimise drop out.

We recognise that in the first few months after experiencing a traumatic event, some people will prefer to delay treatment to see if their symptoms remit.

Given possible benefits of trauma-focussed CBT on PTSD symptoms within the first 3 months following exposure to a traumatic event, and the absence of any alternative treatment with a strong recommendation for its use, patients are likely to consider this treatment.

Preference and values

Trauma-focussed CBT within the first three months of trauma may involve one or a combination of approaches including prolonged exposure, cognitive processing therapy and cognitive therapy. Patients would value information about each treatment in order to make an informed choice between them. Patient preferences and the availability of each treatment are likely to guide selection of TF-CBT vs EMDR, which are both conditionally recommended treatments for adults with PTSD symptoms in the first three months after exposure to a traumatic event.

Based on the evidence gathered through real world effectiveness trials of trauma focused treatments, a proportion of patients may be expected to drop out of treatment. Adequate preparation including providing a rationale for treatment and a realistic preview of what treatment will involve is likely to minimise drop out.

We recognise that in the first few months after experiencing a traumatic event, some people will prefer to delay treatment to see if their symptoms remit.

Resources and other considerations

For patients with work-related PTSD, treatment will be funded by third party insurers. For others with private health insurance, psychology sessions may be partially reimbursed. For patients relying on Medicare, the number of sessions on a mental health plan referral from a GP is limited to 10 per year. This can often be inadequate for comprehensive PTSD assessment and treatment. As such, patient's access to psychological treatment varies according to funding sources including their capacity to pay for their own treatment.

From the perspective of the GP, access to psychological treatments can be slow to procure and those patients less committed to obtaining help can get lost in the process. Further, the requirement to access ATAPS and Better Access via the Primary Health Networks limits GPs capacity to refer directly to a practitioner of choice. Increased clarity regarding which psychologists are offering which therapies would assist GPs to make relevant and useful referrals via the Medicare mental health care plan process.

Rationale

The Guideline Development Group considered the evidence showing benefits of trauma-focussed CBT for adults with PTSD symptoms within the first three months of exposure to a potentially traumatic event relative to waitlist or usual treatment, supportive counselling and relaxation. The Group considered evidence for clinically important benefits across subgroup analyses of brief interventions relative to supportive counselling. The group noted the low to very low certainty of evidence across the body of evidence.

The Guideline Development Group noted the weak evidence from a single study indicating that structured writing therapy was more effective than CBT-T for PTSD prevention and judged it inappropriate to amend the recommendation based on this study due to the very low certainty of this evidence.

The Group agreed to make a conditional recommendation that CBT-T should be offered to adults with symptoms of PTSD.
within the first three months of a traumatic event in preference to supportive counselling, relaxation or no intervention, despite the low certainty in the evidence, in light of the beneficial effects in addition to drawing on the broader evidence that CBT-T has demonstrated efficacy in reducing PTSD symptom severity after the first three months, and is associated with no harm.

### Clinical Question/ PICO

**Population:** Adults within the first three months post traumatic event  
**Intervention:** Trauma-focused CBT  
**Comparator:** Waitlist/ treatment as usual

<table>
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<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
</table>
| **PTSD diagnosis** | Relative risk 0.72  
(CI 95% 0.5 – 1.03)  
Based on data from 607 patients in 7 studies.  
(Randomized controlled) | **568**  
per 1000 | **409**  
per 1000 | Low  
Due to serious inconsistency, Due to serious imprecision | Trauma-focused CBT may decrease PTSD diagnosis |
| **PTSD symptom severity** | Lower better  
Based on data from: 705 patients in 8 studies.  
(Randomized controlled) | **SMD 0.54 lower**  
(CI 95% 0.83 lower – 0.24 lower) | | Low  
Due to serious risk of bias, Due to serious imprecision | Trauma-focused CBT may decrease PTSD symptom severity |

1. **Risk of Bias:** No serious. Difference in trauma type across groups- more sexual assault in intervention group- controlled for in analysis. **Inconsistency:** Serious. The magnitude of statistical heterogeneity was high, with $I^2:74\%$. **Indirectness:** No serious. **Imprecision:** Serious. Wide confidence intervals (CI includes important benefit and unimportant benefit). **Publication bias:** No serious.

2. **Risk of Bias:** Serious. Baseline differences, assessment time-point differences. **Inconsistency:** No serious. The magnitude of statistical heterogeneity was high, with $I^2:69\%$ however all studies showed positive effects therefore not considered important. **Indirectness:** No serious. **Imprecision:** Serious. Wide confidence intervals (CI includes important benefit and unimportant benefit). **Publication bias:** No serious.

### Clinical Question/ PICO

**Population:** Adults within the first three months post-traumatic event  
**Intervention:** Trauma-focused CBT  
**Comparator:** Supportive counselling

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
</table>
| **PTSD diagnosis** | Relative risk 0.61  
(CI 95% 0.36 – 1.04)  
Based on data from 281 | **587**  
| | **358**  
| | Very low  
Due to serious risk of bias, Due | We are uncertain whether trauma-focused CBT is more beneficial |
Outcome Timeframe | Study results and measurements | Comparator | Intervention | Certainty of Evidence (Quality of evidence) | Plain text summary
---|---|---|---|---|---

PTSD symptom severity | Lower better Based on data from: 333 patients in 8 studies. (Randomized controlled) | Supportive counselling | Brief prolonged exposure-based interventions | Very low Due to serious risk of bias, Due to serious inconsistency, Due to serious imprecision 1 | We are uncertain if there is a difference between brief prolonged exposure-based interventions and supportive counselling on PTSD diagnosis

1. **Risk of Bias: Serious.** Incomplete data and/or large loss to follow up, due to unbalanced number of treatment sessions.
2. **Inconsistency: Serious.** The magnitude of statistical heterogeneity was high, with I^2:67%
3. **Imprecision: Serious.** Low number of events (events = 127), Wide confidence intervals (CI includes important benefit and unimportant harm).

1. **Risk of Bias: Serious.** Incomplete data and/or large loss to follow up, due to unbalanced number of treatment sessions.
2. **Inconsistency: No serious.** The magnitude of statistical heterogeneity was high, with I^2:65% however all studies favour TFCBT so inconsistency is not considered important. **Indirectness: No serious.** **Imprecision: Serious.** Low number of patients (n=331), Wide confidence intervals (CI includes important benefit and unimportant benefit). **Publication bias: No serious.**

Clinical Question/ PICO

Population: Adults within the first three months post-traumatic event
Intervention: Brief prolonged exposure-based interventions
Comparator: Supportive counselling

Outcome Timeframe | Study results and measurements | Comparator | Intervention | Certainty of Evidence (Quality of evidence) | Plain text summary
---|---|---|---|---|---

PTSD diagnosis | Relative risk 0.56 (CI 95% 0.29 — 1.06) Based on data from 251 patients in 5 studies. (Randomized controlled) | Supportive counselling | Brief prolonged exposure-based interventions | Very low Due to serious risk of bias, Due to serious inconsistency, Due to serious imprecision 1 | We are uncertain if there is a difference between brief prolonged exposure-based interventions and supportive counselling on PTSD diagnosis

1. **Risk of Bias: Serious.** Incomplete data and/or large loss to follow up, inadequate sequence generation/ generation of comparable groups, resulting in potential for selection bias, due to differences at baseline. **Inconsistency: Serious.** The
magnitude of statistical heterogeneity was high, with I^2:74%. Imprecision: Serious. Low number of events (events = 115), Wide confidence intervals (CI includes important benefit and unimportant harm).

2. Risk of Bias: Serious. Incomplete data and/or large loss to follow up, Inadequate sequence generation/ generation of comparable groups, resulting in potential for selection bias, due to differences at baseline. Inconsistency: No serious. The magnitude of statistical heterogeneity was high, with I^2:69% however all studies favoured brief PE with most showing very large, large or moderate effect sizes. Indirectness: No serious. Imprecision: Serious. Low number of patients (n=262), Wide confidence intervals (CI includes important benefit and unimportant benefit). Publication bias: No serious.

Clinical Question/ PICO

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD diagnosis</td>
<td>Relative risk 0.76 (CI 95% 0.32 – 1.83) Based on data from 30 patients in 1 studies. (Randomized controlled)</td>
<td>Supportive counselling</td>
<td>Brief CPT-based interventions</td>
<td>Very low Due to serious risk of bias, Due to very serious imprecision 1</td>
<td>We are uncertain if there is a difference between brief CPT-based interventions and supportive counselling on PTSD diagnosis</td>
</tr>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better Based on data from: 71 patients in 2 studies. (Randomized controlled)</td>
<td>SMD 0.47 lower ( CI 95% 0.95 lower – 0 higher )</td>
<td>Brief CPT-based interventions may be slightly more beneficial than supportive counselling in decreasing PTSD symptom severity</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Risk of Bias: Serious. Incomplete data and/or large loss to follow up. Inconsistency: No serious. Indirectness: No serious. Imprecision: Very serious. Low number of events (events = 12), Wide confidence intervals (CI includes important benefit and important harm). Publication bias: No serious.

2. Risk of Bias: Serious. Incomplete data and/or large loss to follow up, due to unbalanced number of treatment sessions. Inconsistency: No serious. Indirectness: No serious. Imprecision: Serious. Low number of patients (n=71), Wide confidence intervals (CI includes important benefit and unimportant benefit). Publication bias: No serious.
### Outcome Timeframe

<table>
<thead>
<tr>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relaxation</td>
<td>Trauma-focused CBT</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### PTSD diagnosis

**Relative risk 0.4**

(95% CI 0.1 – 1.6)

*Based on data from 20 patients in 1 studies.*

(Remove controlled)

**Difference: 300 fewer** per 1000

(95% CI 450 fewer – 300 more)

*Very low* Due to very serious risk of bias. Due to very serious imprecision.

*We are uncertain if there is a difference between trauma-focused CBT and relaxation on PTSD diagnosis.*

#### PTSD symptom severity

**Lower better**

*Based on data from: 20 patients in 1 studies.*

(Remove controlled)

**Difference: SMD 0.79 lower**

(95% CI 1.71 lower – 0.13 higher)

*Very low* Due to very serious risk of bias. Due to very serious imprecision.

*We are uncertain if there is a difference between trauma-focused CBT and relaxation on PTSD symptom severity.*

### Clinical Question/ PICO

**Population:** Adults within the first three months post-traumatic event

**Intervention:** Trauma-focused CBT

**Comparator:** Structured writing therapy

### Outcome Timeframe

<table>
<thead>
<tr>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Structured writing therapy</td>
<td>Trauma-focused CBT</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### PTSD diagnosis

**Relative risk 1.57**

(95% CI 0.68 – 3.65)

*Based on data from 43 patients in 1 studies.*

(Remove controlled)

**Difference: 156 more** per 1000

(95% CI 87 fewer – 723 more)

*Very low* Due to serious risk of bias. Due to very serious imprecision.

*We are uncertain if there is a difference between trauma-focused CBT and structed writing therapy on PTSD diagnosis.*

#### PTSD symptom severity

**Lower better**

*Based on data from: 43 patients in 1 studies.*

(Remove controlled)

**Difference: SMD 0.11 lower**

(95% CI 0.49 higher)

*Very low* Due to serious risk of bias. Due to very serious imprecision.

*We are uncertain if there is a difference between trauma-focused CBT and structured writing therapy on PTSD.*
1. **Risk of Bias: Serious.** Due to different time intervals between time points for intervention and control arms, differences in trauma types between arms at baseline, high drop-out with differences in trauma type. **Indirectness: No serious.** **Imprecision: Very serious.** Low number of events (n=15), Wide confidence intervals (CI includes important benefit and important harm). **Publication bias: No serious.**

2. **Risk of Bias: Serious.** Due to different time intervals between time points for intervention and control arms, differences in trauma types between arms at baseline, high drop-out with differences in trauma type. **Indirectness: No serious.** **Imprecision: Very serious.** Low number of patients (n=43), Wide confidence intervals (CI includes important benefit and unimportant harm). **Publication bias: No serious.**

### Clinical Question/ PICO

**Population:** Adults within the first three months post-traumatic event

**Intervention:** Trauma-focused CBT

**Comparator:** Self-help program

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD diagnosis</td>
<td></td>
<td>Relative risk 0.22 (CI 95% 0.03 — 1.45) Based on data from 10 patients in 1 studies. (Randomized controlled)</td>
<td>Self-help program</td>
<td>Trauma-focused CBT</td>
<td>Low</td>
<td>Trauma-focused CBT may be more beneficial than self-help programs for PTSD diagnosis</td>
</tr>
<tr>
<td>PTSD symptom severity</td>
<td></td>
<td>Lower better Based on data from: 37 patients in 1 studies. (Randomized controlled)</td>
<td></td>
<td></td>
<td></td>
<td>We are uncertain if there is a difference between trauma-focused CBT and self-help programs on PTSD symptom severity</td>
</tr>
</tbody>
</table>

1. **Indirectness: No serious.** **Imprecision: Very serious.** Low number of patients (n=10), Wide confidence intervals (includes important benefit and unimportant harm). **Publication bias: No serious.**

2. **Risk of Bias: Serious.** Inadequate concealment of allocation during randomization process, resulting in potential for selection bias, Incomplete data and/or large loss to follow up, due to baseline demographic differences. **Inconsistency: No serious.** **Indirectness: No serious.** **Imprecision: Very serious.** Low number of patients (n=37), Wide confidence intervals (CI includes important benefit and unimportant harm). **Publication bias: No serious.**
Brief EMDR

**Conditional recommendation**

For adults with PTSD symptoms in the first three months following trauma, we suggest offering brief Eye Movement Desensitisation and Reprocessing (EMDR) in preference to doing nothing.

*Brief EMDR can range from one to three sessions and involves clients focusing on fragments of their trauma memory whilst simultaneously engaging in dual attention stimulation using eye movements.*

**Evidence To Decision**

**Benefits and harms**

Evidence from 5 small RCTs suggests large clinically important benefit of 1-3 sessions of brief EMDR on PTSD symptom severity relative to waitlist in adults who have experienced a community critical incident e.g. workplace violence, earthquake, factory explosion, missile attack, intense rocket attacks.

Evidence from one RCT suggests a large, clinically important benefit of brief EMDR on PTSD symptom severity and diagnosis relative to critical incident stress debriefing (CISD) in adults who had experienced workplace violence.

**Certainty of the Evidence**

Overall certainty of evidence for Brief EMDR was MODERATE

Certainty of evidence for Brief EMDR vs waitlist/treatment as usual was MODERATE due to serious risk of bias.

The evidence analyses and risk of bias assessments for this intervention can be found [here](#) for PTSD symptom severity,

Certainty of evidence for Brief EMDR vs Critical Incident Stress Debriefing (CISD) was LOW due to very serious imprecision for PTSD diagnosis (3-6 months), and PTSD symptom severity (3-6 months).

The evidence analyses and risk of bias assessments for this intervention can be found [here](#) for PTSD symptom severity, and [here](#) for PTSD diagnosis

**Preference and values**

Given possible benefits of EMDR on PTSD symptoms within the first 3 months following exposure to a traumatic event, and the absence of any alternative treatment with a strong recommendation for its use, patients are likely to consider this treatment.

Patient preferences and the availability of each treatment are likely to guide selection of EMDR vs TF-CBT, which are both conditionally recommended treatments for adults with PTSD symptoms in the first three months after exposure to a traumatic event.

EMDR may suit patients who value a shorter course of treatment, prefer a less 'cognitive' treatment, and who prefer not to engage in homework assignments.

We recognise that in the first few months after experiencing a traumatic event, some people will prefer to delay treatment to see if their symptoms remit.

**Resources and other considerations**

Delivery of EMDR is restricted to practitioners who have undertaken accredited training. This may limit the availability of
EMDR in the community. The delivery of EMDR should be based on a validated manual (only available for practitioners through EMDR-training) and delivered by practitioners trained to deliver EMDR for PTSD in adults.

Brief EMDR is likely to be advantageous in circumstances where there are limited resources and/or time available as the course of treatment could be completed within the 10 rebated sessions allowable through Medicare on a mental health care plan.

From the perspective of the GP, access to psychological treatments can be slow to procure and those patients less committed to obtaining help can get lost in the process. Further, the requirement to access ATAPS and Better Access via the Primary Health Networks limits GPs capacity to refer directly to a practitioner of choice. Increased clarity regarding which psychologists are offering which therapies would assist GPs to make relevant and useful referrals via the Medicare mental health care plan process.

Rationale
The Guideline Development Group considered the evidence showing a benefit of EMDR for adults with PTSD symptoms within the first three months of exposure to a potentially traumatic event relative to waitlist or usual treatment or critical incident stress debriefing. The group discussed the evidence from the broader evidence base that EMDR is beneficial for PTSD symptom severity after 3 months post-trauma exposure. It was the Group's expert opinion that it was unlikely that effects would differ in the 3 months post-trauma exposure time period. Despite the narrow breadth of trauma type included in the studies (critical incidents in the workplace or community), the Guideline Development Group agreed to make a conditional recommendation that brief EMDR should be offered in preference to no intervention in the first three months after exposure, in light of the evidence of benefit and no harm and drawing from the broader evidence that EMDR is beneficial in adults after 3 months post-trauma exposure.

Clinical Question/ PICO

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<th>Population</th>
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<tr>
<td>Intervention</td>
<td>Brief EMDR</td>
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<tr>
<td>Comparator</td>
<td>Critical Incident Stress Debriefing (CSID)</td>
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</table>
### Outcome Timeframe

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</tr>
</thead>
<tbody>
<tr>
<td>Critical Incident Stress Debriefing (CSID)</td>
<td>Brief EMDR</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### PTSD diagnosis 3-6 months

- Relative risk 0.03 (CI 95% 0.00 – 0.51)
- Based on data from 42 patients in 1 studies.
- (Randomized controlled)

- **Relative risk:** 0.03
- **CI 95%:** 0.00 – 0.51
- Based on data from 42 patients in 1 studies.
- (Randomized controlled)

- **783** per 1000
- **23** per 1000

- **Difference:** 760 fewer per 1000 (CI 95% 738 fewer – 384 fewer)

- Low
- Due to very serious imprecision

**EMDR may be more effective than group debriefing in decreasing PTSD diagnosis**

#### PTSD symptom severity 3-6 months

- Lower better
- Based on data from: 41 patients in 1 studies.
- (Randomized controlled)

- **Difference:** SMD 4.45 lower (CI 95% 5.62 lower – 3.28 lower)

- Low
- Due to very serious imprecision

**EMDR may be more effective than group debriefing in decreasing PTSD symptom severity**

---

1. **Inconsistency:** No serious. **Indirectness:** No serious. **Imprecision:** Very serious. Low number of events (events = 18).
   **Publication bias:** No serious.

2. **Inconsistency:** No serious. **Indirectness:** No serious. **Imprecision:** Very serious. Low number of patients (n=41).
   **Publication bias:** No serious.

### Clinical Question/ PICO

**Population:** Adults within the first three months post traumatic event

**Intervention:** Brief EMDR

**Comparator:** Waitlist/ treatment as usual

### Outcome Timeframe

<table>
<thead>
<tr>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
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<tbody>
<tr>
<td>Waitlist/ treatment as usual</td>
<td>Brief EMDR</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### PTSD symptom severity

- Lower better
- Based on data from: 121 patients in 5 studies.
- (Randomized controlled)

- **Difference:** SMD 2.69 lower (CI 95% 4.18 lower – 1.2 lower)

- Moderate
- Due to serious risk of bias

**Brief EMDR probably decreases PTSD symptom severity**

---

1. **Risk of Bias:** Serious. Due to differences at baseline, unclear intervention/assessment methodology. **Inconsistency:** No serious. The magnitude of statistical heterogeneity was high, with I²:88% however all studies favour EMDR with 4 studies showing very high effects and one moderate, therefore inconsistency not important. **Indirectness:** No serious. **Imprecision:** No serious. **Publication bias:** No serious.
Structured writing therapy

**RESEARCH RECOMMENDATION**

For adults with PTSD symptoms in the first three months after exposure to a traumatic event, we recommend offering TF-CBT, PE, CT or Brief EMDR in preference to structured writing therapy. There is emerging evidence for Structured writing therapy and this could be used in a research context.

Structured writing is a broad term that encompasses interventions that rely exclusively on writing assignments. Of the two studies that employed structured writing interventions, one study adapted their structured writing therapy program from the Interapy program, which is an internet-based 10-session structured writing intervention. The other study conducted by Bugg and colleagues adapted the Pennebaker (1988) writing paradigm, which requires participants to write about the feelings and emotions associated with their traumatic experience once a day for three consecutive days. Across these two studies, participants were individuals with ASD or PTSD who sustained a traumatic injury such as a traffic accident or a sexual or non-sexual assault.

**Evidence To Decision**

**Benefits and harms**

Evidence from a single RCT suggests clinically important benefit from structured writing therapy on PTSD diagnosis and symptom severity relative to waitlist.

Evidence from this RCT suggests structured writing therapy is more beneficial than CBT-T for decreasing PTSD diagnosis and no that there is important difference between CBT-T and structured writing therapy on PTSD symptom severity.

Evidence from another RCT suggests no difference between structured writing intervention and psychoeducation on PTSD symptom severity.

**Certainty of the Evidence**

Overall certainty of evidence for Structured writing therapy was VERY LOW.

Certainty of evidence for Structured writing therapy vs waitlist/treatment as usual was VERY LOW due to serious risk of bias, and very serious imprecision for PTSD symptom severity, and VERY LOW due to serious risk of bias, and serious imprecision for PTSD diagnosis.

The evidence analyses and risk of bias assessments for this intervention can be found here for PTSD symptom severity, and here for PTSD diagnosis.

Certainty of evidence for Structured writing therapy vs Trauma-focused CBT was VERY LOW due to serious risk of bias, and very serious imprecision for PTSD symptom severity and VERY LOW due to serious risk of bias, and very serious imprecision for PTSD diagnosis.

The evidence analyses and risk of bias assessments for this intervention can be found here for PTSD symptom severity, and here for PTSD diagnosis.

Certainty for evidence for Structured writing therapy vs Psychoeducation was LOW due to serious risk of bias, and serious imprecision for PTSD symptom severity.

The evidence analyses and risk of bias assessments for this intervention can be found here.

**Rationale**

The Guideline Development Group considered the clinically important benefit on PTSD diagnosis and symptom severity, and no associated harms from a single study of structured writing therapy relative to waitlist and the clinically important benefit on PTSD diagnosis relative to TF-CBT. The Group agreed that there is not yet enough evidence to make a recommendation in favour of structured writing therapy but that there is potential for this intervention to increase the availability of treatment for...
individuals who are unable to access face to face treatment due to availability, access or cost, barriers. The Group therefore recommend further research of the intervention in broader population and trauma types.

Clinical Question/ PICO

Population: Adults within the first three months post-traumatic event
Intervention: Trauma-focused CBT
Comparator: Structured writing therapy

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator Structured writing therapy</th>
<th>Intervention Trauma-focused CBT</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD diagnosis</td>
<td>Relative risk 1.57 (CI 95% 0.68 — 3.65) Based on data from 43 patients in 1 studies. (Randomized controlled)</td>
<td>273 per 1000 Difference: <strong>156 more</strong> per 1000 (CI 95% 87 fewer — 723 more)</td>
<td>429 per 1000</td>
<td>Very low Due to serious risk of bias, Due to very serious imprecision</td>
<td>We are uncertain if there is a difference between trauma-focused CBT and structured writing therapy on PTSD diagnosis</td>
</tr>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better Based on data from: 43 patients in 1 studies. (Randomized controlled)</td>
<td>Difference: <strong>SMD 0.11 lower</strong> (CI 95% 0.7 lower — 0.49 higher)</td>
<td></td>
<td>Very low Due to serious risk of bias, Due to very serious imprecision</td>
<td>We are uncertain if there is a difference between trauma-focused CBT and structured writing therapy on PTSD symptom severity</td>
</tr>
</tbody>
</table>

1. **Risk of Bias**: **Serious**. Due to different time intervals between time points for intervention and control arms, differences in trauma types between arms at baseline, high drop-out with differences in trauma type. **Inconsistency**: **No serious**, **Indirectness**: **No serious**, **Imprecision**: **Very serious**. Low number of events (n=15), Wide confidence intervals (CI includes important benefit and important harm). **Publication bias**: **No serious**.

2. **Risk of Bias**: **Serious**. Due to different time intervals between time points for intervention and control arms, differences in trauma types between arms at baseline, high drop-out with differences in trauma type. **Inconsistency**: **No serious**, **Indirectness**: **No serious**, **Imprecision**: **Very serious**. Low number of patients (n=43), Wide confidence intervals (CI includes important benefit and unimportant harm). **Publication bias**: **No serious**.

Clinical Question/ PICO

Population: Adults within the first three months post traumatic event
Intervention: Structured writing therapy
Comparator: Waitlist/ treatment as usual

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator Waitlist/ treatment as usual</th>
<th>Intervention Structured writing therapy</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD diagnosis</td>
<td>Relative risk 0.63 (CI 95% 0.27 — 1.43)</td>
<td>435</td>
<td>274</td>
<td>Very low Due to serious</td>
<td>We are uncertain whether structured</td>
</tr>
</tbody>
</table>
1. **Risk of Bias:** Serious. Due to different time intervals between time points for intervention and control arms, differences in trauma types between arms at baseline, high drop-out with differences in trauma type. **Indirectness:** No serious. **Imprecision:** Very serious. Low number of events (events = 15), Wide confidence intervals (CI includes important benefit and important harm). **Publication bias:** No serious.

2. **Risk of Bias:** Serious. Due to different time intervals between time points for intervention and control arms, differences in trauma types between arms at baseline, high drop-out with differences in trauma type. **Indirectness:** No serious. **Imprecision:** Very serious. Low number of patients (n=45), Wide confidence intervals (CI includes important benefit and unimportant benefit). **Publication bias:** No serious.

**Clinical Question/ PICO**

**Population:** Adults within the first three months post-traumatic event  
**Intervention:** Structured writing therapy  
**Comparator:** Psychoeducation
Internet-based guided self-help

**RESEARCH RECOMMENDATION**

For adults with PTSD symptoms in the first three months after exposure to a traumatic event, we recommend offering TF-CBT, PE, CT or Brief EMDR in preference to internet-based guided self-help.

There is emerging evidence for Internet-based guided self-help and it could be used in a research context. Internet-based guided self-help uses internet-based programs to treat individuals with PTSD using CBT approaches. Use of the intervention is guided by a therapist. Patients receive guidance and feedback on homework assignments from the therapist.

**Evidence To Decision**

**Benefits and harms**

Evidence from a single RCT [248] suggests clinically important benefit from internet-based guided self-help relative to waitlist for PTSD symptom severity.

**Certainty of the Evidence**

Certainty of the evidence is LOW due to serious risk of bias and serious imprecision.

The evidence analyses and risk of bias assessments for this intervention can be found [here](#).

**Rationale**

The Guideline Development Group considered the evidence showing a clinically important benefit of internet-based guided self-help on PTSD symptom severity, with no associated harms relative to waitlist. The Group noted that the study population in the single study was parents of children having cancer treatment, and they agreed that the extent to which the results can be generalised to all adults in the first 3 months following trauma is not known. The group agreed that there is currently insufficient evidence to make a recommendation in favour of internet-based guided self-help, but there is potential for this intervention to increase the availability of treatment for individuals unable to access face-to-face treatment due to availability, access or cost barriers. The group, therefore, agreed to recommend further high-quality research of internet-based guided self-help in broad population and trauma types.

**Clinical Question/ PICO**

- **Population:** Adults within the first three months post traumatic event
- **Intervention:** Internet-based guided self-help
- **Comparator:** Waitlist/ treatment as usual

Australian Guidelines for the Prevention and Treatment of Acute Stress Disorder, Posttraumatic Stress Disorder, and Complex Posttraumatic Stress

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Helping to Overcome PTSD through Empowerment (HOPE)

RESEARCH RECOMMENDATION

For adults with PTSD symptoms in the first three months after exposure to a traumatic event, we recommend offering TF-CBT, PE, CT, or Brief EMDR in preference to Helping to Overcome PTSD through Empowerment (HOPE).

There is emerging evidence for HOPE and it could be used in a research context.

Helping to Overcome PTSD through Empowerment (HOPE) is a present-centred cognitive behavioural therapy and empowerment-based individual treatment created to address PTSD in the context of intimate partner violence (IPV) and the clinical challenges of residents of women’s shelters who have ongoing safety issues. HOPE is informed by Herman’s (1992) multistage model of recovery that views recovery from chronic trauma, including IPV, as occurring in three stages: (a) establishing safety, (b) remembrance and mourning, and (c) reconnection. HOPE incorporates many of the traditional components of CBT for PTSD (e.g., cognitive-restructuring, skill building) with a focus on helping women realistically appraise the degree of threat they are under and to learn how to manage their PTSD symptoms without increasing them or risking their safety. HOPE also incorporates empowerment strategies, helping women to identify aspects of their situation that are under their control and providing them with the skills (e.g., assertiveness with safety planning) that aim to empower them.

Evidence To Decision

Benefits and harms

Evidence from 2 RCTs [407] [406] suggests clinically important benefit of PCT for PTSD symptom severity in women who have recently experienced intimate partner violence (IPV).

Certainty of the Evidence

Certainty of the evidence is MODERATE due to serious imprecision.

The evidence analyses and risk of bias assessments for this intervention can be found here

Rationale

The Guideline Development Group considered the evidence showing clinically important benefit of a HOPE intervention on PTSD symptom severity and no associated harms relative to waitlist. The group noted that the study populations in the 2 available RCTs were women who had recently experienced intimate partner violence (IPV) and they agreed that the extent to...
which the results can be generalised to all adults in the first 3 months following trauma is not known. The group agreed that there is not yet enough evidence to make a recommendation in favour of HOPE but the Guideline Development Group considered that it was a promising intervention in this target population and recommended further research to add strength to the evidence base.

### Clinical Question/ PICO

<table>
<thead>
<tr>
<th>Population:</th>
<th>Adults within the first three months post-traumatic event</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention:</td>
<td>Present centered therapy (HOPE)</td>
</tr>
<tr>
<td>Comparator:</td>
<td>Waitlist/TAU</td>
</tr>
</tbody>
</table>

### Outcome Timeframe | Study results and measurements | Comparator | Intervention | Certainty of the Evidence | Plain text summary |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better Based on data from: 119 patients in 2 studies. (Randomized controlled)</td>
<td>Comparator Waitlist/ TAU</td>
<td>Intervention Present centered therapy (HOPE)</td>
<td>Moderate Due to serious imprecision ¹</td>
<td>Present centered therapy (HOPE) probably decreases PTSD symptom severity</td>
</tr>
</tbody>
</table>

1. **Risk of Bias: No serious.** Inadequate/lack of blinding of outcome assessors, resulting in potential for detection bias. **Inconsistency: No serious.** **Indirectness: No serious.** **Imprecision: Serious.** Low number of patients (n=119). Wide confidence intervals (CIs include important benefit and unimportant benefit). **Publication bias: No serious.**

### Behavioural activation

For adults with PTSD symptoms in the first three months after exposure to a traumatic event, there was insufficient evidence to make a recommendation on behavioural activation.

*Behavioural activation aims to help the individual to learn to manage negative feelings through activity planning. Core features of the intervention include psychoeducation, behavioural analysis, activity planning, goal identification, trouble shooting, homework and relapse prevention.*

### Clinical Question/ PICO

<table>
<thead>
<tr>
<th>Population:</th>
<th>Adults within the first three months post traumatic event</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention:</td>
<td>Behavioural activation</td>
</tr>
<tr>
<td>Comparator:</td>
<td>Waitlist/ treatment as usual</td>
</tr>
</tbody>
</table>
Supportive counselling

For adults with PTSD symptoms in the first three months after exposure to a traumatic event, there was insufficient evidence to make a recommendation on supportive counselling.

SC involves active, empathic listening to the patient who is usually provided with unconditional positive regard. The therapist helps the patient to explore and clarify issues, may provide advice, reflect and confirm appropriate reactions, and introduce problem-solving techniques. SC has been used as a non-trauma focused control condition in several trials and focused attention to the index trauma event is usually avoided.

Clinical Question/ PICO

| Population: | Adults within the first three months post-traumatic event |
| Intervention: | Trauma-focused CBT |
| Comparator: | Supportive counselling |

1. **Risk of Bias:** Serious. Due to arms unmatched in terms of gender, 3 males in the intervention group 0 in the control group. Sample was too small to detect differences at baseline in a statistically meaningful way. **Inconsistency:** No serious. **Indirectness:** No serious. **Imprecision:** Very serious. Low number of patients (n=8), Wide confidence intervals (CI includes important benefit and important harm). **Publication bias:** No serious.

