

Australian Guidelines for the treatment of Acute Stress Disorder, Posttraumatic Stress Disorder, and Complex PTSD

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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 a traumatic event

Early psychosocial prevention interventions for children

Individual psychological debriefing

Conditional Recommendation (Against)

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

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.

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.

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.

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.

Early psychosocial treatment interventions for children

Child and Family Traumatic Stress Intervention (CFTSI)

Conditional Recommendation

For children and adolescents within the first three months after exposure to a traumatic event where symptoms of PTSD are present, we suggest doing 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.[15] 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

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.[16]

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.

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).

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 treatments for children with PTSD

Trauma-focussed CBT for child

Strong Recommendation

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

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.

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.

EMDR

Conditional Recommendation

For children and adolescents with symptoms of PTSD we suggest delivering EMDR where trauma-focussed 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-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.

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.

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.

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.

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.

Trauma-focussed 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.

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.

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.

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.

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.

Family therapy

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

Pharmacological treatments for children with PTSD

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).

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 this 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.

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.

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 attention bias modification training (ABMT) in military populations and this may be used in a research context.

Attentional 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 may 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.

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 may 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.

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.

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.

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.

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 may 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.^[145]

Group psychological debriefing

Conditional Recommendation (Against)

For adults within the first three months following exposure to a potentially traumatic event, 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.

Individual psychological debriefing

Conditional Recommendation (Against)

For adults within the first three months following exposure to a potentially traumatic event, 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.

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)^[144] 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.[132]

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-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.

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 may 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^[168] 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.^[168]

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 may 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.^[181]

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.

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.

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.

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.

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.

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 supported psychoeducational intervention.

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.

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.

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.

Early psychosocial treatment interventions for adults

Stepped/collaborative care

Strong Recommendation

For adults with PTSD symptoms in the first three months after exposure to a traumatic event, we recommend a stepped/collaborative care model of care, in which the care provided at each level is evidence-based.

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^{[231][232][233]} 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^[223] 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.

Trauma-focussed CBT (TF-CBT)

Conditional Recommendation

For adults with PTSD symptoms in the first three months after exposure to a traumatic event, we suggest offering trauma-focussed CBT (includes Prolonged Exposure, Cognitive Processing Therapy, Cognitive Therapy) in preference to doing nothing.

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.

Brief EMDR

Conditional Recommendation

For adults with PTSD symptoms in the first three months after exposure to a traumatic event, we suggest offering brief 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.

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^[228] 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^[211] 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 may 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.

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^[219]) 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.^[220]

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.

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.

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.

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 may 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.

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.

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.

Adults with clinically relevant post-traumatic stress symptoms

Psychological treatments for adults with PTSD

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.

Cognitive therapy (CT)

Strong Recommendation

For adults with PTSD we recommend Cognitive Therapy (CT).

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 min for the initial sessions, and 60 minutes for the following sessions).^[324]

EMDR

Strong Recommendation

For adults with PTSD we recommend EMDR.

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.

Prolonged exposure (PE)

Strong Recommendation

For adults with PTSD we recommend Prolonged Exposure.

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).

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.

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.^[358] 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^{[346][358]}, 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.^[361] An example of the latter is DESTRESS-PC, a variant of CBT and stress inoculation training designed for symptoms resulting from military trauma.^[361]

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.^{[347][399]}

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.

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.^[329]

Trauma-focussed CBT (group)

Conditional Recommendation

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

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 ^{[397][387]}, Beck's CBT and other protocols^[314]. All treatment interventions require (to varying degrees) engagement with the traumatic memory, opportunities for cognitive restructuring, and skills aiming to reduce avoidance.

Couples trauma-focused 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 may be used in a research context.

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.^[369]

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 may 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.^[315]

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.^[405]

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.^{[409][334]}

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.^{[402][339]}

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 may 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.^{[301][300]}

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 may be used in a research context.

Virtual Reality therapies, such as virtual reality exposure (VRE^[384]) and VR-graded exposure therapy (VR-GET^[366]) 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 may be used in a research context.

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.

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.

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.

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).

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.

Stabilizing group treatment is based on psycho-education and cognitive behavioural therapy. The program is based on Zlotnick's protocol [409] 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).

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).

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.

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

Pharmacological treatments for adults with PTSD

Selective Serotonin Reuptake Inhibitors (SSRIs)

Conditional Recommendation

For adults with PTSD we suggest SSRIs (sertraline, paroxetine or fluoxetine) in circumstances where:

- a) the person is unwilling or not in a position to engage in or access recommended psychological therapy (TF-CBT, PE, CT, CPT or EMDR); or
- b) the person has a comorbid condition or associated symptoms (e.g., clinically significant depression and high levels of dissociation) where SSRIs are indicated; or
- c) 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); or
- d) the person has not gained significant benefit from recommended psychological therapy; or
- e) 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.

Venlafaxine

Conditional Recommendation

For adults with PTSD we suggest venlafaxine in circumstances where:

- a) the person is unwilling or not in a position to engage in or access recommended psychological therapy (TF-CBT, PE, CT, CPT or EMDR); or
- b) the person has a comorbid condition or associated symptoms (e.g., clinically significant depression and high levels of dissociation) where SSRIs are indicated; or
- c) 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); or
- d) the person has not gained significant benefit from recommended psychological therapy; or
- e) 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.^{[478][479]}

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 but this needs further research.

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 but this needs further research.

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.

Imipramine

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 treatments 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 may 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.

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 this may 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.^[592] 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.^[566] 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 this may be used in a research context.

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.^[559]

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 this may 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.^[555] In the integrated exercise study, veteran participants attended three one hour group sessions each week for 12 weeks, for a total of 36 sessions.^[547] 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 may 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.

Transcendental Meditation (TM)

RESEARCH RECOMMENDATION

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

There is emerging evidence for Transcendental Meditation and this may 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.

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 this may 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,^{[564][557]} Kripalu,^{[550][554]} and trauma-informed yoga^[560].

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).

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.

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.

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.

Saikokaishikankyoto

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

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.

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.

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.

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

Development of the Guidelines Guideline Development Group

Introduction (including guidance for use of MAGICApp)

Summary

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).

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 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 [Phoenix Australia website](#).

The supporting chapters (see <https://www.phoenixaustralia.org/public-consultation-ptsd/>) 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.

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 this chapter 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.

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 (see <https://www.phoenixaustralia.org/public-consultation-ptsd/>).

Key information: 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 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.

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 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

Conditional Recommendation (Against)

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

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.

Key Info

Benefits and harms

Moderate quality evidence from 2 RCTs [4][5] suggests that individual psychological debriefing has no clinically important effect 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).

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.

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.

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.

Clinical Question/ PICO

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ usual care	Individual psychological debriefing		
PTSD symptom severity 3 months	Lower better Based on data from: 231 patients in 2 studies. (Randomized controlled)			Moderate Due to serious imprecision ¹	Individual psychological debriefing probably has no effect or may increase PTSD symptom severity slightly

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

References

[4] Stallard P, Velleman R, Salter E, Howse I, Yule W, Taylor G : A randomised controlled trial to determine the effectiveness

of an early psychological intervention with children involved in road traffic accidents.. Journal of child psychology and psychiatry, and allied disciplines 2006;47(2):127-34 [Pubmed](#)

[5] Zehnder D, Meuli M, Landolt MA : Effectiveness of a single-session early psychological intervention for children after road traffic accidents: a randomised controlled trial.. Child and adolescent psychiatry and mental health 2010;4 7 [Pubmed Journal](#)

[10] Forest Plot: Individual Psychological Debriefing vs WLTAU. [Website](#)

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).

Key Info

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 [3].

Certainty of the Evidence

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

Preference and values

Experience at CASA indicates that for their client group when people make contact about their children/adolescents they need an immediate response. With wait lists, unless requiring a forensic medical within strict timelines, the agency response can be a number of weeks away. Directing caregivers to an on-line intervention or sending them written material appears to assist in managing their anxiety and presumably their child/adolescents anxiety. It would be interesting to have some data on the most effective way to manage wait times.

Resources and other considerations

NOTE ACCESSABILITY ADVANTAGE?

Online format overcomes some geographical and financial barriers to conventional care
 Less resource intensive as clinicians are not required to deliver intervention
 Online interventions can be delivered to large number of people

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ treatment usual care	Self-directed online psychoeducation for caregivers and children		
PTSD symptom severity 3 months	Lower better Based on data from: 56 patients in 1 studies. (Randomized controlled)	Difference: SMD 0.9 lower (CI 95% 1.45 lower - 0.35 lower)		Low Due to serious risk of bias, Due to serious imprecision ¹	Self-directed online psychoeducation for caregivers and children may decrease PTSD symptom severity

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** .

References

[3] Cox CM, Kenardy JA, Hendrikz JK : A randomized controlled trial of a web-based early intervention for children and their parents following unintentional injury.. Journal of pediatric psychology 2010;35(6):581-92 [Pubmed Journal](#)
 [13] Self-directed Online Psychoeducation for Caregiver and Child vs WLTAU. [Website](#)

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.

Key Info

Benefits and harms

Evidence from a single RCT [7] 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.

Preference and values

This type of intervention is aimed to meeting patient (child) needs and preferences. The intervention had excellent uptake in the US but it may need to be shaped for Australian audiences.

Resources and other considerations

This resource is not available as a multi-platform online format as yet and might require some adaptation for Australian circumstances. Furthermore a sustainable financial model is yet to be devised. There are no recommendations for younger children.

NOTE ACCESSABILITY ADVANTAGE?

Online format overcomes some geographical and financial barriers to conventional care
Less resource intensive as clinicians are not required to deliver intervention
Online interventions can be delivered to large number of people

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

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

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** .

References

[7] Kassam-Adams N, Marsac ML, Kohser KL, Kenardy J, March S, Winston FK : Pilot Randomized Controlled Trial of a Novel Web-Based Intervention to Prevent Posttraumatic Stress in Children Following Medical Events.. Journal of pediatric psychology 41(1):138-48 [Pubmed Journal](#)

[12] Self-directed Online Psychoeducation for Children vs WLTAU. [Website](#)

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.

Clinical Question/ PICO

Population: Children and adolescents within the first three months post traumatic event
Intervention: Psychoeducation

Comparator: Waitlist/ treatment as usual

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ treatment as usual	Psychoeducation		
PTSD symptom severity 3 months	Lower better Based on data from: 52 patients in 1 studies. (Randomized controlled)		Difference: SMD 0.12 higher (CI 95% 0.47 lower - 0.7 higher)	Very Low Due to serious risk of bias, Due to very serious imprecision ¹	Psychoeducation may have little or no difference on PTSD symptom severity.

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** .