**PTSD symptom severity**

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better</td>
<td>Waitlist/treatment as usual</td>
<td>Behavioural activation</td>
<td>Very low Due to serious risk of bias. Due to very serious imprecision</td>
<td>We are uncertain whether behavioural activation increases or decreases PTSD symptom severity</td>
</tr>
</tbody>
</table>

Based on data from: 8 patients in 1 studies. (Randomized controlled)

Difference: SMD 0.9 lower

( CI 95% 2.42 lower — 0.62 higher )
**Outcome Timeframe** | **Study results and measurements** | **Comparator** | **Intervention** | **Certainty of the Evidence** | **Plain text summary**
---|---|---|---|---|---
**PTSD diagnosis** | Relative risk 0.61 (CI 95% 0.36 — 1.04) Based on data from 281 patients in 6 studies. (Randomized controlled) | 587 per 1000 | 358 per 1000 | Very low Due to serious risk of bias, Due to serious inconsistency, Due to serious imprecision | We are uncertain whether trauma-focused CBT is more beneficial than supportive counseling for PTSD diagnosis
**PTSD symptom severity** | Lower better Based on data from: 333 patients in 8 studies. (Randomized controlled) | Difference: SMD 0.7 lower (CI 95% 1.08 lower — 0.33 lower) | | | Trauma-focused CBT may be more effective than supportive counseling for decreasing PTSD symptom severity

1. **Risk of Bias: Serious.** Incomplete data and/or large loss to follow up, due to unbalanced number of treatment sessions. **Inconsistency: Serious.** The magnitude of statistical heterogeneity was high, with I^2:67%. **Imprecision: Serious.** Low number of events (events = 127). Wide confidence intervals (CI includes important benefit and unimportant harm).

2. **Risk of Bias: Serious.** Incomplete data and/or large loss to follow up, due to unbalanced number of treatment sessions. **Inconsistency: No serious.** The magnitude of statistical heterogeneity was high, with I^2:65% however all studies favour TFCBT so inconsistency is not considered important. **Indirectness: No serious.** Imprecision: Serious. Low number of patients (n=331), Wide confidence intervals (CI includes important benefit and unimportant benefit). **Publication bias: No serious.**

**Clinical Question/ PICO**

**Population:** Adults within the first three months post traumatic event **Intervention:** Supportive counselling **Comparator:** Waitlist/ treatment as usual

**Outcome Timeframe** | **Study results and measurements** | **Comparator** | **Intervention** | **Certainty of the Evidence** | **Plain text summary**
---|---|---|---|---|---
**PTSD diagnosis** | Relative risk 0.93 (CI 95% 0.61 — 1.39) Based on data from 59 patients in 1 studies. (Randomized controlled) | 633 per 1000 | 589 per 1000 | Very low Due to serious risk of bias, Due to very serious imprecision | We are uncertain whether supportive counselling increases or decreases PTSD diagnosis
**PTSD symptom severity** | Lower better Based on data from: 59 patients in 1 studies. (Randomized controlled) | Difference: SMD 0.09 lower (CI 95% 0.42 lower — 0.6 higher) | | | Supportive counselling may have little or no difference on PTSD symptom severity

1. **Risk of Bias: Serious.** Incomplete data and/or large loss to follow up, due to supportive counselling arm added 12
months into study, differences at baseline in type of assault. **Inconsistency:** No serious. **Indirectness:** No serious. **Imprecision:** Very serious. Low number of events (events = 59), Wide confidence intervals (CI includes important benefit and important harm). **Publication bias:** No serious.

2. **Risk of Bias:** Serious. Incomplete data and/or large loss to follow up, due to supportive counselling arm added 12 months into study, differences at baseline in type of assault. **Inconsistency:** No serious. **Indirectness:** No serious. **Imprecision:** Serious. Low number of patients (n=59), Wide confidence intervals (CI includes unimportant benefit and important harm). **Publication bias:** No serious.

**Computerised neurobehavioural training**

For adults with PTSD symptoms in the first three months after exposure to a traumatic event, there was insufficient evidence to make a recommendation on computerised neurobehavioural training.

**Computerised Neurobehavioral Training aims to teach participants skills in order to improve neurocognitive functioning through an online program. Participants are encouraged to practice new skills through regular practice.**

**Clinical Question/ PICO**

<table>
<thead>
<tr>
<th>Population</th>
<th>Adults within the first three months post-traumatic event</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention</td>
<td>Computerised neurobehavioural training</td>
</tr>
<tr>
<td>Comparator</td>
<td>Computerised games control condition</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better Based on data from: 59 patients in 1 studies (Randomized controlled)</td>
<td>Computerised games control condition</td>
<td>Computerised neurobehavioural training</td>
<td>Low Due to serious risk of bias, Due to serious imprecision 1</td>
<td>There may be little or no difference between Computerised neurobehavioural training and Computerised games control condition on PTSD symptom severity</td>
</tr>
</tbody>
</table>

**Difference:** SMD 0.17 lower (CI 95% 0.69 lower — 0.35 higher)

**Clinical Question/ PICO**

<table>
<thead>
<tr>
<th>Population</th>
<th>Adults within the first three months post-traumatic event</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention</td>
<td>Computerised neurobehavioural training</td>
</tr>
<tr>
<td>Comparator</td>
<td>Reading tasks control condition</td>
</tr>
</tbody>
</table>

1. **Risk of Bias:** Serious. The authors excluded participants who completed less than 60% of the practices (i.e. dropouts), under the assumption that neurocognitive modification requires repeated and extensive training “dose”. 75 of 97 participants (77.3%) contributed to analysis at the first follow-up. Discrepancies between protocol and final paper.

**Inconsistency:** No serious. **Indirectness:** No serious. **Imprecision:** Serious. Low number of patients (n=59), Wide confidence intervals (CI includes important benefit and unimportant harm). **Publication bias:** No serious.
Nurse-led psychological intervention

For adults with PTSD symptoms in the first three months after exposure to a traumatic event, there was insufficient evidence to make a recommendation on nurse-led psychological intervention.

Clinical Question/ PICO

| Population: | Adults within the first three months post-traumatic event |
| Intervention: | Nurse-led psychological intervention |
| Comparator: | TAU |

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better Based on data from: 49 patients in 1 studies. (Randomized controlled)</td>
<td>TAU</td>
<td>Nurse-led psychological intervention</td>
<td>Low Due to serious risk of bias, Due to serious imprecision</td>
<td>Nurse-led psychological intervention may have little or no difference on PTSD symptom severity</td>
</tr>
</tbody>
</table>

1. **Risk of Bias: Serious.** The authors excluded participants who completed less than 60% of the practices (i.e. dropouts), under the assumption that neurocognitive modification requires repeated and extensive training “dose”. 75 of 97 participants (77.3%) contributed to analysis at the first follow-up. Discrepancies between protocol and final paper. **Inconsistency: No serious. Indirectness: No serious. Imprecision: Very serious.** Low number of patients ($n=49$), Wide confidence intervals (CI includes important benefit and important harm). **Publication bias: No serious.**

Early pharmacological interventions for adults

Early pharmacological interventions for all
This section addresses the provision of pharmacological interventions for all those exposed – not only those who are presenting with adjustment problems.

Clinical question
“For adults within the first three months of a traumatic event, do pharmacological interventions when compared to placebo result in a clinically significant reduction/prevention of symptoms, or presence of disorder?”

Hydrocortisone

RESEARCH RECOMMENDATION

For adults with PTSD symptoms in the first three months after exposure to a traumatic event, we recommend offering TF-CBT, PE, CT or Brief EMDR in preference to hydrocortisone.

There is emerging evidence for hydrocortisone and this could be used in a research context.

*Hydrocortisone is the synthetic form of the adrenal gland-produced hormone cortisol. It has been used to try to bring about homeostasis (stability) to the hypothalamic-pituitary-adrenal axis by inhibiting further release of adrenaline and noradrenaline.*

Evidence To Decision

Benefits and harms
Evidence from 3 RCTs [282][293][294] suggests clinically important benefit from hydrocortisone on PTSD diagnosis and symptom severity in adults with symptoms of PTSD within three months following exposure to a traumatic event

No adverse events were reported in these studies but the Guideline Development Group made note of the potential harms of hydrocortisone, particularly in longer term use.

Certainty of the Evidence
Certainty of the evidence is VERY LOW due to serious risk of bias and very serious imprecision for PTSD symptom severity and PTSD diagnosis.

The evidence analyses and risk of bias assessments for this intervention can be found here for PTSD symptom severity and here for PTSD diagnosis.

Rationale
The Guideline Development Group considered the evidence from 3 RCTs suggesting clinically important benefit of hydrocortisone on PTSD diagnosis and symptom severity in adults with symptoms of PTSD, relative to placebo, within three months following exposure to a traumatic event. The Guideline Development Group noted that the existing studies involved different dosages and timings and could effectively be considered 3 different interventions. No adverse events were reported in these studies. The Guideline Development Group made note of the very low certainty of evidence from these studies as well as evidence of the potential harms of hydrocortisone in the broader literature and expert opinion, particularly in longer-term use. The Group agreed that it would, therefore, be inappropriate to recommend hydrocortisone and instead recommend further research to strengthen the evidence base and refine optimal administration and dosage details.

Clinical Question/ PICO

<table>
<thead>
<tr>
<th>Population:</th>
<th>Adults within the first three months post traumatic event</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention:</td>
<td>Hydrocortisone</td>
</tr>
</tbody>
</table>
### Comparator: Placebo

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator Placebo</th>
<th>Intervention Hydrocortisone</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD diagnosis 3-6 months</td>
<td>Relative risk 0.21 (CI 95% 0.05 — 0.89) Based on data from 88 patients in 3 studies. (Randomized controlled)</td>
<td>196 per 1000</td>
<td>41 per 1000</td>
<td>Very low Due to serious risk of bias, Due to very serious imprecision</td>
<td>We are uncertain whether hydrocortisone improves or worsen PTSD diagnosis</td>
</tr>
<tr>
<td>PTSD symptom severity 3-6 months</td>
<td>Lower better Based on data from: 43 patients in 1 studies. (Randomized controlled)</td>
<td>Difference: <strong>155 fewer</strong> per 1000 ( CI 95% 186 fewer — 22 fewer )</td>
<td>Difference: SMD <strong>0.63 lower</strong> ( CI 95% 1.25 lower — 0.02 lower )</td>
<td>Very low Due to serious risk of bias, Due to very serious imprecision</td>
<td>We are uncertain whether hydrocortisone improves or worsen PTSD symptom severity</td>
</tr>
</tbody>
</table>

1. **Risk of Bias: Serious.** Incomplete data and/or large loss to follow up, Selective outcome reporting, due to baseline demographic differences. **Inconsistency:** No serious. **Indirectness:** No serious. **Imprecision:** Very serious. Low number of events (events = 10), Wide confidence intervals (CI includes important benefit and unimportant benefit). **Publication bias:** No serious. One commercially funded study.

2. **Risk of Bias: Serious.** Incomplete data and/or large loss to follow up, Missing intention-to-treat analysis, baseline demographic differences. **Inconsistency:** No serious. **Indirectness:** No serious. **Imprecision:** Very serious. Low number of patients (n= 43), Wide confidence intervals (CI includes important benefit and unimportant benefit). **Publication bias:** No serious.

### Docosahexaenoic acid

For adults with PTSD symptoms in the first three months after exposure to a traumatic event, there was insufficient evidence to make a recommendation on docosahexaenoic acid.

### Clinical Question/ PICO

**Population:** Adults within the first three months of a traumatic event  
**Intervention:** Docosahexaenoic Acid  
**Comparator:** Placebo

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator Placebo</th>
<th>Intervention Docosahexaenoic Acid</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD diagnosis 3-6 months</td>
<td>Relative risk 2.15 (CI 95% 0.2 — 23.04) Based on data from 110</td>
<td>18 per 1000</td>
<td>39 per 1000</td>
<td>Low Due to very serious</td>
<td>Docosahexaenoic acid may increase PTSD diagnosis</td>
</tr>
</tbody>
</table>

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### Escitalopram

For adults with PTSD symptoms in the first three months after exposure to a traumatic event, there was insufficient evidence to make a recommendation on escitalopram.

### Clinical Question/ PICO

<table>
<thead>
<tr>
<th>Population</th>
<th>Adults within the first three months of a traumatic event</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention</td>
<td>Escitalopram</td>
</tr>
<tr>
<td>Comparator</td>
<td>Placebo</td>
</tr>
</tbody>
</table>

#### Outcome Timeframe

<table>
<thead>
<tr>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Placebo</td>
<td>Docosahexaenoic Acid</td>
<td>Imprecision</td>
<td>Docosahexaenoic acid probably has little or no difference on PTSD symptom severity.</td>
</tr>
</tbody>
</table>

#### PTSD symptom severity 3-6 months

<table>
<thead>
<tr>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Placebo</td>
<td>Docosahexaenoic Acid</td>
<td>Imprecision</td>
<td>Docosahexaenoic acid probably has little or no difference on PTSD symptom severity.</td>
</tr>
</tbody>
</table>

1. Inconsistency: No serious. Indirectness: No serious. Imprecision: Very serious. Low number of events (events = 3), Wide confidence intervals (CI includes important benefit and important harm). Publication bias: No serious.
### Oxytocin

For adults with PTSD symptoms in the first three months after exposure to a traumatic event, there was insufficient evidence to make a recommendation on oxytocin.

### Clinical Question/ PICO

**Population:** Adults within the first three months post traumatic event  
**Intervention:** Oxytocin  
**Comparator:** Placebo

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PTSD diagnosis</strong> 3-6 months</td>
<td>Relative risk 1.05 (CI 95% 0.61 – 1.79) Based on data from 68 patients in 2 studies. (Randomized controlled)</td>
<td>Placebo</td>
<td>Escitalopram</td>
<td>Very low Due to very serious risk of bias, Due to very serious imprecision ¹</td>
<td>Escitalopram may have little or no difference on PTSD diagnosis</td>
</tr>
<tr>
<td><strong>PTSD symptom severity</strong> 3-6 months</td>
<td>Lower better Based on data from: 68 patients in 2 studies. (Randomized controlled)</td>
<td>Placebo</td>
<td>Oxytocin</td>
<td>Very low Due to very serious risk of bias, Due to serious imprecision ²</td>
<td>We are uncertain whether escitalopram increases or decreases PTSD symptom severity</td>
</tr>
</tbody>
</table>

1. **Risk of Bias:** Very serious. Inadequate/lack of blinding of outcome assessors, resulting in potential for detection bias, Inadequate sequence generation/ generation of comparable groups (used Equipose stratified randomisation), resulting in potential for selection bias, Due to means not reported and differences at baseline, unbalanced loss to follow up.  
   **Inconsistency:** No serious.  
   **Indirectness:** No serious.  
   **Imprecision:** Very serious. Low number of events (events = 24), Wide confidence intervals (CI includes important benefit and important harm).  
   **Publication bias:** No serious.
2. **Risk of Bias:** Very serious. Inadequate/lack of blinding of outcome assessors, resulting in potential for detection bias, Inadequate sequence generation/ generation of comparable groups (used Equipose stratified randomisation), resulting in potential for selection bias, Due to means not reported and differences at baseline, unbalanced loss to follow up.  
   **Inconsistency:** No serious.  
   **Indirectness:** No serious.  
   **Imprecision:** Serious. Low number of patients (n= 68).  
   **Publication bias:** No serious.

---

Oxytocin may decrease PTSD symptom severity slightly.
Propranolol

For adults with PTSD symptoms in the first three months after exposure to a traumatic event, there was insufficient evidence to make a recommendation on propranolol.

Clinical Question/ PICO

- **Population:** Adults within the first three months post traumatic event
- **Intervention:** Propranolol
- **Comparator:** Placebo

### Outcome Timeframe

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator Placebo</th>
<th>Intervention Propranolol</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD diagnosis 3-6 months</td>
<td>Relative risk 0.72 (CI 95% 0.29 — 1.77) Based on data from 82 patients in 3 studies. (Randomized controlled)</td>
<td>222 per 1000</td>
<td>160 per 1000</td>
<td>Very low Due to serious risk of bias, Due to very serious imprecision</td>
<td>We are uncertain whether propranolol increases or decreases PTSD diagnosis</td>
</tr>
<tr>
<td>PTSD symptom severity 3-6 months</td>
<td>Lower better Based on data from: 52 patients in 2 studies. (Randomized controlled)</td>
<td>Difference: <strong>62 fewer</strong> per 1000 ( CI 95% 158 fewer — 171 more )</td>
<td>Difference: SMD <strong>0.06 higher</strong> ( CI 95% 0.49 lower — 0.61 higher )</td>
<td>Low Due to serious risk of bias, Due to serious imprecision</td>
<td>Propranolol may have little or no difference on PTSD symptom severity</td>
</tr>
</tbody>
</table>

1. **Risk of Bias:** Serious. Incomplete data and/or large loss to follow up (34%). **Inconsistency:** No serious. **Indirectness:** No serious. **Imprecision:** Very serious. Low number of events (events = 16), Wide confidence intervals (CI includes important benefit and important harm). **Publication bias:** No serious.

2. **Risk of Bias:** Serious. Incomplete data and/or large loss to follow up, Selective outcome reporting, difficulties reaching recruitment targets, poor drug adherence. **Inconsistency:** No serious. **Indirectness:** No serious. **Imprecision:** Serious. Low number of patients (n=52), Wide confidence intervals (CI includes unimportant benefit and important harm). **Publication bias:** No serious. Some authors reported funding from pharmaceutical company.

Australian Guidelines for the Prevention and Treatment of Acute Stress Disorder, Posttraumatic Stress Disorder, and Complex Posttraumatic Stress
Gapapentin

For adults with PTSD symptoms in the first three months after exposure to a traumatic event, there was insufficient evidence to make a recommendation on gabapentin.

Clinical Question/ PICO

<table>
<thead>
<tr>
<th>Population:</th>
<th>Adults within the first three months post traumatic event</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention:</td>
<td>Gabapentin</td>
</tr>
<tr>
<td>Comparator:</td>
<td>Placebo</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator Placebo</th>
<th>Intervention Gabapentin</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD diagnosis 3-6 months</td>
<td>Relative risk 0.8 (CI 95% 0.18 – 3.59) Based on data from 26 patients in 1 studies. (Randomized controlled)</td>
<td>250 per 1000</td>
<td>200 per 1000</td>
<td>Very low Due to serious risk of bias, Due to very serious imprecision</td>
<td>We are uncertain whether gabapentin increases or decreases PTSD diagnosis</td>
</tr>
</tbody>
</table>

1. **Risk of Bias: Serious.** Incomplete data and/or large loss to follow up, Missing intention-to-treat analysis, due to <10% of eligible participants agreed to participate. **Inconsistency: No serious. Indirectness: No serious. Imprecision: Very serious.** Low number of patients (n=6), Wide confidence intervals (CI includes important benefit and important harm). **Publication bias: No serious.**
Adults with clinically relevant post-traumatic stress symptoms

Psychological interventions for adults with PTSD

“For adults with PTSD, do psychological treatments when compared to treatment as usual, waiting list or no treatment, result in a reduction of symptoms, or presence of disorder?”

Cognitive processing therapy (CPT)

**Strong recommendation**

For adults with PTSD, we recommend cognitive processing therapy (CPT).

Cognitive processing therapy (CPT) is a form of cognitive therapy refined specifically for the treatment of PTSD. CPT is a 12-session cognitive-behavioural manualised treatment for PTSD that systematically addresses key posttraumatic themes, including safety, trust, power and control, self-esteem and intimacy. The primary goal of treatment is to create more balanced, adaptive, multi-faceted trauma appraisals and beliefs (both looking back on the traumatic experience and in the present).

Treatment helps the person to identify unhelpful thoughts and beliefs ('stuck points'), challenge them, and replace them with rational alternatives in an adaptation of standard cognitive therapy approaches. It has a smaller exposure component than imaginal exposure therapy (restricted to writing an account of the experience). It also helps to address associated problems such as depression, guilt and anger.

Evidence To Decision

**Benefits and harms**

Evidence from 4 RCTs [390][393][425][442] suggests a large clinically important benefit of CPT for PTSD symptom severity relative to waitlist or usual treatment (including CBT, psychoeducation, supportive counselling, non-trauma focused symptom management).

Evidence from a single RCT [442] suggests no important difference in benefit between CPT and prolonged exposure.

Evidence from a single study [367] suggests CPT is more beneficial than Dialogical Exposure Therapy for PTSD symptom severity.

**Certainty of the Evidence**

Overall certainty of evidence for Cognitive processing therapy (CPT) was MODERATE.

Certainty of evidence for Cognitive processing therapy (CPT) vs waitlist/treatment as usual was MODERATE due to serious imprecision.

The evidence analyses and risk of bias assessments for this intervention can be found here

Certainty of evidence for Cognitive processing therapy (CPT) vs Prolonged exposure (PE) was LOW due to serious imprecision, and serious risk of bias.

The evidence analyses and risk of bias assessments for this intervention can be found here

Certainty of evidence for Trauma-focused CBT (CPT) vs Dialogical exposure therapy (DET) was LOW due to serious risk of bias, and serious imprecision.

The evidence analyses and risk of bias assessments for this intervention can be found here

**Preference and values**
Most patients would be willing to undergo Cognitive Processing Therapy, given the benefits and no reported harms.

Patient preferences and the availability of specific treatments are likely to guide selection of one of the recommended treatments (TF-CBT, CPT, CT, PE, EMDR) for adults with PTSD.

Based on the evidence gathered through real world effectiveness trials of trauma focused treatments, a proportion of patients may be expected to drop out of treatment. Adequate preparation including providing a rationale for treatment and a realistic preview of what treatment will involve is likely to minimise drop out.

Resources and other considerations

For patients with work-related PTSD, treatment will be funded by third party insurers. For others with private health insurance, psychology sessions may be partially reimbursed. For patients relying on Medicare, the number of sessions on a mental health plan referral from a GP is limited to 10 per year. This can often be inadequate for comprehensive PTSD assessment and treatment. As such, patient's access to psychological treatment varies according to funding sources including their capacity to pay for their own treatment.

From the perspective of the GP, access to psychological treatments can be slow to procure and those patients less committed to obtaining help can get lost in the process. Further, the requirement to access ATAPS and Better Access via the Primary Health Networks limits GPs capacity to refer directly to a practitioner of choice. Increased clarity regarding which psychologists are offering which therapies would assist GPs to make relevant and useful referrals via the Medicare mental health care plan process.

Rationale

The Guideline Development Group agreed to make a strong recommendation for the use of CPT for adults with PTSD on the basis of large, clinically important benefits, with no associated harms, and the fact that CPT has been widely used in clinical practice over several years.

Clinical Question/ PICO

<table>
<thead>
<tr>
<th>Population</th>
<th>Adults with PTSD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention</td>
<td>Trauma-focused CBT (CPT)</td>
</tr>
<tr>
<td>Comparator</td>
<td>Dialogical exposure therapy (DET)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better Based on data from: 138 patients in 1 studies. (Randomized controlled)</td>
<td>Difference: <strong>SMD 0.39 lower</strong> ( CI 95% 0.73 lower — 0.05 lower )</td>
<td>Low Due to serious risk of bias, Due to serious imprecision 1</td>
<td>Trauma-focused CBT (CPT) may be more beneficial than DET for PTSD symptom severity</td>
<td></td>
</tr>
</tbody>
</table>

1. Risk of Bias: Serious. Due to methods were poorly described. Training cases for CPT were taken from the randomised sample and subsequently excluded from analysis. Inconsistency: No serious. Indirectness: No serious. Imprecision: Serious.
Clinical Question/ PICO

**Population:** Adults with PTSD  
**Intervention:** Cognitive Processing Therapy  
**Comparator:** Waitlist/ treatment as usual

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
</table>
| PTSD symptom severity | Lower better  
Based on data from: 298 patients in 4 studies.  
(Randomized controlled) | Comparator: Waitlist/ treatment as usual  
Intervention: Cognitive Processing Therapy  
**Difference:** SMD 1.03 lower  
( CI 95% 1.45 lower — 0.61 lower ) | Moderate  
Due to serious imprecision  
1 | Cognitive processing therapy probably decreases PTSD symptom severity |

1. **Inconsistency:** No serious. The magnitude of statistical heterogeneity was high, with I^2:65% however all studies show positive effects so not important. **Indirectness:** No serious. **Imprecision:** Serious. Low number of patients (n=298), Wide confidence intervals (CIs include important benefit and unimportant benefit). **Publication bias:** No serious.

Clinical Question/ PICO

**Population:** Adults with PTSD  
**Intervention:** Cognitive processing therapy (CPT)  
**Comparator:** Prolonged exposure (PE)

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
</table>
| PTSD symptom severity | Based on data from: 124 patients in 1 studies.  
(Randomized controlled) | Comparator: Prolonged exposure (PE)  
Intervention: Cognitive processing therapy (CPT)  
**Difference:** SMD 0.18 lower  
( CI 95% 0.53 lower — 0.17 higher ) | Low  
Due to serious imprecision, Due to serious risk of bias  
1 | There may be little or no difference between Cognitive processing therapy (CPT) and PE on PTSD symptom severity. |

1. **Risk of Bias:** Serious. The issue of researcher allegiance cannot be ruled out. **Inconsistency:** No serious. **Indirectness:** No serious. **Imprecision:** Serious. Low number of patients (n=124), Wide confidence intervals (CIs include important benefit and unimportant harm), Only data from one study. **Publication bias:** No serious.
Cognitive therapy (CT)

**Strong recommendation**

For adults with PTSD, we recommend cognitive therapy (CT).

CT is a variant of trauma-focused CBT in which the therapist and patient collaboratively develop an individualised version of Ehlers and Clark’s model of PTSD, which serves as the framework for therapy. Ehlers and Clark (2000) suggested that PTSD becomes persistent when individuals process the trauma in a way that leads to a sense of serious, current threat. The sense of threat is hypothesised to arise as a consequence of excessively negative appraisals of the trauma and/or its sequelae, and a disturbance of the autobiographical memory for the trauma which leads to involuntary re-experiencing of aspects of the trauma. The problem is maintained by unhelpful behavioral and cognitive strategies that are intended to control the symptoms and perceived threat. Accordingly, CT for PTSD aims to modify excessively negative appraisals, correct the autobiographical memory disturbance, and remove the problematic behavioural and cognitive strategies. CT is generally administered for 12 weekly treatment sessions (of 90 minutes for the initial sessions, and 60 minutes for the following sessions).¹³³

Evidence To Decision

**Benefits and harms**

Evidence from 4 RCTs [378][380][381][382] suggests large clinically important benefit of cognitive therapy for PTSD symptom severity relative to waitlist.

**Certainty of the Evidence**

The certainty of the evidence is LOW due to serious risk of bias and serious imprecision.

The evidence analyses and risk of bias assessments for this intervention can be found here.

**Preference and values**

Most patients would be willing to undergo Cognitive Therapy, given the benefits and no reported harms.

Patient preferences and the availability of specific treatments are likely to guide selection of one of the recommended treatments (TF-CBT, CPT, CT, PE, EMDR) for adults with PTSD.

**Resources and other considerations**

For patients with work-related PTSD, treatment will be funded by third party insurers. For others with private health insurance, psychology sessions may be partially reimbursed. For patients relying on Medicare, the number of sessions on a mental health plan referral from a GP is limited to 10 per year. This can often be inadequate for comprehensive PTSD assessment and treatment. As such, patient’s access to psychological treatment varies according to funding sources including their capacity to pay for their own treatment.

From the perspective of the GP, access to psychological treatments can be slow to procure and those patients less committed to obtaining help can get lost in the process. Further, the requirement to access ATAPS and Better Access via the Primary Health Networks limits GPs capacity to refer directly to a practitioner of choice. Increased clarity regarding which psychologists are offering which therapies would assist GPs to make relevant and useful referrals via the Medicare mental health care plan process.

**Rationale**

The Guideline Development Group (GDG) agreed to make a strong recommendation for the use of cognitive therapy for adults with PTSD, despite the uncertainty in the evidence for its benefits. This was based on three factors: 1) the judgement of the GDG that cognitive therapy has shown large clinically important benefits, has no associated harms, and has been widely used in clinical practice over several years; 2) the GDG’s expert opinion that the current uncertainty in the evidence would be removed by future research into this intervention giving strength to the evidence base; and 3) the GDG also considered the...
recommendations of other PTSD treatment guidelines internationally. The only other guidelines to name CT as an intervention in its own right (rather than within the broad category of TR-CBT) were the ISTSS and American Psychological Association Guidelines. CT received a strong recommendation for adults with PTSD in both of these guidelines.

### Clinical Question/ PICO

| Population: | Adults with PTSD |
| Intervention: | Cognitive Therapy |
| Comparator: | Waitlist |

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better Based on data from: 189 patients in 4 studies. (Randomized controlled)</td>
<td>Waitlist</td>
<td>Cognitive Therapy</td>
<td>Low Due to serious imprecision, Due to serious risk of bias ¹</td>
<td>Cognitive therapy may decrease PTSD symptom severity</td>
</tr>
</tbody>
</table>

1. **Risk of Bias:** Serious. Unclear if treatment adherence was measured, Incomplete data and/or large loss to follow up. Inconsistency: No serious. Indirectness: No serious. Imprecision: Serious. Low number of patients (n=182). **Publication bias:** No serious.

### EMDR

EMDR is a standardised, eight-phase, trauma-focused therapy involving the use of bilateral physical stimulation (eye movements, taps or tones). EMDR is based on the assumption that, during a traumatic event, overwhelming emotions or dissociative processes may interfere with information processing. This leads to the experience being stored in an ‘unprocessed’ way, disconnected from existing memory networks.

In EMDR the person is asked to focus on the trauma-related imagery, and the associated thoughts, emotions, and body sensations while bilateral physical stimulation, such as moving their eyes back and forth, occurs. Processing targets may involve past events, present triggers and adaptive future functioning. It is proposed that this dual attention facilitates the processing of the traumatic memory into existing knowledge networks, although the precise mechanism involved is not known.

### Evidence To Decision

**Benefits and harms**

Evidence from 11 RCTs [352][354][370][375][400][405][419][438][445][446][460]) suggests a large clinically important benefit of EMDR on PTSD symptom severity relative to wait list or usual treatment.
Evidence suggests small to moderate, clinically important benefits relative to CBT-T [368][376][402][413][414][434][438][446][458][460], supportive counselling [448] and relaxation training [369][370][458][460].

Evidence suggests trivial unimportant differences between EMDR and EFT [408] or REM desensitisation [353].

**Certainty of the Evidence**

Overall certainty of evidence for EMDR was MODERATE.

Certainty of certainty of evidence for EMDR vs waitlist/treatment as usual was MODERATE due to serious risk of bias.

The evidence analyses and risk of bias assessments for this intervention can be found [here](#).

Certainty of certainty of evidence for EMDR vs Trauma-focused CBT was VERY LOW due to serious risk of bias, serious inconsistency, and serious imprecision.

The evidence analyses and risk of bias assessments for this intervention can be found [here](#).

Certainty of certainty of evidence for EMDR vs Supportive counselling was MODERATE due to serious imprecision.

The evidence analyses and risk of bias assessments for this intervention can be found [here](#).

Certainty of certainty of evidence for EMDR vs Emotional freedom techniques (EFT) was VERY LOW due to serious risk of bias, and very serious imprecision.

The evidence analyses and risk of bias assessments for this intervention can be found [here](#).

Certainty of certainty of evidence for EMDR vs Relaxation training was MODERATE due to serious imprecision.

The evidence analyses and risk of bias assessments for this intervention can be found [here](#).

Certainty of certainty of evidence for EMDR vs REM desensitization was VERY LOW due to serious risk of bias, and very serious imprecision.

The evidence analyses and risk of bias assessments for this intervention can be found [here](#).

**Preference and values**

Most patients would be willing to undergo EMDR, given the benefits and no reported harms.

Patient preferences and the availability of specific treatments are likely to guide selection of one of the recommended treatments (TF-CBT, CPT, CT, PE, EMDR) for adults with PTSD.

EMDR may suit patients who prefer a less 'cognitive' treatment, and who prefer not to engage in homework assignments.

**Resources and other considerations**

For patients with work-related PTSD, treatment will be funded by third party insurers. For others with private health insurance, psychology sessions may be partially reimbursed. For patients relying on Medicare, the number of sessions on a mental health plan referral from a GP is limited to 10 per year. This can often be inadequate for comprehensive PTSD.
The Guideline Development Group agreed to make a strong recommendation for EMDR due to the evidence that EMDR is effective in reducing PTSD symptom severity and has no associated harms. This evidence shows benefit for individuals that have experienced a range of traumas such as combat trauma, sexual assault, refugee-related trauma and occupational trauma, from a range of locations including USA, Australia, Sweden, Turkey, Iran, and Scotland.