References

- [2] Kenardy J, Thompson K, Le Brocq R, Olsson K : Information-provision intervention for children and their parents following pediatric accidental injury.. European child & adolescent psychiatry 2008;17(5):316-25 [Pubmed Journal](#)
- [11] Psychoeducation vs WLTAU. [Website](#)

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

Outcome	Study results and	Absolute effect estimates	Certainty of	Plain text summary
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Timeframe	measurements	Waitlist/ usual care	Self-directed online psychoeducation for caregivers only	the Evidence (Quality of evidence)
PTSD symptom severity 3 months	Lower better Based on data from: 100 patients in 1 studies. (Randomized controlled)	Difference: SMD 0.09 lower (CI 95% 0.48 lower - 0.3 higher)		Very Low Due to serious risk of bias, Due to very serious imprecision ¹ We are uncertain whether self-directed online psychoeducation for caregivers only increases or decreases PTSD symptom severity

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** .

References

[6] Marsac ML, Hildenbrand AK, Kohser KL, Winston FK, Li Y, Kassam-Adams N : Preventing posttraumatic stress following pediatric injury: a randomized controlled trial of a web-based psycho-educational intervention for parents.. Journal of pediatric psychology 2013;38(10):1101-11 [Pubmed Journal](#)

[14] Self-directed Online Psychoeducation for Caregivers vs WLTAU. [Website](#)

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?"

Child and Family Traumatic Stress Intervention (CFTSI)

Conditional Recommendation

For children and adolescents within the first three months after exposure to a traumatic event where symptoms of PTSD are present, we suggest doing 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.[15] 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.

Key Info

Benefits and harms

Low quality evidence from a single RCT [15] 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

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

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.

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.

Clinical Question/ PICO

Population: Children and adolescents within the first three months post traumatic event
Intervention: Child and Family Traumatic Stress Intervention (CFTSI)
Comparator: Supportive care

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

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** .

References

- [15] Berkowitz SJ, Stover CS, Marans SR : The Child and Family Traumatic Stress Intervention: secondary prevention for youth at risk of developing PTSD.. Journal of child psychology and psychiatry, and allied disciplines 2011;52(6):676-85 [Pubmed Journal](#)
- [20] CFTSI vs Supportive Intervention. [Website](#)

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 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.[16]

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

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

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** .

References

[16] Kassam-Adams N, García-España JF, Marsac ML, Kohser KL, Baxt C, Nance M, Winston F : A pilot randomized controlled trial assessing secondary prevention of traumatic stress integrated into pediatric trauma care.. Journal of traumatic stress 2011;24(3):252-9 [Pubmed Journal](#)

[21] Stepped Preventative Care vs WLTAU. [Website](#)

Brief trauma-focused 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-focused CBT.

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ treatment as usual	Brief trauma- focused CBT		
PTSD symptom severity 3 months	Lower better Based on data from: 51 patients in 1 studies. (Randomized controlled)	Difference: SMD 0.02 lower (CI 95% 0.57 lower - 0.53 higher)		Low Due to very serious imprecision ¹	Brief trauma-focused CBT may have little or no difference 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= 51), Wide confidence intervals (CIs include important benefit and important harm) ; **Publication bias: No serious** .

References

[18] Kramer DN, Landolt MA : Early psychological intervention in accidentally injured children ages 2-16: a randomized controlled trial.. European journal of psychotraumatology 2014;5 [Pubmed Journal](#)

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Meditation	Trauma-focused CBT (NET)		
PTSD symptom severity 3 months	Lower better Based on data from: 31 patients in 1 studies. (Randomized controlled)		Difference: SMD 0.12 lower (CI 95% 0.82 lower - 0.59 higher)	Very Low Due to very serious imprecision, Due to serious indirectness ¹	There may be little or no difference between NET and meditation on PTSD symptom severity.

1. **Inconsistency: No serious . Indirectness: Serious .** Differences between the population of interest and those studied; children in refugee camp post-tsunami, Sri Lanka ; **Imprecision: Very Serious .** Low number of patients (n=31), Wide confidence intervals (CIs include important benefit and important harm) ; **Publication bias: No serious .**

References

- [17] Catani C, Kohiladevy M, Ruf M, Schauer E, Elbert T, Neuner F : Treating children traumatized by war and Tsunami: a comparison between exposure therapy and meditation-relaxation in North-East Sri Lanka.. BMC psychiatry 2009;9 22 [Pubmed Journal](#)
- [22] TFCBT (NET) vs Meditation. [Website](#)

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.

Key Info

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Placebo	Propranolol		
PTSD symptom severity 3 months	Lower better Based on data from: 20 patients in 1 studies. (Randomized controlled)	Difference: SMD 0.04 higher (CI 95% 0.84 lower - 0.92 higher)		Low Due to very serious imprecision ¹	Propranolol may have little or no difference on PTSD symptom severity

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 .**

References

[23] Nugent NR, Christopher NC, Crow JP, Browne L, Ostrowski S, Delahanty DL : The efficacy of early propranolol administration at reducing PTSD symptoms in pediatric injury patients: a pilot study.. Journal of traumatic stress 2010;23(2):282-7 [Pubmed Journal](#)

Children and adolescents with clinically relevant post-traumatic stress symptoms

Psychological treatments for children 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 for child.

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.

Key Info

Benefits and harms

High quality evidence from 15 RCTs [26][27][31][35][36][38][46][49][53][57][58][60][61][63][70][71] suggests large clinically important benefits of CBT-T (child) on PTSD symptomology in children and adolescents relative to waitlist or usual care.

Moderate quality evidence from 6 RCTs [31][43][44][45][64][65] suggest large clinically important benefits of CBT-T (child) on PTSD symptomology relative to non-directive counselling

Low quality evidence from a single RCT [55] suggests small clinically important benefits of CBT-T (child) relative to psychoeducation.

Evidence from 2 RCTs [36][48] suggests that EMDR has a greater clinically important benefit on PTSD symptom severity than CBT-T (child)

Moderate quality evidence from 2 RCTs [37][53] 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 [37] 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 HIGH

Certainty of evidence for CBT-T (child) vs waitlist/usual care was HIGH

Certainty of evidence for CBT-T (child) vs non-directive counselling was MODERATE due to serious imprecision.

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

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

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

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

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 practitioners with ongoing supervision.

Children and their caregivers will likely value information about the intervention, its aim, content, duration and mode of delivery, expectations, and more likely if the child stays engaged with treatment. Children and their caregivers may have various preferences regarding intensity and pace. As talking about their trauma is of concern to some parents, an initial parent-only therapy information session is advised. During that session it is noted 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 caregiver. Both 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
Intervention: Trauma-focused CBT for child
Comparator: Waitlist/ treatment as usual

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ treatment as usual	Trauma-focused CBT for child		
PTSD symptom severity	Lower better Based on data from: 657 patients in 15 studies. (Randomized controlled)		Difference: SMD 1.46 lower (CI 95% 1.94 lower - 0.99 lower)	High ₁	Trauma-focused CBT for child decreases PTSD symptom severity

1. **Risk of bias: No 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 I² = 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** .

References

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[38] Deblinger E, Steer RA, Lippmann J : Two-year follow-up study of cognitive behavioral therapy for sexually abused children suffering post-traumatic stress symptoms.. *Child abuse & neglect* 1999;23(12):1371-8 [Pubmed](#)

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[53] King NJ, Tonge BJ, Mullen P, Myerson N, Heyne D, Rollings S, Martin R, Ollendick TH : Treating sexually abused children with posttraumatic stress symptoms: a randomized clinical trial.. Journal of the American Academy of Child and Adolescent Psychiatry 2000;39(11):1347-55 [Pubmed](#)

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[94] CBT (Child) vs WLTAU. [Website](#)

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 Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Non-directive counselling	Trauma-focused CBT for child		
PTSD symptom severity	Lower better Based on data from: 239 patients in 6 studies. (Randomized controlled)	Difference: SMD 0.96 lower (CI 95% 1.23 lower - 0.69 lower)		Moderate Due to serious imprecision ¹	Trauma-focused CBT for child is probably more effective than non- directive counselling for decreasing PTSD

symptom severity

1. **Inconsistency: No serious . Indirectness: No serious . Imprecision: Serious . Low number of patients (n=239) ; Publication bias: No serious .**

References

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- [74] CBT-T (Child) vs Non-directive Counselling. [Website](#)

Clinical Question/ PICO

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Psychoeducation	Trauma-focused CBT for child		
PTSD symptom severity	Lower better Based on data from: 127 patients in 1 studies. (Randomized controlled)			Low Due to serious risk of bias, Due to serious imprecision ¹	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, Differences at baseline ; **Inconsistency: No serious** . **Indirectness: No serious** . **Imprecision: Serious** . Low number of patients (n=127), Wide confidence intervals (CI includes important benefit and unimportant benefit) ;

References

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[80] CBT-T (Child) vs Psychoeducation. [Website](#)

Clinical Question/ PICO

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		EMDR	Trauma-focused CBT for child		
PTSD symptom severity	Lower better Based on data from: 99 patients in 2 studies. (Randomized controlled)			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

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) ;

References

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[82] CBT-T (child) vs EMDR. [Website](#)

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	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Trauma-focused CBT for child	Trauma-focused CBT for caregiver		
PTSD symptom severity	Lower better Based on data from: 46 patients in 1 studies. (Randomized controlled)			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

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

References

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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	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Trauma-focused CBT for child	Trauma-focused CBT for caregiver and child		
PTSD symptom severity	Lower better Based on data from: 70 patients in 2 studies. (Randomized controlled)	Difference: SMD 0.46 lower (CI 95% 0.93 lower - 0.02 higher)		Moderate Due to serious imprecision ¹	CBT-T for caregiver and child is probably more effective than CBT-T for child alone in decreasing PTSD symptom severity

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 .**

References

[38] Deblinger E, Steer RA, Lippmann J : Two-year follow-up study of cognitive behavioral therapy for sexually abused children suffering post-traumatic stress symptoms.. Child abuse & neglect 1999;23(12):1371-8 [Pubmed](#)

[53] King NJ, Tonge BJ, Mullen P, Myerson N, Heyne D, Rollings S, Martin R, Ollendick TH : Treating sexually abused children with posttraumatic stress symptoms: a randomized clinical trial.. Journal of the American Academy of Child and Adolescent Psychiatry 2000;39(11):1347-55 [Pubmed](#)

[92] TFCBT (Caregiver and Child) vs TFCBT (Child). [Website](#)

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.

Key Info

Benefits and harms

Moderate quality evidence from 7 RCTs suggests large clinically important benefit of CBT-T for caregiver and child relative to waitlist or usual care [29][38][37][47][50][53][59][68], and low quality evidence from 4 RCTs suggest a small clinically important benefit relative to non-directive counselling [32][34] and CBT-T for child only [37][53].

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 [67].

Evidence from a single RCT (n=48) suggests no important difference between CBT-T for caregiver and child and EMDR [40].

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.

Certainty for Trauma-focused CBT for caregiver and child vs non-directive counselling was LOW due to serious risk of bias, and serious imprecision.

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

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ treatment as usual	Trauma-focused CBT for caregiver and child		
PTSD symptom severity	Lower better Based on data from: 660 patients in 7 studies. (Randomized controlled)	Difference: SMD 0.82 lower (CI 95% 1.08 lower - 0.55 lower)		Moderate Due to serious imprecision ¹	CBT-T for caregiver and child probably decreases PTSD symptom severity

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 I² = 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** .