Clinical Question/ PICO

| Population: | Adults with PTSD |
| Intervention: | EMDR |
| Comparator: | Waitlist/ treatment as usual |

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator Waitlist/ treatment as usual</th>
<th>Intervention EMDR</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
</table>
| PTSD symptom severity | Lower better. Based on data from: 415 patients in 11 studies. (Randomized controlled) | Difference: **SMD 1.23 lower**  
( CI 95% 1.65 lower — 0.81 lower ) | Moderate  
Due to serious risk of bias ¹ | EMDR probably decreases PTSD symptom severity |

1. **Risk of Bias: Serious.** Inadequate/lack of blinding of outcome assessors, resulting in potential for detection bias, Incomplete data and loss to follow up unlikely to impact effect size. **Inconsistency: No serious.** The magnitude of statistical heterogeneity was high, with I^2:70% however all studies showed positive effects with the majority showing very large effect size so not important. **Indirectness: No serious. Imprecision: No serious. Publication bias: No serious.**

Clinical Question/ PICO

| Population: | Adults with PTSD |
| Intervention: | EMDR |
| Comparator: | Trauma-focused CBT |

---

¹ Due to serious risk of bias
1. **Risk of Bias: Serious.** Inadequate sequence generation/generation of comparable groups, resulting in potential for selection bias in 1 study, incomplete data and large loss to follow up, due to [baseline differences]. **Inconsistency: Serious.** The magnitude of statistical heterogeneity was high, with I^2:60%. **Indirectness: No serious.** **Imprecision: Serious.** Low number of patients (n=337), wide confidence intervals (CIs include important benefit and unimportant harm). **Publication bias: No serious.**

Clinical Question/ PICO

**Population:** Adults with PTSD  
**Intervention:** EMDR  
**Comparator:** Supportive counselling

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
</table>
| PTSD symptom severity | Lower better  
Based on data from: 337 patients in 10 studies.  
(Randomized controlled) | Trauma-focused CBT | EMDR | Very low  
Due to serious risk of bias, Due to serious inconsistency, Due to serious imprecision | We are uncertain if there is a difference between EMDR and CBT-T on PTSD symptom severity |

Difference: SMD 0.21 lower  
( CI 95% 0.57 lower — 0.15 higher )

1. **Inconsistency: No serious.** **Indirectness: No serious.** **Imprecision: Serious.** Low number of patients (n=57). Only data from one study. **Publication bias: No serious.**

Clinical Question/ PICO

**Population:** Adults with PTSD  
**Intervention:** EMDR  
**Comparator:** Emotional freedom techniques (EFT)
<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator Emotional freedom techniques (EFT)</th>
<th>Intervention</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PTSD symptom severity</strong></td>
<td>Lower better Based on data from: 46 patients in 1 studies. (Randomized controlled)</td>
<td>Difference: SMD 0.08 higher ( CI 95% 0.5 lower — 0.65 higher )</td>
<td>Very low Due to serious risk of bias, Due to very serious imprecision ¹</td>
<td>We are uncertain if there is a difference between EMDR and EFT on PTSD symptom severity</td>
<td></td>
</tr>
</tbody>
</table>

1. **Risk of Bias: Serious.** Incomplete data and large loss to follow up. **Inconsistency: No serious.** **Indirectness: No serious.** **Imprecision: Very serious.** Low number of patients (n=46), Wide confidence intervals (CIs include important benefit and important harm), Only data from one study. **Publication bias: No serious.**

**Clinical Question/ PICO**

Population: Adults with PTSD  
Intervention: EMDR  
Comparator: Relaxation training

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator Relaxation training</th>
<th>Intervention</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PTSD symptom severity</strong></td>
<td>Lower better Based on data from: 117 patients in 4 studies. (Randomized controlled)</td>
<td>Difference: SMD 0.24 lower ( CI 95% 0.61 lower — 0.13 higher )</td>
<td>Moderate Due to serious imprecision ¹</td>
<td>EMDR is probably more beneficial than relaxation training on PTSD symptom severity</td>
<td></td>
</tr>
</tbody>
</table>

1. **Inconsistency: No serious.** **Indirectness: No serious.** **Imprecision: Serious.** Low number of patients (n=117), Wide confidence intervals (CIs include important benefit and unimportant harm). **Publication bias: No serious.**

**Clinical Question/ PICO**

Population: Adults with PTSD  
Intervention: EMDR  
Comparator: REM desensitisation

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator REM desensitisation</th>
<th>Intervention</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PTSD symptom</strong></td>
<td>Very low</td>
<td>We are uncertain if there is a difference between EMDR and REM desensitisation on PTSD symptom severity</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Australian Guidelines for the Prevention and Treatment of Acute Stress Disorder, Posttraumatic Stress Disorder, and Complex Posttraumatic Stress

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1. **Risk of Bias: Serious.** Incomplete data and large loss to follow up, Participants were required to start taking medication before the start of the study.Methods and interventions poorly reported. Interventions poorly described. **Inconsistency: No serious.** **Indirectness: No serious.** **Imprecision: Very serious.** Low number of patients (n=21), Wide confidence intervals (CIs include important benefit and important harm), Only data from one study. **Publication bias: No serious.**

### Prolonged exposure (PE)

*Strong recommendation*

For adults with PTSD we recommend prolonged exposure (PE).

Exposure therapy is long established as an effective treatment for a range of anxiety disorders. The key objective of exposure therapy is to help the person confront the object of their anxieties. A fundamental principle underlying the process of exposure is that of habituation, the notion that if people can be kept in contact with the anxiety-provoking stimulus for long enough, their anxiety will inevitably reduce. This may occur within an exposure session (within-session habituation) or across a series of sessions (between-session habituation). More contemporary models emphasise information processing as a key mechanism.

Prolonged Exposure is a manualised therapy (Foa, Hembree & Rothbaum, 2007). It consists of psychoeducation about common reactions to trauma, breathing retraining, in vivo exposure (approaching safe situations that patients avoided due to trauma-related fear), imagery exposure (repeated recounting of trauma memories during sessions and listening to recordings of the recounting made during therapy sessions), and processing (discussion of thoughts and feelings related to the exposure exercises).

### Evidence To Decision

#### Benefits and harms

Evidence from 12 RCTs [355][385][386][387][388][389][429][435][441][442][446][462] suggests a large clinically important benefit from PE on PTSD symptom severity in adults with PTSD.

Evidence from a single RCT [433] suggests a small unimportant difference between PE and a group psychoeducation intervention in adult veterans with PTSD

Evidence from a single RCT [442] suggests no important difference in benefit between PE and CPT

#### Certainty of the Evidence

Overall certainty of evidence for Prolonged Exposure was MODERATE.

Certainty of evidence for Prolonged Exposure vs waitlist/treatment as usual was MODERATE due to serious risk of bias.

The evidence analyses and risk of bias assessments for this intervention can be found here
Certainty of evidence for Prolonged Exposure vs Health Education was MODERATE due to serious imprecision.

The evidence analyses and risk of bias assessments for this intervention can be found here

Certainty of evidence for Cognitive processing therapy (CPT) vs Prolonged exposure was LOW due to serious imprecision, and serious risk of bias.

The evidence analyses and risk of bias assessments for this intervention can be found here

Preference and values
Most patients would be willing to undergo Cognitive Processing Therapy, given the benefits and no reported harms.

Patient preferences and the availability of specific treatments are likely to guide selection of one of the recommended treatments (TF-CBT, CPT, CT, PE, EMDR) for adults with PTSD.

Based on the evidence gathered through real world effectiveness trials of trauma focused treatments, a proportion of patients may be expected to drop out of treatment. Adequate preparation including providing a rationale for treatment and a realistic preview of what treatment will involve is likely to minimise drop out.

Resources and other considerations
For patients with work-related PTSD, treatment will be funded by third party insurers. For others with private health insurance, psychology sessions may be partially reimbursed. For patients relying on Medicare, the number of sessions on a mental health plan referral from a GP is limited to 10 per year. This can often be inadequate for comprehensive PTSD assessment and treatment. As such, patient's access to psychological treatment varies according to funding sources including their capacity to pay for their own treatment.

From the perspective of the GP, access to psychological treatments can be slow to procure and those patients less committed to obtaining help can get lost in the process. Further, the requirement to access ATAPS and Better Access via the Primary Health Networks limits GPs capacity to refer directly to a practitioner of choice. Increased clarity regarding which psychologists are offering which therapies would assist GPs to make relevant and useful referrals via the Medicare mental health care plan process.

Rationale
The Guideline Development Group agreed to make a strong recommendation for the use of PE for adults with PTSD. There was a large body of moderate certainty evidence suggesting that PE reduces PTSD symptom severity relative to waitlist or usual treatment and is not associated with harms. These benefits have been shown in a variety of trauma types including active and ex-serving military, sexual assault, people living with HIV, and physical assault.

Clinical Question/ PICO

<table>
<thead>
<tr>
<th>Population:</th>
<th>Adults with PTSD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention:</td>
<td>Cognitive processing therapy (CPT)</td>
</tr>
<tr>
<td>Comparator:</td>
<td>Prolonged exposure (PE)</td>
</tr>
</tbody>
</table>
### PTSD symptom severity

#### Outcome Timeframe
- Study results and measurements
- Comparator: Prolonged exposure (PE)
- Intervention: Cognitive processing therapy (CPT)
- Certainty of the Evidence (Quality of evidence)

#### Comparator
- Prolonged exposure (PE)
- Interventions: Cognitive processing therapy (CPT)

#### Certainty of the Evidence
- Low

#### Plain text summary
- There may be little or no difference between Cognitive processing therapy (CPT) and PE on PTSD symptom severity.

#### Risk of Bias: Serious. The issue of researcher allegiance cannot be ruled out. Inconsistency: No serious. Indirectness: No serious. Imprecision: Serious. Low number of patients (n=124), Wide confidence intervals (CIs include important benefit and unimportant harm), Only data from one study. Publication bias: No serious.

### Clinical Question/ PICO

**Population:** Adults with PTSD  
**Intervention:** Prolonged Exposure  
**Comparator:** Waitlist/ treatment as usual

#### Outcome Timeframe
- Study results and measurements
- Comparator: Waitlist/ treatment as usual
- Intervention: Prolonged Exposure
- Certainty of the Evidence (Quality of evidence)

#### Comparator
- Waitlist/ treatment as usual
- Prolonged Exposure

#### Certainty of the Evidence
- Moderate

#### Plain text summary
- Prolonged exposure probably decreases PTSD symptom severity.

#### Risk of Bias: Serious. Completer data only in 2 studies. Inadequate of blinding of outcome assessors, resulting in potential for detection bias in 1 study. Inconsistency: No serious. The magnitude of statistical heterogeneity was high, with I^2:85% however all studies showed positive effects favouring PE. Differences were between studies with very large and moderate effect sizes so not important. Indirectness: No serious. Imprecision: No serious. Publication bias: No serious.

### Clinical Question/ PICO

**Population:** Adults with PTSD  
**Intervention:** Prolonged exposure  
**Comparator:** Health Education
1. **Inconsistency:** No serious. **Indirectness:** No serious. **Imprecision:** Serious. Low number of patients (n=134), Wide confidence intervals (CIs include important benefit and unimportant harm), Only data from one study. **Publication bias:** No serious.

**Trauma-focussed CBT (TF-CBT)**

**Strong recommendation**

**For adults with PTSD we recommend trauma-focussed CBT.**

*Trauma-focussed cognitive-behavioural therapy (TF-CBT) is a broad term that encompasses any treatment that employs the standard principles of CBT combined with some form of trauma processing. Generally, TF-CBT involves the integration of CBT principles with components of exposure therapy, including imaginal exposure and graded in vivo exposure. Across most studies from the systematic review that underpins these Guidelines, the typical format of TF-CBT involves psychoeducation, breathing/relaxation training (arousal reduction strategies), imaginal exposure, in vivo exposure, and cognitive restructuring.*

**Evidence To Decision**

**Benefits and harms**

Evidence from 7 RCTs suggests clinically important benefit of CBT-T on PTSD symptom severity relative to waitlist or usual care (including supportive counselling and relaxation training) ([244][365][379][421][422][438][469]).

**Certainty of the Evidence**

Certainty of evidence for Trauma-focussed CBT vs waitlist/treatment as usual was MODERATE due to serious imprecision.

The evidence analyses and risk of bias assessments for this intervention can be found [here](#).

**Preference and values**

Most patients would be willing to undergo trauma-focussed CBT, given the benefits and no reported harms.

Patient preferences and the availability of specific treatments are likely to guide selection of one of the recommended treatments (TF-CBT, CPT, CT, PE, EMDR) for adults with PTSD.

Patients may also have various preferences regarding intensity and pace of treatment.

Based on the evidence gathered through real world effectiveness trials of trauma focused treatments, a proportion of patients may be expected to drop out of treatment. Adequate preparation including providing a rationale for treatment and
Rationale

The Guideline Development Group were confident in making a strong recommendation for TF-CBT based on extensive evidence that TF-CBT reduces PTSD symptom severity relative to waitlist or usual treatment (including supportive counselling and relaxation training) in adults with PTSD, that it is not associated with any harms and has been widely used in clinical practice over several years. The Group noted that the benefit of TF-CBT was shown in a variety of trauma types including military, motor vehicle accident, sexual and physical assault and terrorist attack.

Resources and other considerations

For patients with work-related PTSD, treatment will be funded by third party insurers. For others with private health insurance, psychology sessions may be partially reimbursed. For patients relying on Medicare, the number of sessions on a mental health plan referral from a GP is limited to 10 per year. This can often be inadequate for comprehensive PTSD assessment and treatment. As such, patient's access to psychological treatment varies according to funding sources including their capacity to pay for their own treatment.

From the perspective of the GP, access to psychological treatments can be slow to procure and those patients less committed to obtaining help can get lost in the process. Further, the requirement to access ATAPS and Better Access via the Primary Health Networks limits GPs capacity to refer directly to a practitioner of choice. Increased clarity regarding which psychologists are offering which therapies would assist GPs to make relevant and useful referrals via the Medicare mental health care plan process.

Clinical Question/ PICO

<table>
<thead>
<tr>
<th>Population:</th>
<th>Adults with PTSD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention:</td>
<td>Trauma focused-CBT</td>
</tr>
<tr>
<td>Comparator:</td>
<td>Waitlist/ treatment as usual</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator Waitlist/ treatment as usual</th>
<th>Intervention Trauma focused-CBT</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Based on data from: 291 patients in 7 studies. (Randomized controlled)</td>
<td>Difference: <strong>SMD 0.97 lower</strong> ( CI 95% 1.32 lower — 0.63 lower )</td>
<td>Moderate Due to serious imprecision ¹</td>
<td>Trauma focused-CBT probably decreases PTSD symptom severity</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. **Risk of Bias:** No serious. Incomplete data and/or large loss to follow up in 1 study, due to therapy delivered by a single therapist in 1 study. **Inconsistency:** No serious. **Imprecision:** Serious. Low number of patients (n= 291), Wide confidence intervals (CI includes important and unimportant benefit). **Publication bias:** No serious. Asymmetrical funnel plot.
Guided internet-based trauma-focussed CBT

**Conditional recommendation**

For adults with PTSD where trauma-focussed cognitive behavioural therapies or EMDR are unavailable or unacceptable, we suggest guided internet-based trauma-focussed CBT.

Most internet-based interventions for PTSD commence with psychoeducation, and then present the rationale for CBT-based treatment. These programs incorporate cognitive techniques, with the aim of identifying and modifying unhelpful patterns of cognition. Usually, behavioural components are included; generally encompassing imaginal and in vivo exposure. Internet-based interventions vary in the level of therapist assistance provided. Guided internet-based programs can be delivered by a specialist therapist who provides input and feedback on homework, and encourages engagement with the program, or by a non-specialist mental health professional who intervenes to check on progress or provides input on demand, often by telephone or by email. An example of the latter is DESTRESS-PC, a variant of CBT and stress inoculation training designed for symptoms resulting from military trauma.

### Evidence To Decision

**Benefits and harms**

Evidence from 3 RCTs suggests large clinically important benefit from guided internet-based CBT-T relative to waitlist or attention control.

Evidence from a single RCT suggests a small clinically important benefit of guided internet-based CBT-T above that of internet-based supportive counseling without a trauma focus.

Evidence from a single RCT suggests no important difference between guided internet-based CBT-T and internet-based psychotherapy.

### Certainty of the Evidence

Overall certainty of evidence for Guided internet-based trauma focussed CBT was LOW.

Certainty of evidence for Guided internet-based trauma focussed CBT vs waitlist/treatment as usual was LOW due to serious imprecision, and serious inconsistency.

Certainty of evidence for Guided internet-based trauma focussed CBT vs Attention Control was MODERATE due to serious imprecision.

Certainty of evidence for Guided internet-based trauma focussed CBT vs Internet-based non-trauma-focussed supportive counselling was VERY LOW due to serious risk of bias, and very serious imprecision.

Certainty of evidence for Guided internet-based trauma focused CBT vs Internet-based psychoeducation was VERY LOW due to serious risk of bias, and very serious imprecision.

### Preference and values

Given possible benefits of guided internet-based trauma-focused CBT, patients are likely to consider this if individual trauma-focussed CBT is not available.
Although not a frontline recommended treatment, some patients may have a preference for guided internet-based treatment in addition to, or instead of, individual treatment. This may be due to a number of factors including cost, convenience, ability to pace the treatment, and PTSD-related avoidance.

As noted in relation to face-to-face trauma-focussed CBT, it is possible that elements of the guided internet based trauma-focussed CBT will lead to a temporary increase in distress. Patient drop-out rates for guided internet based trauma-focussed CBT have been reported as variable.

Resources and other considerations

There are a number of online programs available with differing costs and degree of therapist contact to guide the process.

Access to psychological treatments can be slow to procure and those patients less committed to obtaining help can get lost in the process. With online services, accessibility is less of an issue, with this treatment readily available to the majority. However language barriers, literacy/technology barriers, and physical inability to use a computer, still exist for some.

Rationale

The Guideline Development Group considered the evidence showing benefits of guided internet-based TF-CBT for adults with PTSD relative to waitlist, attention control and internet-based supportive counseling without a trauma focus. The Guideline Development Group agreed to make a conditional recommendation despite low certainty of the evidence to offer guided internet-based TF-CBT for adults with PTSD to those who are unwilling to undertake first-line treatment or unable to access it for reasons of availability or cost.

Clinical Question/ PICO

| Population: | Adults with PTSD |
| Intervention: | Guided internet-based trauma focused CBT |
| Comparator: | Waitlist/ treatment as usual |

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator Waitlist/ treatment as usual</th>
<th>Intervention Guided internet-based trauma focused CBT</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better Based on data from: 84 patients in 2 studies. (Randomized controlled)</td>
<td></td>
<td></td>
<td>Low Due to serious imprecision, Due to serious inconsistency, Due to serious inconsistency 1</td>
<td>Guided internet-based trauma focused CBT may decrease PTSD symptom severity</td>
</tr>
</tbody>
</table>

1. **Risk of Bias:** No serious. Inadequate/lack of blinding of outcome assessors, resulting in potential for detection bias in 1 study. **Inconsistency:** Serious. The magnitude of statistical heterogeneity was high, with I^2:87% however this may be
explained by differences in baseline PTSD severity between studies. **Indirectness: No serious. Imprecision: Serious.** Low number of patients (n=84), Wide confidence intervals (CIs include important benefit and unimportant harm). **Publication bias: No serious.**

### Clinical Question/ PICO

- **Population:** Adults with PTSD
- **Intervention:** Guided internet-based trauma focused CBT
- **Comparator:** Attention control

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of Evidence</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better</td>
<td>SMD 1.05 lower (CI 95% 1.59 lower — 0.52 lower)</td>
<td>Guided internet-based trauma focused CBT</td>
<td>Moderate</td>
<td>Due to serious imprecision ¹</td>
</tr>
</tbody>
</table>

1. **Inconsistency: No serious. Indirectness: No serious. Imprecision: Serious.** Low number of patients (n=62). **Publication bias: No serious.**

### Clinical Question/ PICO

- **Population:** Adults with PTSD
- **Intervention:** Guided internet-based trauma-focused CBT
- **Comparator:** Internet-based non-trauma-focused supportive counselling

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of Evidence</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better</td>
<td>SMD 0.4 lower (CI 95% 1.12 lower — 0.31 higher)</td>
<td>Guided internet-based trauma-focused CBT</td>
<td>Very low</td>
<td>Due to serious risk of bias, Due to very serious imprecision ¹</td>
</tr>
</tbody>
</table>

1. **Risk of Bias: Serious.** Incomplete data and/or large loss to follow up, due to [evaluated by originators of the
intervention). **Inconsistency:** No serious. **Indirectness:** No serious. **Imprecision:** Very serious. Low number of patients (n=31), Wide confidence intervals (CIs include important benefit and important harm), Only data from one study. **Publication bias:** No serious.

### Clinical Question/ PICO

<table>
<thead>
<tr>
<th>Population:</th>
<th>Adults with PTSD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention:</td>
<td>Guided internet-based trauma-focused CBT</td>
</tr>
<tr>
<td>Comparator:</td>
<td>Internet-based psychoeducation</td>
</tr>
</tbody>
</table>

### Outcome

<table>
<thead>
<tr>
<th>PTSD symptom severity</th>
<th>Study results and measurements</th>
<th>Comparator Internet-based psychoeducation</th>
<th>Intervention Guided internet-based trauma-focused CBT</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lower better</td>
<td>Based on data from: 51 patients in 1 studies. (Randomized controlled)</td>
<td>Difference: <strong>SMD 0.11 higher</strong> (CI 95% 0.45 lower — 0.66 higher)</td>
<td>Very low Due to serious risk of bias, Due to very serious imprecision</td>
<td>We are uncertain if there is a difference between guided internet-based trauma-focused CBT and Internet-based psychoeducation on PTSD symptom severity</td>
<td></td>
</tr>
</tbody>
</table>

1. **Risk of Bias:** Serious. Lack of blinding of outcome assessors, resulting in potential for detection bias. **Inconsistency:** No serious. **Indirectness:** No serious. **Imprecision:** Very serious. Wide confidence intervals (CIs include important benefit and important harm), Low number of patients (n=51), Only data from one study. **Publication bias:** No serious.

### Narrative exposure therapy (NET)

**Conditional recommendation**

For adults with PTSD where trauma is linked to genocide, civil conflict, torture, political detention or displacement, we suggest Narrative Exposure Therapy (NET)

**NET allows PTSD sufferers to describe and develop a coherent, chronological, autobiographical narrative of their life that includes their traumatic experiences (a testimony). The therapist facilitates emotional processing through the use of cognitive-behavioural techniques.**

Narrative exposure therapy (NET) is a standardised short-term intervention adapted from testimony therapy (traditionally used with survivors of torture and civilian casualties of war), as well as from mainstream exposure approaches. It was originally developed both to treat survivors and to document human rights violations. In NET, the person is asked to construct a narrative of their life from early childhood to present, focussing in detail on the traumatic events and elaborating on the associated thoughts and emotions. It is proposed that NET works in two ways: promoting habituation to traumatic memories through exposure, and reconstructing the individual’s autobiographic memory.

A number of RCTs have successfully been conducted in a variety of cultural settings, demonstrating NET’s applicability in both western and non-western countries. e.g.[404][456]
Evidence To Decision

Benefits and harms
Evidence from 7 RCTs [353][360][404][427][432][456][464][465] suggests clinically important benefit of NET for PTSD symptom severity in adults who have experienced genocide, civil conflict, torture, political detention, displacement or natural disaster.

Certainty of the Evidence
Certainty of the evidence is LOW due to serious risk of bias, and serious imprecision.

The evidence analyses and risk of bias assessments for this intervention can be found here

Preference and values
Given possible benefits of Narrative Exposure Therapy (NET) in the context of refugee trauma, refugees are likely to consider this treatment.

NET has been developed and predominantly applied in the context of low-resource crisis regions but is also used in resettlement environments. The acceptability of NET amongst refugee populations who have resettled in Australia is less clear.

The written biography received at the end of treatment, that serves to recapture the individual’s self-respect and acknowledges their human rights, may be an incentive for treatment completion.

Resources and other considerations
A number of people who have developed PTSD following refugee experiences (i.e., genocide, civil conflict, torture, political detention, displacement, or natural disaster) will be seen through specialised treatment and support services.

Some may be eligible for Medicare funded services but others will not.

Interpreters are an integral part of the work with many refugees. Delivering treatment through an interpreter, provided the interpreter is appropriately accredited and the clinician is skilled in working with interpreters, poses no barrier to effective treatment. In fact, the presence of an interpreter is often an asset in building rapport and in bringing a cultural understanding to the therapeutic relationship.

Rationale
The Guideline Development Group considered the evidence showing benefits of Narrative Exposure Therapy (NET) for PTSD symptom severity. The Group noted the low certainty of the evidence and discussed the specificity of NET for adults with PTSD following experiences of genocide, civil conflict, torture, political detention, displacement or natural disaster. The group agreed to suggest that NET be offered to refugees and asylum seekers with PTSD.

Clinical Question/ PICO

<table>
<thead>
<tr>
<th>Population</th>
<th>Adults with PTSD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention</td>
<td>Narrative Exposure Therapy (NET)</td>
</tr>
<tr>
<td>Comparator</td>
<td>Waitlist/ treatment as usual</td>
</tr>
</tbody>
</table>

Australian Guidelines for the Prevention and Treatment of Acute Stress Disorder, Posttraumatic Stress Disorder, and Complex Posttraumatic Stress

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Present-centred therapy (PCT)

**Conditional recommendation**

For adults with PTSD where trauma-focussed cognitive behavioural therapies or EMDR are unavailable or unacceptable, we suggest present-centred therapy (PCT).

PCT is designed to target daily challenges that PTSD sufferers encounter as a result of their symptoms. It includes psychoeducation about the impact of PTSD symptoms, the development of effective strategies to deal with day-to-day challenges and homework to practice newly developed skills.

Present-centred therapy is a variant of supportive counselling. These approaches are often used as comparison conditions in randomised controlled trials. PCT is a non-trauma focussed manualised intervention designed to target daily challenges that PTSD sufferers encounter. It includes psychoeducation about the impact of PTSD symptoms, the development of effective strategies to deal with day-to-day challenges and homework to practice newly developed skills. Typically 10 group sessions of 90 minutes are delivered by therapists who help participants identify stressors and discuss them in a supportive, nondirective manner.

Evidence To Decision

**Benefits and harms**

Evidence from 3 RCTs suggests moderate clinically important benefit of PCT on PTSD symptom severity relative to waitlist [391],[422] and no difference between PCT and non-trauma-focused CBT [391].

Evidence from 5 RCTs suggests CBT-T is more beneficial than PCT on PTSD symptom severity [388],[422],[439],[450],[457].

Evidence from a single RCT [440] found moderate clinically important benefit of virtual reality therapy relative to present centered therapy (PCT) in veterans.

**Certainty of the Evidence**

1. **Risk of Bias:** Serious. Inadequate sequence generation/ generation of comparable groups, resulting in potential for selection bias. Selective outcome reporting, unvalidated translated measures, differential follow-up duration, Inadequate/ lack of blinding of participants and personnel, resulting in potential for performance bias. **Inconsistency:** No serious. The magnitude of statistical heterogeneity was high, with I^2:77% however all studies show positive effects with most showing large effect sizes. Heterogeneity is largely resulting from 1 study with very large effect size (SMD= -4.01). **Indirectness:** No serious. **Imprecision:** Serious. Low number of patients (n=252), Wide confidence intervals (CIs include important benefit and unimportant benefit). **Publication bias:** No serious.
Rationale

The Guideline Development Group considered the evidence showing benefits of present-centred therapy (PCT) on PTSD symptom severity relative to waitlist or usual treatment for adults with PTSD. The group noted the evidence that CBT-T showed a greater benefit than PCT in this population and agreed that while the certainty of this evidence was low, PCT should not be used in preference to trauma focused CBT but could be offered to individuals when first line treatments are not available or not acceptable.

Overall certainty of evidence for Present Centred Therapy was MODERATE.

Certainty of evidence for Present Centred Therapy vs waitlist/treatment as usual was MODERATE due to serious imprecision.

The evidence analyses and risk of bias assessments for this intervention can be found here

Certainty of evidence for Present Centred Therapy vs Trauma-focused CBT was LOW due to serious inconsistency and serious imprecision.

The evidence analyses and risk of bias assessments for this intervention can be found here

Certainty of evidence for Present Centred Therapy vs Non-trauma-focused CBT was LOW due to very serious imprecision.

The evidence analyses and risk of bias assessments for this intervention can be found here

Certainty of evidence for Virtual Reality Therapy vs Present centred therapy was LOW due to very serious imprecision.

The evidence analyses and risk of bias assessments for this intervention can be found here

Preference and values

Given possible benefits of Present Centred Therapy, patients are likely to consider this if trauma-focussed CBT or EMDR are not available.

Although TF-CBT and EMDR have a stronger evidence base, people who do not want to talk about traumatic experiences may actually prefer present-centred therapy.

There is some evidence that individuals who receive PCT as treatment for PTSD demonstrate less drop out than for trauma-focussed therapies.

Resources and other considerations

Not all interventions are approved for use in government programs. For example, the Medicare Benefits Schedule specifies that only cognitive behaviour therapy and interpersonal therapy (and narrative therapy for Aboriginal and Torres Strait Islander people) are eligible interventions under the Better Access to Mental Health Care initiative.
Australian Guidelines for the Prevention and Treatment of Acute Stress Disorder, Posttraumatic Stress Disorder, and Complex Posttraumatic Stress

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better</td>
<td>Present centred therapy</td>
<td>Non-trauma-focused CBT</td>
<td>Low</td>
<td>Low due to serious imprecision</td>
</tr>
<tr>
<td></td>
<td>Based on data from: 649 patients in 5 studies. (Randomized controlled)</td>
<td></td>
<td></td>
<td>Due to serious inconsistency, Due to serious imprecision</td>
<td>Trauma-focused CBT may be more beneficial than PCT on PTSD symptom severity</td>
</tr>
</tbody>
</table>

1. **Risk of Bias: No serious.** Issues with treatment fidelity in both studies. Data for one therapist excluded due to poor treatment fidelity, excluding data from this therapist reduced the final sample to 86 participants from the original 129. **Inconsistency: Serious.** The magnitude of statistical heterogeneity was high, with I^2:74%. **Imprecision: Serious.** Wide confidence intervals (CI includes important benefit and unimportant benefit).

**Clinical Question/ PICO**

**Population:** Adults with PTSD  
**Intervention:** Non-trauma-focused CBT  
**Comparator:** Present centred therapy (PCT)

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence</th>
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</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better</td>
<td>Present centred therapy (PCT)</td>
<td>Non-trauma-focused CBT</td>
<td>Low</td>
<td>Low due to very serious imprecision</td>
</tr>
<tr>
<td></td>
<td>Based on data from: 101 patients in 1 studies. (Randomized controlled)</td>
<td></td>
<td></td>
<td>Due to very serious imprecision</td>
<td>There may be little or no difference between Non-trauma focused CBT and PCT on PTSD symptom severity</td>
</tr>
</tbody>
</table>

1. **Risk of Bias: No serious.** Only 80% of participants had full PTSD. **Inconsistency: No serious.** **Indirectness: No serious.** **Imprecision: Very serious.** Low number of patients (n=101), wide confidence intervals (CIs include important benefit and important harm), only data from one study. **Publication bias: No serious.**

**Clinical Question/ PICO**

**Population:** Adults with PTSD  
**Intervention:** Present centred therapy  
**Comparator:** Waitlist/ treatment as usual
1. **Risk of Bias**: No serious. Only 80% of participants had full PTSD. **Inconsistency**: No serious. **Indirectness**: No serious. **Imprecision**: Serious. Low number of patients (n=138), wide confidence intervals (CIs include important benefit and unimportant benefit). **Publication bias**: No serious.

### Stress inoculation training (SIT)

**Conditional recommendation**

For adults with PTSD where trauma-focussed cognitive behavioural therapies or EMDR are unavailable or unacceptable, we suggest stress inoculation training (SIT).

*The stress inoculation training (SIT) used in these studies is an anxiety management program for use with rape victims adapted from Veronen and Kilpatrick (1983). The nine sessions include breathing retraining, and ‘coping strategies’ such as muscle relaxation, thought stopping, cognitive restructuring and role play.*

### Evidence To Decision

#### Benefits and harms

Evidence from 2 RCTs suggests large clinically important benefit of SIT on PTSD symptom severity relative to waitlist [385][386] or supportive counselling [385].

#### Certainty of the Evidence

Overall certainty of evidence for Stress inoculation training (SIT) was LOW.

Certainty of evidence for Stress inoculation training vs waitlist/treatment as usual was LOW due to serious risk of bias, and serious imprecision.

The evidence analyses and risk of bias assessments for this intervention can be found [here](#).

Certainty of evidence for Stress inoculation training vs Supportive counselling was VERY LOW due to serious risk of bias, and very serious imprecision.

The evidence analyses and risk of bias assessments for this intervention can be found [here](#).
Preference and values

Given possible benefits of stress inoculation training for PTSD, patients are likely to consider this if trauma-focussed CBT or EMDR are not available.

Although TF-CBT and EMDR have a stronger evidence base, as stress inoculation training (SIT) does not have a trauma focus, people who do not want to talk about their traumatic experiences may prefer SIT.

Resources and other considerations

Not all interventions are approved for use in government programs. For example, the Medicare Benefits Schedule specifies that only cognitive behaviour therapy and interpersonal therapy (and narrative therapy for Aboriginal and Torres Strait Islander people) are eligible interventions under the Better Access to Mental Health Care initiative.

Rationale

The Guideline Development Group considered the evidence showing benefits of stress inoculation training for PTSD symptom severity relative to waitlist or supportive counselling for adults with PTSD. The Group noted the low certainty of this evidence and agreed that stress inoculation training should not be provided in preference to a first line treatment for PTSD, but could be offered to those who are unwilling to undertake first line treatment or when this treatment is not available.

Clinical Question/ PICO

<table>
<thead>
<tr>
<th>Population:</th>
<th>Adults with PTSD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention:</td>
<td>Stress inoculation training (SIT)</td>
</tr>
<tr>
<td>Comparator:</td>
<td>Supportive counselling</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better Based on data from: 25 patients in 1 studies. (Randomized controlled)</td>
<td>Supportive counselling</td>
<td>Stress inoculation training (SIT)</td>
<td>Very low Due to serious risk of bias, Due to very serious imprecision</td>
<td>We are uncertain if there is a difference between SIT and supportive counselling on PTSD symptom severity</td>
</tr>
</tbody>
</table>

1. **Risk of Bias: Serious.** Incomplete data and large loss to follow up. **Imprecision: Very serious.** Low number of patients (n=25).
Trauma-focused CBT (group)

For adults with PTSD where individual trauma-focused cognitive behavioural therapies or EMDR are unavailable or unacceptable, we suggest group trauma-focused CBT.

Trauma-focused CBT has been previously described as an early psychosocial treatment intervention for adults. In the group context, typically up to 16 sessions are delivered and run for 60-90 minutes each. Group interventions in the included studies encompass CPT [454][444], Beck’s CBT and other protocols[371]. All treatment interventions require (to varying degrees) engagement with the traumatic memory, opportunities for cognitive restructuring, and skills aiming to reduce avoidance.

Evidence To Decision

Benefits and harms
Evidence from 6 RCTs suggests large clinically important benefit from group CBT-T on PTSD symptom severity relative to waitlist or usual care [355][359][371][383][467] or applied muscle relaxation [399].

Evidence from 3 RCTs found no important difference between group CBT-T and Group CPT [443][449][454].

Evidence from a single RCT found individual CBT-T had a small important benefit above that of Group CBT-T [444].

Certainty of the Evidence
Overall certainty of evidence for Group Trauma-Focused CBT was LOW.

Certainty of evidence for Group Trauma-Focused CBT vs waitlist/treatment as usual was LOW due to serious risk of bias, and serious imprecision.

The evidence analyses and risk of bias assessments for this intervention can be found here

Certainty of evidence for Group Trauma-Focused CBT vs Group present centred therapy was LOW due to serious risk of bias, and serious imprecision.

The evidence analyses and risk of bias assessments for this intervention can be found here

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better Based on data from: 58 patients in 2 studies. (Randomized controlled)</td>
<td>Waitlist/ treatment as usual</td>
<td>Stress Inoculation Therapy</td>
<td>Low Due to serious risk of bias, Due to serious imprecision</td>
<td>Stress inoculation therapy may decrease PTSD symptom severity</td>
</tr>
<tr>
<td>Difference: SMD 1.53 lower ( CI 95% 2.13 lower — 0.93 lower )</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Rationale

The Guideline Development Group considered the limited evidence showing benefits of group trauma focused CBT for PTSD symptom severity relative to waitlist or applied muscle relaxation for adults with PTSD. The Group noted the low certainty of this evidence. The Group also discussed the evidence that individual CBT-T was more beneficial in this population than group CBT-T and they agreed that group trauma focused CBT should not be provided in preference to individual CBT-T or EMDR, but could be offered when these first line treatments are not available, not feasible, or not acceptable to the individual, or in addition to individual treatment.

Preference and values

Given possible benefits of group trauma-focused CBT, patients are likely to consider this if individual trauma-focused CBT is not available.

Although not a frontline recommended treatment, some patients may have a preference for group based treatment in addition to, or instead of, individual treatment. Potential additive benefits are validation of the traumatic experience and responses through sharing with others, provision of mutual support, feeling accepted by others and reducing isolation.

Given possible benefits of Present Centred Therapy, patients are likely to consider this if trauma-focused CBT or EMDR are not available.

Although TF-CBT and EMDR have a stronger evidence base, people who do not want to talk about traumatic experiences may actually prefer present-centred therapy.

There is some evidence that individuals who receive PCT as treatment for PTSD demonstrate less drop out than for trauma-focused therapies.

Resources and other considerations

Under Medicare, group sessions are available in addition to individual sessions, and in this context group therapy can be used as an adjunct.

However, there may be limited availability of practitioners offering group trauma-focused CBT available through Medicare.

Not all interventions are approved for use in government programs. For example, the Medicare Benefits Schedule specifies that only cognitive behaviour therapy and interpersonal therapy (and narrative therapy for Aboriginal and Torres Strait Islander people) are eligible interventions under the Better Access to Mental Health Care initiative.

Clinical Question/ PICO

<table>
<thead>
<tr>
<th>Population:</th>
<th>Adults with PTSD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention:</td>
<td>Group trauma-focused CBT</td>
</tr>
<tr>
<td>Comparator:</td>
<td>Waitlist/ treatment as usual</td>
</tr>
<tr>
<td>Outcome Timeframe</td>
<td>Study results and measurements</td>
</tr>
<tr>
<td>------------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better Based on data from: 247 patients in 5 studies (Randomized controlled)</td>
</tr>
</tbody>
</table>

1. **Risk of Bias:** Serious. Incomplete data and/or large loss to follow up, Missing intention-to-treat analysis, due to [failure to account for clustering in analysis]. **Inconsistency:** No serious. **Indirectness:** No serious. **Imprecision:** Serious. Low number of patients (n=247), . Wide confidence intervals (CIs include important benefit and unimportant benefit). **Publication bias:** No serious.

**Clinical Question/ PICO**

- **Population:** Adults with PTSD
- **Intervention:** Group trauma-focused CBT
- **Comparator:** Group present centred therapy

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator Group present centred therapy</th>
<th>Intervention Group trauma-focused CBT</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better Based on data from: 617 patients in 3 studies (Randomized controlled)</td>
<td>Difference: SMD 0.14 lower ( CI 95% 0.3 lower — 0.02 higher )</td>
<td>Low Due to serious risk of bias, Due to serious imprecision</td>
<td>Group trauma-focused CBT may have little or no difference on PTSD symptom severity</td>
<td></td>
</tr>
</tbody>
</table>

1. **Risk of Bias:** Serious. Inadequate sequence generation/ generation of comparable groups, resulting in potential for selection bias. Incomplete data and/or large loss to follow up, differences at baseline. **Inconsistency:** Serious. The magnitude of statistical heterogeneity was high, with I^2:96%. **Imprecision:** Serious. Wide confidence intervals (CIs include important benefit and unimportant harm).

**Clinical Question/ PICO**

- **Population:** Adults with PTSD
- **Intervention:** Group trauma-focused CBT
- **Comparator:** Individual trauma-focused CBT
Couples trauma-focussed CBT

Evidence To Decision

Rationale

The Guideline Development Group considered the evidence showing clinically important benefit of Couples TF-CBT on PTSD symptom severity and no associated harms relative to waitlist. The group noted that evidence was limited to a single RCT in couples where one partner had PTSD and they agreed that the extent to which the results can be generalised to all adults with PTSD is unknown. The group agreed that there is not yet enough evidence to make a recommendation in favour of Couples TF-CBT but the Guideline Development Group considered that it was a promising intervention for this target population and recommended further research to add strength to the evidence base.
Clinical Question/ PICO

Population: Adults with PTSD
Intervention: Couples CBT with a trauma focus
Comparator: Waitlist/ treatment as usual

Outcome Timeframe | Study results and measurements | Comparator Waitlist/ treatment as usual | Intervention Couples CBT with a trauma focus | Certainty of the Evidence (Quality of evidence) | Plain text summary
---|---|---|---|---|---
PTSD symptom severity | Lower better Based on data from: 40 patients in 1 studies. (Randomized controlled) | Difference: SMD 1.12 lower ( CI 95% 1.79 lower — 0.45 lower ) | Low Due to very serious imprecision 1 | Couples CBT with a trauma focus may decrease PTSD symptom severity

1. Inconsistency: No serious. Indirectness: No serious. Imprecision: Very serious. Low number of patients (n=40), Wide confidence intervals (CIs include important benefit and unimportant benefit), Only data from one study. Publication bias: No serious.

Group and individual (combined) trauma-focused CBT

RESEARCH RECOMMENDATION

For adults with PTSD we recommend offering TF-CBT, PE, CT, CPT or EMDR in preference to group and individual (combined) TF-CBT.

There is emerging evidence for group and individual (combined) TF-CBT and this could be used in a research context.

The treatment intervention used in this study was CPT-SA, an adaptation of Resick and Schnicke's (1993) cognitive processing therapy for rape victims. The intervention consisted of 17 weeks of a manual-based group and individual therapy, with participants attending a 90 minutes group each week and a 60 minute individual therapy session for the first nine weeks and the 17th week.

Evidence To Decision

Benefits and harms

Evidence from a single RCT suggests a large, clinically important benefit on PTSD symptom severity compared to waitlist controls.

Certainty of the Evidence

Certainty of the evidence is LOW due to serious risk of bias and serious imprecision.

The evidence analyses and risk of bias assessments for this intervention can be found here

Rationale

The Guideline Development Group considered the evidence showing clinically important benefit of combined group and individual TF-CBT on PTSD symptom severity and no associated harms relative to waitlist. The group noted that evidence was limited to a single RCT in females who has experienced rape and they agreed that the extent to which the results can be
generalised to all adults with PTSD is unknown. The group agreed that there is not yet enough evidence to recommend offering combined group and individual TF-CBT but the Guideline Development Group considered that it was a promising intervention and recommended further research in broader population and trauma types to add strength to the evidence base.

Clinical Question/ PICO

<table>
<thead>
<tr>
<th>Population:</th>
<th>Adults with PTSD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention:</td>
<td>Group and individual CBT with a trauma focus</td>
</tr>
<tr>
<td>Comparator:</td>
<td>Waitlist/ treatment as usual</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better Based on data from: 55 patients in 1 studies. (Randomized controlled)</td>
<td>Waitlist/ treatment as usual</td>
<td>Group and individual CBT with a trauma focus</td>
<td>Low Due to serious risk of bias, Due to serious imprecision</td>
<td>Group and individual CBT with a trauma focus may decrease PTSD symptom severity</td>
</tr>
</tbody>
</table>

**Difference:** SMD 2.32 lower (CI 95% 3.02 lower — 1.63 lower)

1. **Risk of Bias:** Serious. Failure to account for clustering in the analyses. **Inconsistency:** No serious. **Indirectness:** No serious. **Imprecision:** Serious. Low number of patients (n=55), Only data from one study. **Publication bias:** No serious.

Meta-cognitive therapy

**RESEARCH RECOMMENDATION**

For adults with PTSD we recommend offering TF-CBT, PE, CT, CPT or EMDR in preference to meta-cognitive therapy.

There is emerging evidence for meta-cognitive therapy and this could be used in a research context.

*Meta-cognitive therapy, a form of non-trauma focussed CBT, targets the disrupted thinking style characteristic of PTSD (threat monitoring, worry, and rumination) rather than focussing on trauma-processing.* [462]

**Evidence To Decision**

**Benefits and harms**

Evidence from 2 RCTs suggests large clinically important benefit of meta-cognitive therapy on PTSD symptom severity relative to waitlist [461]/[462].

**Certainty of the Evidence**

Certainty of evidence is VERY LOW for meta-cognitive therapy due to serious risk of bias, and very serious imprecision.

The evidence analyses and risk of bias assessments for this intervention can be found [here](#).
Rationale

The Guideline Development Group considered the evidence showing clinically important benefit of meta-cognitive therapy on PTSD symptom severity and no associated harms relative to waitlist. The group noted that certainty of the evidence was very low and limited to 2 RCTs with a combined sample size of just 40 participants and they agreed that the extent to which the results can be generalised to all adults with PTSD is unknown. The group agreed that there is not yet enough evidence to recommend offering meta-cognitive therapy but the Guideline Development Group considered that it was a promising intervention and recommended further research in broader population and trauma types to add strength to the evidence base.

Clinical Question/ PICO

<table>
<thead>
<tr>
<th>Population:</th>
<th>Adults with PTSD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention:</td>
<td>Metacognitive Therapy</td>
</tr>
<tr>
<td>Comparator:</td>
<td>Waitlist/ treatment as usual</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator Waitlist/ treatment as usual</th>
<th>Intervention Metacognitive Therapy</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better</td>
<td>Difference: SMD 2.36 lower (CI 95% 4.22 lower – 0.51 lower)</td>
<td>Very low Due to serious risk of bias, Due to very serious imprecision 1</td>
<td>We are uncertain whether metacognitive therapy increases or decreases PTSD symptom severity</td>
<td></td>
</tr>
</tbody>
</table>

1. Risk of Bias: Serious. Inadequate/lack of blinding of outcome assessors, resulting in potential for detection bias. Inconsistency: No serious. The magnitude of statistical heterogeneity was high, with I^2: 77% but both studies have very large positive effect size so not important. Indirectness: No serious. Imprecision: Very serious. Low number of patients (n=40), Wide confidence intervals (CIs include important benefit and unimportant benefit). Publication bias: No serious.

Non-trauma-focussed CBT (affect regulation)

RESEARCH RECOMMENDATION

For adults with PTSD we recommend offering TF-CBT, PE, CT, CPT or EMDR in preference to non-trauma-focussed CBT (affect regulation).

There is emerging evidence for non-trauma-focussed CBT (affect regulation) and this could be used in a research context.

The non-trauma-focussed CBT interventions included in the systematic review use a variety of non-trauma focussed affect regulation techniques.[466][391]

Evidence To Decision

Benefits and harms

Evidence from 2 RCTs suggests large clinically important benefit of Non-trauma-focussed CBT on PTSD symptom severity relative to waitlist [391][466].
No clinically important difference was found between Non-trauma-focussed CBT and PCT [391].

Certainty of the Evidence

Overall certainty of evidence for non-trauma-focused CBT was LOW.

Certainty of evidence for non-trauma-focused CBT vs waitlist was LOW due to serious imprecision, and serious risk of bias.

The evidence analyses and risk of bias assessments for this intervention can be found here.

Certainty of evidence for non-trauma-focused CBT vs Present centred therapy (PCT) was LOW due to very serious imprecision.

The evidence analyses and risk of bias assessments for this intervention can be found here.

Rationale

The Guideline Development Group considered the evidence showing clinically important benefit of affect regulation, a form of non-trauma focussed CBT on PTSD symptom severity and no associated harms relative to waitlist. The group noted that certainty of the evidence was low and limited to 2 RCTs in females who had experienced sexual abuse or victimisation and they agreed that the extent to which the results can be generalised to all adults with PTSD is unknown. The group agreed that there is not yet enough evidence to recommend offering affect regulation but the Guideline Development Group considered that it was a promising intervention and recommended further research in broader population and trauma types to add strength to the evidence base.

Clinical Question/ PICO

| Population: | Adults with PTSD |
| Intervention: | Non-trauma-focused CBT |
| Comparator: | Waitlist |

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator Waitlist</th>
<th>Intervention Non-trauma-focused CBT</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better Based on data from: 126 patients in 2 studies. (Randomized controlled)</td>
<td>Difference: SMD 0.93 lower (CI 95% 1.3 lower — 0.56 lower)</td>
<td>Low Due to serious imprecision, Due to serious risk of bias</td>
<td>Non-CBT-T may decrease PTSD symptom severity</td>
<td></td>
</tr>
</tbody>
</table>

1. Risk of Bias: Serious. Incomplete data and/or large loss to follow up, Therapist credentials/experience is not reported. It is unclear whether or not treatment adherence was assessed. Failure to account for clustering in the analyses. Inconsistency: No serious. Indirectness: No serious. Imprecision: Serious. Low number of patients (n=126), Wide confidence intervals (CIs include important benefit and unimportant benefit). Publication bias: No serious.
Clinical Question/ PICO

Population: Adults with PTSD
Intervention: Non-trauma-focused CBT
Comparator: Present centred therapy (PCT)

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator Present centred therapy (PCT)</th>
<th>Intervention Non-trauma-focused CBT</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better Based on data from: 101 patients in 1 studies. (Randomized controlled)</td>
<td>Difference: <strong>SMD 0.04 lower</strong> ( CI 95% 0.43 lower — 0.35 higher )</td>
<td>Low Due to very serious imprecision 1</td>
<td>There may be little or no difference between Non-trauma focused CBT and PCT on PTSD symptom severity</td>
<td></td>
</tr>
</tbody>
</table>

1. **Risk of Bias:** No serious. Only 80% of participants had full PTSD. **Inconsistency:** No serious. **Indirectness:** No serious. **Imprecision:** Very serious. Low number of patients (n=101), wide confidence intervals (CIs include important benefit and important harm), only data from one study. **Publication bias:** No serious.

Reconsolidation of Traumatic Memories (RTM)

**RESEARCH RECOMMENDATION**

For adults with PTSD we recommend offering TF-CBT, PE, CT, CPT or EMDR in preference to Reconsolidation of Traumatic Memories (RTM).

There is emerging evidence for RTM and this could be used in a research setting.

RTM is a brief intervention that involves activation of a traumatic memory. The participant’s trauma narrative is ended as soon as autonomic arousal is observed. A procedure follows that includes imagining a black and white movie of the event, dissociating from its content, and re-winding it when fully-associating over two seconds. This is designed to change the perspective from which the memory is recalled. RTM is administered in three sessions of up to 120 minutes each.\[459]\[396]

Evidence To Decision

**Benefits and harms**

Evidence from 2 RCTs [396][459] suggest a large clinically important benefit of RTM for PTSD symptom severity relative to waitlist.

**Certainty of the Evidence**

Certainty of the evidence is MODERATE due to serious imprecision.

The evidence analyses and risk of bias assessments for this intervention can be found [here](#).

**Rationale**

The Guideline Development Group considered the evidence showing clinically important benefit of Reconsolidation of Traumatic Memories (RTM) for PTSD symptom severity.
Memories (RTM) on PTSD symptom severity and no associated harms relative to waitlist. The group noted that certainty of the evidence was moderate but limited to 2 RCTs in male veterans and they agreed that the extent to which the results can be generalised to all adults with PTSD is unknown. The group agreed that there is not yet enough evidence to recommend offering Reconsolidation of Trauma Memories (RTM) but they considered that it was a promising intervention and recommended further research in broader population and trauma types to add strength to the evidence base.

**Clinical Question/ PICO**

| Population: | Adults with PTSD |
| Intervention: | Reconsolidation of traumatic memories (RTM) |
| Comparator: | Waitlist/ treatment as usual |

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator Waitlist/ treatment as usual</th>
<th>Intervention Reconsolidation of traumatic memories (RTM)</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better Based on data from: 99 patients in 2 studies. (Randomized controlled)</td>
<td>Difference: SMD 2.69 lower ( CI 95% 4 lower — 1.37 lower )</td>
<td>Moderate Due to serious imprecision ¹</td>
<td>Reconsolidation of traumatic memories (RTM) probably decreases PTSD symptom severity</td>
<td></td>
</tr>
</tbody>
</table>

1. **Inconsistency:** No serious. The magnitude of statistical heterogeneity was high, with I^2:75% but difference is between 2 studies both with very large positive effects so not important. **Indirectness:** No serious. **Imprecision:** Serious. Low number of patients (n=99). **Publication bias:** No serious.

**Single-session TF-CBT**

**RESEARCH RECOMMENDATION**

For adults with PTSD we recommend offering TF-CBT, PE, CT, CPT or EMDR in preference to single-session TF-CBT.

There is emerging evidence for single-session TF-CBT and it could be used in a research context.

*These studies delivered a single session of modified behavioural treatment to earthquake survivors. The 60 minute treatment session focusses on reduction of fear and avoidance through exposure to simulated tremors in an earthquake simulator and self-exposure instructions.* [358][357]

**Evidence To Decision**

**Benefits and harms**

Evidence from 2 RCTs [357][358] suggests small unimportant benefit of a single session of CBT-T on PTSD symptom severity relative to waitlist or usual treatment

**Certainty of the Evidence**
Rationale
The Guideline Development Group considered the evidence showing clinically important benefit of a single session of TF-CBT on PTSD symptom severity and no associated harms relative to waitlist. The group noted that certainty of the evidence was low and limited to 2 RCTs in earthquake survivors in Turkey and they agreed that the extent to which the results can be generalised to all adults with PTSD is unknown. The group agreed that there is not yet enough evidence to recommend offering single session TF-CBT but they considered that it was a promising intervention and recommended further research in broader population and trauma types to add strength to the evidence base.

Certainty of the evidence is LOW due to serious risk of bias and serious imprecision.

The evidence analyses and risk of bias assessments for this intervention can be found here.

Clinical Question/ PICO

<table>
<thead>
<tr>
<th>Population:</th>
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<tbody>
<tr>
<td>Adults with PTSD</td>
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<table>
<thead>
<tr>
<th>Intervention:</th>
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</thead>
<tbody>
<tr>
<td>Single Session CBT-T</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Comparator:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waitlist/ treatment as usual</td>
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<table>
<thead>
<tr>
<th>Outcome</th>
<th>Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better</td>
<td>Based on data from: 90 patients in 2 studies. (Randomized controlled)</td>
<td>Comparator Waitlist/ treatment as usual</td>
<td>Intervention Single Session CBT-T</td>
<td>Low Due to serious risk of bias, Due to serious imprecision</td>
<td>Single session CBT-T may decrease PTSD symptom severity slightly</td>
</tr>
</tbody>
</table>

1. **Risk of Bias:** Serious. Inadequate of blinding of outcome assessors, resulting in potential for detection bias. Incomplete data, Participants who did not complete at least one follow up were replaced. **Inconsistency:** No serious. **Indirectness:** No serious. **Imprecision:** Serious. Low number of patients (n=90), Wide confidence intervals (CIs include important benefit and unimportant benefit). **Publication bias:** No serious.

Virtual Reality Therapy

**RESEARCH RECOMMENDATION**

For adults with PTSD we recommend offering TF-CBT, CPT, or EMDR in preference to Virtual Reality Therapy.

There is emerging evidence for Virtual Reality Therapy and this could be used in a research context.

**Virtual Reality therapies,** such as virtual reality exposure (VRE) and VR-graded exposure therapy (VR-GET) are exposure therapies which integrate real-time computer graphics with other sensory input devices to immerse a participant in a virtual environment and facilitate the processing of memories associated with the traumatic event. Typically up to 12 graded sessions of virtual reality are administered, with the first session(s) focusing on psychoeducation and anxiety management techniques.
Evidence To Decision

Benefits and harms
Evidence from three RCTs [394][423][441] suggest small clinically unimportant benefit of virtual reality therapy on PTSD symptoms in active military soldiers relative to waitlist.

Evidence from 2 RCTs [441][424] found no difference between virtual reality therapy and control exposure.

Evidence from a single RCT [440] found moderate clinically important benefit of virtual reality therapy relative to present centered therapy (PCT) in veterans.

Certainty of the Evidence
Overall certainty of evidence for Virtual Reality Therapy was LOW.

Certainty of evidence for Virtual Reality Therapy vs waitlist/treatment as usual was LOW due to serious risk of bias, and serious imprecision.

The evidence analyses and risk of bias assessments for this intervention can be found here

Certainty of evidence for Virtual Reality Therapy vs Control exposure was VERY LOW due to serious inconsistency, and very serious imprecision.

The evidence analyses and risk of bias assessments for this intervention can be found here

Certainty of evidence for Virtual Reality Therapy vs Present centred therapy was LOW due to very serious imprecision.

The evidence analyses and risk of bias assessments for this intervention can be found here

Rationale
The Guideline Development Group considered the evidence showing small but clinically unimportant benefit of Virtual Reality Therapy on PTSD symptom severity relative to waitlist, but no difference with control exposure and a moderate benefit compared to PCT. The group noted that certainty of the evidence was low to very low and limited to RCTs in active and veteran military populations and they agreed that the extent to which the results can be generalised to all adults with PTSD is unknown. The group agreed that there is not yet enough evidence to recommend offering Virtual Reality Therapy but they considered that it was a promising intervention and recommended further research in broader population and trauma types to add strength to the evidence base.

Clinical Question/ PICO

Population: Adults with PTSD
Intervention: Virtual Reality Therapy
Comparator: Waitlist/ treatment as usual
### Outcome 

<table>
<thead>
<tr>
<th>Comparator</th>
<th>Study results and measurements</th>
<th>Intervention</th>
<th>Certainty of the Evidence</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waitlist/ treatment as usual</td>
<td>Lowest better</td>
<td>Virtual reality Therapy</td>
<td>Low</td>
<td>Virtual reality therapy may decrease PTSD symptom severity slightly</td>
</tr>
<tr>
<td>Control exposure</td>
<td>Difference: SMD 0.43 lower (CI 95% 0.83 lower — 0.03 lower)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Clinical Question/ PICO

**Population:** Adults with PTSD  
**Intervention:** Virtual reality therapy  
**Comparator:** Control exposure

### PTSD symptom severity

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lower better</td>
<td>Based on data from: 104 patients in 3 studies. (Randomized controlled)</td>
<td>Control exposure</td>
<td>Virtual reality therapy</td>
<td>Very low Due to serious inconsistency, Due to very serious imprecision 1</td>
<td>We are uncertain whether virtual reality therapy increases or decreases PTSD symptom severity</td>
</tr>
<tr>
<td>Difference: SMD 0.01 higher (CI 95% 0.68 lower — 0.71 higher)</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

### Risk of Bias

1. **Risk of Bias: Serious.** Selective outcome reporting, Inadequate/lack of blinding of outcome assessors, resulting in potential for detection bias. **Inconsistency: No serious. Indirectness: No serious. Imprecision: Serious.** Low number of patients (n=104), Wide confidence intervals (CIs include important benefit and unimportant benefit). **Publication bias: No serious.**

### Clinical Question/ PICO

**Population:** Adults with PTSD  
**Intervention:** Virtual reality therapy  
**Comparator:** Present centred therapy

### PTSD symptom severity

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
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<th>Intervention</th>
<th>Certainty of the Evidence</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lower better</td>
<td>Based on data from: 147 patients in 2 studies. (Randomized controlled)</td>
<td>Control exposure</td>
<td>Virtual reality therapy</td>
<td>Very low Due to serious inconsistency, Due to very serious imprecision 1</td>
<td>We are uncertain whether virtual reality therapy increases or decreases PTSD symptom severity</td>
</tr>
<tr>
<td>Difference: SMD 0.01 higher (CI 95% 0.68 lower — 0.71 higher)</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
**Evidence To Decision**

**Benefits and harms**

Evidence from a single RCT [452] suggests a large clinically important benefit from written exposure therapy on PTSD symptom severity relative to waitlist.

Evidence from a single RCT [454] found no clinically important difference between written exposure therapy and CBT-T.

**Certainty of the Evidence**

Overall certainty of evidence for Written Exposure Therapy was LOW.

Certainty of evidence for Written exposure therapy vs waitlist/treatment as usual was LOW due to very serious imprecision.

The evidence analyses and risk of bias assessments for this intervention can be found [here](#).

Certainty of evidence for Written exposure therapy vs Trauma-focused CBT was LOW due to very serious imprecision.

The evidence analyses and risk of bias assessments for this intervention can be found [here](#).

**Rationale**

The Guideline Development Group considered the evidence showing large clinically important benefit of written exposure therapy on PTSD symptom severity relative to waitlist, and no difference with TF-CBT. The group noted that certainty of the evidence was low and limited to 2 RCTs in veterans and motor vehicle accident survivors and they agreed that the extent to
which the results can be generalised to all adults with PTSD is unknown. The group agreed that there is not yet enough evidence to recommend offering written exposure therapy but they considered that it was a promising intervention and recommended further research in broader population and trauma types to add strength to the evidence base.

Clinical Question/ PICO

Population: Adults with PTSD
Intervention: Written exposure therapy
Comparator: Waitlist/treatment as usual

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better</td>
<td>Comparator: Waitlist/treatment as usual</td>
<td>Intervention: Written exposure therapy</td>
<td>Low due to very serious imprecision</td>
<td>Written exposure therapy may decrease PTSD symptom severity</td>
</tr>
</tbody>
</table>

1. Inconsistency: No serious. Indirectness: No serious. Imprecision: Very serious. Low number of patients (n=46), Only data from one study. Publication bias: No serious.

Clinical Question/ PICO

Population: Adults with PTSD
Intervention: Written exposure therapy
Comparator: Trauma-focused CBT

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better</td>
<td>Comparator: Trauma-focused CBT</td>
<td>Intervention: Written exposure therapy</td>
<td>Low due to very serious imprecision</td>
<td>There may be little or no difference between Written exposure therapy and Trauma-focused CBT on PTSD symptom severity</td>
</tr>
</tbody>
</table>

1. Inconsistency: No serious. Indirectness: No serious. Imprecision: Very serious. Low number of patients (n=126), Wide confidence intervals (CIs include important benefit and important harm), Only data from one study. Publication bias: No serious.
**Brief Eclectic Psychotherapy**

For adults with PTSD there was insufficient evidence to make a recommendation on Brief Eclectic Psychotherapy.

Brief Eclectic Psychotherapy draws on elements of TF-CBT and psychodynamic therapy, including the relationship between the patient and the therapist. It includes exposure to traumatic memories, therapeutic letter writing and consideration of how the individual has been affected by their experience(s). It usually ends with a farewell ritual.

**Clinical Question/ PICO**

| Population: | Adults with PTSD |
| Intervention: | Brief Eclectic Psychotherapy |
| Comparator: | Waitlist/ treatment as usual |

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better Based on data from: 72 patients in 2 studies. (Randomized controlled)</td>
<td>Difference: SMD 0.38 lower (CI 95% 0.85 lower — 0.09 higher)</td>
<td>Moderate Due to serious imprecision</td>
<td>Brief eclectic psychotherapy probably decreases PTSD symptom severity slightly</td>
<td></td>
</tr>
</tbody>
</table>

1. **Inconsistency:** No serious. **Indirectness:** No serious. **Imprecision:** Serious. Low number of patients (n=72), Wide confidence intervals (CIs include important benefit and unimportant harm). **Publication bias:** No serious.

**Supportive counseling (SC)**

For adults with PTSD there was insufficient evidence to make a recommendation on supportive counseling.

SC involves active, empathic listening to the patient who is usually provided with unconditional positive regard. The therapist helps the patient to explore and clarify issues, may provide advice, reflect and confirm appropriate reactions, and introduce problem-solving techniques.

**Clinical Question/ PICO**

| Population: | Adults with PTSD |
| Intervention: | Supportive counselling |
| Comparator: | Waitlist/ treatment as usual |

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom</td>
<td>Low</td>
<td>Supportive counselling</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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### Psychodynamic therapy

For adults with PTSD there was insufficient evidence to make a recommendation on psychodynamic therapy.

*Psychodynamic therapy uses psychoanalytic theories and practices to help individuals understand and resolve their problems by increasing awareness of their inner world and its influences over current and past relationships.*

### Clinical Question/ PICO

**Population:** Adults with PTSD  
**Intervention:** Psychodynamic therapy

#### Outcome Timeframe  | Study results and measurements | Comparator | Intervention | Certainty of the Evidence (Quality of evidence) | Plain text summary
---|---|---|---|---|---
PTSD symptom severity | Lower better  
Based on data from: 25 patients in 1 studies.  
(Randomized controlled) | **Difference:** SMD 0.13 lower  
( CI 95% 0.92 lower — 0.65 higher ) | **Very low**  
Due to very serious imprecision, Due to serious indirectness  
1 | We are uncertain if there is a difference between supportive counselling and psychoeducation on PTSD symptom severity

1. **Risk of Bias: No serious.** Treatment adherence was not monitored. Inconsistency: No serious. Indirectness: Serious. Differences between the population of interest and those studied (Sudanese refugees in Uganda). Imprecision: Very serious. Low number of patients (n=25). Wide confidence intervals (CIs include important benefit and important harm), Only data from one study. **Publication bias: No serious.**
### Observed and experiential integration (OEI)

For adults with PTSD there was insufficient evidence to make a recommendation on observed and experiential integration (OEI).