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[53] King NJ, Tonge BJ, Mullen P, Myerson N, Heyne D, Rollings S, Martin R, Ollendick TH : Treating sexually abused children with posttraumatic stress symptoms: a randomized clinical trial.. Journal of the American Academy of Child and Adolescent Psychiatry 2000;39(11):1347-55 [Pubmed](#)

[59] Murray LK, Skavenski S, Kane JC, Mayeya J, Dorsey S, Cohen JA, Michalopoulos LTM, Imasiku M, Bolton PA : Effectiveness of Trauma-Focused Cognitive Behavioral Therapy Among Trauma-Affected Children in Lusaka, Zambia: A Randomized Clinical Trial.. JAMA pediatrics 2015;169(8):761-9 [Pubmed](#) [Journal](#)

[68] Scheeringa MS, Weems CF, Cohen JA, Amaya-Jackson L, Guthrie D : Trauma-focused cognitive-behavioral therapy for posttraumatic stress disorder in three-through six year-old children: a randomized clinical trial.. Journal of child psychology and psychiatry, and allied disciplines 2011;52(8):853-60 [Pubmed](#) [Journal](#)

[77] CBT-T (Caregiver and Child) vs WLTAU. [Website](#)

Clinical Question/ PICO

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Non-directive counselling	Trauma-focused CBT for caregiver and child		
PTSD symptom severity	Lower better Based on data from: 206 patients in 2 studies. (Randomized controlled)	Difference: SMD 0.37 lower (CI 95% 0.64 lower - 0.09 lower)		Low Due to serious risk of bias, Due to serious imprecision ¹	CBT-T for caregiver and child may be more effective than non- directive counselling for decreasing PTSD symptom severity

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** .

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[34] Cohen JA, Mannarino AP, Iyengar S : Community treatment of posttraumatic stress disorder for children exposed to intimate partner violence: a randomized controlled trial.. Archives of pediatrics & adolescent medicine 2011;165(1):16-21 [Pubmed](#) [Journal](#)

[76] CBT-T (Caregiver and Child) vs Non-directive Counselling. [Website](#)

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 Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		EMDR	Trauma-focused CBT for caregiver and child		
PTSD symptom severity	Lower better Based on data from: 48 patients in 1 studies. (Randomized controlled)	Difference: SMD 0.05 higher (CI 95% 0.52 lower - 0.62 higher)		Very Low Due to serious risk of bias, Due to very serious imprecision ¹	We are uncertain if there is any difference between CBT-T for caregiver and child and EMDR in decreasing PTSD symptom severity

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** .

References

[40] Diehle J, Opmeer BC, Boer F, Mannarino AP, Lindauer RJL : Trauma-focused cognitive behavioral therapy or eye movement desensitization and reprocessing: what works in children with posttraumatic stress symptoms? A randomized controlled trial.. European child & adolescent psychiatry 2015;24(2):227-36 [Pubmed Journal](#)

[75] CBT-T (Caregiver and Child) vs EMDR. [Website](#)

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	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Trauma-focused CBT for child	Trauma-focused CBT for caregiver and child		
PTSD symptom severity	Lower better Based on data from: 70 patients in 2 studies. (Randomized controlled)	Difference: SMD 0.46 lower (CI 95% 0.93 lower - 0.02 higher)		Moderate Due to serious imprecision ¹	CBT-T for caregiver and child is probably more effective than CBT-T for child alone in decreasing PTSD symptom severity

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 .**

References

[38] Deblinger E, Steer RA, Lippmann J : Two-year follow-up study of cognitive behavioral therapy for sexually abused children suffering post-traumatic stress symptoms.. Child abuse & neglect 1999;23(12):1371-8 [Pubmed](#)

[53] King NJ, Tonge BJ, Mullen P, Myerson N, Heyne D, Rollings S, Martin R, Ollendick TH : Treating sexually abused children with posttraumatic stress symptoms: a randomized clinical trial.. Journal of the American Academy of Child and Adolescent Psychiatry 2000;39(11):1347-55 [Pubmed](#)

[92] TFCBT (Caregiver and Child) vs TFCBT (Child). [Website](#)

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Stepped care trauma-focused CBT for caregiver and child	Trauma-focused CBT for caregiver and child		
PTSD symptom severity	Lower better Based on data from: 53 patients in 1 studies. (Randomized controlled)	Difference: SMD 0.09 lower (CI 95% 0.66 lower - 0.48 higher)		Very Low Due to serious risk of bias, Due to very serious imprecision ¹	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

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 (CI's include important benefit and important harm) ; **Publication bias: No serious .**

References

[67] Salloum A, Wang W, Robst J, Murphy TK, Scheeringa MS, Cohen JA, Storch EA : Stepped care versus standard trauma-focused cognitive behavioral therapy for young children.. Journal of child psychology and psychiatry, and allied disciplines 2016;57(5):614-22 [Pubmed Journal](#)

[91] TFCBT (Caregiver and Child) vs Stepped Care TFCBT (Caregiver and Child). [Website](#)

EMDR

Conditional Recommendation

For children and adolescents with symptoms of PTSD we suggest delivering EMDR where trauma-focussed 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-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.

Key Info

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 ([30][36], n=93). Another study suggests a small unimportant benefit ([25], n=33) and a small study by Soberman 2002 ([72], n=21) suggests very small unimportant harm.

Evidence from 2 RCTs ([36][48], n=99) suggests EMDR to be more beneficial than CBT-T for children for reducing PTSD symptom severity.

Evidence from 1 RCT ([40], 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.
 Certainty of evidence for EMDR vs trauma-focused CBT for child was LOW due to serious risk of bias, and serious imprecision.

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 CBT-T on PTSD symptom severity. The Group agreed that in light of the stronger evidence base for CBT-T, a weaker recommendation for EMDR was warranted. The Guideline Development Group recommends that EMDR be offered when CBT- T 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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		EMDR	Trauma-focused CBT for child		
PTSD symptom severity	Lower better Based on data from: 99 patients in 2 studies. (Randomized controlled)			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

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) ;

References

[36] de Roos C, van der Oord S, Zijlstra B, Lucassen S, Perrin S, Emmelkamp P, de Jongh AD : Comparison of eye movement desensitization and reprocessing therapy, cognitive behavioral writing therapy, and wait-list in pediatric posttraumatic stress disorder following single-incident trauma: a multicenter randomized clinical trial.. Journal of child psychology and psychiatry, and allied disciplines 2017;58(11):1219-1228 [Pubmed Journal](#)

[48] Jaberghaderi N, Greenwald R, Rubin A, Zand S, Dolatabadi S : Jaberghaderi, N., Greenwald, R., Rubin, A., Zand, S. O., & Dolatabadi, S. (2004). A comparison of CBT and EMDR for sexually-abused Iranian girls. Clinical Psychology & Psychotherapy: An International Journal of Theory & Practice, 11(5), 358-368.. [Website](#)

[82] CBT-T (child) vs EMDR. [Website](#)

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ treatment as usual	EMDR		
PTSD symptom severity	Lower better Based on data from: 147 patients in 4 studies. (Randomized controlled)		Difference: SMD 0.74 lower (CI 95% 1.46 lower - 0.02 lower)	Low Due to serious imprecision, Due to serious inconsistency ¹	EMDR may decrease PTSD symptom severity slightly

1. **Risk of bias: No serious** . Incomplete data and/or large loss to follow up (unbalanced) in 1 study ; **Inconsistency: Serious** . The magnitude of statistical heterogeneity was high, with $I^2 = 75\%$; **Indirectness: No serious** . **Imprecision: Serious** . Low number of patients (n=147), Wide confidence intervals (CI's include important benefit and unimportant benefit) ; **Publication bias: No serious** .

References

[25] Ahmad A, Larsson BO, Sundelin-Wahlsten V : EMDR treatment for children with PTSD: results of a randomized controlled trial.. Nordic journal of psychiatry 2007;61(5):349-54 [Pubmed](#)

[30] Chemtob CM, Nakashima J, Carlson JG : Brief treatment for elementary school children with disaster-related posttraumatic stress disorder: a field study.. Journal of clinical psychology 2002;58(1):99-112 [Pubmed](#)

[36] de Roos C, van der Oord S, Zijlstra B, Lucassen S, Perrin S, Emmelkamp P, de Jongh AD : Comparison of eye movement desensitization and reprocessing therapy, cognitive behavioral writing therapy, and wait-list in pediatric posttraumatic stress disorder following single-incident trauma: a multicenter randomized clinical trial.. Journal of child psychology and psychiatry, and allied disciplines 2017;58(11):1219-1228 [Pubmed Journal](#)

[72] Soberman G, Greenwald R, Rule D : A Controlled Study of Eye Soberman, G. B., Greenwald, R., & Rule, D. L. (2002). A

controlled study of eye movement desensitization and reprocessing (EMDR) for boys with conduct problem. *Journal of aggression, maltreatment & trauma*, 6(1), 217-236.. [Journal](#)

[83] EMDR (vs WLTAU). [Website](#)

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.

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.

Key Info

Benefits and harms

Evidence from 2 RCTs [62][73] 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 [61] 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

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

Resources and other considerations

Group interventions may be useful in instances where a large number of people are affected or there is limited access to services

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ treatment as usual	Group trauma- focused CBT for child		
PTSD symptom severity	Lower better Based on data from: 216 patients in 2 studies. (Randomized controlled)		Difference: SMD 0.83 lower (CI 95% 1.59 lower - 0.07 lower)	Low Due to serious risk of bias, Due to serious imprecision ¹	Group trauma-focused CBT for child probably decreases PTSD symptom severity

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=216), Wide confidence intervals (CI includes important benefit and unimportant benefit) ; **Publication bias: No serious** .

References

[62] Pfeiffer E, Sachser C, Rohlmann F, Goldbeck L : Effectiveness of a trauma-focused group intervention for young refugees: a randomized controlled trial.. Journal of child psychology and psychiatry, and allied disciplines 2018;59(11):1171-1179 [Pubmed](#) [Journal](#)

[73] Stein B, Jaycox L, Kataoka S, Marleen W, Tu W, Elliott M, Fink A : Stein, B. D., Jaycox, L. H., Kataoka, S. H., Wong, M., Tu, W., Elliott, M. N., & Fink, A. (2003). A mental health intervention for schoolchildren exposed to violence: a randomized controlled trial. Jama, 290(5), 603-611.. [Pubmed](#)

[81] CBT-T (Child) vs WLTAU. [Website](#)

Clinical Question/ PICO

Population: Children and adolescents with clinically relevant post-traumatic stress symptoms
Intervention: Group trauma-focused CBT for child
Comparator: Group resilience building intervention

Outcome Timeframe	Study results and measurements	Absolute effect estimates Group resilience building intervention Group trauma-focused CBT for child		Certainty of the Evidence (Quality of evidence)	Plain text summary
PTSD symptom severity	Lower better Based on data from: 50 patients in 1 studies. (Randomized controlled)	Difference: SMD 0.16 lower (CI 95% 0.72 lower - 0.4 higher)		Low Due to very serious imprecision ¹	There is probably little or no difference between Group trauma-focused CBT for child and Group resilience building intervention on PTSD symptom severity

1. **Inconsistency: No serious . Indirectness: No serious . Imprecision: Very Serious .** Low number of patients (n=50), Wide confidence intervals ; **Publication bias: No serious .**

References

[62] Pfeiffer E, Sachser C, Rohlmann F, Goldbeck L : Effectiveness of a trauma-focused group intervention for young refugees: a randomized controlled trial.. Journal of child psychology and psychiatry, and allied disciplines 2018;59(11):1171-1179 [Pubmed Journal](#)

[73] Stein B, Jaycox L, Kataoka S, Marleen W, Tu W, Elliott M, Fink A : Stein, B. D., Jaycox, L. H., Kataoka, S. H., Wong, M., Tu, W., Elliott, M. N., & Fink, A. (2003). A mental health intervention for schoolchildren exposed to violence: a randomized controlled trial. *Jama*, 290(5), 603-611.. [Pubmed](#)

[87] kidNET vs Non-directive Counselling. [Website](#)

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.