**OEI involves alternately covering and uncovering the eyes ("switching") and the eyes tracking different locations in the visual field ("glitch-work") while experiencing a disturbing thought, feeling or memory. It also includes observation of differences between the two eyes’ perceptions.**

### Clinical Question/ PICO

<table>
<thead>
<tr>
<th>Population:</th>
<th>Adults with PTSD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention:</td>
<td>Observed and experiential integration (OEI)</td>
</tr>
<tr>
<td>Comparator:</td>
<td>Waitlist/ treatment as usual</td>
</tr>
</tbody>
</table>

### Outcome

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator Waitlist/ treatment as usual</th>
<th>Intervention Observed and experiential integration (OEI)</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better Based on data from: 10 patients in 1 studies. (Randomized controlled)</td>
<td>Difference: SMD 2.86 lower ( CI 95% 4.9 lower — 0.83 lower )</td>
<td>Very low Due to serious risk of bias, Due to very serious imprecision</td>
<td>We are uncertain whether observed and experiential integration (OEI) increases or decreases PTSD symptom severity</td>
<td></td>
</tr>
</tbody>
</table>

1. **Risk of Bias: Serious.** Lack of blinding of outcome assessors, resulting in potential for detection bias. **Inconsistency: No serious. Indirectness: No serious. Imprecision: Very serious.** Low number of patients (n=10), Only data from one study.
Relaxation training

For adults with PTSD there was insufficient evidence to make a recommendation on Relaxation training.

Clinical Question/ PICO

| Population: | Adults with PTSD |
| Intervention: | Relaxation training |
| Comparator: | Waitlist/ treatment as usual |

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better Based on data from: 53 patients in 2 studies. (Randomized controlled)</td>
<td>Comparator:</td>
<td>Intervention:</td>
<td>Certainty of the Evidence (Quality of evidence)</td>
<td>Relaxation training may have little or no difference on PTSD symptom severity</td>
</tr>
</tbody>
</table>

1. **Inconsistency: Serious.** The magnitude of statistical heterogeneity was high, with I^2:54%. **Indirectness: No serious.** **Imprecision: Serious.** Low number of patients (n=53), Wide confidence intervals (CIs include important benefit and unimportant harm). **Publication bias: No serious.**

Stabilising group treatment

For adults with PTSD there was insufficient evidence to make a recommendation on stabilising group treatment.

*Stabilizing group treatment is based on psycho-education and cognitive behavioural therapy. The program is based on Zlotnick’s protocol [466] with additional sessions on assertiveness, bodily experiences and sexuality, distrust, guilt and shame, saying goodbye and future.*

Clinical Question/ PICO

| Population: | Adults with PTSD |
| Intervention: | Stabilising group treatment |
| Comparator: | Waitlist/ treatment as usual |
**Clinical Question/ PICO**

- **Population:** Adults with PTSD
- **Intervention:** Group interpersonal therapy (IPT)
- **Comparator:** Waitlist / treatment as usual

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PTSD symptom severity</strong></td>
<td>Lower better</td>
<td>Waitlist / treatment as usual</td>
<td>Stabilising group treatment</td>
<td>Low</td>
<td>Stabilising group treatment may have little or no difference on PTSD symptom severity</td>
</tr>
</tbody>
</table>

1. **Risk of Bias:** Serious. Selective outcome reporting, not all outcomes in protocol were reported, heterogeneous TAU. **Inconsistency:** No serious. **Indirectness:** No serious. Participants had complex PTSD and severe comorbidity related to child abuse. **Imprecision:** Serious. Low number of patients (n=71), only data from one study. **Publication bias:** No serious.

**Group interpersonal therapy (IPT)**

For adults with PTSD there was insufficient evidence to make a recommendation on group interpersonal therapy (IPT).

*IPT is an attachment-based treatment that focuses on current interpersonal problems and the resolution of these to improve symptoms.*

1. **Risk of Bias:** Serious. Large loss to follow up. **Inconsistency:** No serious. **Indirectness:** No serious. **Imprecision:** Very serious. Low number of patients (n=48), wide confidence intervals (CIs include important benefit and unimportant benefit), only data from one study. **Publication bias:** No serious.
Dialogical exposure therapy (DET)

For adults with PTSD there was insufficient evidence to make a recommendation on dialogical exposure therapy (DET).

DET uses CBT techniques (with and without a trauma focus) and a Gestalt based exposure method (chair work) in a dialogical framework. Supported by the therapist, the individual enters into a dialogue with aspect of the traumatic experience.

Clinical Question/ PICO

<table>
<thead>
<tr>
<th>Population</th>
<th>Adults with PTSD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention</td>
<td>Trauma-focused CBT</td>
</tr>
<tr>
<td>Comparator</td>
<td>Dialogical exposure therapy (DET)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better Based on data from: 138 patients in 1 studies. (Randomized controlled)</td>
<td>Dialogical exposure therapy (DET)</td>
<td>Trauma-focused CBT</td>
<td>Low Due to serious risk of bias, Due to serious imprecision</td>
<td>Trauma-focused CBT may be more beneficial than DET on PTSD symptom severity</td>
</tr>
</tbody>
</table>

1. **Risk of Bias:** Serious. Due to methods were poorly described. Training cases for CPT were taken from the randomised sample and subsequently excluded from analysis. **Inconsistency:** No serious. **Indirectness:** No serious. **Imprecision:** Serious. Low number of patients (n=138), Wide confidence intervals (CIs include important benefit and unimportant benefit), Only data from one study. **Publication bias:** No serious.

Interpersonal therapy (IPT)

For adults with PTSD there was insufficient evidence to make a recommendation on interpersonal therapy.

IPT is an attachment-based treatment that focuses on current interpersonal problems and the resolution of these to improve symptoms.

Clinical Question/ PICO

<table>
<thead>
<tr>
<th>Population</th>
<th>Adults with PTSD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention</td>
<td>Trauma-focused CBT</td>
</tr>
<tr>
<td>Comparator</td>
<td>Interpersonal Therapy (IPT)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better</td>
<td>Interpersonal Therapy (IPT)</td>
<td>Trauma-focused CBT</td>
<td>Very low Due to serious</td>
<td>We are uncertain if there is a difference between</td>
</tr>
</tbody>
</table>

| Difference: SMD 0.09 lower | Low Due to serious |

1. **Certainty of Evidence:** Very low. **We are uncertain if there is a difference between**
Acceptance and Commitment Therapy (ACT)

For adults with PTSD there was insufficient evidence to make a recommendation on acceptance and commitment therapy (ACT).

Clinical Question/ PICO

Population: Adults with PTSD
Intervention: Acceptance and commitment therapy (ACT) + TAU
Comparator: TAU

Australian Guidelines for the Prevention and Treatment of Acute Stress Disorder, Posttraumatic Stress Disorder, and Complex Posttraumatic Stress

1. Risk of Bias: Serious. Due to problems with recruitment and a high number of drop outs. Imprecision: Very serious. Low number of patients (n=64), Wide confidence intervals (CI includes important benefit and important harm), Only data from one study.

Clinical Question/ PICO

Population: Adults with PTSD
Intervention: Interpersonal therapy
Comparator: Relaxation training

Outcome Timeframe | Study results and measurements | Comparator | Intervention | Certainty of the Evidence (Quality of evidence) | Plain text summary
---|---|---|---|---|---
PTSD symptom severity | Lower better | SMD 0.15 lower | Very low | We are uncertain if there is a difference between interpersonal therapy and relaxation training on PTSD symptom severity
| Based on data from: 60 patients in 1 studies. (Randomized controlled) | ( CI 95% 0.67 lower — 0.38 higher ) | Due to serious risk of bias, Due to very serious imprecision 1 | Based on data from: 60 patients in 1 studies. (Randomized controlled) | Due to very serious imprecision

1. Risk of Bias: Serious. Incomplete data and/or large loss to follow up, due to [difficulties in recruitment]. Inconsistency: No serious. Indirectness: No serious. Imprecision: Very serious. Low number of patients (n=60), Wide confidence intervals (CIs include important benefit and important harm), Only data from one study. Publication bias: No serious.
Pharmacological interventions for adults with PTSD

"For adults with PTSD, do pharmacological treatments when compared to placebo result in a clinically important reduction of symptoms?"

Selective Serotonin Reuptake Inhibitors (SSRIs)

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator TAU</th>
<th>Intervention Acceptance and commitment therapy (ACT) + TAU</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better Based on data from: 51 patients in 1 studies. (Randomized controlled)</td>
<td>Difference: SMD 0.45 lower (CI 95% 1.01 lower — 0.11 higher)</td>
<td>Low Due to serious risk of bias, Due to serious imprecision</td>
<td>ACT + TAU may have little or no difference on PTSD symptom severity</td>
<td></td>
</tr>
</tbody>
</table>

1. **Risk of Bias: Serious.** Inadequate sequence generation/ generation of comparable groups, resulting in potential for selection bias, Incomplete data and/or large loss to follow up. **Inconsistency: No serious.** **Indirectness: No serious.** **Imprecision: Serious.** Low number of patients (n=51), Wide confidence intervals (CIs include important harm and unimportant benefit). **Publication bias: No serious.**

**Pharmacological interventions for adults with PTSD**

For adults with PTSD, we suggest SSRIs (sertraline, paroxetine, or fluoxetine) in circumstances where any of the following applies:

- The person is unwilling or not in a position to engage in or access recommended psychological therapy (TF-CBT, PE, CT, CPT or EMDR).
- The person has a comorbid condition or associated symptoms (e.g., clinically significant depression and high levels of dissociation) where SSRIs are indicated.
- The person's circumstances are not sufficiently stable to commence recommended psychological therapy (as a result, for example, of significant ongoing life stress such as domestic violence).
- The person has not gained significant benefit from recommended psychological therapy.
- There is a significant wait time before psychological treatment is available.

The most common approach to the pharmacological treatment of PTSD is through prescription of a selective serotonin reuptake inhibitor (SSRI). This class of drugs is widely prescribed for depression and anxiety and includes fluoxetine, paroxetine, and sertraline, each of which are conditionally recommended for use in the pharmacological treatment of PTSD.

**Evidence To Decision**

**Benefits and harms**

Evidence from 18 RCTs suggest a small, statistically significant but clinically unimportant benefit from SSRIs for PTSD symptom severity relative to placebo.

This evidence is drawn from RCTs on 3 different SSRIs;
Evidence from 5 RCTs suggests a small, clinically unimportant benefit from Fluoxetine for PTSD symptoms relative to placebo [500][513][519][520][533].

Evidence from 4 RCTs suggests a small, clinically important benefit from Paroxetine for PTSD symptoms relative to placebo [517][518][530][528].

Evidence from 9 RCTs suggests a small, clinically unimportant benefit from Sertraline for PTSD symptoms relative to placebo [496][497][502][504][511][516][523][536][524]. Evidence from a single RCT suggests that sertraline was more effective than citalopram in reducing PTSD symptoms [531] while evidence from 2 RCTs found a small unimportant difference in favour of Nefazadone relative to Sertraline [522][526].

**Certainty of the Evidence**

Overall certainty of the evidence for SSRIs was LOW.

- Certainty of the evidence for SSRI's vs placebo was LOW due to serious risk of bias and serious imprecision.
  
The evidence analyses and risk of bias assessments for this intervention can be found here

- Certainty of evidence for Sertraline vs Citalopram was VERY LOW due to serious publication bias, and very serious imprecision.
  
The evidence analyses and risk of bias assessments for this intervention can be found here

- Certainty of evidence for Sertraline vs Nefazadone was LOW due to serious risk of bias, and serious imprecision.
  
The evidence analyses and risk of bias assessments for this intervention can be found here

- Certainty of evidence for Sertraline vs Venlafaxine was VERY LOW due to serious imprecision, serious publication bias, and serious risk of bias.
  
The evidence analyses and risk of bias assessments for this intervention can be found here

**Preference and values**

Although psychological treatments are recommended as the first line treatment for PTSD, in clinical practice, medication is often the first if not the only treatment offered for PTSD. This arises where TF-CBT or EMDR is not available, not readily accessible, or not acceptable to the individual. Further, for those who receive psychological therapy, it is often delivered in conjunction with pharmacological therapy as it can improve patients' ability to engage in and benefit from evidence-based psychological treatments.

Where medication is indicated, the choice between sertraline, paroxetine, fluoxetine and venlafaxine will be made by the prescribing doctor in collaboration with the patient, and in light of their treatment response and side effect profile. The dosage will be tailored to individual needs. The maximum benefit from medication depends upon adequate dosages and duration of treatment. Ensuring treatment adherence is therefore key to successful pharmacotherapy for PTSD.

**Resources and other considerations**

Sertraline, paroxetine and fluoxetine are also commonly used to treat a range of conditions such as depression and anxiety disorders. This makes them a familiar and accessible treatment for GPs to commence, noting that there is often considerable delay before psychological therapy can be arranged.
Rationale
The Guideline Development Group considered the evidence suggesting a small, statistically significant but clinically unimportant benefit from SSRIs for PTSD symptom severity relative to placebo for adults with PTSD. The specific SSRIs tested include fluoxetine (5 RCTs), paroxetine (4 RCTs) and sertraline (9 RCTs). The Guideline Development Group discussed the low certainty of this evidence and drawing upon their expert opinion agreed on the important role SSRIs have to play in the treatment of PTSD for some adults. The Group agreed to make a conditional recommendation for the use of SSRIs for adults with PTSD in circumstances where the person’s preference is for medication rather than psychological treatment, where they are not sufficiently stable to commence psychological therapy or where it is not available.

Clinical Question/ PICO

<table>
<thead>
<tr>
<th>Population</th>
<th>Adults with PTSD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention</td>
<td>Selective serotonin re-uptake inhibitors (SSRIs)</td>
</tr>
<tr>
<td>Comparator</td>
<td>Placebo</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better Based on data from: 3,185 patients in 18 studies. (Randomized controlled)</td>
<td>Comparator: Placebo</td>
<td>Intervention: SSRIs</td>
<td>Low Due to serious imprecision, Due to serious risk of bias ¹</td>
<td>SSRIs may decrease PTSD symptom severity slightly</td>
</tr>
</tbody>
</table>

1. **Risk of Bias: Serious.** Two studies reported large loss to follow up, 2 studies unpublished data, several studies unclear drop-out reporting. **Inconsistency: No serious.** The magnitude of statistical heterogeneity was moderate, with I²: 53 %, however this is mainly due to one study with a very large effect size. All studies but 2 show positive effects with most showing small to moderate effect size. **Indirectness: No serious. Imprecision: Serious.** Wide confidence intervals (CIs include important benefit and unimportant benefit). **Publication bias: No serious.** Some commercially funded studies, but not most.

Clinical Question/ PICO

<table>
<thead>
<tr>
<th>Population</th>
<th>Adults with PTSD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention</td>
<td>Citalopram</td>
</tr>
<tr>
<td>Comparator</td>
<td>Sertraline</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom</td>
<td>Lower better Based on data from: 3,185 patients in 18 studies. (Randomized controlled)</td>
<td>Comparator: Sertraline</td>
<td>Intervention: Citalopram</td>
<td>Very low</td>
<td>We are uncertain if there</td>
</tr>
</tbody>
</table>

Due to serious imprecision, Due to serious risk of bias ¹
### Clinical Question/ PICO

**Population:** Adults with PTSD  
**Intervention:** Sertraline  
**Comparator:** Nefazadone

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator Nefazadone</th>
<th>Intervention Sertraline</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better Based on data from: 80 patients in 2 studies. (Randomized controlled)</td>
<td></td>
<td></td>
<td>Low</td>
<td>There may be little or no difference between Sertraline and Nefazadone on PTSD symptom severity</td>
</tr>
</tbody>
</table>

1. **Risk of Bias:** Serious. Incomplete data and/or large unbalanced loss to follow up (more drop outs in Nefazadone arm), Selective outcome reporting, due to baseline differences. **Inconsistency:** No serious. **Indirectness:** No serious. **Imprecision:** Serious. Low number of patients (n=80), Wide confidence intervals (CIs include unimportant benefit and important harm). **Publication bias:** No serious.

### Clinical Question/ PICO

**Population:** Adults with PTSD  
**Intervention:** Venlafaxine  
**Comparator:** Sertraline

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator Sertraline</th>
<th>Intervention Venlafaxine</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td></td>
<td></td>
<td></td>
<td>Very low</td>
<td>We are uncertain if there</td>
</tr>
</tbody>
</table>

1. **Inconsistency:** No serious. **Indirectness:** No serious. **Imprecision:** Very serious. Low number of patients (n=48), Wide confidence intervals (CIs include unimportant harm and important harm), Only data from one study. **Publication bias:** Serious. Mostly commercially funded studies.
<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator Sertraline</th>
<th>Intervention Venlafaxine</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>severity</td>
<td>Lower better Based on data from: 352 patients in 1 studies. (Randomized controlled)</td>
<td>Difference: SMD 0.07 lower (CI 95% 0.28 lower — 0.14 higher)</td>
<td>Due to serious imprecision, Due to serious publication bias, Due to serious risk of bias</td>
<td>is a difference between venlafaxine and sertraline on PTSD symptom severity</td>
<td></td>
</tr>
</tbody>
</table>

1. **Risk of Bias: Serious.** Incomplete data and/or large loss to follow up, due to [unclear reporting]. **Inconsistency: No serious.** **Indirectness: No serious.** **Imprecision: Serious.** Low number of patients (n=352), Wide confidence intervals (CIs include important benefit and unimportant harm), Only data from one study, **Publication bias: Serious.** Mostly commercially funded studies.

### Venlafaxine

**Conditional recommendation**

For adults with PTSD, we suggest venlafaxine in circumstances where any of the following applies:

- The person is unwilling or not in a position to engage in or access recommended psychological therapy (TF-CBT, PE, CT, CPT or EMDR).
- The person has a comorbid condition or associated symptoms (e.g., clinically significant depression and high levels of dissociation) where SNRIs are indicated.
- The person's circumstances are not sufficiently stable to commence recommended psychological therapy (as a result, for example, of significant ongoing life stress such as domestic violence).
- The person has not gained significant benefit from recommended psychological therapy.
- There is a significant wait time before psychological treatment is available.

*Venlafaxine is an antidepressant from the Serotonin and Noradrenaline Reuptake Inhibitor (SNRI) class. Two studies included in the review suggest that venlafaxine is generally well tolerated and may be of benefit in the treatment of patients with PTSD.*[^504][^505]

### Evidence To Decision

#### Benefits and harms

Evidence from 3 RCTs suggest a small, statistically significant but clinically unimportant effect of Venlafaxine on PTSD symptom severity relative to placebo[^505][^504] and no difference between venlafaxine and sertraline[^504].

#### Certainty of the Evidence

- Overall certainty of evidence for Venlafaxine was MODERATE.
- Certainty of evidence for Venlafaxine vs Placebo was MODERATE due to serious risk of bias.
- The evidence analyses and risk of bias assessments for this intervention can be found [here](#).
- Certainty of evidence for Venlafaxine vs Sertraline was VERY LOW due to serious imprecision, serious publication bias, and serious risk of bias.
Rationale
The Guideline Development Group considered the evidence suggesting a small, statistically significant but clinically unimportant benefit from venlafaxine for PTSD symptom severity relative to placebo for adults with PTSD. The Guideline Development Group agreed that while evidence was limited, the available evidence was of moderate certainty and, drawing on expert opinion, the Group agreed that venlafaxine has an important part to play in the treatment of PTSD for some adults. The Group agreed to make a conditional recommendation for the use of SSRIs for adults with PTSD in circumstances where the person’s preference is for medication rather than psychological treatment, where they are not sufficiently stable to commence psychological therapy or where it is not available.

Preference and values
Although psychological treatments are recommended as the first line treatment for PTSD, in clinical practice, medication is often the first if not the only treatment offered for PTSD. This arises where TF-CBT or EMDR is not available, not readily accessible, or not acceptable to the individual. Further, for those who receive psychological therapy, it is often delivered in conjunction with pharmacological therapy as it can improve patients’ ability to engage in and benefit from evidence-based psychological treatments.

Where medication is indicated, the choice between sertraline, paroxetine, fluoxetine and venlafaxine will be made by the prescribing doctor in collaboration with the patient, and in light of their treatment response and side effect profile. The dosage will be tailored to individual needs. The maximum benefit from medication depends upon adequate dosages and duration of treatment. Ensuring treatment adherence is therefore key to successful pharmacotherapy for PTSD.

Resources and other considerations
Venlafaxine is commonly used to treat a range of conditions such as depression and anxiety disorders. This makes it a familiar and accessible treatment for GPs to commence, noting that there is often considerable delay before psychological therapy can be arranged.

Clinical Question/ PICO

| Population: | Adults with PTSD |
| Intervention: | Serotonin and nor-adrenaline re-uptake inhibitors- Venlafaxine |
| Comparator: | Placebo |

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom</td>
<td>Lower better</td>
<td>Placebo</td>
<td>Serotonin and nor-adrenaline re-uptake inhibitors- Venlafaxine</td>
<td>Moderate</td>
<td>Venlafaxine probably decreases PTSD</td>
</tr>
</tbody>
</table>

The evidence analyses and risk of bias assessments for this intervention can be found here
## Ketamine

**Outcome Timeframe**

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Based on data from: 352 patients in 1 studies. (Randomized controlled)</td>
<td>Sertraline</td>
<td>Venlafaxine</td>
<td>Very low Due to serious imprecision, Due to serious publication bias, Due to serious risk of bias</td>
<td>We are uncertain if there is a difference between venlafaxine and sertraline on PTSD symptom severity</td>
</tr>
</tbody>
</table>

**Risk of Bias:** Serious. Incomplete data and/or large loss to follow up, due to [unclear reporting]. **Inconsistency:** No serious. **Indirectness:** No serious. **Imprecision:** Serious. Low number of patients (n=352), Wide confidence intervals (CIs include important benefit and unimportant harm), Only data from one study. **Publication bias:** Serious. Mostly commercially funded studies.

### RESEARCH RECOMMENDATION

Where medication is indicated for the treatment of PTSD we suggest an SSRI or SNRI antidepressant. There is emerging evidence for the use of ketamine in the treatment of PTSD and it could be used in a research context.

*Ketamine is an antagonist of the glutamate N-methyl-D-aspartate (NMDA) receptor.*
Evidence To Decision

Benefits and harms

Evidence from a single RCT suggests a moderate, clinically important benefit from ketamine on PTSD symptom severity relative to placebo [510].

Ketamine administration was associated with several adverse events and numerous side effects. One participant discontinued treatment likely due to dissociative effects. Several patients experienced elevation in blood pressure requiring acute treatment with β-blockers. Side effects included blurred vision, dry mouth, restlessness, fatigue, nausea/vomiting, poor coordination, and headache.

Certainty of the Evidence

Certainty of the evidence is VERY LOW due to serious risk of bias, publication bias and very serious imprecision.

The evidence analyses and risk of bias assessments for this intervention can be found here.

Rationale

The Guideline Development Group considered the evidence showing moderate clinically important benefit of ketamine on PTSD symptom severity relative to placebo. The group noted that certainty of the evidence was very low and limited to a single RCT with a small sample size of 41 participants and they agreed that the extent to which the results can be generalised to all adults with PTSD is unknown. The group discussed the evidence that ketamine was associated in this study with adverse events including elevated blood pressure, blurred vision, dry mouth, restlessness, fatigue, nausea/vomiting, poor coordination, and headache. The group agreed that it would not be appropriate to recommend offering ketamine at this stage but they considered that it was a promising intervention due to the fact that as an antagonist to the N-methyl-D-aspartate-type glutamate (NMDA) receptor, ketamine has the potential to reduce PTSD symptoms through its anxiolytic properties. The group agreed to recommend further research in broader population and trauma types to add strength to the evidence base.

Clinical Question/ PICO

<table>
<thead>
<tr>
<th>Population: Adults with PTSD</th>
<th>Intervention: Ketamine</th>
<th>Comparator: Placebo</th>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator Placebo</th>
<th>Intervention Ketamine</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better Based on data from: 35 patients in 1 studies. (Randomized controlled)</td>
<td>Difference: SMD 0.55 lower (CI 95% 1.23 lower – 0.13 higher)</td>
<td>Very low Due to very serious imprecision, Due to serious publication bias, Due to serious risk of bias 1</td>
<td>We are uncertain whether ketamine increases or decreases PTSD symptom severity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Risk of Bias: Serious. Incomplete data and/or large loss to follow up, Missing intention-to-treat analysis. Inconsistency: No serious. Indirectness: No serious. Imprecision: Very serious. Wide confidence intervals (CIs includes important benefit and unimportant harm), Low number of patients (n= 35), Only data from one study. Publication bias: Serious. Authors named
Quetiapine

RESEARCH RECOMMENDATION

Where medication is indicated for the treatment of PTSD we suggest an SSRI or SNRI antidepressant. There is emerging evidence for the use of quetiapine in the treatment of PTSD and it could be used in a research context.

*Quetiapine is an atypical antipsychotic that is used for individuals with significant agitation.*

Evidence To Decision

Benefits and harms

Evidence from a single RCT suggests a moderate, clinically important benefit of quetiapine on PTSD symptom severity [534].

Certainty of the Evidence

Certainty of the evidence is VERY LOW due to serious risk of bias, serious publication bias and serious imprecision.

The evidence analyses and risk of bias assessments for this intervention can be found here.

Preference and values

Patients prefer to have a clear "treatment strategy" with confidence in the doctor and the strategy, but they don't usually want medication as the first step – they would like to try other strategies first.

Rationale

The Guideline Development Group considered the evidence showing moderate clinically important benefit of quetiapine on PTSD symptom severity relative to placebo. The group noted that certainty of the evidence was very low and limited to a single RCT with a small sample size of 80 participants and they agreed that the extent to which the results can be generalised to all adults with PTSD is unknown. The group agreed that it would not be appropriate to recommend offering quetiapine at this stage but they considered that it was a promising intervention in particular considering the potential benefit of quetiapine for reducing agitation. The group agreed to recommend further research in broader population and trauma types to add strength to the evidence base.

Clinical Question/ PICO

- **Population:** Adults with PTSD
- **Intervention:** Antipsychotics- Quetiapine
- **Comparator:** Placebo
**Mirtazapine**

For adults with PTSD there was insufficient evidence to make a recommendation on mirtazapine.

**Clinical Question/ PICO**

**Population:** Adults with PTSD  
**Intervention:** Nor-adrenergic and specific serotonin antidepressant- Mirtazapine  
**Comparator:** Placebo

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator Placebo</th>
<th>Intervention Nor-adrenergic and specific serotonin antidepressant-Mirtazapine</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better Based on data from: 21 patients in 1 studies. (Randomized controlled)</td>
<td>Difference: SMD 1.89 lower ( CI 95% 3 lower — 0.78 lower )</td>
<td>Very low Due to very serious imprecision, Due to serious publication bias, Due to serious risk of bias</td>
<td>We are uncertain whether Mirtazapine increases or decreases PTSD symptom severity</td>
<td></td>
</tr>
</tbody>
</table>

1. **Risk of Bias:** Serious. Due to [baseline differences]. **Inconsistency:** No serious. **Indirectness:** No serious. **Imprecision:** Very serious. Low number of patients (n=21), Only data from one study. **Publication bias:** Serious. Mostly commercially funded studies.
### Amitriptyline

For adults with PTSD there was insufficient evidence to make a recommendation on amitriptyline.

#### Clinical Question/ PICO

- **Population:** Adults with PTSD
- **Intervention:** Tricyclic antidepressant - Amitriptyline
- **Comparator:** Placebo

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better</td>
<td>Placebo</td>
<td>Tricyclic antidepressant - Amitriptyline</td>
<td>Very low due to serious risk of bias, Due to very serious imprecision</td>
<td>We are uncertain whether amitriptyline increases or decreases PTSD symptom severity</td>
</tr>
<tr>
<td></td>
<td>Based on data from: 33 patients in 1 studies. (Randomized controlled)</td>
<td>Difference: SMD 0.9 lower ( CI 95% 1.62 lower — 0.18 lower )</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. **Risk of Bias:** Serious. Missing intention-to-treat analysis, Incomplete data and/or large loss to follow up. **Inconsistency:** No serious. **Indirectness:** No serious. **Imprecision:** Very serious. Low number of patients (n=32), Wide confidence intervals (CIs include important benefit and unimportant benefit), Only data from one study. **Publication bias:** No serious.

### Imipramine

For adults with PTSD there was insufficient evidence to make a recommendation on imipramine.

#### Clinical Question/ PICO

- **Population:** Adults with PTSD
- **Intervention:** Tricyclic antidepressant - Imipramine
- **Comparator:** Placebo

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better</td>
<td>Placebo</td>
<td>Tricyclic antidepressant - Imipramine</td>
<td>Very low due to very serious imprecision, Due to very serious risk of bias</td>
<td>We are uncertain whether imipramine increases or decreases PTSD symptom severity</td>
</tr>
<tr>
<td></td>
<td>Based on data from: 41 patients in 1 studies. (Randomized controlled)</td>
<td>Difference: SMD 0.24 lower ( CI 95% 0.86 lower — 0.38 higher )</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. **Risk of Bias:** Very serious. Incomplete data and/or large loss to follow up, due to [baseline differences]. **Inconsistency:**
Brofaromine

For adults with PTSD there was insufficient evidence to make a recommendation on brofaromine.

Clinical Question/ PICO

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better Based on data from: 178 patients in 2 studies. (Randomized controlled)</td>
<td>Comparator: Placebo</td>
<td>Intervention: Monoamine oxidase inhibitors - Brofaromine</td>
<td>Very low Due to serious risk of bias, Due to serious inconsistency, Due to serious imprecision, Due to serious publication bias</td>
<td>We are uncertain whether brofaromine increases or decreases PTSD symptom severity</td>
</tr>
</tbody>
</table>

1. **Risk of Bias: Serious.** Selective outcome reporting, Incomplete data and/or large loss to follow up. **Inconsistency:** Serious. The magnitude of statistical heterogeneity was high, with I^2 2.59%. **Indirectness: No serious.** Imprecision: Serious. Low number of patients (n=178), Wide confidence intervals (CIs include important benefit and unimportant harm). **Publication bias: Serious.** One commercially funded study.

Phenelzine

For adults with PTSD there was insufficient evidence to make a recommendation on phenelzine.

Clinical Question/ PICO

<table>
<thead>
<tr>
<th>Population</th>
<th>Intervention</th>
<th>Comparator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults with PTSD</td>
<td>Monoamine oxidase inhibitors - Phenelzine</td>
<td>Placebo</td>
</tr>
</tbody>
</table>
Australian Guidelines for the Prevention and Treatment of Acute Stress Disorder, Posttraumatic Stress Disorder, and Complex Posttraumatic Stress

Olanzapine

For adults with PTSD there was insufficient evidence to make a recommendation on olanzapine.

Clinical Question/ PICO

Population: Adults with PTSD
Intervention: Antipsychotics- Olanzapine
Comparator: Placebo

1. Risk of Bias: Very serious. Incomplete data and/or large loss to follow up, due to [baseline differences]. Inconsistency: No serious. Indirectness: No serious. Imprecision: Very serious. Wide confidence intervals (CIs include important benefit and unimportant benefit), Low number of patients (n= 37), Only data from one study. Publication bias: No serious.

Clinical Question/ PICO

Population: Adults with PTSD
Intervention: Phenelzine
Comparator: Imipramine

1. Risk of Bias: Very serious. Incomplete data and/or large loss to follow up, due to [baseline differences]. Inconsistency: No serious. Indirectness: No serious. Imprecision: Very serious. Wide confidence intervals (CIs include important benefit and unimportant benefit), Low number of patients (n= 41), Only data from one study. Publication bias: No serious.
**Clinical Question/ PICO**

- **Population:** Adults with PTSD
- **Intervention:** Antiepileptics- Divalproex
- **Comparator:** Placebo

## Outcome/ Timeframe

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better</td>
<td>Placebo</td>
<td>Antipsychotics- Olanzapine</td>
<td>Very low Due to serious inconsistency, Due to very serious imprecision, Due to serious publication bias, Due to serious risk of bias ¹</td>
<td>We are uncertain whether Olanzapine increases or decreases PTSD symptom severity.</td>
</tr>
<tr>
<td></td>
<td>Based on data from: 43 patients in 2 studies. (Randomized controlled)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. **Risk of Bias:** Serious. Incomplete data and/or large loss to follow up, due to [unclear reporting]. **Inconsistency:** Serious. The magnitude of statistical heterogeneity was high, with $I^2:62\%$. **Indirectness:** No serious. **Imprecision:** Very serious. Low number of patients (n= 43), Wide confidence intervals (CIs include important benefit and important harm). **Publication bias:** Serious. Mostly commercially funded studies.

### Divalproex

For adults with PTSD there was insufficient evidence to make a recommendation on divalproex.

## Outcome/ Timeframe

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better</td>
<td>Placebo</td>
<td>Antiepileptics- Divalproex</td>
<td>Very low Due to serious publication bias, Due to very serious imprecision ¹</td>
<td>We are uncertain whether divalproex increases or decreases PTSD symptom severity.</td>
</tr>
<tr>
<td></td>
<td>Based on data from: 82 patients in 1 studies. (Randomized controlled)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. **Inconsistency:** No serious. **Indirectness:** No serious. **Imprecision:** Very serious. Low number of patients (n= 82), Wide confidence intervals (CIs include important benefit and important harm), Only data from one study. **Publication bias:** Serious. Mostly commercially funded studies.
Lamotrigine

For adults with PTSD there was insufficient evidence to make a recommendation on lamotrigine.

Clinical Question/ PICO

| Population: | Adults with PTSD |
| Intervention: | Antiepileptics- Lamotrigine |
| Comparator: | Placebo |

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator Placebo</th>
<th>Intervention Antiepileptics- Lamotrigine</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better Based on data from: 14 patients in 1 studies. (Randomized controlled)</td>
<td></td>
<td></td>
<td></td>
<td>Very low Due to very serious imprecision, Due to serious publication bias, Due to serious risk of bias ¹</td>
</tr>
<tr>
<td></td>
<td>Difference: SMD 0 lower ( CI 95% 1.16 lower — 1.16 higher )</td>
<td></td>
<td></td>
<td></td>
<td>We are uncertain whether Lamotrigine increases or decreases PTSD symptom severity.</td>
</tr>
</tbody>
</table>

1. **Risk of Bias**: Serious. Incomplete data and/or large loss to follow up, due to [unbalanced attrition]. **Inconsistency**: No serious. **Indirectness**: No serious. **Imprecision**: Very serious. Low number of patients (n= 14), Wide confidence intervals (CIs include important benefit and important harm), Only data from one study. **Publication bias**: Serious. Mostly commercially funded studies.

Tiagabine

For adults with PTSD there was insufficient evidence to make a recommendation on tiagabine.

Clinical Question/ PICO

| Population: | Adults with PTSD |
| Intervention: | Antiepileptics- Tiagabine |
| Comparator: | Placebo |

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator Placebo</th>
<th>Intervention Antiepileptics- Tiagabine</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better Based on data from: 202 patients in 1 studies. (Randomized controlled)</td>
<td></td>
<td></td>
<td></td>
<td>Very low Due to serious risk of bias, Due to serious publication bias,</td>
</tr>
<tr>
<td></td>
<td>Difference: SMD 0.02 lower ( CI 95% 0.3 lower — 0.26 higher )</td>
<td></td>
<td></td>
<td></td>
<td>We are uncertain whether tiagabine increases or decreases PTSD symptom severity.</td>
</tr>
</tbody>
</table>
### Topiramate

For adults with PTSD there was insufficient evidence to make a recommendation on topiramate.

**Clinical Question/ PICO**

<table>
<thead>
<tr>
<th>Population</th>
<th>Adults with PTSD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention</td>
<td>Antiepileptics- Topiramate</td>
</tr>
<tr>
<td>Comparator</td>
<td>Placebo</td>
</tr>
</tbody>
</table>

**Outcome**

**PTSD symptom severity**

Lower better Based on data from: 31 patients in 1 studies. (Randomized controlled)

**Study results and measurements**

<table>
<thead>
<tr>
<th>Comparator</th>
<th>Placebo</th>
</tr>
</thead>
</table>

**Intervention**

Antiepileptics- Topiramate

**Certainty of the Evidence**

Quality of evidence

**Plain text summary**

Due to serious imprecision

1. **Risk of Bias:** Serious. Incomplete data and/or large loss to follow up, Selective outcome reporting. **Inconsistency:** No serious. **Indirectness:** No serious. **Imprecision:** Serious. Low number of patients (n=202), Only data from one study . **Publication bias:** Serious. Mostly commercially funded studies.

### Ganaxolone

For adults with PTSD there was insufficient evidence to make a recommendation on ganaxolone.

**Clinical Question/ PICO**

<table>
<thead>
<tr>
<th>Population</th>
<th>Adults with PTSD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention</td>
<td>Ganaxolone</td>
</tr>
</tbody>
</table>

**Outcome**

**PTSD symptom severity**

Lower better Based on data from: 31 patients in 1 studies. (Randomized controlled)

**Study results and measurements**

<table>
<thead>
<tr>
<th>Comparator</th>
<th>Placebo</th>
</tr>
</thead>
</table>

**Intervention**

Ganaxolone

**Certainty of the Evidence**

Quality of evidence

**Plain text summary**

Topiramate may have little or no difference on PTSD symptom severity

1. **Risk of Bias:** Serious, due to [baseline differences]. **Inconsistency:** No serious. **Indirectness:** No serious. **Imprecision:** Serious. Low number of patients (n= 69), Wide confidence intervals (CIs include important benefit and unimportant harm). **Publication bias:** No serious. One commercially funded study.
Comparative study:

<table>
<thead>
<tr>
<th>Comparator:</th>
<th>Placebo</th>
</tr>
</thead>
</table>

### Outcome Timeframe

#### Study results and measurements

<table>
<thead>
<tr>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Placebo</td>
<td>Ganaxolone</td>
<td>Low</td>
<td>Ganaxolone may have little or no difference on PTSD symptom severity.</td>
</tr>
</tbody>
</table>

#### PTSD symptom severity

- Lower better
- Based on data from: 99 patients in 1 studies.
- (Randomized controlled)

**Comparison:**

<table>
<thead>
<tr>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Placebo</td>
<td>Ganaxolone</td>
<td>Low</td>
<td>说出来</td>
</tr>
</tbody>
</table>

**Difference:**

**SMD 0.12 lower**

**CI 95% 0.51 lower — 0.28 higher**

**Certainty of the Evidence:**

**Low**

Due to serious risk of bias, Due to serious imprecision.

### Neurokinin-1 antagonist

For adults with PTSD there was insufficient evidence to make a recommendation on neurokinin-1 antagonist.

#### Clinical Question/ PICO

**Population:** Adults with PTSD

**Intervention:** Neurokinin-1 antagonist

**Comparator:** Placebo

### Outcome Timeframe

#### Study results and measurements

<table>
<thead>
<tr>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Placebo</td>
<td>Neurokinin-1 antagonist</td>
<td>Very low</td>
<td>We are uncertain whether Neurokinin-1 antagonist increases or decreases PTSD symptom severity</td>
</tr>
</tbody>
</table>

#### PTSD symptom severity

- Lower better
- Based on data from: 39 patients in 1 studies.
- (Randomized controlled)

**Comparison:**

<table>
<thead>
<tr>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Placebo</td>
<td>Neurokinin-1 antagonist</td>
<td>Very low</td>
<td>We are uncertain whether Neurokinin-1 antagonist increases or decreases PTSD symptom severity</td>
</tr>
</tbody>
</table>

**Difference:**

**SMD 0.27 lower**

**CI 95% 0.9 lower — 0.36 higher**

**Certainty of the Evidence:**

**Very low**

Due to serious risk of bias, Due to very serious imprecision, Due to serious publication bias.

### Risk of Bias

1. **Risk of Bias: Serious.** Incomplete data and/or large loss to follow up, due to unbalanced drop-out, or deviations from protocol. **Inconsistency: No serious.** **Indirectness: No serious.** **Imprecision: Serious.** Low number of patients (n= 99), Wide confidence intervals (CIs include important benefit and unimportant harm), Only data from one study. **Publication bias: No serious.**

2. **Risk of Bias: Serious.** Incomplete data and/or large loss to follow up, Missing intention-to-treat analysis. **Inconsistency: No serious.** **Indirectness: No serious.** **Imprecision: Very serious.** Low number of patients (n= 39), Wide confidence intervals (CIs includes important benefit and unimportant harm), Only data from one study. **Publication bias: Serious.** Mostly commercially funded studies.
Non-psychological and non-pharmacological interventions for adults with PTSD

“For adults with PTSD, do non-psychological and non-pharmacological treatments/interventions, when compared to waitlist, treatment as usual or no treatment, result in reduction of symptoms?”

**Acupuncture**

**RESEARCH RECOMMENDATION**

For adults with PTSD we recommend offering TF-CBT, PE, CT, CPT or EMDR in preference to acupuncture.

There is emerging evidence for acupuncture and this could be used in a research context.

Acupuncture involves the insertion of fine needles at specific points on the body (acupressure points) to reduce symptoms of PTSD.

**Evidence To Decision**

**Benefits and harms**

Evidence from a single RCT suggests clinically important benefit from acupuncture for PTSD symptom severity relative to waitlist and CBT-T [467].

**Certainty of the Evidence**

Overall certainty of evidence for Acupuncture was LOW.

Certainty of evidence for Acupuncture vs waitlist/treatment as usual was LOW due to very serious imprecision.

The evidence analyses and risk of bias assessments for this intervention can be found [here](#).

Certainty of evidence for Acupuncture vs Trauma-focused CBT was LOW due to very serious imprecision.

The evidence analyses and risk of bias assessments for this intervention can be found [here](#).

**Rationale**

The Guideline Development Group considered the evidence showing large clinically important benefit of acupuncture on PTSD symptom severity relative to waitlist, and TF-CBT. The group noted that certainty of the evidence was low and limited to a single RCT and they agreed that the extent to which the results can be generalised to all adults with PTSD is unknown. The group agreed that there is not yet enough evidence to recommend offering acupuncture but they considered that it was a promising intervention and recommended further research in broader population and trauma types to add strength to the evidence base.

**Clinical Question/ PICO**

<table>
<thead>
<tr>
<th>Population:</th>
<th>Adults with PTSD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention:</td>
<td>Acupuncture</td>
</tr>
<tr>
<td>Comparator:</td>
<td>Waitlist/ treatment as usual</td>
</tr>
</tbody>
</table>
**Clinical Question/ PICO**

- **Population:** Adults with PTSD
- **Intervention:** Acupuncture
- **Comparator:** Trauma-focused CBT

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator Trauma-focused CBT</th>
<th>Intervention</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better Based on data from: 49 patients in 1 studies. (Randomized controlled)</td>
<td>Difference: SMD 0.35 lower (CI 95% 0.91 lower — 0.22 higher)</td>
<td>Low Due to very serious imprecision 1</td>
<td>Acupuncture may be more beneficial than CBT-T on PTSD symptom severity</td>
<td></td>
</tr>
</tbody>
</table>

1. **Inconsistency:** No serious. **Indirectness:** No serious. **Imprecision:** Very serious. Low number of patients (n=48), Wide confidence intervals (CIs include important benefit and important harm), Only one study. **Publication bias:** No serious.
Mindfulness-based stress reduction (MBSR)

RESEARCH RECOMMENDATION

For adults with PTSD we recommend offering TF-CBT, PE, CT, CPT or EMDR in preference to mindfulness-based stress reduction (MBSR).

There is emerging evidence for MBSR and it could be used in a research context.

Therapeutic applications of mindfulness are commonly called mindfulness-based interventions (MBIs). The first MBI, Mindfulness-Based Stress Reduction (MBSR), was developed in 1979 by Professor Jon Kabat-Zinn from the University of Massachusetts Medical Centre. The original intent of MBSR was to help outpatients attending a stress reduction clinic to relieve the suffering associated with stress, pain, and illness. Since then, other programs based on the foundational and structural approach of MBSR have been developed. MBSR is a program that uses a variety of techniques to cultivate the state of mindfulness (i.e., nonjudgmental present-moment awareness; Kabat–Zinn, 1994). It is typically delivered in a series of weekly 2.5-hour group meetings in the context of a day-long retreat. Mindfulness training delivered via telehealth (2 sessions in person and 6 by telephone) showed a positive effect for veterans when compared with psychoeducation. This brief treatment was based on MBSR principles but was delivered in individual sessions and did not include the full program.

Evidence To Decision

Benefits and harms

Evidence from 2 RCTs suggests a small clinically unimportant benefit from MBSR for PTSD symptom severity relative to placebo.

Evidence from 2 RCTs suggests no difference in benefit between MBSR and PCT on PTSD symptom severity.

Evidence from a single RCT suggests a large, clinically important benefit of MBSR relative to psychoeducation on PTSD symptom severity.

Certainty of the Evidence

Overall certainty of evidence for Mindfulness-based stress reduction was LOW.

Certainty of evidence for Mindfulness-based stress reduction vs waitlist/treatment as usual was LOW due to serious imprecision, and serious risk of bias.

The evidence analyses and risk of bias assessments for this intervention can be found here.

Certainty of evidence for Mindfulness-based stress reduction vs Present centred therapy was VERY LOW due to serious risk of bias, serious inconsistency, and very serious imprecision.

The evidence analyses and risk of bias assessments for this intervention can be found here.

Certainty of evidence for Mindfulness-based stress reduction vs Psychoeducation was VERY LOW due to serious risk of bias, serious inconsistency, and very serious imprecision.

The evidence analyses and risk of bias assessments for this intervention can be found here.

Rationale

The Guideline Development Group considered the evidence showing small clinically unimportant benefit of mindfulness-based stress reduction (MBSR) on PTSD symptom severity relative to waitlist, equivalent benefit compared to PCT and a greater benefit than psychoeducation. The group noted that certainty of the evidence was low to very low agreed that with mixed effects and high level of uncertainty it is not appropriate at this stage to recommend offering mindfulness based stress reduction.
(MBSR). The Group agreed that it was a promising intervention and recommended further research in broader population and trauma types to add strength to the evidence base.

### Clinical Question/ PICO

| Population: | Adults with PTSD |
| Intervention: | Mindfulness-based stress reduction |
| Comparator: | Waitlist/ treatment as usual |

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better Based on data from: 99 patients in 2 studies. (Randomized controlled)</td>
<td></td>
<td></td>
<td></td>
<td>Mindfulness-based stress reduction may decrease PTSD symptom severity slightly</td>
</tr>
</tbody>
</table>

### Outcome Timeframe

<table>
<thead>
<tr>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waitlist/ treatment as usual</td>
<td>Mindfulness-based stress reduction</td>
<td>Low Due to serious risk of bias, Due to serious inconsistency, Due to very serious imprecision</td>
<td>Mindfulness-based stress reduction may decrease PTSD symptom severity slightly</td>
</tr>
</tbody>
</table>

#### Risk of Bias: Serious. Incomplete data (completer analysis), Lack of blinding of outcome assessors, resulting in potential for detection bias. **Inconsistency: No serious. Indirectness: No serious. Imprecision: Serious.** Low number of patients (n=99). **Publication bias: No serious.**

### Clinical Question/ PICO

| Population: | Adults with PTSD |
| Intervention: | Mindfulness-based stress reduction |
| Comparator: | Present centred therapy |

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better Based on data from: 324 patients in 3 studies. (Randomized controlled)</td>
<td></td>
<td></td>
<td></td>
<td>We are uncertain if there is a difference between mindfulness-based stress reduction and PCT on PTSD symptom severity</td>
</tr>
</tbody>
</table>

#### Risk of Bias: Serious. Incomplete data and/or large loss to follow up, due to [baseline differences between groups]. **Inconsistency: Serious.** The magnitude of statistical heterogeneity was high, with $I^2: 63\%$. **Indirectness: No serious.** **Imprecision: Very serious.** Low number of patients (n=324), Wide confidence intervals (CIs include important benefit and important harm). **Publication bias: No serious.**
Neurofeedback Evidence To Decision

Rationale

The Guideline Development Group considered the evidence showing large clinically important benefit of neurofeedback on PTSD symptom severity relative to waitlist or usual care. The group noted that while the certainty of the evidence was moderate, it was limited to 3 small RCTs and they agreed that the extent to which the results can be generalised to all adults...
with PTSD is unknown. The group agreed that there is not yet enough evidence to recommend offering neurofeedback but they considered that it was a promising intervention and recommended further research in broader population and trauma types to add strength to the evidence base.

**Clinical Question/ PICO**

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator: Waitlist/treatment as usual</th>
<th>Intervention: Neurofeedback</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better Based on data from: 94 patients in 3 studies. (Randomized controlled)</td>
<td>Difference: <strong>SMD 1.55 lower</strong> (CI 95% 2.94 lower – 0.15 lower)</td>
<td>Moderate Due to serious imprecision</td>
<td>Neurofeedback probably decreases PTSD symptom severity</td>
</tr>
</tbody>
</table>

1. **Inconsistency:** No serious. The magnitude of statistical heterogeneity was high, with I²: 87%, however all studies showed positive effects and heterogeneity was mainly due to one study with a very large effect size (SMD= -3.25).

**Indirectness:** No serious. **Imprecision:** Serious. Low number of patients (n=94); Wide confidence intervals (CIs include important benefit and unimportant benefit). **Publication bias:** No serious.

**Physical exercise**

**RESEARCH RECOMMENDATION**

For adults with PTSD we recommend offering TF-CBT, PE, CT, CPT or EMDR in preference to physical exercise. There is emerging evidence for physical exercise and it could be used in a research context.

The physical exercise consisted of a 12-week intervention with a weekly supervised exercise session, two unsupervised home-based exercise sessions, and a walking program facilitated by the provision of a pedometer and exercise diary.[581] In the integrated exercise study, veteran participants attended three one hour group sessions each week for 12 weeks, for a total of 36 sessions.[573] Exercise sessions included aerobic exercise, strength training with weights and resistance bands, and yoga movements and poses presented within a framework of mindfulness principles.

**Evidence To Decision**

**Benefits and harms**

Evidence from 2 RCTs[573][581] suggest a small unimportant benefit of physical exercise relative to waitlist for PTSD symptom severity.

In the absence of medical contraindications for exercise, the guideline development group was not aware of any negative effects of exercise on PTSD symptoms.

**Certainty of the Evidence**
Rationale
The Guideline Development Group considered the evidence showing small, statistically significant but clinically unimportant benefit of physical exercise on PTSD symptom severity relative to waitlist. The Group noted that certainty of the evidence was low and limited to a 2 RCTs in military and police veterans and they agreed that the extent to which the results can be generalised to all adults with PTSD is unknown. The Group agreed that there is not yet enough evidence to recommend offering physical exercise but they considered that physical exercise has been gaining momentum in the research community as a treatment for PTSD and that additional RCTs are required to provide more definitive evidence of a positive relationship between exercise and PTSD. The Group therefore agreed to recommended further research in broader population and trauma types to add strength to the evidence base.

Certainty of the evidence was LOW due to serious risk of bias and serious imprecision.

The evidence analyses and risk of bias assessments for this intervention can be found here

Preference and values
Exercise is often recommended in the context of good overall health as an adjunct to PTSD treatment. It is not associated with the stigma of standard mental health treatment and has high acceptability for individuals.

Resources and other considerations
Aerobic exercise is a low-cost, widely accessible activity known to provide multiple health benefits, including cardiovascular health and musculoskeletal health, as well as reduced rates of co-morbidity and mortality.

Clinical Question/ PICO
- **Population:** Adults with PTSD
- **Intervention:** Physical exercise
- **Comparator:** Waitlist/ treatment as usual

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better Based on data from: 105 patients in 2 studies. (Randomized controlled)</td>
<td>Comparator Waitlist/ treatment as usual</td>
<td>Intervention Physical exercise</td>
<td>Low Due to serious imprecision, Due to serious risk of bias</td>
<td>Physical exercise may decrease PTSD symptom severity slightly</td>
</tr>
</tbody>
</table>

1. **Risk of Bias:** Serious. Missing intention-to-treat analysis, Incomplete data and/or large loss to follow up. **Inconsistency:** No serious. **Indirectness:** No serious. **Imprecision:** Serious. Low number of patients (n=105). **Publication bias:** No serious.
Repetitive Transcranial Magnetic Stimulation (rTMS)

RESEARCH RECOMMENDATION

For adults with PTSD we recommend offering TF-CBT, PE, CT, CPT or EMDR in preference to repetitive transcranial magnetic stimulation (rTMS).

There is emerging evidence for rTMS and this could be used in a research context.

Repetitive TMS (rTMS) is a non-invasive procedure that involves the application of electrical current pulses, induced by a strong pulsating electromagnetic field. Electromagnetic energy passes through the scalp and skull without inducing pain or injury. rTMS aims to stimulate nerve cells in targeted areas of the brain which can lead to an increase or decrease in brain activity in specific regions. It is thought that the dorsolateral prefrontal cortex may be implicated in PTSD symptoms, and that interventions such as rTMS that can target this area of the brain might ameliorate symptoms of PTSD.

Evidence To Decision

Benefits and harms

Evidence from 3 RCTs suggest a large clinically important benefit of rTMS for PTSD symptom severity relative to waitlist [564][571][591].

Certainty of the Evidence

Certainty of the evidence is MODERATE due to serious imprecision.

The evidence analyses and risk of bias assessments for this intervention can be found here

Rationale

The Guideline Development Group considered the evidence showing large clinically important benefit of repetitive transcranial magnetic stimulation (rTMS) on PTSD symptom severity relative to waitlist. The Group noted that certainty of the evidence was moderate but limited to 3 small RCTs and they agreed that the extent to which the results can be generalised to all adults with PTSD is unknown. The Group agreed that there is not yet enough evidence to recommend offering rTMS but they considered that it was a promising intervention and recommended further research in broader population and trauma types to add strength to the evidence base.

Clinical Question/ PICO

<table>
<thead>
<tr>
<th>Population</th>
<th>Intervention</th>
<th>Comparator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults with PTSD</td>
<td>Repetitive transcranial magnetic stimulation (rTMS)</td>
<td>Sham TMS</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better</td>
<td>Sham TMS</td>
<td>Repetitive transcranial magnetic stimulation (rTMS)</td>
<td>Moderate</td>
<td>Repetitive transcranial magnetic stimulation (rTMS) probably</td>
</tr>
</tbody>
</table>

Difference: SMD 1.43 lower (CI 95% 2.45 lower – 0.41 lower)
Transcendental Meditation (TM)

**RESEARCH RECOMMENDATION**

For adults with PTSD we recommend offering TF-CBT, PE, CT, CPT or EMDR in preference to transcendental meditation (TM).

There is emerging evidence for Transcendental Meditation and this could be used in a research context.

*TM is a specific type of silent meditation developed by Maharishi Mahesh Yogi that involves repetition of a sound (a mantra) to facilitate a settled state of restful alertness. TM differs from mindfulness practice in that mindfulness involves focusing on the present moment in a specifically recommended way, whereas TM is taught as the effortless thinking of a mantra without concentration or contemplation.*

Evidence To Decision

**Benefits and harms**

Evidence from a single RCT suggests a small, clinically important benefit of TM relative to health education and no clinically important difference between TM and PE on PTSD symptom severity [433].

**Certainty of the Evidence**

Overall certainty of evidence for Transcendental meditation was MODERATE.

Certainty of evidence for Transcendental meditation vs Prolonged Exposure was MODERATE due to serious imprecision.

The evidence analyses and risk of bias assessments for this intervention can be found [here](#).

Certainty of evidence for Transcendental meditation vs Psychoeducation was MODERATE due to serious imprecision.

The evidence analyses and risk of bias assessments for this intervention can be found [here](#).

**Rationale**

The Guideline Development Group considered the evidence showing small clinically important benefit of transcendental Meditation (TM) on PTSD symptom severity relative to health education and equivalent outcomes compared to prolonged exposure, however the group noted that in this trial, the effect of prolonged exposure was not as strong as reported in several other studies. The Group noted that certainty of the evidence was moderate but limited to a single RCT in military veterans, and they agreed that the extent to which the results can be generalised to all adults with PTSD is unknown. The Group agreed that
there is not yet enough evidence to recommend offering TM but they considered that it was a promising intervention and recommended further research in broader population and trauma types to add strength to the evidence base.

### Clinical Question/ PICO

- **Population:** Adults with PTSD
- **Intervention:** Transcendental meditation
- **Comparator:** Prolonged exposure

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator Intervention</th>
<th>Intervention</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better</td>
<td>Prolonged exposure</td>
<td>Transcendental meditation</td>
<td>Moderate Due to serious imprecision</td>
<td>There is probably little or no difference between Transcendental meditation and Prolonged exposure on PTSD symptom severity</td>
</tr>
</tbody>
</table>

1. **Inconsistency:** No serious. **Indirectness:** No serious. **Imprecision:** Serious. Low number of patients (n=136), Wide confidence intervals (CIs include important benefit and unimportant harm), Only data from one study. **Publication bias:** No serious.

### Clinical Question/ PICO

- **Population:** Adults with PTSD
- **Intervention:** Transcendental meditation
- **Comparator:** Psychoeducation

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator Intervention</th>
<th>Intervention</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better</td>
<td>Psychoeducation</td>
<td>Transcendental meditation</td>
<td>Moderate Due to serious imprecision</td>
<td>Transcendental meditation is probably more beneficial than psychoeducation on PTSD symptom severity</td>
</tr>
</tbody>
</table>

1. **Inconsistency:** No serious. **Indirectness:** No serious. **Imprecision:** Serious. Low number of patients(n=134), Wide confidence intervals (CIs include important benefit and unimportant benefit), Only data from one study. **Publication bias:** No serious.
Yoga

RESEARCH RECOMMENDATION

For adults with PTSD we recommend offering TF-CBT, PE, CT, CPT or EMDR in preference to yoga.

There is emerging evidence for yoga and it could be used in a research context.

Yoga is a mind-body practice that typically combines physical postures, regulation of the breath, and techniques to cultivate attention. The emphasis on each of these factors varies according to the type of practice. The studies providing evidence for yoga are largely pilot studies. The populations studied include veterans and women, with the types of yoga investigated including Sudarshan Kriya (SKY) yoga, Kripalu, and trauma-informed yoga.

Evidence To Decision

Benefits and harms

Evidence from 5 RCTs suggests a small, clinically unimportant benefit from yoga on PTSD symptom severity relative to waitlist. The evidence is low due to serious risk of bias and serious imprecision. The evidence analyses and risk of bias assessments for this intervention can be found here.

Certainty of the Evidence

Certainty of the evidence is LOW due to serious risk of bias and serious imprecision.

Rationale

The Guideline Development Group considered the evidence showing small statistically important but clinically unimportant benefit of yoga on PTSD symptom severity relative to waitlist. The Group noted that certainty of the evidence was low but also discussed that it was not associated with any harms. The Group agreed that there is not yet enough evidence to recommend offering yoga but they considered that it was a promising intervention and recommended further research in broader population and trauma types to add strength to the evidence base.

Clinical Question/ PICO

<table>
<thead>
<tr>
<th>Population</th>
<th>Intervention</th>
<th>Comparator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults with PTSD</td>
<td>Yoga</td>
<td>Waitlist/ treatment as usual</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better</td>
<td>Waitlist/ treatment as usual</td>
<td>Yoga</td>
<td>Low</td>
<td>Yoga may decrease PTSD symptom severity slightly</td>
</tr>
<tr>
<td></td>
<td>Based on data from: 162 patients in 5 studies. (Randomized controlled)</td>
<td></td>
<td></td>
<td>Due to serious imprecision, Due to serious risk of bias ³</td>
<td></td>
</tr>
</tbody>
</table>

| Difference: SMD 0.4 lower | (CI 95% 0.72 lower — 0.09 lower) |

1. Risk of Bias: Serious. Inadequate concealment of allocation during randomization process, resulting in potential for selection bias, . Incomplete data and/or large loss to follow up, due to [participants were offered financial incentives to
Mantram repetition

For adults with PTSD there was insufficient evidence to make a recommendation on mantram repetition.

*Mantram repetition involves repeating a holy word(s) or phrase(s).*

Clinical Question/ PICO

<table>
<thead>
<tr>
<th>Population: Adults with PTSD</th>
<th>Intervention: Mantram repetition</th>
<th>Comparator: Waitlist/ treatment as usual</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better Based on data from: 175 patients in 2 studies. (Randomized controlled)</td>
<td>Comparator Waitlist/ treatment as usual</td>
<td>Intervention Mantram repetition</td>
<td>Low Due to serious risk of bias, Due to serious imprecision</td>
<td>Mantram repetition may decrease PTSD symptom severity slightly</td>
</tr>
</tbody>
</table>

Group music therapy

For adults with PTSD there was insufficient evidence to make a recommendation on group music therapy.

Group music therapy includes a combination of active and receptive musical activities with percussion instruments that emphasizes improvisation. Instrumental support is provided by music therapists.

Clinical Question/ PICO

<table>
<thead>
<tr>
<th>Population:</th>
<th>Adults with PTSD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention:</td>
<td>Group music therapy</td>
</tr>
<tr>
<td>Comparator:</td>
<td>Waitlist/treatment as usual</td>
</tr>
</tbody>
</table>

### Outcome

<table>
<thead>
<tr>
<th>Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better</td>
<td>Based on data from: 173 patients in 1 studies. (Randomized controlled)</td>
<td>Difference: SMD 0.37 lower (CI 95% 0.68 lower – 0.07 lower)</td>
<td>Moderate Due to serious imprecision</td>
<td>Mantram repetition is probably more beneficial than PCT on PTSD symptom severity.</td>
</tr>
</tbody>
</table>

1. **Inconsistency: No serious. Indirectness: No serious. Imprecision: Serious.** Low number of patients (n=173). Wide confidence intervals (CIs include important benefit and unimportant benefit), Only data from one study. **Publication bias: No serious.**

### Outcome

<table>
<thead>
<tr>
<th>Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better</td>
<td>Based on data from: 16 patients in 1 studies. (Randomized controlled)</td>
<td>Difference: SMD 2.12 lower (CI 95% 3.41 lower – 0.83 lower)</td>
<td>Very low Due to very serious imprecision, Due to serious risk of bias</td>
<td>We are uncertain whether group music therapy increases or decreases PTSD symptom severity</td>
</tr>
</tbody>
</table>

1. **Risk of Bias: Serious.** Inadequate/lack of blinding of outcome assessors, resulting in potential for detection bias. **Inconsistency: No serious. Indirectness: No serious. Imprecision: Very serious.** Low number of patients (n=16), Only data from one study. **Publication bias: No serious.**
Nature adventure therapy

For adults with PTSD there was insufficient evidence to make a recommendation on nature adventure therapy.

Nature adventure therapy is a **group-based rehabilitation intervention based upon the theoretical framework of experiential learning. It uses activity-based interventions such as sailing, to provide opportunity for personal growth.**

**Clinical Question/ PICO**

| Population: | Adults with PTSD |
| Intervenion: | Nature adventure therapy |
| Comparator: | Waitlist/ treatment as usual |

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator Waitlist/ treatment as usual</th>
<th>Intervention Nature adventure therapy</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better Based on data from: 42 patients in 1 studies. (Randomized controlled)</td>
<td>Difference: <strong>SMD 0.4 lower</strong> ( CI 95% 1.01 lower — 0.22 higher )</td>
<td>Very low Due to serious risk of bias, Due to serious indirectness, Due to very serious imprecision</td>
<td>We are uncertain whether nature adventure therapy increases or decreases PTSD symptom severity</td>
<td></td>
</tr>
</tbody>
</table>

1. **Risk of Bias:** **Serious.** Incomplete data and/or large loss to follow up. **Inconsistency:** No serious. **Indirectness:** Serious. Differences between the population of interest and those studied (Israeli veterans who had active service >5yrs previous). **Imprecision:** Very serious. Low number of patients (n=42), Wide confidence intervals (CIs include important benefit and unimportant harm), Only data from one study. **Publication bias:** No serious.

Somatic experiencing

For adults with PTSD there was insufficient evidence to make a recommendation on somatic experiencing.

**Somatic Experiencing involves a focus on perceived body sensations and to learn how to regulate these with the aim of resolving symptoms.**

**Clinical Question/ PICO**

| Population: | Adults with PTSD |
| Intervention: | Somatic experiencing |
| Comparator: | Waitlist/ treatment as usual |
### Saikokaishikankyoto

For adults with PTSD there was insufficient evidence to make a recommendation on Saikokaishikankyoto.

*This is a traditional Japanese herbal medicine.*

#### Clinical Question/ PICO

<table>
<thead>
<tr>
<th>Population:</th>
<th>Adults with PTSD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention:</td>
<td>Saikokaishikankyoto</td>
</tr>
<tr>
<td>Comparator:</td>
<td>Waitlist/ treatment as usual</td>
</tr>
</tbody>
</table>

#### Outcome

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better Based on data from: 60 patients in 1 studies. (Randomized controlled)</td>
<td>Difference: SMD 0.75 lower (CI 95% 1.28 lower — 0.22 lower)</td>
<td>Somatic experiencing</td>
<td>Moderate Due to serious imprecision</td>
<td>Somatic experiencing probably decreases PTSD symptom severity slightly</td>
</tr>
</tbody>
</table>

**1.** Inconsistency: **No serious.** Single study. Indirectness: **No serious.** Imprecision: **Serious.** Wide confidence intervals (CIs include important benefit and unimportant benefit), Low number of patients (n=60), Only data from one study. Publication bias: **No serious.**

---

1. Risk of Bias: **Serious.** Inadequate/lack of blinding of participants and personnel, resulting in potential for performance bias, due to [baseline differences between conditions], Selective outcome reporting. Inconsistency: **No serious.** Indirectness: **No serious.** Imprecision: **Serious.** Low number of patients (n=43), Wide confidence intervals (CIs include important benefit and unimportant benefit), Only data from one study. Publication bias: **Serious.** Mostly commercially funded studies.
**Attentional bias modification**

For adults with PTSD there was insufficient evidence to make a recommendation on attentional bias modification.