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.

Key Info

Benefits and harms

Evidence from a single RCT [54] 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

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ treatment as usual	Individual and group trauma-focused CBT for caregiver and child		
PTSD symptom severity	Lower better Based on data from: 71 patients in 1 studies. (Randomized controlled)		Difference: SMD 1.24 lower (CI 95% 1.75 lower - 0.73 lower)	Moderate Due to serious imprecision ¹	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 .**

References

[54] Langley AK, Gonzalez A, Sugar CA, Solis D, Jaycox L : Bounce back: Effectiveness of an elementary school-based intervention for multicultural children exposed to traumatic events.. Journal of consulting and clinical psychology 2015;83(5):853-65 [Pubmed](#) [Journal](#)

[86] Individual and Group TFCBT (Caregiver and Child) vs WLTAU. [Website](#)

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.

Key Info

Benefits and harms

Evidence from a single RCT ([56], 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 ([69], 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.

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

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence	Plain text summary
		Case management	Parent-child		

			(Quality of evidence)	
PSTD symptom severity	Lower better Based on data from: 65 patients in 1 studies. (Randomized controlled)	Difference: SMD 0.95 lower (CI 95% 1.47 lower - 0.44 lower)	Moderate Due to serious imprecision ¹	Play therapy probably decreases PTSD symptom severity

1. **Inconsistency: No serious . Indirectness: No serious . Imprecision: Serious .** Low number of patients (n=65) ; **Publication bias: No serious .**

References

[56] Lieberman AF, Van Horn P, Ippen CG : Toward evidence-based treatment: child-parent psychotherapy with preschoolers exposed to marital violence.. Journal of the American Academy of Child and Adolescent Psychiatry 2005;44(12):1241-8
[Pubmed](#)

Clinical Question/ PICO

Population: Children and adolescents with clinically relevant post-traumatic stress symptoms
Intervention: Parent-child relationship enhancement (play therapy)
Comparator: Trauma-focused CBT for caregiver and child

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Trauma-focused CBT for caregiver and child	Parent-child relationship enhancement (play therapy)		
PSTD symptom severity	Lower better Based on data from: 26 patients in 1 studies. (Randomized controlled)	Difference: SMD 0.11 lower (CI 95% 0.88 lower - 0.66 higher)		Very Low Due to serious risk of bias, Due to very serious imprecision ¹	We are uncertain whether parent-child relationship enhancement improves or worsen 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: Very Serious .** Low number of patients (n=26), Wide confidence intervals (CI included important benefit and important harm) ; **Publication bias: No serious .**

References

[69] Schottelkorb A, Dumas D, Garcia R : Schottelkorb, A. A., Dumas, D. M., & Garcia, R. (2012). Treatment for childhood refugee trauma: A randomized, controlled trial. International Journal of Play Therapy, 21(2), 57.. [Journal Website](#)

[97] Play Therapy vs CBT (Caregiver and Child). [Website](#)

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.

Key Info

Benefits and harms

Evidence from 2 RCTs suggests a large, clinically important benefit from kidNET for PTSD symptom severity in former child soldiers [41] and traumatised refugees [66].

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 [41].

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.

Certainty of evidence for Narrative Exposure Therapy for children (kidNET) vs non-directive counselling was LOW due to very serious imprecision.

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	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ treatment as usual	kidNET		
PTSD symptom severity	Lower better Based on data from: 79 patients in 2 studies. (Randomized controlled)	Difference: SMD 1.1 lower (CI 95% 2.51 lower - 0.32 higher)		Low Due to serious imprecision, Due to serious inconsistency, Due to serious inconsistency ¹	KidNET may improve PTSD symptom severity

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 I²:85%. 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** .

References

- [41] Ertl V, Pfeiffer A, Schauer E, Elbert T, Neuner F : Community-implemented trauma therapy for former child soldiers in Northern Uganda: a randomized controlled trial.. JAMA 2011;306(5):503-12 [Pubmed](#) [Journal](#)
- [66] Ruf M, Schauer M, Neuner F, Catani C, Schauer E, Elbert T : Narrative exposure therapy for 7- to 16-year-olds: a randomized controlled trial with traumatized refugee children.. Journal of traumatic stress 2010;23(4):437-45 [Pubmed](#) [Journal](#)
- [88] kidNET vs WLTAU. [Website](#)

Clinical Question/ PICO

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Non-directive counselling	kidNET		
PTSD symptom severity	Lower better	Difference: SMD 0.16 lower		Low Due to very	There is probably little or no difference

Based on data from: 50 patients in 1 studies. (Randomized controlled)	(CI 95% 0.72 lower - 0.4 higher)	serious imprecision ¹	between the effectiveness of kidNET and Non-directive counselling on PTSD symptom severity
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1. **Inconsistency: No serious . Indirectness: No serious . Imprecision: Very Serious .** Low number of patients (n=50), Wide confidence intervals (CI includes important benefit and important harm) ; **Publication bias: No serious .**

References

[41] Ertl V, Pfeiffer A, Schauer E, Elbert T, Neuner F : Community-implemented trauma therapy for former child soldiers in Northern Uganda: a randomized controlled trial.. JAMA 2011;306(5):503-12 [Pubmed Journal](#)

[87] kidNET vs Non-directive Counselling. [Website](#)

Trauma-focused CBT for caregiver

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

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.

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ treatment as usual	Trauma-focused CBT for caregiver		
PTSD symptom severity	Lower better Based on data from: 44 patients in 1 studies. (Randomized controlled)	Difference: SMD 0.61 lower (CI 95% 1.21 lower - 0 higher)		Low Due to very serious imprecision ¹	Trauma-focused CBT for caregiver may decrease PTSD symptom severity slightly

1. **Imprecision: Very Serious** . Low number of patients (n=44), Wide confidence intervals (CI includes important benefit and no effect) ;

References
 [38] Deblinger E, Steer RA, Lippmann J : Two-year follow-up study of cognitive behavioral therapy for sexually abused children suffering post-traumatic stress symptoms.. Child abuse & neglect 1999;23(12):1371-8 [Pubmed](#)

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 caregiver and child

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Trauma-focused CBT for caregiver and child	Trauma-focused CBT for caregiver		
PTSD symptom severity	Lower better Based on data from: 44 patients in 1 studies. (Randomized controlled)	Difference: SMD 0.61 higher (CI 95% 0.01 higher - 1.22 higher)		Low Due to very serious imprecision ¹	Trauma-focused CBT for caregiver and child may be more beneficial than CBT-T for caregiver only for PTSD symptom severity

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

References
 [38] Deblinger E, Steer RA, Lippmann J : Two-year follow-up study of cognitive behavioral therapy for sexually abused children suffering post-traumatic stress symptoms.. Child abuse & neglect 1999;23(12):1371-8 [Pubmed](#)
 [95] TFCBT (Caregiver and Child) vs TFCBT (Caregiver). [Website](#)

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	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Trauma-focused CBT for child	Trauma-focused CBT for caregiver		
PTSD symptom severity	Lower better Based on data from: 46 patients in 1 studies. (Randomized controlled)	Difference: SMD 0.09 lower (CI 95% 0.49 lower - 0.67 higher)		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

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

References

[38] Deblinger E, Steer RA, Lippmann J : Two-year follow-up study of cognitive behavioral therapy for sexually abused children suffering post-traumatic stress symptoms.. Child abuse & neglect 1999;23(12):1371-8 [Pubmed](#)

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
Intervention: Group trauma-focused CBT for caregiver and child
Comparator: Supportive group therapy

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ treatment as usual	Group Trauma- focused CBT for caregiver and child		
PTSD symptom				Very Low	We are uncertain

severity	Lower better Based on data from: 44 patients in 1 studies. (Randomized controlled)	Difference: SMD 0.01 higher (CI 95% 0.58 lower - 0.6 higher)	Due to serious risk of bias, due to very serious imprecision ¹	whether group trauma-focused CBT for caregiver and child increases or decreases PTSD symptom severity
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1. **Risk of bias: Serious** . Selective outcome reporting ; **Imprecision: Very Serious** . Low number of patients (n=44), Wide confidence intervals (CI includes important benefit and important harm) ;

References

[39] Deblinger E, Stauffer LB, Steer RA : Comparative efficacies of supportive and cognitive behavioral group therapies for young children who have been sexually abused and their nonoffending mothers.. Child maltreatment 2001;6(4):332-43 [Pubmed](#)

[85] Group TFCBT (Caregiver and Child) vs Supportive Group Therapy. [Website](#)

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	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ treatment as usual	Non-directive counselling		
PTSD symptom severity	Lower better Based on data from: 74 patients in 2 studies. (Randomized controlled)	Difference: SMD 0.29 lower (CI 95% 0.75 lower - 0.18 higher)		Moderate Due to serious imprecision ¹	Non-directive counseling probably decreases PTSD symptom severity slightly

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** .

References

[31] Chen Y, Shen WW, Gao K, Lam CS, Chang WC, Deng H : Effectiveness RCT of a CBT intervention for youths who lost parents in the Sichuan, China, earthquake.. Psychiatric services (Washington, D.C.) 2014;65(2):259-62 [Pubmed Journal](#)

[41] Ertl V, Pfeiffer A, Schauer E, Elbert T, Neuner F : Community-implemented trauma therapy for former child soldiers in Northern Uganda: a randomized controlled trial.. JAMA 2011;306(5):503-12 [Pubmed Journal](#)

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ treatment as usual	Group psychoeducation		
PTSD symptom severity	Lower better	Difference: SMD 1.3 lower		Very Low Due to serious	We are uncertain whether group

Based on data from: 166 patients in 1 studies. (Randomized controlled)	(CI 95% 1.64 lower - 0.96 lower)	imprecision, Due to serious risk of bias, Due to serious indirectness ¹	psychoeducation increases or decreases PTSD symptom severity
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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** .