*ABM is a treatment designed for the management of anxiety disorders based on the finding that patients with anxiety disorders selectively attend to threatening information. It involves computer-based training to keep attention away from threatening information.*

**Clinical Question/ PICO**

- **Population:** Adults with PTSD
- **Intervention:** Attentional bias modification
- **Comparator:** Attention control placebo

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator Attention control placebo</th>
<th>Intervention Attentional bias modification</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better Based on data from: 102 patients in 1 studies. (Randomized controlled)</td>
<td>Difference: SMD 0.23 lower (CI 95% 0.62 lower — 0.16 higher)</td>
<td>Moderate Due to serious imprecision</td>
<td>Attentional bias modification probably decreases PTSD symptom severity slightly</td>
<td></td>
</tr>
</tbody>
</table>

1. **Inconsistency:** No serious. One study. **Indirectness:** No serious. Population comparable. **Imprecision:** Serious. Only data from one study (n=102), Low number of patients. **Publication bias:** No serious.

**Hypnotherapy**

For adults with PTSD there was insufficient evidence to make a recommendation on hypnotherapy.

*Hypnotherapy uses hypnosis to induce an altered state of consciousness before undertaking therapeutic work.*

**Clinical Question/ PICO**

- **Population:** Adults with PTSD
- **Intervention:** Hypnotherapy
- **Comparator:** Waitlist/ treatment as usual

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator Waitlist/ treatment as usual</th>
<th>Intervention Hypnotherapy</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better Based on data from: 52 patients in 1 studies.</td>
<td>Difference: SMD 0.04 lower (CI 95% 0.58 lower — 0.51 higher)</td>
<td>Very low Due to serious risk of bias, Due to serious</td>
<td>We are uncertain whether hypnotherapy increases or decreases PTSD symptom severity</td>
<td></td>
</tr>
</tbody>
</table>

**Australian Guidelines for the Prevention and Treatment of Acute Stress Disorder, Posttraumatic Stress Disorder, and Complex Posttraumatic Stress**
For adults with PTSD there was insufficient evidence to make a recommendation on electroacupuncture.

Electroacupuncture combines traditional Chinese acupuncture with modern electrotherapy. Acupuncture points are stimulated via needles connected to electrodes that deliver a continuous 100Hz wave.
### Stellate Ganglion Block (SGB)

For adults with PTSD there was insufficient evidence to make a recommendation on stellate ganglion block (SGB).

The stellate ganglion is a structure in the sympathetic chain commonly found at the level of the seventh cervical vertebra. Injecting local anesthetic around the stellate ganglion (stellate ganglion block [SGB]) has been shown to inhibit both efferent sympathetic effects and visceral pain fibers to the upper extremity and face. The SGB is now commonly used for the treatment of hypersympathetic activity influencing the upper extremity, such as Raynaud phenomena, or in sympathetically maintained pain as observed in complex regional pain syndrome.

### Clinical Question/ PICO

<table>
<thead>
<tr>
<th>Population:</th>
<th>Adults with PTSD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention:</td>
<td>Stellate Ganglion Block</td>
</tr>
<tr>
<td>Comparator:</td>
<td>Sham procedure</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcome Timeframe</th>
<th>Study results and measurements</th>
<th>Comparator</th>
<th>Intervention</th>
<th>Certainty of the Evidence (Quality of evidence)</th>
<th>Plain text summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD symptom severity</td>
<td>Lower better</td>
<td>Sham</td>
<td>SGB</td>
<td>Very low</td>
<td>There is probably little or no difference between Stellate Ganglion Block and Sham on PTSD symptom severity</td>
</tr>
</tbody>
</table>

#### 1. Risk of Bias: Serious. Incomplete data and/or large loss to follow up, Selective outcome reporting. Inconsistency: No serious. Indirectness: No serious. Imprecision: Very serious. Low number of patients (n=42), Wide confidence intervals (CIs include important benefit and important harm), Only data from one study. Publication bias: No serious.
Development of the Guidelines

The development of the Guidelines is described in the Plain Language Statement, Executive Summary, and Chapter 1 - Introduction.

Detailed methodology is presented in Chapter 1 - Introduction, in Chapter 5, and below.

Methodology

Approach to the systematic review

The evidence review that informed these Guidelines comprised the following:

1. Existing systematic reviews of the evidence conducted by the International Society for Traumatic Stress Studies (ISTSS) for their 2018 PTSD Prevention and Treatment Guidelines (research published up to 10 October 2018)
2. An update of the ISTSS systematic reviews to identify and incorporate new trials published subsequent to the last search (conducted by Phoenix Australia; research published up to 6 June 2019)
3. A systematic review of evidence addressing an additional question on pre-incident preparedness (conducted by Phoenix Australia; research published up to 6 June 2019)
4. Preparation of GRADE evidence profiles, in which a summary of findings from the body of evidence for each clinical question and an assessment of the certainty of evidence for each critical outcome was presented.

The methodology for these evidence reviews is outlined in Figure 1, Chapter 1, and described in more detail below. For completeness, the description of the systematic review methods as reported in the ISTSS guidelines is included as Appendix 1 (below). and Appendix 3 (also below) sets out the detailed search strategies used.

Formulating clinical questions and determining outcomes

The Guideline Development Group (GDG) formed for the current guideline, discussed and agreed to use the clinical questions from the recently completed ISTSS evidence review. In reviewing the questions, the GDG identified pre-incident preparedness as a priority question that had not been included in the ISTSS evidence review and agreed that this should be addressed in the Australian guidelines. The GDG also considered whether to specify questions for a systematic review of evidence on treatments for Complex PTSD (CPTSD) for adults, and children and adolescents. However, the GDG decided against this because there is currently no direct evidence about the treatment of people with CPTSD. Instead a chapter (Chapter 7) is included on considerations for the care of people with CPTSD, current issues and future research. The chapter is informed by research, but not based on a systematic review.

Across all questions, two outcomes (PTSD symptom severity and diagnosis) were prioritised as being critical for making recommendations about prevention and treatment of PTSD in the ISTSS guideline. The Guideline Development Group (GDG) for the current guideline agreed that these outcomes were critical for decision making and of importance to the expected end users of the guideline.

In line with recommendations in the Guideline, evidence was reviewed separately for adults, and for children and adolescents for each of the following:

- pre-incident preparedness
- intervention within the first 3 months of a traumatic event
- treatment for those with clinically relevant post-traumatic stress symptoms

Psychosocial, pharmacological and non-psychosocial and non-pharmacological interventions were considered.

Criteria for selecting studies

For each clinical question, criteria for selecting studies (‘eligibility criteria’) were specified using the Population, Interventions, Comparators, and Outcomes (PICO) framework. The final list of 22 questions is presented in Table 1 below and a summary of PICO criteria are provided in Table 2.

Table 1: Clinical Questions
Pre-incident preparedness
Q 1: For children and adolescents exposed to trauma do pre-incident preparedness interventions improve outcomes compared to no pre-incident preparedness interventions?
Q 2: For adults exposed to trauma, do pre-incident preparedness interventions improve outcomes compared to no pre-incident preparedness interventions?

For children and adolescents within the first three months of a traumatic event:
Q 3: do psychosocial interventions, when compared to intervention as usual, waiting list, no intervention, or other treatment, result in a clinically important improvement of outcomes?
Q 4: do psychosocial interventions, when compared to other psychosocial interventions, result in a clinically important improvement of outcomes?
Q 5: do pharmacological interventions, when compared to placebo, or other pharmacological or psychosocial interventions, result in a clinically important improvement of outcomes?
Q 6: do pharmacological interventions, when compared to other pharmacological or psychosocial interventions, result in a clinically important improvement of outcomes?

For children and adolescents with PTSD:
Q 7: do psychological treatments, when compared to treatment as usual, waiting list, or no treatment, result in a clinically important improvement of outcomes?
Q 8: do psychological treatments, when compared to other psychological treatments, result in a clinically important improvement of outcomes?
Q 9: do pharmacological treatments, when compared to placebo or other treatments, result in a clinically important improvement of outcomes?
Q 10: do pharmacological treatments, when compared to other pharmacological or psychosocial interventions, result in a clinically important improvement of outcomes?
Q 11: do non-psychological and non-pharmacological treatments/interventions, when compared to treatment as usual, waiting list, no treatment, or other treatment, result in a clinically important improvement of outcomes?
Q 12: do non-psychological and non-pharmacological treatments/interventions, when compared to other treatments, result in a clinically important improvement of outcomes?

For adults within the first three months of a traumatic event:
Q 13: do psychosocial interventions, when compared to intervention as usual, waiting list, or no intervention, result in a clinically important improvement of outcomes?
Q 14: do psychosocial interventions, when compared to other psychosocial interventions, result in a clinically important improvement of outcomes?
Q 15: do pharmacological interventions, when compared to placebo or other pharmacological or psychosocial interventions, result in a clinically important improvement of outcomes?
Q 16: do pharmacological interventions when compared to placebo or other pharmacological or psychosocial interventions result in a clinically important improvement of outcomes?
Q 17: do psychological treatments, when compared to treatment as usual, waiting list, or no treatment, result in a clinically important improvement of outcomes?
Q 18: do psychological treatments, when compared to other psychological treatments, result in a clinically important improvement of outcomes?
Q 19: do pharmacological treatments, when compared to placebo, result in a clinically important improvement of outcomes?
Q 20: do pharmacological treatments, when compared to other pharmacological or psychosocial interventions, result in a clinically important improvement of outcomes?
Q 21: do non-psychological and non-pharmacological treatments/interventions, when compared to treatment as usual, waiting list or no treatment, result in a clinically important improvement of outcomes?
Q 22: do non-psychological and non-pharmacological treatments/interventions, when compared to other treatments, result in a clinically important improvement of outcomes?

Studies were screened on title and abstract by two independent reviewers against the eligibility criteria, which were consistent with the inclusion criteria used in the ISTSS Guidelines, to determine eligibility for a full-text assessment. Studies meeting the eligibility criteria or for which eligibility criteria remained unclear were included in full text screening. Screening at the title and abstract level was performed independently by both reviewers. Any disagreements were resolved by discussion. Full-text assessment was also performed independently by both reviewers. Disagreement were resolved by discussion.

Table 2: PICO Eligibility Criteria

<table>
<thead>
<tr>
<th>Pre-incident preparedness</th>
<th>Early intervention</th>
<th>Treatment</th>
</tr>
</thead>
</table>

212 of 258
<table>
<thead>
<tr>
<th>Types of studies</th>
<th>Any randomised controlled trial (including cluster and cross-over trials)</th>
<th>Any randomised controlled trial (including cluster and cross-over trials)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusions:</td>
<td>• not solely a dismantling study</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• no minimum sample size</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• unpublished studies were eligible</td>
<td></td>
</tr>
<tr>
<td>Exclusions:</td>
<td>• editorials, letters to the editor, reviews, dissertations, and protocol papers</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Types of participants</th>
<th>Adults or children/adolescents exposed to a traumatic event as specified by PTSD diagnostic criteria for DSM-III, DSM-III-R, DSM-IV, DSM-5, ICD-9, ICD-10 or ICD-11.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults:</td>
<td>• At least 70% of participants required to be diagnosed with PTSD according to DSM or ICD criteria by means of a structured interview or diagnosis by a clinician</td>
</tr>
<tr>
<td>Children and adolescents:</td>
<td>• At least 70% diagnosed with partial or full DSM or ICD PTSD by means of a structured interview or diagnosis by a clinician</td>
</tr>
<tr>
<td></td>
<td>• Partial PTSD is defined as at least one symptom per cluster and presence of impairment</td>
</tr>
<tr>
<td>PTSD diagnosis</td>
<td>• Duration of PTSD symptoms required to be three months or more</td>
</tr>
<tr>
<td></td>
<td>• No restrictions on the basis of comorbidity, but PTSD required to be the primary diagnosis.</td>
</tr>
<tr>
<td></td>
<td>• No restriction on the basis of severity of PTSD symptoms or the type of traumatic event.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Types of interventions</th>
<th>Pre-incident preparedness interventions delivered before trauma exposure, aimed at preventing symptoms of PTSD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any intervention aimed at preventing, treating or reducing symptoms of PTSD which</td>
<td>• was not provided pre-trauma, and</td>
</tr>
<tr>
<td></td>
<td>• began no later than 3 months after the traumatic event.</td>
</tr>
<tr>
<td>Eligible interventions included:</td>
<td>• psychosocial prevention (e.g. psychological debriefing, psychoeducation)</td>
</tr>
<tr>
<td></td>
<td>• psychosocial treatment (e.g. brief trauma-focussed CBT)</td>
</tr>
<tr>
<td></td>
<td>• pharmacological treatment</td>
</tr>
<tr>
<td>Any psychological interventions aimed at reducing symptoms of PTSD</td>
<td>• Delivered by any mode, including to individuals, groups or couples</td>
</tr>
<tr>
<td>Eligible interventions included</td>
<td>• psychosocial (e.g. cognitive processing therapy)</td>
</tr>
<tr>
<td></td>
<td>• pharmacological treatments</td>
</tr>
<tr>
<td></td>
<td>• non-psychosocial and non-pharmacological treatments (e.g. mindfulness-based stress reduction)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Types of comparators</th>
<th>Other pre-incident preparedness interventions or no pre-incident preparedness intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>For psychosocial interventions:</td>
<td>• waitlist, treatment as usual, symptom monitoring, repeated assessment, other minimal attention control group</td>
</tr>
<tr>
<td></td>
<td>• alternative psychological treatment.</td>
</tr>
<tr>
<td>For pharmacological interventions:</td>
<td>• placebo,</td>
</tr>
<tr>
<td></td>
<td>• other pharmacological intervention</td>
</tr>
<tr>
<td></td>
<td>• psychosocial intervention.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Types of outcomes</th>
<th>Critical: ASD or PTSD symptom change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Important: ASD or PTSD diagnosis</td>
<td>--------------------------------------</td>
</tr>
</tbody>
</table>
Across all questions, the following additional eligibility criteria were used:

- **Date of publication**: All studies included in these Guidelines were published within the dates of the search, i.e. **January 2008 to June 2019**
- **Language**: All included studies were published in English

**Search methods**

**Literature sources**
For the ISTSS systematic reviews, systematic reviews developed through the Cochrane Collaboration, the UK National Institute for Health and Care Excellence (NICE) and the World Health Organisation (WHO) were identified. RCTs from these reviews were used as the initial set of studies and re-evaluated by the ISTSS review team. Searches were conducted by the ISTSS team to update the identified systematic reviews, in addition to asking experts in the field to identify missing studies. The ISTSS searches were then updated by Phoenix Australia for the period of October 2018 to June 2019. In addition, searching was conducted for the two new scoping questions between the period of 2008 and June 2019. These searches were conducted in the CENTRAL (Cochrane), Medline, PSYCInfo, and PILOTS databases.

**Search strategy**
The ISTSS systematic reviews, the updates to these reviews, and the searches for the two new questions involved the same search strategy. The search terms 'PTSD', 'posttrauma*', 'post-trauma*', 'post trauma*', 'combat disorder*', 'stress disorder*' were used to be as broad as possible and ensure that all relevant RCTs were captured.

**Data extraction and analysis**
Evidence tables were used to guide the extraction of data from the individual studies and summarise results. Two researchers independently extracted data from included studies. Studies that fulfilled the inclusion criteria were further scrutinised to determine if data were available to use in the meta-analyses. If sufficient data were not available, requests were made to authors for data that could be used. All available data addressing specific scoping questions were meta-analyzed using Revman (Version 5.3) software (The Nordic Cochrane Centre, 2014) using a fixed-effects model where statistical heterogeneity, as indicated by $I^2$, was less than 30%, where heterogeneity was > 30% or higher, a random-effects model was used.

**Appraisal of individual studies: risk of bias assessment**
Individual studies were summarised and appraised independently by two people using version one of the Cochrane Collaboration’s risk of bias tool. Inter-rater reliability was calculated and disagreements were resolved by discussion. Assessment involved judging whether there was a low, uncertain or high risk of bias for each of the following domains: Random sequence generation (selection bias); Allocation concealment (selection bias); Blinding of participants and personnel (performance bias); Blinding of outcome assessment (detection bias); Incomplete outcome data (attrition bias); Selective reporting (reporting bias); and Other bias.

**Assessment of the certainty of the body of evidence**
The Grading of Recommendations, Assessment, Development and Evaluations (GRADE) system was used to assess the certainty of the evidence base. Evidence from RCTs starts at high certainty and may be downgraded for serious or very serious concerns relating to each of the following domains.

1. **Risk of bias**: based on the overall risk of bias (methodological limitations) of the trials contributing to each result. For the purpose of grading the evidence, an overall judgement of risk of bias was first made across studies for each risk bias domain, and then across domains. This judgment considered the extent to which studies at high or unclear risk of bias influenced the meta-analysis (i.e. weight).
2. **Indirectness**: the extent to which the PICO characteristics of the body of evidence adequately address the clinical questions (PICO) for the guideline.
3. **Imprecision**: whether the confidence interval includes both appreciable benefit and harm (or vice versa) and whether the optimal information size was met (based on a rule of thumb of >400 participants for continuous outcomes; > 300 events for binary). Judgments of appreciable benefit (or harm) were based on the thresholds below.
4. **Inconsistency**: the extent to which there is unexplained inconsistency in results across studies. Judgements were based on visual inspection of data (overlap in confidence intervals, the direction and magnitude of effect) and statistical measures and tests of heterogeneity.
5. **Publication bias.** The likelihood of small study effect or other evidence of publication bias.

A body of evidence is rated as being of high quality (i.e., further research is very unlikely to change our confidence in the estimate of effect), moderate quality (i.e. further research is likely to have an important impact on our confidence in the estimate effect and may change the estimate), low quality (i.e. further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate) or very low quality (i.e. we are very uncertain about the estimate).

The following thresholds were used for judging the clinical importance of effects on symptom severity (reported as standardised mean difference) and for judging imprecision:

- for interventions delivered 3 or more months post trauma, >0.8 for waitlist comparisons, >0.5 for treatment attention control comparisons, >0.4 for placebo control comparisons and >0.2 for active treatment control comparisons for continuous outcomes and <0.65 for binary outcomes
- for interventions delivered within 3 months, >0.5 for treatment comparisons and >0.2 for prevention comparisons for continuous outcomes and <0.8 for binary outcomes
- for the pre-incident preparedness, 0.2 for any control comparison

Evidence profiles reporting relative and absolute effects, the GRADE of evidence for each outcome, and the rationale for GRADE judgements were prepared in MAGICApp.

**Development of recommendations**

The GRADE Evidence to Decision (EtD) framework was used by the Guideline Development Group (GDG) to develop recommendations. The framework, as implemented in MAGICApp, prompts guideline developers to consider the following criteria for each intervention option.

**The balance of benefits and harms.** The GDG considered whether the balance between desirable and undesirable effects favoured the intervention, and whether the effects were clinically important.

**The certainty of evidence.** The GDG judged the overall certainty of evidence across the critical outcomes. In general, strong recommendations were underpinned by high or moderate certainty evidence.

**Patients' values and preferences.** The GDG considered whether all patients would feel that the desirable effects of the intervention outweighed the harms. Input from the consumer representatives on the GDG informed discussion during the GDG meeting and the summary of values and preferences presented in MAGICApp.

**Resources, equity, acceptability and feasibility.** The GDG considered each of these factors in relation to the implementation of each intervention. Funding and access to services were key considerations. Implications for special populations are considered in Chapter 9.

Recommendations for or against each intervention were made by the GDG after considering each of these criteria. The strength of each recommendation (strong or conditional) was determined and worded in accordance with GRADE guidelines. Decisions were made through consensus and key considerations are presented in MAGICApp.

**Limitations of the review**

This systematic review of the treatments for ASD and PTSD is limited by the following factors. The review:

- does not cover questions pertaining to an assessment of some additional multi-component treatments versus other multi-component treatments or versus placebo/waitlist for the populations under review
- does not assess levels of evidence lower than randomised controlled trials
- does not provide a comprehensive review of potential safety issues (i.e., studies too small to detect many adverse events, particularly rare adverse events) – this is of particular relevance to the section on pharmacological treatments

These Guidelines were based in part on the ISTSS Guidelines, which have their own limitations. In updating these Guidelines, some of these limitations must be acknowledged, despite the use of a near-identical methodology.

- Some studies that potentially met the inclusion criteria may have been missed.
- Effect sizes were calculated on the difference in post-treatment scores between the groups, the assumption being that randomisation negated any potential baseline differences between the groups. This assumption may be valid for large trials but is not necessarily correct for small trials.

**Appendix 1: Methodology used for the ISTSS Guidelines**

The following information has been extracted from the ISTSS Guidelines methodology and development process paper.\(^5\)

**Methodology overview**

The ISTSS Guidelines recommendations were developed through a rigorous process that was overseen by the ISTSS Guidelines
Committee. Scoping questions were developed and systematic reviews were undertaken to identify relevant RCTs. Meta-analyses were then conducted with usable data from included studies, and the results were used to generate recommendations for prevention and treatment interventions.

Given the limited resources available, it was not possible to commission new comprehensive systematic reviews in every area. It was, however, possible to develop a robust and replicable process that systematically gathered and considered the RCT evidence currently available for any intervention in a standardised manner. A process adapted from approaches taken by the Australian Centre for Posttraumatic Mental Health (now Phoenix Australia–Centre for Posttraumatic Mental Health), the Cochrane Collaboration, the United Kingdom’s National Institute for Health and Care Excellence (NICE), and the World Health Organization (WHO) was used. General scoping questions were agreed on by the Committee in a PICO (population, intervention, comparator, outcomes) format (e.g., "For adults with PTSD, do psychological treatments, when compared to treatment as usual, waiting list, or no treatment, result in a clinically important improvement of outcomes?") for the prevention and treatment of PTSD in children, adolescents, and adults. Prior to finalisation, the committee sought and integrated feedback from the ISTSS membership around these scoping questions.

High-quality systematic reviews developed through the Cochrane Collaboration, NICE, and the WHO were identified that addressed the scoping questions except those pertaining to non-psychological and non-pharmacological interventions. RCTs from these reviews were used as the basis of the evidence to be considered and re-evaluated according to the criteria agreed for the ISTSS Treatment Guidelines. Existing reviews (Bisson, Andrew, Roberts, Cooper, & Lewis, 2013; Hoskins et al., 2015; Lewis, Roberts, Bethell, & Bisson, 2015; NICE, 2018b; Roberts, Kitchiner, Kenardy, & Bisson, 2009; Rose, Bisson, Churchill, Wessely, 2005; Sijbrandij, Kleiboer, Bisson, Barbui, & Cuijpers, 2015) were supplemented with additional systematic searches for more recent RCTs and by asking experts in the field and the ISTSS membership to determine if there were any missing studies. New systematic reviews were undertaken for the non-psychological and non-pharmacological scoping questions. The Cochrane Collaboration Mental Health Disorders Group completed additional searches, using their comprehensive search strategies to identify RCTs of any intervention designed to prevent or treat PTSD. The evidence for each of the scoping questions was summarised and its certainty assessed by two researchers using the Cochrane Collaboration’s risk of bias rating tool (to assess for potential methodological concerns within identified studies) and the GRADE system (i.e., the level of confidence that the estimate of the effect of an intervention is correct).

Systematic reviews and meta-analyses

New systematic searches were undertaken by the Cochrane Collaboration for the period 1 January 2008 to 31 March 2018, using their comprehensive search strategies, to identify RCTs of any intervention designed to prevent or treat PTSD. Additional RCTs were identified through consultation with experts in the field, including the ISTSS Board and the entire ISTSS membership. The new searches identified 5,500 potential new studies. These and the studies included in existing systematic reviews were assessed against the inclusion criteria agreed upon for the ISTSS Guidelines prior to the additional searches being undertaken. The inclusion criteria were designed to focus on reduction in symptoms of PTSD as the primary outcome and differed slightly for early intervention and treatment studies (i.e., as opposed to early interventions studies, treatment studies required a defined severity of PTSD symptoms to be included).

The inclusion criteria for early intervention studies were:

- Any randomised controlled trial (including cluster and cross-over trials) evaluating the efficacy of interventions aimed at preventing, treating or reducing symptoms of PTSD.
- Study participants have been exposed to a traumatic event as specified by PTSD diagnostic criteria for DSM-III, DSM-III-R, DSM-IV, DSM-5, ICD-9, ICD-10 or ICD-11.
- Intervention is not provided pre-trauma.
- Intervention begins no later than three months after the traumatic event.
- Eligible comparator interventions for psychosocial interventions: waitlist, treatment as usual, symptom monitoring, repeated assessment, other minimal attention control group, or an alternative psychological treatment.
- Eligible comparator interventions for pharmacological interventions: placebo, other pharmacological or psychosocial intervention.
- The RCT is not solely a dismantling study.
- Study outcomes include a standardised measure of PTSD symptoms (either clinician-administered or self-report).
- No restriction on the basis of severity of PTSD symptoms or the type of traumatic event.
- Individual, group and couple interventions.
- No minimum sample size.
- Only studies published in English.
- Unpublished studies eligible.

The inclusion criteria for treatment studies were:

- Any randomised controlled trial (including cluster and cross-over trials) evaluating the efficacy of psychological interventions aimed at reducing symptoms of PTSD.
- For adults, at least 70% of participants required to be diagnosed with PTSD according to DSM or ICD criteria by means of
structured interview or diagnosis by a clinician.

- For children and adolescents, at least 70% diagnosed with partial or full DSM or ICD
- PTSD by means of a structured interview or diagnosis by a clinician (partial PTSD is defined as at least one symptom per cluster and presence of impairment), or score above a standard cut-off of a validated self-report measure.
- No restrictions on the basis of comorbidity, but PTSD required to be the primary diagnosis.
- Eligible comparator interventions for psychosocial interventions: waitlist, treatment as usual, symptom monitoring, repeated assessment, other minimal attention control group, or an alternative psychological treatment.
- Eligible comparator interventions for pharmacological interventions: placebo or other pharmacological or psychosocial intervention.
- The RCT is not solely a dismantling study.
- Duration of PTSD symptoms required to be three months or more.
- No restriction on the basis of severity of PTSD symptoms or the type of traumatic event.
- Individual, group, and couple interventions.
- No minimum sample size.
- Only studies published in English.
- Unpublished studies eligible.

A total of 361 RCTs fulfilled the criteria for inclusion in the meta-analyses undertaken. Two researchers independently extracted data from included studies. Studies that fulfilled the inclusion criteria were further scrutinised to determine if data were available to use in the meta-analyses, and to assess risk of bias according to the Cochrane Collaboration criteria. If sufficient data were not available, requests were made to authors for data that could be used. A total of 327 (91%) of the included RCTs provided data that were included in the meta-analyses.

The final meta-analyses and reference lists of all eligible studies can be found on the ISTSS website.

Appendix 2: PICOs and selection criteria

Pre-incident preparedness

PICO 1:
For children and adolescents exposed to trauma, do pre-incident preparedness interventions improve outcomes compared to no pre-incident preparedness interventions?

Selection criteria
Population: Children and adolescents exposed to trauma, including the subgroup with ASD
Intervention: Pre-incident preparedness intervention
Comparator: No pre-incident preparedness intervention
Primary outcome: Symptoms of ASD or PTSD
Secondary outcome: PTSD diagnosis

PICO 2:
For adults exposed to trauma, do pre-incident preparedness interventions improve outcomes compared to no pre-incident preparedness interventions?

Selection criteria
Population: Adults exposed to trauma, including the subgroup with ASD
Intervention: Pre-incident preparedness intervention
Comparator: No pre-incident preparedness intervention
Primary outcome: Symptoms of ASD or PTSD
Secondary outcome: PTSD diagnosis

For CHILDREN AND ADOLESCENTS

Early psychosocial interventions

PICO 3:
For children and adolescents within the first three months of a traumatic event, do psychosocial interventions, when compared to intervention as usual, waiting list, no intervention, or other treatment, result in a clinically important improvement of outcomes?

Selection criteria
Population: Children and adolescents within the first three months post traumatic event
Intervention: Psychosocial interventions
Comparator | Intervention as usual  
Other treatment | Waiting list or no intervention  
Primary outcome | ASD or PTSD symptom change  
Secondary outcome | ASD or PTSD diagnosis

PICO 4:
For children and adolescents within the first three months of a traumatic event, do psychosocial interventions, when compared to other psychosocial interventions, result in a clinically important improvement of outcomes?

**Selection criteria**
Population: Children and adolescents within the first three months post traumatic event  
Intervention: Psychosocial interventions  
Comparator: Other psychosocial interventions  
Primary outcome: ASD or PTSD symptom change  
Secondary outcome: ASD or PTSD diagnosis

PICO 5:
For children and adolescents within the first three months of a traumatic event, do pharmacological interventions, when compared to placebo, or other pharmacological or psychosocial interventions, result in a clinically important improvement of outcomes?

**Selection criteria**
Population: Children and adolescents within the first three months post traumatic event  
Intervention: Pharmacological interventions  
Comparator: Placebo  
Other pharmacological or psychosocial interventions  
Primary outcome: ASD or PTSD symptom change  
Secondary outcome: ASD or PTSD diagnosis

PICO 6:
For children and adolescents within the first three months of a traumatic event, do pharmacological interventions, when compared to other pharmacological or psychosocial interventions, result in a clinically important improvement of outcomes?

**Selection criteria**
Population: Children and adolescents within the first three months post traumatic event  
Intervention: Pharmacological intervention  
Comparator: Other pharmacological or psychosocial interventions  
Primary outcome: ASD or PTSD symptom change

Psychological treatment for PTSD

PICO 7:
For children and adolescents with clinically relevant posttraumatic stress symptoms, do psychological treatments, when compared to treatment as usual, waiting list, or no treatment, result in a clinically important improvement of outcomes?

**Selection criteria**
Population: Children and adolescents with clinically relevant posttraumatic stress symptoms  
Intervention: Psychological treatment  
Comparator: Treatment as usual  
Wait list or no treatment  
Primary outcome: PTSD symptom change

PICO 8:
For children and adolescents with clinically relevant posttraumatic stress symptoms, do psychological treatments, when compared to other psychological treatments, result in a clinically important improvement of outcomes?

**Selection criteria**
Population: Children and adolescents with clinically relevant posttraumatic stress symptoms  
Intervention: Psychological treatments  
Comparator: Other psychological treatments  
Primary outcome: PTSD symptom change

Pharmacological treatments for PTSD

PICO 9:
For children and adolescents with clinically relevant posttraumatic stress symptoms, do pharmacological treatments, when compared to placebo or other treatments, result in a clinically important improvement of outcomes?

**Selection criteria**
- **Population**: Children and adolescents with clinically relevant posttraumatic stress symptoms
- **Intervention**: Pharmacological treatment
- **Comparator**: Placebo, Other treatment
- **Primary outcome**: PTSD symptom change

**PICO 10:**
For children and adolescents with clinically relevant posttraumatic stress symptoms, do pharmacological treatments, when compared to other pharmacological or psychosocial interventions, result in a clinically important improvement of outcomes?

**Selection criteria**
- **Population**: Children and adolescents with clinically relevant posttraumatic stress symptoms
- **Intervention**: Pharmacological treatment
- **Comparator**: Other pharmacological or psychosocial interventions
- **Primary outcome**: PTSD symptom change

**Non-psychological and non-pharmacological treatments/interventions:**

**PICO 11:**
For children and adolescents with clinically relevant posttraumatic stress symptoms, do non-psychological and non-pharmacological treatments/interventions, when compared to treatment as usual, waiting list, no treatment, or other treatment, result in a clinically important improvement of outcomes?

**Selection criteria**
- **Population**: Children and adolescents with clinically relevant posttraumatic stress symptoms
- **Intervention**: Non-psychological and non-pharmacological treatments
- **Comparator**: Treatment as usual, Waiting list or no treatment, Other treatment
- **Primary outcome**: PTSD symptom change

**PICO 12:**
For children and adolescents with clinically relevant posttraumatic stress symptoms, do non-psychological and non-pharmacological treatments/interventions, when compared to other treatments, result in a clinically important improvement of outcomes?

**Selection criteria**
- **Population**: Children and adolescents with clinically relevant posttraumatic stress symptoms
- **Intervention**: Non-psychological and non-pharmacological treatments
- **Comparator**: Other treatments
- **Primary outcome**: PTSD symptom change

**For ADULTS**

**Early psychosocial interventions**

**PICO 13:**
For adults within the first three months of a traumatic event, do psychosocial interventions, when compared to intervention as usual, waiting list, or no intervention, result in a clinically important improvement of outcomes?

**Selection criteria**
- **Population**: Adults within the first three months post traumatic event
- **Intervention**: Psychosocial interventions
- **Comparator**: Intervention as usual, Waiting list or no intervention
- **Primary outcome**: ASD or PTSD symptom change
- **Secondary outcome**: ASD or PTSD diagnosis

**PICO 14:**
For adults within the first three months of a traumatic event, do psychosocial interventions, when compared to other psychosocial interventions, result in a clinically important improvement of outcomes?

**Selection criteria**
- **Population**: Adults within the first three months post traumatic event
PICO 15:
For adults within the first three months of a traumatic event, do pharmacological interventions, when compared to placebo result in a clinically important improvement of outcomes?

Selection criteria
Population: Adults within the first three months post traumatic event
Intervention: Pharmacological intervention
Comparator: Placebo
Primary outcome: ASD or PTSD symptom change

PICO 16:
For adults within the first three months of a traumatic event, do pharmacological interventions when compared to other pharmacological or psychosocial interventions result in a clinically important improvement of outcomes?