References

[28] Berger R, Gelkopf M : School-based intervention for the treatment of tsunami-related distress in children: a quasi-randomized controlled trial.. *Psychotherapy and psychosomatics* 2009;78(6):364-71 [Pubmed Journal](#)

[90] Psychoeducation vs WLTAU. [Website](#)

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates Waitlist/ treatment as usual Family therapy		Certainty of the Evidence (Quality of evidence)	Plain text summary
PTSD symptom severity	Lower better Based on data from: 149 patients in 1 studies. (Randomized controlled)	Difference: SMD 0.37 lower (CI 95% 0.7 lower - 0.05 lower)		Low Due to serious risk of bias, Due to serious imprecision ¹	Family therapy may decrease PTSD symptom severity slightly

1. **Risk of bias: Serious** . Large unbalanced loss to follow up ; **Inconsistency: No serious** . **Indirectness: No serious** . **Imprecision: Serious** . Low number of patients (n=149) ; **Publication bias: No serious** .

References

[51] Kazak AE, Alderfer MA, Streisand R, Simms S, Rourke MT, Barakat LP, Gallagher P, Cnaan A : Treatment of posttraumatic stress symptoms in adolescent survivors of childhood cancer and their families: a randomized clinical trial.. Journal of family psychology : JFP : journal of the Division of Family Psychology of the American Psychological Association (Division 43) 2004;18(3):493-504 [Pubmed](#)

[84] Family Therapy vs WLTAU. [Website](#)

Pharmacological treatments for children 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?"

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Placebo	Sertraline		
PTSD symptom severity	Lower better Based on data from: 129 patients in 1 studies. (Randomized controlled)	Difference: SMD 0.19 higher (CI 95% 0.15 lower - 0.54 higher)		Low Due to serious imprecision, Due to serious risk of bias ¹	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), Wide confidence intervals (CI includes unimportant benefit and important harm) ; **Publication bias: No serious** .

References

[99] Robb AS, Cueva JE, Sporn J, Yang R, Vanderburg DG : Sertraline treatment of children and adolescents with posttraumatic stress disorder: a double-blind, placebo-controlled trial.. Journal of child and adolescent psychopharmacology 2010;20(6):463-71 [Pubmed Journal](#)

[100] Sertraline vs Placebo. [Website](#)

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 this 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.

Key Info

Benefits and harms

Evidence from a single RCT [101] 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.

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
Intervention: Mind-body skills group
Comparator: Waitlist/ treatment as usual

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ treatment as usual	Mind-body skills group		
PTSD symptom severity	Lower better Based on data from: 77 patients in 1 studies. (Randomized controlled)	Difference: SMD 1.52 lower (CI 95% 2.03 lower - 1.01 lower)		Low Due to serious risk of bias, Due to serious imprecision ¹	Mind-body skills group may decrease PTSD symptom severity

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** .

References

- [101] Gordon JS, Staples JK, Blyta A, Bytyqi M, Wilson AT : Treatment of posttraumatic stress disorder in postwar Kosovar adolescents using mind-body skills groups: a randomized controlled trial.. The Journal of clinical psychiatry 2008;69(9):1469-76 [Pubmed](#)
- [103] Mind-Body Skills Group vs WLTAU (Sx). [Website](#)

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.

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.

Key Info

Certainty of the Evidence

Very Low

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ treatment as usual	Trauma-focused expressive art therapy		
PTSD symptom severity	Lower better Based on data from: 29 patients in 1 studies. (Randomized controlled)	Difference: SMD 1.46 lower (CI 95% 2.3 lower - 0.63 lower)		Low Due to very serious imprecision ¹	Trauma-focused expressive art therapy 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 .**

References

[102] Lyshak-Stelzer F, Singer P, Patricia J, Chemtob C : Lyshak-Stelzer, F., Singer, P., Patricia, S. J., & Chemtob, C. M. (2007). Art therapy for adolescents with posttraumatic stress disorder symptoms: A pilot study. *Art Therapy, 24*(4), 163-169.. [Website](#)

[104] Art Therapy vs WLTAU (Sx) . [Website](#)

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 attention bias modification training (ABMT) in military populations and this may be used in a research context.

Attentional 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.

Key Info

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 [109].

Evidence suggests a clinically important benefit of 4 sessions of ABMT on PTSD diagnosis relative to attention control training (ACT) [109] but no difference in effect on PTSD symptom severity between ABMT and ACT after either a single session [110] or 4 sessions [109].

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.

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.

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.

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		No training control	Attention bias modification training (ABMT)		
PTSD diagnosis	Relative risk 0.32 (CI 95% 0.1 - 0.97) Based on data from 308 patients in 1 studies. (Randomized controlled)	68 per 1000	22 per 1000	Low Due to very serious imprecision ¹	Attention bias modification may decrease PTSD diagnosis
PTSD symptom severity	Lower better Based on data from: 308 patients in 1 studies. (Randomized controlled)	Difference: SMD 0.15 lower (CI 95% 0.37 lower - 0.08 higher)		Moderate Due to serious imprecision ²	Attention bias modification probably has little or no difference on PTSD symptom severity

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

References

[109] Wald I, Fruchter E, Ginat K, Stolín E, Dagan D, Bliese PD, Quartana PJ, Sipos ML, Pine DS, Bar-Haim Y : Selective prevention of combat-related post-traumatic stress disorder using attention bias modification training: a randomized controlled trial.. Psychological medicine 2016;46(12):2627-36 [Pubmed Journal](#)

[113] ABMT (4 sessions) vs Control (Dx). [Website](#)

[114] ABMT (4 sessions) vs Control (Sx). [Website](#)

Clinical Question/ PICO

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Attention Control Training (ACT)	Attention bias modification (ABMT)		

<p>PTSD diagnosis</p>	<p>Relative risk 0.56 (CI 95% 0.17 - 1.88) Based on data from 365 patients in 1 studies. (Randomized controlled)</p>	<p>39 per 1000</p> <p>22 per 1000</p> <p>Difference: 17 fewer per 1000 (CI 95% 32 fewer - 34 more)</p>	<p>Low Due to very serious imprecision ¹</p>	<p>Attention bias modification (ABMT) may be more effective than ACT in decreasing PTSD diagnosis</p>
<p>PTSD symptom severity</p>	<p>Lower better Based on data from: 297 patients in 1 studies. (Randomized controlled)</p>	<p>Difference: SMD 0.02 higher (CI 95% 0.21 lower - 0.25 higher)</p>	<p>Low Due to very serious imprecision ²</p>	<p>There may be little or no difference between Attention bias modification and Attention control training on PTSD symptom severity</p>

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 .**

References

[109] Wald I, Fruchter E, Ginat K, Stolin E, Dagan D, Bliese PD, Quartana PJ, Sipos ML, Pine DS, Bar-Haim Y : Selective prevention of combat-related post-traumatic stress disorder using attention bias modification training: a randomized controlled trial.. *Psychological medicine* 2016;46(12):2627-36 [Pubmed Journal](#)

[111] ABMT (4 session) vs ACT (4 sessions) (Dx). [Website](#)

[112] AMBT (4 sessions) vs ACT (4 sessions) (Sx). [Website](#)

Clinical Question/ PICO

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Attention Control Training (ACT)	Single session Attention Bias Modification Training (ABMT)		
<p>PTSD symptom severity</p>	<p>Lower better Based on data from: 297 patients in 1 studies. (Randomized controlled)</p>	<p>Difference: SMD 0.19 higher (CI 95% 0.2 lower - 0.59 higher)</p>		<p>Low Due to serious imprecision, Due to serious risk of bias ¹</p>	<p>There may be little or no difference between single session ABMT and ACT on PTSD symptom severity</p>

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 .**

References

[110] Wald I, Bitton S, Levi O, Zusmanovich S, Fruchter E, Ginat K, Charney DS, Pine DS, Bar-Haim Y : Acute delivery of attention bias modification training (ABMT) moderates the association between combat exposure and posttraumatic symptoms: A feasibility study.. *Biological psychology* 2017;122 93-97 [Pubmed Journal](#)

[122] Single session ABMT vs ACT (Sx). [Website](#)

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 may 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.

Key Info

Benefits and harms

Evidence from a single RCT [109] suggests clinically important benefit of 4 sessions of predeployment ACT for Israeli soldiers relative to no training on PTSD diagnosis and clinically unimportant benefit on PTSD symptom severity.

Evidence suggests ACT is not as effective as ABMT on PTSD diagnosis [109] and suggests no difference in effect on PTSD symptom severity between ABMT and ACT after either a single session [110] or 4 sessions [109].

Certainty of the Evidence

Overall certainty of evidence 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.

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

Rationale

The Guideline Development Group noted the reduced risk of developing PTSD in Israeli soldiers delivered four 10-minute sessions of Attention Control Training (ACT) 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

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Attention Control Training (ACT)	Attention bias modification (ABMT)		
PTSD diagnosis	Relative risk 0.56 (CI 95% 0.17 - 1.88) Based on data from 365 patients in 1 studies. (Randomized controlled)	39 per 1000	22 per 1000	Low Due to very serious imprecision ¹	Attention bias modification (ABMT) may be more effective than ACT in decreasing PTSD diagnosis
PTSD symptom severity	Lower better Based on data from: 297 patients in 1 studies. (Randomized controlled)	Difference: SMD 0.02 higher (CI 95% 0.21 lower - 0.25 higher)		Low Due to very serious imprecision ²	There may be little or no difference between Attention bias modification and Attention control training on PTSD symptom severity

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

References

[109] Wald I, Fruchter E, Ginat K, Stolín E, Dagan D, Bliese PD, Quartana PJ, Sipos ML, Pine DS, Bar-Haim Y : Selective prevention of combat-related post-traumatic stress disorder using attention bias modification training: a randomized controlled trial.. *Psychological medicine* 2016;46(12):2627-36 [Pubmed Journal](#)

[111] ABMT (4 session) vs ACT (4 sessions) (Dx). [Website](#)

[112] AMBT (4 sessions) vs ACT (4 sessions) (Sx). [Website](#)

Clinical Question/ PICO

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		No training control	Attention Control Training (ACT)		
PTSD diagnosis	Relative risk 0.57 (CI 95% 0.23 - 1.42) Based on data from 365 patients in 1 studies. (Randomized controlled)	68 per 1000	39 per 1000	Low Due to very serious imprecision ¹	Attention control training (ACT) may decrease PTSD diagnosis
PTSD symptom severity	Lower better Based on data from: 297 patients in 1 studies. (Randomized controlled)	Difference: SMD 0.16 lower (CI 95% 0.39 lower - 0.07 higher)		Moderate Due to serious imprecision ²	There is probably little or no difference between Attention control training and no training control on PTSD symptom severity

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 .**

References

- [109] Wald I, Fruchter E, Ginat K, Stolín E, Dagan D, Bliese PD, Quartana PJ, Sipos ML, Pine DS, Bar-Haim Y : Selective prevention of combat-related post-traumatic stress disorder using attention bias modification training: a randomized controlled trial.. *Psychological medicine* 2016;46(12):2627-36 [Pubmed Journal](#)
- [114] ABMT (4 sessions) vs Control (Sx). [Website](#)
- [115] ACT (4 sessions) vs Control (Dx). [Website](#)

Clinical Question/ PICO

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Attention Control Training (ACT)	Single session Attention Bias Modification Training (ABMT)		
PTSD symptom severity	Lower better Based on data from: 297 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** .