Selection criteria
Population: Adults within the first three months post traumatic event
Intervention: Pharmacological intervention
Comparator: Other pharmacological or psychosocial interventions
Primary outcome: ASD or PTSD symptom change

PICO 17:
For adults with PTSD, do psychological treatments, when compared to treatment as usual, waiting list, or no treatment, result in a clinically important improvement of outcomes?

Selection criteria
Population: Adults with PTSD
Intervention: Psychological treatment
Comparator: Treatment as usual, wait list, or no treatment
Primary outcome: PTSD symptom change

PICO 18:
For adults with PTSD, do psychological treatments, when compared to other psychological treatments, result in a clinically important improvement of outcomes?

Selection criteria
Population: Adults with PTSD
Intervention: Psychological treatments
Comparator: Other psychological treatments
Primary outcome: PTSD symptom change

PICO 19:
For adults with PTSD, do pharmacological treatments, when compared to placebo, result in a clinically important improvement of outcomes?

Selection criteria
Population: Adults with PTSD
Intervention: Pharmacological treatment
Comparator: Placebo
Primary outcome: PTSD symptom change

PICO 20:
For adults with PTSD, do pharmacological treatments, when compared to other pharmacological or psychosocial interventions, result in a clinically important improvement of outcomes?

Selection criteria
Population: Adults with PTSD
Intervention: Pharmacological treatment
Comparator: Other pharmacological or psychosocial interventions
Primary outcome: PTSD symptom change

Non-psychological and non-pharmacological treatments/interventions:

PICO 21:
For adults with PTSD, do non-psychological and non-pharmacological treatments/interventions, when compared to treatment as usual, waiting list or no treatment, result in a clinically important improvement of outcomes?

Selection criteria
Population: Adults with PTSD
Intervention: Non-psychological and non-pharmacological treatments
Comparator: Treatment as usual, waiting list or no treatment
Primary outcome: PTSD symptom change

PICO 22:
For adults with PTSD, do non-psychological and non-pharmacological treatments/interventions, when compared to other treatments, result in a clinically important improvement of outcomes?

Selection criteria
Population: Adults with PTSD
Intervention: Non-psychological and non-pharmacological treatments
Comparator: Other treatments
Primary outcome: PTSD symptom change

Appendix 3: Detailed search strategies

ISTSS Search one (6 May 2016)

CCMDCTR-Studies Register
#1 (PTSD or posttrauma* or post-trauma* or "post trauma*" or "combat disorder*" or "stress disorder"):sco,stc
#2 (PTSD or posttrauma* or post-trauma* or "post trauma*" or "combat disorder*" or "stress disorder"):ti,ab,kw,ky,emt,mh,mc

ISTSS Search two (3 March 2018)
The Cochrane Central Register of Controlled Trials (CENTRAL)

#1 MeSH descriptor: [Stress Disorders, Post-Traumatic] this term only
#2 (PTSD or ((posttrauma* or post-trauma* or post trauma*) near/3 (stress* or disorder* or psych* or symptom*)) or acute stress disorder* or combat disorder* or war neuros*)
#3 (((acute or traumatic) near/1 stress*) and (expos* or psyc*))
#4 (traumatised near/1 (victim* or survivor*))
#5 (traumatized near/1 (victim* or survivor*))
#6 (trauma* near/2 (event* or memor* or flashback* or nightmare*))
#7 (((trauma* or posttrauma* or post-trauma* or victim* or survivor*) and (exposure near/3 (therap* or psychotherap* or training or counsel*))))
#8 MeSH descriptor: [Crisis Intervention] this term only
#9 (critical incident near/1 (stress or debrief* or de-brief*))
#10 (debriefing or de-briefing)
#11 (crisis intervention* or CISD)
#12 ((stress or group* or psychological or crisis) near/3 (debrief* or de-brief*))
#13 (trauma* near/2 (event* or memor* or flashback* or nightmare*))
#14 (EMDR or (eye movement desensitization and reprocessing))

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EMDR or (eye movement desensitisation and reprocessing)

#1 or #2 or #3 or #4 or #5 or #6 or #7 or #8 or #9 or #10 or #11 or #12 or #13 or #14 or #15

**Medline**

#1 Stress Disorders, Post-Traumatic/

#2 (PTSD or ((posttrauma* or post-trauma* or post trauma*) adj3 (stress* or disorder* or psych* or symptom?)) or acute stress disorder* or combat disorder* or war neuros*),ti,ab,kf.

#3 (((acute or traumatic) adj stress*) and (expos* or psyc*)),ti,ab,kf.

#4 (traumati#ed adj (victim? or survivor?)),ti,ab,kf.

#5 (trauma* adj2 (event? or memor* or flashback* or nightmare?)),ti,ab,kf.

#6 (((trauma* or posttrauma* or post-trauma* or victim* or survivor?) and (exposure adj3 (therap* or psychotherap* or training or counsel*)))),ti,ab,kf,hw.

#7 Crisis Intervention/

#8 (critical incident adj (stress or debrief* or de-brief*)).ti,ab,kf.

#9 (debriefing or de-briefing).ti,kf.

#10 (crisis intervention? or CISD).ti,ab,kf.

#11 ((stress or group? or psychological or crisis) adj3 (debrief* or de-brief*)),ti,ab,kf.

#12 (trauma* adj2 (event? or memor* or flashback* or nightmare?)).ti,kf.

#13 (EMDR or (eye movement desensit#ation and reprocessing)).ti,ab,kf,sh.

#14 (1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13)

#15 randomized controlled trial.pt.

#16 controlled clinical trial.pt.

#17 randomized.ab.

#18 placebo.ab.

#19 clinical trials as topic.sh.

#20 randomly.ab.

#21 trial.ti.

#22 (15 or 16 or 17 or 18 or 19 or 20 or 21)

#23 (14 and 22)

#24 (2014* or 2015* or 2016* or 2017* or 2018*).yr,dt,ed,.ep.

#25 (23 and 24)

**Embase**

#1 posttraumatic stress disorder/

#2 "trauma and stressor related disorders"/

#3 combat disorders/

#4 psychological trauma/

#5 stress disorders, post-traumatic/

#6 stress disorders, traumatic, acute/
#7 (PTSD or ((posttrauma* or post-trauma* or post trauma*) adj3 (stress* or disorder* or psych* or symptom?)) or acute stress disorder* or combat disorder* or war neuros*).ti,ab,kw.

#8 ((acute or traumatic) adj stress*) and (expos* or psyc*).ti,ab,kw.

#9 (traumatized adj (victim? or survivor?!)).ti,ab,kw.

#10 (trauma* adj2 (event? or memor* or flashback* or nightmare?!)).ti,ab,kw.

#11 (EMDR or (eye movement desensitization and reprocessing)).ti,kw.

#12 ((trauma* or posttrauma* or post-trauma* or victim* or survivor?) and (exposure adj3 (therap* or psychotherap* or training or counsel?!))).ti,ab,kw.

#13 (critical incident adj (stress or debrief* or de-brief*)).ti,ab,kw.

#14 (debriefing or de-briefing).ti,ab,kw.

#15 (crisis intervention? or CISD).ti,ab,kw.

#16 ((stress or group? or psychological or crisis) adj3 (debrief* or de-brief*)).ti,ab,kw.

#17 (trauma* adj2 (event? or memor* or flashback* or nightmare?!)).ti,ab,kw.

#18 (1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17)

#19 crossover-procedure/ or double-blind procedure/ or randomized controlled trial/ or single-blind procedure/ or (random* or factorial* or crossover* or cross over* or placebo* or (doubi* adj blind*)) or (singl* adj blind*) or assign* or allocat* or volunteer*).tw.

#20 (18 and 19)

#21 (2014* or 2015* or 2016* or 2017* or 2018*).yr,dc.

#22 (20 and 21)

**PsychINFO**

#1 posttraumatic stress disorder/ or complex ptsd/ or desnos/ or acute stress disorder/ or combat experience/ or "debriefing (psychological)"/ or emotional trauma/ or post-traumatic stress/ or exp stress reactions/ or traumatic neurosis/

#2 exp disasters/

#3 (PTSD or ((posttrauma* or post-trauma* or post trauma*) adj3 (stress* or disorder* or psych* or symptom?)) or acute stress disorder* or combat disorder* or war neuros*).ti,ab.

#4 ((acute or traumatic) adj stress*) and (expos* or psyc*).ti,ab.

#5 (traumatized adj (victim? or survivor?!)).ti,ab.

#6 (trauma* adj2 (event? or memor* or flashback* or nightmare?!)).ti,ab.

#7 (EMDR or (eye movement desensitization and reprocessing)).ti,ab.

#8 ((trauma* or posttrauma* or post-trauma* or victim* or survivor?) and (exposure adj3 (therap* or psychotherap* or training or counsel?!))).ti,ab.

#9 crisis intervention/

#10 (critical incident adj (stress or debrief* or de-brief*)).ti,ab.

#11 (debriefing or de-briefing).ti,ab.

#12 (crisis intervention? or CISD).ti,ab.

#13 ((stress or group? or psychological or crisis) adj3 (debrief* or de-brief*)).ti,ab.

#14 (trauma* adj2 (event? or memor* or flashback* or nightmare?!)).ti,ab.

#15 (1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14)
| #16 | clinical trials.sh. |
| #17 | (random#ed or random#ation or random#ing).ti,ab,id. |
| #18 | (RCT or at random or (random* adj3 (assign* or allocat* or control* or crossover or cross-over or design* or divide* or division or number))).ti,ab,id. |
| #19 | (control* and (trial or study or group) and (placebo or waitlist* or wait* list* or ((treatment or care) adj2 usual))).ti,ab,id,hw. |
| #20 | ((single or double or triple or treble) adj2 (blind* or mask* or dummy)).ti,ab,id. |
| #21 | trial.ti. |
| #22 | placebo.ti,ab,id,hw. |
| #23 | treatment outcome.md. |
| #24 | treatment effectiveness evaluation.sh. |
| #25 | mental health program evaluation.sh. |
| #26 | (16 or 17 or 18 or 19 or 20 or 21 or 22 or 23 or 24 or 25) |
| #27 | (15 and 26) |
| #28 | (2014* or 2015* or 2016* or 2017* or 2018*).yr,dc,mo. |
| #29 | (27 and 28) |

**PILOTS**

| #1 | ti((posttrauma* near/4 (stress* or disorder* or psych* or symptom*))) OR ab((posttrauma* near/4 (stress* or disorder* or psych* or symptom*))) |
| #2 | ti((post-trauma* near/4 (stress* or disorder* or psych* or symptom*))) OR ab((post-trauma* near/4 (stress* or disorder* or psych* or symptom*))) |
| #3 | ti((post trauma* near/4 (stress* or disorder* or psych* or symptom*))) OR ab((post trauma* near/4 (stress* or disorder* or psych* or symptom*))) |
| #4 | ti((PTSD or acute stress disorder* or combat disorder* or war neuros*)) OR ab((PTSD or acute stress disorder* or combat disorder* or war neuros*)) |
| #5 | ti(((acute or traumatic) near/2 stress*) and (expos* or psyc*)) OR ab(((acute or traumatic) near/2 stress*) and (expos* or psyc*)) |
| #6 | ti((traumatised near/2 (victim* or survivor*))) OR ab((traumatised near/2 (victim* or survivor*))) |
| #7 | ti((trauma* near/3 (event* or memor* or flashback* or nightmare*))) OR ab((trauma* near/3 (event* or memor* or flashback* or nightmare*))) |
| #8 | ti(((trauma* or posttrauma* or post-trauma* or victim* or survivor*) and (exposure near/4 (therap* or psychotherap* or training or counsel*))) OR ab(((trauma* or posttrauma* or post-trauma* or victim* or survivor*) and (exposure near/4 (therap* or psychotherap* or training or counsel*)))) |
| #9 | ti((critical incident near/2 (stress or debrief* or de-brief*))) OR ab((critical incident near/2 (stress or debrief* or de-brief*))) |
| #10 | ti((debriefing or de-briefing)) OR ab((debriefing or de-briefing)) |
| #11 | ti((crisis intervention* or CISD)) OR ab((crisis intervention* or CISD)) |
| #12 | ti(((stress or group* or psychological or crisis) near/4 (debrief* or de-brief*))) OR ab(((stress or group* or psychological or crisis) near/4 (debrief* or de-brief*))) |
| #13 | ti((trauma* near/3 (event* or memor* or flashback* or nightmare*))) OR ab((trauma* near/3 (event* or memor* or flashback* or nightmare*))) |
| #14 | ti((EMDR or (eye movement desensitisation and reprocessing))) OR ab((EMDR or (eye movement desensitisation and reprocessing))) |
Phoenix Searches
Pre-incident preparedness (6 June 2019)
Databases: CENTRAL, Medline, EMBASE, PsycINFO, PILOTS

#1 PTSD.mp. or "post-traumatic stress disorder".mp. or "posttraumatic stress disorder".mp. or "post traumatic stress disorder".mp.

#2 preparedness.mp. or pre-incident.mp. or inoculation or prevent*.mp. or resilien*.mp. or protect*.mp. or pre-trauma.mp. or plan*.mp.

#3 intervention.mp. or training.mp. or program.mp. or trial.mp.

#4 #1 AND #2 AND #3

#5 limit 21 to english language

Update to ISTSS Search (6 June 2019)
Databases: CENTRAL, Medline, EMBASE, PsycINFO, PILOTS

#1 PTSD.mp. or posttrauma*.mp. or post-trauma*.mp. or "post trauma*".mp. or "combat disorder*".mp. or "stress disorder*".mp.

#2 Limit #1 (publication date May 2018-June 2019 and english language)

[1] The Cochrane Collaboration's risk of bias criteria\(^2\) determine low, uncertain or high risk ratings for: Random sequence generation (selection bias); Allocation concealment (selection bias); Blinding of participants and personnel (performance bias); Blinding of outcome assessment (detection bias); Incomplete outcome data (attrition bias); Selective reporting (reporting bias); and Other bias.

High certainty: Further research is very unlikely to change our confidence in the estimate of effect.
Moderate certainty: Further research is likely to have an important impact on our confidence in the estimate of effect and may change the estimate.
Low certainty: Further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate.
Very low certainty: We are very uncertain about the estimate.
Guideline Development Group

The members of the Guideline Development Group and the Phoenix Australia project team are listed in the Acknowledgments document on the Guidelines website.
References

1. FOREST PLOT Brief CBT vs WL/TAU. Website

2. FOREST PLOT Psychoeducation vs WL/TAU. Website

3. FOREST PLOT Self-directed Online Psychoeducation for Children vs WL/TAU. Website

4. FOREST PLOT Self-directed Online Psychoeducation for Caregiver and Child vs WL/TAU. Website

5. FOREST PLOT Self-directed Online Psychoeducation for Caregivers vs WL/TAU. Website

6. FOREST PLOT Individual Psychological Debriefing vs WL/TAU. Website


15. FOREST PLOT Brief CBT-T vs WL/TAU. Website

16. FOREST PLOT CFTSI vs Supportive Intervention. Website

17. FOREST PLOT Stepped Preventative Care vs WL/TAU. Website

18. FOREST PLOT TFCBT (NET) vs Meditation. Website


23. FOREST PLOT Propranolol vs Placebo. Website


25. FOREST PLOT: CBT-T (Child) vs Non-directive Counselling. Website

26. FOREST PLOT: CBT-T (Caregiver and Child) vs EMDR. Website

27. FOREST PLOT: CBT-T (Caregiver and Child) vs Non-directive Counselling. Website

28. FOREST PLOT: CBT-T (Caregiver and Child) vs WL/TAU. Website

29. FOREST PLOT: CBT-T (Caregiver) vs CBT-T (Child). Website

30. FOREST PLOT: CBT-T (Caregiver) vs WL/TAU. Website

31. FOREST PLOT: CBT-T (Child) vs Psychoeducation. Website

32. FOREST PLOT: CBT-T (Child) vs WL/TAU. Website

33. FOREST PLOT: CBT-T (child) vs EMDR. Website

34. FOREST PLOT: EMDR (vs WL/TAU). Website

35. FOREST PLOT: Family Therapy vs WL/TAU. Website

36. FOREST PLOT: Group TF-CBT (Caregiver and Child) vs Supportive Group Therapy. Website

37. FOREST PLOT: Individual and Group TF-CBT (Caregiver and Child) vs WL/TAU. Website

38. FOREST PLOT: kidNET vs Non-directive Counselling. Website

39. FOREST PLOT: kidNET vs WL/TAU. Website

40. FOREST PLOT: Non-directive Counselling vs WL/TAU. Website

41. FOREST PLOT: Psychoeducation vs WL/TAU. Website

42. FOREST PLOT: TF-CBT (Caregiver and Child) vs Stepped Care TF-CBT (Caregiver and Child). Website
43. FOREST PLOT: TF-CBT (Caregiver and Child) vs TF-CBT (Child). [Website](#)

44. FOREST PLOT: Group TF-CBT (Child) vs Group Non-TF-CBT (Child). [Website](#)

45. FOREST PLOT: CBT (Child) vs WL/TAU. [Website](#)

46. FOREST PLOT: TF-CBT (Caregiver and Child) vs TF-CBT (Caregiver). [Website](#)

47. FOREST PLOT: Play Therapy vs Case Management. [Website](#)

48. FOREST PLOT: Play Therapy vs CBT (Caregiver and Child). [Website](#)

49. FOREST PLOT: Group TF-CBT (Child) vs WL/TAU. [Website](#)


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99. FOREST PLOT: Sertraline vs Placebo. Website


101. FOREST PLOT: Mind-Body Skills Group vs WL/TAU (Sx). Website

102. FOREST PLOT: Art Therapy vs WL/TAU (Sx). Website


105. FOREST PLOT: ABMT (4 session) vs ACT (4 sessions) (Dx). Website

106. FOREST PLOT: AMBT (4 sessions) vs ACT (4 sessions) (Sx). Website

107. FOREST PLOT: ABMT (4 sessions) vs Control (Dx). Website

108. FOREST PLOT: ABMT (4 sessions) vs Control (Sx). Website

109. FOREST PLOT: ACT (4 sessions) vs Control (Dx). Website

110. FOREST PLOT: ACT (4 sessions) vs Control (Sx). Website

111. FOREST PLOT: CBM-I vs Control (Dx). Website
112. FOREST PLOT: HRVB vs CBM-I (Dx). [Website]

113. FOREST PLOT: HRVB vs CBM-I (Sx). [Website]

114. FOREST PLOT: HRVB vs Control (Dx). [Website]

115. FOREST PLOT: HRVB vs Control (Sx). [Website]

116. FOREST PLOT: MAPS vs TAU (Sx). [Website]

117. FOREST PLOT: Single session ABMT vs ACT (Sx). [Website]

118. FOREST PLOT: SIT vs SM/CPB (Dx). [Website]

119. FOREST PLOT: SIT vs SM (Sx). [Website]

120. FOREST PLOT: CBM-I v Control PTSD Sx. [Website]


127. FOREST PLOT: EMDR vs CISD (Sx). [Website]

128. FOREST PLOT: EMDR vs Reassurance (Dx). [Website]

129. FOREST PLOT: EMDR vs WLTAU (Dx). [Website]

130. FOREST PLOT: EMDR vs WLTAU (Sx). [Website]

131. FOREST PLOT: Group 512 PM vs Group Debriefing (Sx). [Website]

132. FOREST PLOT: Group 512 PM vs WLTAU (Sx). [Website]
133. FOREST PLOT: Group Debriefing vs WLTAU (Sx). Website

134. FOREST PLOT: Group Education vs WLTAU (Sx). Website

135. FOREST PLOT: Group Stress Management vs WLTAU (Sx). Website

136. FOREST PLOT: Individual Debriefing vs WLTAU (Sx). Website

137. FOREST PLOT: Psychoeducation vs WLTAU (Dx). Website

138. FOREST PLOT: Psychoeducation vs WLTAU (Sx). Website

139. FOREST PLOT: Reassurance vs WLTAU (Dx). Website

140. FOREST PLOT: Tetris vs WLTAU (Dx). Website

141. FOREST PLOT: Tetris vs WLTAU (Sx). Website

142. FOREST PLOT: Trauma-focused Counselling vs Heart Stress Counselling. Website

143. FOREST PLOT: Individual Debriefing vs WLTAU (Dx). Website


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165. FOREST PLOT: Brief Dyadic Therapy vs WL/TAU. Website

166. FOREST PLOT: Intensive Care Diaries. Website

167. FOREST PLOT: Three step early intervention vs WL/TAU. Website

168. FOREST PLOT: Brief Individual Trauma Processing Therapy vs WL/TAU. Website

169. FOREST PLOT: Brief Individual Trauma Processing Therapy vs WL/TAU (Dx). Website

170. FOREST PLOT: Brief individual trauma processing therapy vs Supportive listening. Website

171. FOREST PLOT: Internet-based CBT vs WL/TAU (Sx). Website
172. FOREST PLOT: Brief Interpersonal Counselling (IPC) vs TAU (Sx). [Website]

173. FOREST PLOT: Brief Interpersonal Counselling (IPC) vs TAU (Dx). [Website]

174. FOREST PLOT: Collaborative care vs TAU. [Website]

175. FOREST PLOT: Communication facilitator in Intensive care unit. [Website]

176. FOREST PLOT: Nurse-led intensive care recovery program. [Website]

177. FOREST PLOT: Telephone-based CBT. [Website]

178. FOREST PLOT: Collaborative Care vs TAU (Dx). [Website]

179. FOREST PLOT: Telephone + internet-based CBT vs Critical illness education. [Website]

180. FOREST PLOT: Supported psychoeducational intervention vs WL/TAU. [Website]

181. FOREST PLOT: Internet-based CBT vs WL/TAU (Dx). [Website]

182. FOREST PLOT: Intensive care diaries vs WL (Dx). [Website]


204. FOREST PLOT: EMDR vs CISD (Dx). Website

205. FOREST PLOT: CBT-T vs WL/TAU (Dx). Website

206. FOREST PLOT: CBT-T vs WL/TAU (Sx). Website

207. FOREST PLOT: CBT-T vs Structured Writing Therapy (Dx). Website

208. FOREST PLOT: CBT-T vs Structured Writing Therapy (Sx). Website

209. FOREST PLOT: PE vs WLTAU (Sx). Website
210. FOREST PLOT: PE vs WLTAU (Dx). Website
211. FOREST PLOT: CT vs WLTAU (Sx). Website
212. FOREST PLOT: CT vs WLTAU (Dx). Website
213. FOREST PLOT: Brief PE vs Supportive Counselling (Dx). Website
214. FOREST PLOT: Brief PE vs Supportive Counselling (Sx). Website
215. FOREST PLOT: Brief CPT vs Supportive Counselling (Dx). Website
216. FOREST PLOT: Brief CPT vs Supportive Counselling (Sx). Website
217. FOREST PLOT: Brief EMDR vs WLTAU. Website
218. FOREST PLOT: Structured Writing Therapy vs WL (Sx). Website
219. FOREST PLOT: Stepped Collaborative Care vs WLTAU (Dx). Website
220. FOREST PLOT: Stepped Collaborative Care vs WLTAU (Sx). Website
221. FOREST PLOT: Neurobehavioural Training vs Reading Tasks. Website
222. FOREST PLOT: CBT-T vs Supportive Counselling (Dx). Website
223. FOREST PLOT: CBT-T vs Supportive Counselling (Sx). Website
224. FOREST PLOT: CBT-T vs Relaxation (Dx). Website
225. FOREST PLOT: CBT-T vs Relaxation (Sx). Website
226. FOREST PLOT: CBT-T vs Self-help program (Dx). Website
227. FOREST PLOT: CBT-T vs Self-help program (Sx). Website
228. FOREST PLOT: Prolonged exposure vs cognitive therapy (Sx). Website
229. FOREST PLOT: Prolonged exposure vs Cognitive therapy (Dx). Website
230. FOREST PLOT: Present Centered Therapy (HOPE) vs WL/TAU. Website
231. FOREST PLOT: Structured writing therapy vs WL (Dx). Website
232. FOREST PLOT: Structured Writing Therapy vs Psychoeducation. Website
233. FOREST PLOT: Internet-based guided self-help vs WL/TAU. Website
234. FOREST PLOT: Behavioural activation vs TAU. Website
235. FOREST PLOT: Supportive counselling vs attention control (Sx). [Website]

236. FOREST PLOT: Supportive counselling vs Attention control (Dx). [Website]

237. FOREST PLOT: Nurse-led psychological intervention vs WL/TAU (Sx). [Website]

238. FOREST PLOT: Computerised neurobehavioural training vs Computerised games control condition. [Website]

239. FOREST PLOT: Computerised neurobehavioural training vs Reading tasks. [Website]


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272. FOREST PLOT: Docosahexaenoic Acid vs Placebo (Dx). Website

273. FOREST PLOT: Docosahexaenoic Acid vs Placebo (Sx). Website

274. FOREST PLOT: Escitalopram vs Placebo (Dx). Website

275. FOREST PLOT: Escitalopram vs Placebo (Sx). Website

276. FOREST PLOT: Gabapentin vs Placebo (Dx). Website

277. FOREST PLOT: Hydrocortisone vs Placebo (Dx). Website

278. FOREST PLOT: Hydrocortisone vs Placebo (Sx). Website

279. FOREST PLOT: Oxytocin vs Placebo (Sx). Website

280. FOREST PLOT: Propranolol vs Placebo (Dx). Website

281. FOREST PLOT: Propranolol vs Placebo (Sx). Website


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296. FOREST PLOT: Couples CBT-T vs WLTAU. Website

297. FOREST PLOT: CBT-T (CPT) vs DET. Website

298. FOREST PLOT: CPT vs PE. Website

299. FOREST PLOT: CPT vs WLTAU. Website

300. FOREST PLOT: CT vs WLTAU. Website

301. FOREST PLOT: EMDR vs CBT-T. Website

302. FOREST PLOT: EMDR vs Emotional freedom techniques. Website

303. FOREST PLOT: EMDR vs Relaxation training. Website

304. FOREST PLOT: EMDR vs REM Desensitization. Website

305. FOREST PLOT: EMDR vs Supportive counselling. Website

306. FOREST PLOT: EMDR vs WLTAU. Website

307. FOREST PLOT: Group and individual CBT-T (combined) vs WLTAU. Website

308. FOREST PLOT: Group CBT-T vs Group PCT. Website

309. FOREST PLOT: Group CBT-T vs Individual CBT-T. Website
310. FOREST PLOT: Group CBT-T vs WLTAU. Website

311. FOREST PLOT: Group IPT vs WLTAU. Website

312. FOREST PLOT: Guided internet-based CBT vs WLTAU. Website

313. FOREST PLOT: Internet-based CBT-T vs Internet based non-trauma-focused supportive counselling. Website

314. FOREST PLOT: Internet-based CBT-T vs Internet-based psychoeducation. Website

315. FOREST PLOT: IPT vs Relaxation training. Website

316. FOREST PLOT: NET vs WLTAU. Website

317. FOREST PLOT: Non-CBT-T vs PCT. Website

318. FOREST PLOT: Non-CBT-T vs WLTAU. Website

319. FOREST PLOT: OEI vs WLTAU. Website

320. FOREST PLOT: Psychodynamic therapy vs WLTAU. Website

321. FOREST PLOT: Stabilising group treatment vs WLTAU. Website

322. FOREST PLOT: Group CBT-T vs Applied muscle relaxation. Website

323. FOREST PLOT: Cognitive Therapy vs WLTAU. Website

324. FOREST PLOT: SIT vs Supportive counselling. Website

325. FOREST PLOT: Guided internet-based CBT-T vs attention control. Website

326. FOREST PLOT: CBT-T vs Supportive Counselling. Website

327. FOREST PLOT: CBT-T vs Psychodynamic Therapy. Website

328. FOREST PLOT: Prolonged Exposure vs Health Education. Website

329. FOREST PLOT: ACT + TAU vs TAU.

330. FOREST PLOT: CBT-T vs WLTAU. Website

331. FOREST PLOT: CBT-T vs Non-CBT-T. Website

332. FOREST PLOT: CBT-T (PE) vs IPT. Website

333. FOREST PLOT: PE vs WLTAU. Website

334. FOREST PLOT: CBT-T vs PCT. Website
335. FOREST PLOT: CBT-T vs Relaxation Training. Website

336. FOREST PLOT: Non-CBT-T vs WLTAU. Website

337. FOREST PLOT: Present centred therapy vs WLTAU. Website

338. FOREST PLOT: Brief Eclectic Psychotherapy vs WLTAU. Website

339. FOREST PLOT: SIT vs WLTAU. Website

340. FOREST PLOT: Metacognitive Therapy vs WLTAU. Website

341. FOREST PLOT: WET vs WLTAU. Website

342. FOREST PLOT: VR-Exposure vs Present centred therapy. Website

343. FOREST PLOT: CBT-T (NET) vs Psychoeducation. Website

344. FOREST PLOT: Single session CBT vs WLTAU. Website

345. FOREST PLOT: Supportive counselling vs WLTAU. Website

346. FOREST PLOT: Supportive Counselling vs Psychoeducation. Website

347. FOREST PLOT: RTM vs WLTAU. Website

348. FOREST PLOT: Relaxation training vs WLTAU. Website

349. FOREST PLOT: VR-Exposure vs Control exposure therapy. Website

350. FOREST PLOT: WET vs CBT-T. Website

351. FOREST PLOT: VR-exposure vs WLTAU. Website


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472. FOREST PLOT: SSRIs vs Placebo. Website

473. FOREST PLOT: Sertraline vs Placebo. Website

474. FOREST PLOT: Fluoxetine vs Placebo. Website

475. FOREST PLOT: Mirtazapine vs Placebo. Website

476. FOREST PLOT: Amitriptyline vs Placebo. Website

477. FOREST PLOT: Paroxetine vs Placebo. Website

478. FOREST PLOT: Imipramine vs Placebo. Website

479. FOREST PLOT: Brofaromine vs Placebo. Website

480. FOREST PLOT: Citralopram vs Sertraline. Website

481. FOREST PLOT: Venlafaxine vs Sertraline. Website

482. FOREST PLOT: Divalproex vs Placebo. Website

483. FOREST PLOT: Phenelzine vs Imipramine. Website

484. FOREST PLOT: Topiramate vs Placebo. Website

485. FOREST PLOT: Venlafaxine vs Placebo. Website

486. FOREST PLOT: Tiagabine vs Placebo. Website

487. FOREST PLOT: Quetiapine vs Placebo. Website

488. FOREST PLOT: Ketamine vs Placebo. Website

489. FOREST PLOT: Neurokinin-1 Antagonist vs Placebo. Website

490. FOREST PLOT: Lamotrigine vs Placebo. Website

491. FOREST PLOT: Ganaxolone vs Placebo. Website

492. FOREST PLOT: Olanzapine vs Placebo. Website

493. FOREST PLOT: Sertraline vs Nefazadone. Website

494. FOREST PLOT: Phenelzine vs Placebo. Website


524. Pfizer 588 (unpublished data) 12 week, double-blind comparison of flexible doses of Lustral (sertraline) versus placebo (primarily female physical/sexual assault population). 


537. FOREST PLOT: Fluoxetine vs Placebo.

538. FOREST PLOT: Sertraline vs Placebo.

539. FOREST PLOT Transcendental meditation vs Prolonged exposure. Website

540. FOREST PLOT: Transcendental meditation vs Health education. Website

541. FOREST PLOT: Attention bias modification vs WL. Website

542. FOREST PLOT: Acupuncture vs CBT-T. Website

543. FOREST PLOT: Electroacupuncture vs Paroxetine. Website

544. FOREST PLOT: Physical exercise vs WL. Website

545. FOREST PLOT: Hypnotherapy vs CBT-T. Website

546. FOREST PLOT SGB vs Sham procedure. Website

547. FOREST PLOT: Somatic experiencing vs WL. Website

548. FOREST PLOT: Group music therapy vs WL. Website

549. FOREST PLOT: Mindfulness based stress reduction vs Psychoeducation. Website

550. FOREST PLOT: Mantrum repetition vs PCT. Website

551. FOREST PLOT: Hypnotherapy vs WL. Website
552. FOREST PLOT: Mantram repetition vs WL. [Website]

553. FOREST PLOT: Neurofeedback vs WL. [Website]

554. FOREST PLOT: Transcendental meditation vs Prolonged exposure. [Website]

555. FOREST PLOT: rTMS vs WL. [Website]

556. FOREST PLOT: Saikokeishikankyoto vs WL. [Website]

557. FOREST PLOT: Nature adventure therapy vs WL. [Website]

558. FOREST PLOT: Mindfulness based stress reduction vs PCT. [Website]

559. FOREST PLOT: Mindfulness based stress reduction vs WL. [Website]

560. FOREST PLOT: Transcendental meditation vs Heath education. [Website]

561. FOREST PLOT: Yoga vs WL. [Website]

562. FOREST PLOT: Acupuncture vs WL. [Website]