References

[110] Wald I, Bitton S, Levi O, Zusmanovich S, Fruchter E, Ginat K, Charney DS, Pine DS, Bar-Haim Y : Acute delivery of attention bias modification training (ABMT) moderates the association between combat exposure and posttraumatic symptoms: A feasibility study.. *Biological psychology* 2017;122 93-97 [Pubmed Journal](#)

[122] Single session ABMT vs ACT (Sx). [Website](#)

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 may 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.

Key Info

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 [107].

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 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.

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Control	Heart rate variability biofeedback (HRVB)		
PTSD diagnosis	Relative risk 0.33 (CI 95% 0.07 - 1.47) Based on data from 227 patients in 1 studies. (Randomized controlled)	67 per 1000	22 per 1000	Very Low Due to serious risk of bias, Due to very serious imprecision ¹	We are uncertain whether heart rate variability biofeedback (HRVB) increases or decreases PTSD diagnosis
PTSD symptom severity	Lower better Based on data from: 227 patients in 1 studies. (Randomized controlled)	Difference: SMD 0.23 lower (CI 95% 0.49 lower - 0.04 higher)		Low Due to serious imprecision, Due to serious risk of bias ²	Heart rate variability biofeedback (HRVB) may decrease PTSD symptom severity

- 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** .
- 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** .

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[107] Pyne JM, Constans JI, Nanney JT, Wiederhold MD, Gibson DP, Kimbrell T, Kramer TL, Pitcock JA, Han X, Williams DK, Chartrand D, Gevirtz RN, Spira J, Wiederhold BK, McCraty R, McCune TR : Heart Rate Variability and Cognitive Bias Feedback Interventions to Prevent Post-deployment PTSD: Results from a Randomized Controlled Trial.. *Military medicine* 2019;184(1-2):e124-e132 [Pubmed Journal](#)

[119] HRVB vs Control (Dx). [Website](#)

[120] HRVB vs Control (Sx). [Website](#)

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)

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Training as usual (TAU)	MAPS resilience training		
PTSD symptom severity	Lower better Based on data from: 61 patients in 1 studies. (Randomized controlled)		Difference: SMD 0.41 higher (CI 95% 0.1 lower - 0.92 higher)	Moderate Due to serious imprecision ¹	MAPS resilience training probably increases PTSD symptom severity

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

References

[108] Skeffington PM, Rees CS, Mazzucchelli TG, Kane RT : The Primary Prevention of PTSD in Firefighters: Preliminary Results of an RCT with 12-Month Follow-Up.. *PloS one* 2016;11(7):e0155873 [Pubmed Journal](#)

[121] MAPS vs TAU (Sx). [Website](#)

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)

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Cognitive bias modification for interpretation (CBM-I)	Heart rate variability biofeedback (HRVB)		
PTSD diagnosis	Relative risk 0.35 (CI 95% 0.07 - 1.74) Based on data from 172 patients in 1 studies. (Randomized controlled)	63 per 1000	22 per 1000	Low Due to serious imprecision, Due to serious risk of bias ¹	Heart rate variability biofeedback (HRVB) may be more beneficial than CBM-I for decreasing PTSD diagnosis
PTSD symptom severity	Lower better Based on data from: 172 patients in 1 studies. (Randomized controlled)	Difference: SMD 0.06 lower (CI 95% 0.36 lower - 0.24 higher)		Low Due to serious imprecision, Due to serious risk of bias ²	There may be little or no difference between HRVB and CBM-I on PTSD symptom severity

- 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** .
- 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** .

References

[107] Pyne JM, Constans JI, Nanney JT, Wiederhold MD, Gibson DP, Kimbrell T, Kramer TL, Pitcock JA, Han X, Williams DK, Chartrand D, Gevirtz RN, Spira J, Wiederhold BK, McCraty R, McCune TR : Heart Rate Variability and Cognitive Bias Feedback Interventions to Prevent Post-deployment PTSD: Results from a Randomized Controlled Trial.. *Military medicine* 2019;184(1-2):e124-e132 [Pubmed Journal](#)

[117] HRVB vs CBM-I (Dx). [Website](#)

[118] HRVB vs CBM-I (Sx). [Website](#)

Clinical Question/ PICO

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Control	Cognitive bias modification for interpretation (CBM-I)		
PTSD diagnosis	Relative risk 0.94 (CI 95% 0.33 - 2.7) Based on data from 215 patients in 1 studies. (Randomized controlled)	67 per 1000	63 per 1000	Low Due to serious imprecision, Due to serious risk of bias ¹	There may be little or no difference between CBM-I and control on PTSD diagnosis
PTSD symptom severity	Lower better Based on data from: 215 patients in 1 studies. (Randomized controlled)	Difference: SMD 0.16 lower (CI 95% 0.44 lower - 0.12 higher)		Low Due to serious imprecision, Due to serious risk of bias ²	There may be little or no difference between CBM-I and control on PTSD symptom severity

- 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** .
- 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** .

References

[107] Pyne JM, Constans JI, Nanney JT, Wiederhold MD, Gibson DP, Kimbrell T, Kramer TL, Pitcock JA, Han X, Williams DK, Chartrand D, Gevirtz RN, Spira J, Wiederhold BK, McCraty R, McCune TR : Heart Rate Variability and Cognitive Bias Feedback Interventions to Prevent Post-deployment PTSD: Results from a Randomized Controlled Trial.. *Military medicine* 2019;184(1-2):e124-e132 [Pubmed Journal](#)

[116] CBM-I vs Control (Dx). [Website](#)

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

Population: Adults
Intervention: Stress inoculation training (SIT)
Comparator: Control

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Control	Stress inoculation training (SIT)		
PTSD diagnosis	Relative risk 0.95 (CI 95% 0.35 - 2.52) Based on data from 454 patients in 2 studies. (Randomized controlled)	139 per 1000	132 per 1000	Very Low Due to serious risk of bias, Due to serious indirectness, Due to very serious imprecision ¹	We are uncertain whether stress inoculation training (SIT) increases or decreases PTSD diagnosis
PTSD symptom severity	Lower better Based on data from: 267 patients in 1 studies. (Randomized controlled)	Difference: 7 fewer per 1000 (CI 95% 90 fewer - 211 more)		Very Low Due to serious imprecision, Due to serious risk of bias, Due to serious indirectness ²	We are uncertain if these is a difference between SIT and control on PTSD symptom severity
		Difference: SMD 0.01 higher (CI 95% 0.23 lower - 0.25 higher)			

- 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 ;
- 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** .

References

- [105] Hourani L, Tueller S, Kizakevich P, Lewis G, Strange L, Weimer B, Bryant S, Bishop E, Hubal R, Spira J : Toward Preventing Post-Traumatic Stress Disorder: Development and Testing of a Pilot Predeployment Stress Inoculation Training Program.. *Military medicine* 2016;181(9):1151-60 [Pubmed](#) [Journal](#)
- [106] Hourani L, Tueller S, Kizakevich P, Strange L, Lewis G, Weimer B, Morgan J, Cooney D, Jessica N : Hourani, L., Tueller, S., Kizakevich, P., Strange, L., Lewis, G., Weimer, B., ... & Nelson, J. (2018). Effect of stress inoculation training with relaxation breathing on perceived stress and posttraumatic stress disorder in the military: A longitudinal study. *International Journal of Stress Management*, 25(S1), 124.. [Journal](#)
- [123] SIT vs SM/CBP (Dx).
- [124] SIT vs SM (Sx). [Website](#)

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 may 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.^[145]

Key Info

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 [145].

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.

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

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ treatment as usual	Group 512 PIM		
PTSD symptom severity	Lower better Based on data from: 758 patients in 1 studies. (Randomized controlled)		Difference: SMD 0.54 lower (CI 95% 0.68 lower - 0.39 lower)	Low Due to serious risk of bias, Due to serious indirectness ¹	Group 512 PIM may decrease PTSD symptom severity

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** .

References

[145] Wu S, Zhu X, Zhang Y, Liang J, Liu X, Yang Y, Yang H, Miao D : A new psychological intervention: "512 Psychological Intervention Model" used for military rescuers in Wenchuan Earthquake in China.. Social psychiatry and psychiatric epidemiology 2012;47(7):1111-9 [Pubmed Journal](#)

[153] Group 512 PM vs WLTAU (Sx). [Website](#)

Clinical Question/ PICO

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Group debriefing	Group 512 PIM		
PTSD symptom severity 3-6 months	Lower better Based on data from: 739 patients in 1 studies. (Randomized controlled)		Difference: SMD 0.42 lower (CI 95% 0.57 lower - 0.27 lower)	Low Due to serious risk of bias, Due to serious indirectness ¹	Group 512 PM may be more effective than group debriefing in decreasing PTSD symptom severity

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** .

References

[145] Wu S, Zhu X, Zhang Y, Liang J, Liu X, Yang Y, Yang H, Miao D : A new psychological intervention: "512 Psychological Intervention Model" used for military rescuers in Wenchuan Earthquake in China.. *Social psychiatry and psychiatric epidemiology* 2012;47(7):1111-9 [Pubmed Journal](#)

[152] Group 512 PM vs Group Debriefing (Sx) . [Website](#)

Group psychological debriefing

Conditional Recommendation (Against)

For adults within the first three months following exposure to a potentially traumatic event, 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.

Key Info

Benefits and harms

Evidence from 3 RCTs suggests that Group debriefing has no effect on PTSD symptom severity [145][141][126].

Certainty of the Evidence

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

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.

Resources and other considerations

In a workplace context, the distinction between an operational debrief and a psychological debrief is not always clearly understood or maintained.

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 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

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

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** .

References

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- [141] Tuckey MR, Scott JE : Group critical incident stress debriefing with emergency services personnel: a randomized controlled trial.. *Anxiety, stress, and coping* 2014;27(1):38-54 [Pubmed](#) [Journal](#)
- [145] Wu S, Zhu X, Zhang Y, Liang J, Liu X, Yang Y, Yang H, Miao D : A new psychological intervention: "512 Psychological Intervention Model" used for military rescuers in Wenchuan Earthquake in China.. *Social psychiatry and psychiatric epidemiology* 2012;47(7):1111-9 [Pubmed](#) [Journal](#)
- [154] Group Debriefing vs WLTAU (Sx). [Website](#)

Individual psychological debriefing

Conditional Recommendation (Against)

For adults within the first three months following exposure to a potentially traumatic event, 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.

Key Info

Benefits and harms

Evidence from 3 RCTs suggests that individual debriefing may slightly increase PTSD diagnosis [127][130][138].

Evidence from 5 RCTs suggests that individual debriefing has no effect on PTSD symptom severity [127][130][133][137][138].

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

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

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

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates Waitlist/ treatment as usual Individual debriefing		Certainty of the Evidence (Quality of evidence)	Plain text summary
PTSD diagnosis 3-6 months	Relative risk 1.12 (CI 95% 0.78 - 1.59) Based on data from 278 patients in 3 studies. (Randomized controlled)	287 per 1000	321 per 1000	Very Low Due to serious risk of bias, Due to very serious imprecision ¹	We are uncertain whether individual debriefing increases or decreases PTSD diagnosis
		Difference: 34 more per 1000 (CI 95% 63 fewer - 169 more)			
PTSD symptom severity 3-6 months	Lower better Based on data from: 358 patients in 5 studies. (Randomized controlled)	Difference: SMD 0.09 higher (CI 95% 0.12 lower - 0.3 higher)		Low Due to serious risk of bias, Due to serious imprecision ²	Individual debriefing may have little or no effect on PTSD symptom severity

- 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** .
- 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** .

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- [138] Rose S, Brewin CR, Andrews B, Kirk M : A randomized controlled trial of individual psychological debriefing for victims of violent crime.. Psychological medicine 1999;29(4):793-9 [Pubmed](#)
- [157] Individual Debriefing vs WLTAU (Sx). [Website](#)
- [164] Individual Debriefing vs WLTAU (Dx). [Website](#)

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) ^[144] 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.[132]

Key Info

Benefits and harms

Evidence from 1 RCT [132] 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 [132] 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 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 procur 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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ treatment as usual	EMDR		
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)	189 per 1000	30 per 1000	Very Low Due to serious risk of bias, Due to very serious imprecision ¹	We are uncertain whether EMDR increases or decreases PTSD diagnosis
		Difference: 159 fewer per 1000 (CI 95% 185 fewer - 38 more)			

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** .

References

[132] Gil-Jardiné C, Evrard G, Al Joboory S, Tortes Saint Jammes J, Masson F, Ribéreau-Gayon R, Galinski M, Salmi L-R, Revel P, Régis CA, Valdenaire G, Lagarde E : Emergency room intervention to prevent post concussion-like symptoms and post-

traumatic stress disorder. A pilot randomized controlled study of a brief eye movement desensitization and reprocessing intervention versus reassurance or usual care.. Journal of psychiatric research 2018;103 229-236 [Pubmed Journal](#)

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[140] Tarquinio C, Rotonda C, Houllé WA, Montel S, Rydberg JA, Minary L, Dellucci H, Tarquinio P, Fayard A, Alla F : Early Psychological Preventive Intervention For Workplace Violence: A Randomized Controlled Explorative and Comparative Study Between EMDR-Recent Event and Critical Incident Stress Debriefing.. Issues in mental health nursing 2016;37(11):787-799 [Pubmed](#)

[150] EMDR vs WLTAU (Dx). [Website](#)

[151] EMDR vs WLTAU (Sx). [Website](#)

Clinical Question/ PICO

Population: Adults within the first three months post traumatic event
Intervention: EMDR
Comparator: Reassurance

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Reassurance	EMDR		
PTSD diagnosis 3-6 months	Relative risk 0.19 (CI 95% 0.02 - 1.47) Based on data from 72 patients in 1 studies. (Randomized controlled)	158 per 1000	30 per 1000	Very Low Due to serious risk of bias, Due to very serious imprecision ¹	We are uncertain whether EMDR increases or decreases PTSD diagnosis
		Difference: 128 fewer per 1000 (CI 95% 155 fewer - 74 more)			

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** .

References

[132] Gil-Jardiné C, Evrard G, Al Joboory S, Tortes Saint Jammes J, Masson F, Ribéreau-Gayon R, Galinski M, Salmi L-R, Revel P, Régis CA, Valdenaire G, Lagarde E : Emergency room intervention to prevent post concussion-like symptoms and post-traumatic stress disorder. A pilot randomized controlled study of a brief eye movement desensitization and reprocessing intervention versus reassurance or usual care.. Journal of psychiatric research 2018;103 229-236 [Pubmed Journal](#)

[149] EMDR vs Reassurance (Dx). [Website](#)

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ treatment as usual	Individual psychoeducation/ self-help		
PTSD diagnosis 3-6 months	Relative risk 1.7 (CI 95% 0.85 - 3.39) Based on data from 142 patients in 1 studies. (Randomized controlled)	149 per 1000	253 per 1000	Low Due to very serious imprecision ¹	Individual psychoeducation/self- help may increase PTSD diagnosis
PTSD Severity 3-6 months	Lower better Based on data from: 272 patients in 3 studies. (Randomized controlled)	Difference: SMD 0.05 lower (CI 95% 0.28 lower - 0.19 higher)		Moderate Due to serious imprecision ²	Individual psychoeducation/self- help probably has little or no effect on PTSD severity

- 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 .**
- 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 .**

References

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- [139] Scholes C, Turpin G, Mason S : A randomised controlled trial to assess the effectiveness of providing self-help information to people with symptoms of acute stress disorder following a traumatic injury.. Behaviour research and therapy 2007;45(11):2527-36 [Pubmed](#)
- [142] Turpin G, Downs M, Mason S : Effectiveness of providing self-help information following acute traumatic injury: randomised controlled trial.. The British journal of psychiatry : the journal of mental science 2005;187 76-82 [Pubmed](#)
- [158] Psychoeducation vs WLTAU (Dx). [Website](#)

[159] Psychoeducation vs WLTAU (Sx). [Website](#)

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

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

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** .

References

[126] Adler AB, Litz BT, Castro CA, Suvak M, Thomas JL, Burrell L, McGurk D, Wright KM, Bliese PD : A group randomized trial of critical incident stress debriefing provided to U.S. peacekeepers.. Journal of traumatic stress 2008;21(3):253-63
[Pubmed Journal](#)

[156] Group Stress Management vs WLTAU (Sx). [Website](#)

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ treatment as usual	Computerised visuospatial task		
PTSD diagnosis	Relative risk 0.58 (CI 95% 0.13 - 2.6) Based on data from 127 patients in 2 studies. (Randomized controlled)	164 per 1000	92 per 1000	Very Low Due to serious risk of bias, Due to serious inconsistency, Due to very serious imprecision ¹	We are uncertain whether computerised visuospatial task increases or decreases PTSD diagnosis
PTSD symptom severity	Lower better Based on data from: 127 patients in 2 studies. (Randomized controlled)	Difference: SMD 0.11 lower (CI 95% 0.46 lower - 0.24 higher)		Very Low Due to serious risk of bias, Due to very serious imprecision ²	We are uncertain whether computerised visuospatial task increases or decreases PTSD symptom severity

- 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** .
- 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= 127), Wide confidence intervals (CI's include important harm and benefit) ; **Publication bias: No serious** .

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- [135] Iyadurai L, Blackwell SE, Meiser-Stedman R, Watson PC, Bonsall MB, Geddes JR, Nobre AC, Holmes EA : Preventing intrusive memories after trauma via a brief intervention involving Tetris computer game play in the emergency department: a proof-of-concept randomized controlled trial.. Molecular psychiatry 2018;23(3):674-682 [Pubmed Journal](#)

[161] Tetris vs WLTAU (Dx). [Website](#)

[162] Tetris vs WLTAU (Sx). [Website](#)

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.

Clinical Question/ PICO

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ treatment as usual	Group education		
PTSD symptom severity	Lower better Based on data from: 47 patients in 1 studies. (Randomized controlled)		Difference: SMD 0.2 higher (CI 95% 0.39 lower - 0.78 higher)	Very Low Due to serious risk of bias, Due to very serious imprecision ¹	We are uncertain whether group education improves or worsen PTSD symptom severity

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=47), Wide confidence intervals (CI includes important benefit and important harm) ; **Publication bias: No serious** .

References

[141] Tuckey MR, Scott JE : Group critical incident stress debriefing with emergency services personnel: a randomized controlled trial.. Anxiety, stress, and coping 2014;27(1):38-54 [Pubmed Journal](#)

[155] Group Education vs WLTAU (Sx). [Website](#)

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

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ treatment as usual	Reassurance		
PTSD diagnosis 3-6 months	Relative risk 0.83 (CI 95% 0.31 - 2.25) Based on data from 75 patients in 1 studies. (Randomized controlled)	189 per 1000	157 per 1000	Very Low Due to serious risk of bias, Due to very serious imprecision ¹	We are uncertain whether reassurance increases or decreases PTSD diagnosis
		Difference: 32 fewer per 1000 (CI 95% 130 fewer - 236 more)			

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** .

References

[132] Gil-Jardiné C, Evrard G, Al Joboory S, Tortes Saint Jammes J, Masson F, Ribéreau-Gayon R, Galinski M, Salmi L-R, Revel P, Régis CA, Valdenaire G, Lagarde E : Emergency room intervention to prevent post concussion-like symptoms and post-traumatic stress disorder. A pilot randomized controlled study of a brief eye movement desensitization and reprocessing intervention versus reassurance or usual care.. Journal of psychiatric research 2018;103 229-236 [Pubmed Journal](#)

[160] Reassurance vs WLTAU (Dx). [Website](#)

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.

Clinical Question/ PICO

Population: Adults within the first three months post traumatic event
Intervention: Trauma-focused counselling
Comparator: Heart stress counselling

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Heart stress counselling	Trauma-focused counselling		
PTSD diagnosis 3-6 months	Relative risk 2.84 (CI 95% 0.12 - 68.86) Based on data from 183 patients in 1 studies. (Randomized controlled)	0 per 1000	0 per 1000	Low Due to very serious imprecision ¹	Trauma-focused counselling may be less beneficial than heart stress counselling for PTSD diagnosis
		Difference: 0 fewer per 1000 (CI 95% 0 fewer - 0 fewer)			

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

References

[143] von Känel R, Barth J, Princip M, Meister-Langraf RE, Schmid J-P, Znoj H, Herbert C, Schnyder U : Early Psychological Counseling for the Prevention of Posttraumatic Stress Induced by Acute Coronary Syndrome: The MI-SPRINT Randomized Controlled Trial.. *Psychotherapy and psychosomatics* 2018;87(2):75-84 [Pubmed Journal](#)

[163] Trauma-focused Counselling vs Heart Stress Counselling. [Website](#)

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 may 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[168] 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.^[168]

Key Info

Benefits and harms

Evidence from 2 RCTs [168][178] 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

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ treatment as usual	Brief dyadic therapies		
PTSD symptom severity 3-6 months	Lower better Based on data from: 103 patients in 2 studies. (Randomized controlled)		Difference: SMD 0.41 lower (CI 95% 0.81 lower - 0.02 lower)	Low Due to serious imprecision. Due to serious risk of bias ¹	Brief dyadic therapies probably decreases PTSD symptom severity

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** .

References

[168] Brunet A, Des Groseilliers IB, Cordova MJ, Ruzek JI : Randomized controlled trial of a brief dyadic cognitive-behavioral intervention designed to prevent PTSD.. European journal of psychotraumatology 2013;4 [Pubmed](#) [Journal](#)

[178] Kazak AE, Simms S, Alderfer MA, Rourke MT, Crump T, McClure K, Jones P, Rodriguez A, Boeving A, Hwang W-T, Reilly A : Feasibility and preliminary outcomes from a pilot study of a brief psychological intervention for families of children newly diagnosed with cancer.. Journal of pediatric psychology 2005;30(8):644-55 [Pubmed](#)

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 may 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.^[181]

Key Info

Benefits and harms

Evidence from a single study [181] 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

Low

Overall certainty of the evidence is MODERATE due to very serious imprecision.

Certainty of the evidence is MODERATE due to serious imprecision for PTSD diagnosis.

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

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ treatment as usual	Guided internet- based CBT		
PTSD diagnosis 3-6 months	Relative risk 0.5 (CI 95% 0.18 - 1.45) Based on data from 185 patients in 1 studies. (Randomized controlled)	102 per 1000	51 per 1000	Low Due to very serious imprecision ¹	Internet-based CBT may improve PTSD diagnosis
PTSD symptom severity	Lower better Based on data from: 300 patients in 1 studies. (Randomized controlled)	Difference: SMD 0.27 lower (CI 95% 0.5 lower - 0.04 lower)		Moderate Due to serious imprecision ²	Guided internet-based CBT probably decreases PTSD symptom severity

- 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 .**
- Imprecision: Serious .** Low number of patients (n=300), CI includes important benefit and unimportant benefit ;

References

[181] MOUTHAN J, Sijbrandij M, de Vries G-J, Reitsma JB, van de Schoot R, Goslings JC, Luitse JSK, Bakker FC, Gersons BPR, Olf M : Internet-based early intervention to prevent posttraumatic stress disorder in injury patients: randomized controlled trial.. Journal of medical Internet research 2013;15(8):e165 [Pubmed Journal](#)

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: Waitlist/ treatment as usual

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ treatment as usual	Brief individual trauma processing therapy		
PTSD diagnosis 3-6 months	Relative risk 0.55 (CI 95% 0.36 - 0.85) Based on data from 315 patients in 3 studies. (Randomized controlled)	206 per 1000	113 per 1000	Low Due to serious imprecision, Due to serious risk of bias ¹	Brief individual trauma processing therapy may decrease PTSD diagnosis
PTSD symptom severity 3-6 months	Lower better Based on data from: 329 patients in 3 studies. (Randomized controlled)	Difference: SMD 0.04 lower (CI 95% 0.41 lower - 0.49 higher)		Very Low Due to serious risk of bias, Due to serious inconsistency, Due to very serious imprecision ²	We are uncertain whether brief individual trauma processing therapy improves or worsen PTSD symptom severity

- 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** .
- 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 I²:72% . ; **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** .

References

[167] Brom D, Kleber RJ, Hofman MC : Victims of traffic accidents: incidence and prevention of post-traumatic stress disorder.. Journal of clinical psychology 1993;49(2):131-40 [Pubmed](#)

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[180] Marchland A, Guay S, Boyer R, Iucci S, Martin A, St-Hilaire M-H : Marchand, A., Guay, S., Boyer, R., Iucci, S., Martin, A., & St-Hilaire, M. H. (2006). A randomized controlled trial of an adapted form of individual critical incident stress debriefing for victims of an armed robbery. *Brief treatment and crisis intervention*, 6(2), 122.. [Journal](#)

[182] Rothbaum BO, Kearns MC, Price M, Malcoun E, Davis M, Ressler KJ, Lang D, Houry D : Early intervention may prevent the development of posttraumatic stress disorder: a randomized pilot civilian study with modified prolonged exposure.. *Biological psychiatry* 2012;72(11):957-63 [Pubmed Journal](#)

[183] Ryding E, Wijma K, Wijma B : Ryding, E. L., Wijma, K., & Wijma, B. (1998). Postpartum counselling after an emergency cesarean. *Clinical Psychology & Psychotherapy: An International Journal of Theory and Practice*, 5(4), 231-237.. [Journal](#)

Clinical Question/ PICO

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Supportive listening	Brief individual trauma processing therapy		
PTSD symptom severity 3-6 months	Lower better Based on data from: 51 patients in 2 studies. (Randomized controlled)	Difference: SMD 0.54 lower (CI 95% 1.42 lower - 0.34 higher)		Very Low Due to serious risk of bias, Due to serious inconsistency, Due to very serious imprecision ¹	We are uncertain whether there is a difference between brief individual trauma processing therapy and supportive listening on PTSD symptom severity

1. **Risk of bias: Serious** . Incomplete data and/or large loss to follow up, not participant flowchart, due to lack of detailed reporting throughout paper ; **Inconsistency: Serious** . The magnitude of statistical heterogeneity was high, with I²:52%, although studies are by the same group and was a replication study ; **Indirectness: No serious** . **Imprecision: Very Serious** . Low number of patients (n=51), Wide confidence intervals (CI includes important benefit and important harm) ; **Publication bias: No serious** .

References

[172] Gidron Y, Gal R, Freedman S, Twiser I, Lauden A, Snir Y, Benjamin J : Translating research findings to PTSD prevention: results of a randomized-controlled pilot study.. *Journal of traumatic stress* 2001;14(4):773-80 [Pubmed](#)

[173] Gidron Y, Gal R, Givati G, Lauden A, Snir Y, Benjamin J : Interactive effects of memory structuring and gender in preventing posttraumatic stress symptoms.. *The Journal of nervous and mental disease* 2007;195(2):179-82 [Pubmed](#)

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

Population: Adults in the first three months post traumatic event
Intervention: Three step early intervention for mothers of infants born prematurely
Comparator: Waitlist/ treatment as usual

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ treatment as usual	Three step early intervention for mothers premature infants		
PTSD symptom severity	Lower better Based on data from: 55 patients in 1 studies. (Randomized controlled)	Difference: SMD 0.08 lower (CI 95% 0.61 lower - 0.45 higher)		Very Low Due to serious risk of bias, Due to very serious imprecision ¹	We are uncertain whether three step early intervention for mothers premature infants improves or worsen PTSD symptom severity

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** .

References

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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

Population: Adults in the first three months post traumatic event
Intervention: Intensive care diaries
Comparator: Waitlist/ treatment as usual

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ treatment as usual	Intensive care diaries		
PTSD diagnosis 3-6 months	Relative risk 0.38 (CI 95% 0.17 - 0.82) Based on data from 322 patients in 1 studies. (Randomized controlled)	131 per 1000	50 per 1000	Very Low Due to serious risk of bias, Due to very serious imprecision ¹	We are uncertain whether intensive care diaries increases or decreases PTSD diagnosis
PTSD symptom severity 3-6 months	Lower better Based on data from: 322 patients in 1 studies. (Randomized controlled)	Difference: 81 fewer per 1000 (CI 95% 109 fewer - 24 fewer)		Very Low Due to serious risk of bias, Due to very serious imprecision ²	We are uncertain whether intensive care diaries increases or decreases PTSD symptom severity

- 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, 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** .
- 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, 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** .

References

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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

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ treatment as usual	Brief Interpersonal Counselling		
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	148 per 1000	Very Low Due to very serious risk of bias, Due to very serious imprecision ¹	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 ²	We are uncertain whether brief interpersonal counselling increases or decreases PTSD symptom severity

- 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** .
- 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** .

References

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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.

Clinical Question/ PICO

Population: Adults in the first three months post traumatic event
Intervention: Collaborative care
Comparator: Waitlist/ treatment as usual

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ treatment as usual	Collaborative care		
PTSD diagnosis 3-6 months	Relative risk 0.39 (CI 95% 0.1 - 1.58) Based on data from 26 patients in 1 studies. (Randomized controlled)	429 per 1000	167 per 1000	Very Low Due to serious risk of bias, Due to very serious imprecision ¹	We are uncertain whether collaborative care increases or decreases PTSD diagnosis
PTSD symptom severity 3-6 months	Lower better Based on data from: 26 patients in 1 studies. (Randomized controlled)	Difference: SMD 0.41 higher (CI 95% 0.37 lower - 1.19 higher)		Very Low Due to serious risk of bias, Due to very serious imprecision ²	We are uncertain whether collaborative care increases or decreases PTSD symptom severity

- 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** .
- 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** .

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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 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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ treatment as usual	Supported psychoeducational intervention		
PTSD symptom severity 3-6 months	Lower better Based on data from: 23 patients in 1 studies. (Randomized controlled)	Difference: SMD 0.41 lower (CI 95% 1.35 lower - 0.53 higher)		Very Low Due to serious risk of bias, Due to serious indirectness, Due to very serious imprecision ¹	We are uncertain whether supported psychoeducational intervention increases or decreases PTSD symptom severity

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) ;

References

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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	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ treatment as usual	Telephone-based CBT		
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 ¹	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 .**

References

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Clinical Question/ PICO

Population: Adults in the first three months post traumatic event
Intervention: Telephone + Internet-based CBT
Comparator: Critical illness educational intervention

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Critical illness educational intervention	Telephone + Internet based CBT		
PTSD symptom severity	Lower better Based on data from: 175 patients in 1 studies. (Randomized controlled)	Difference: SMD 0.13 higher (CI 95% 0.16 lower - 0.43 higher)		Low Due to serious indirectness, Due to serious imprecision ¹	Telephone-based CBT may have little or no difference on PTSD symptom severity

1. **Inconsistency: No serious . Indirectness: Serious .** Differences between the population of interest and those studied; severely ill ICU patients with expected mortality 50% ; **Imprecision: Serious .** Low number of patients (n=175), Wide confidence intervals (CI include unimportant benefit and important harm ; **Publication bias: No serious .**

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of a Telephone- and Web-based Coping Skills Training Program Compared with an Education Program for Survivors of Critical Illness and Their Family Members. A Randomized Clinical Trial.. American journal of respiratory and critical care medicine 2018;197(1):66-78 [Pubmed Journal](#)

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ treatment as usual	Communication facilitator in an intensive care setting		
PTSD symptom severity 3-6 months	Lower better Based on data from: 168 patients in 1 studies. (Randomized controlled)	Difference: SMD 0.11 lower (CI 95% 0.41 lower - 0.19 higher)		Low Due to serious risk of bias, Due to serious imprecision ¹	Communication facilitator in an intensive care setting may have little or no effect on PTSD symptom severity

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** .

References

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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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		WL/TAU	Nurse-led intensive care recovery program		
PTSD symptom severity	Lower better Based on data from: 215 patients in 1 studies. (Randomized controlled)		Difference: SMD 0.02 lower (CI 95% 0.29 lower - 0.25 higher)	Very Low Due to serious risk of bias, Due to very serious imprecision, Due to serious indirectness ¹	We are uncertain whether nurse-led intensive care recovery program increases or decreases PTSD symptom severity

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

Strong Recommendation

For adults with PTSD symptoms in the first three months after exposure to a traumatic event, we recommend a stepped/collaborative care model of care, in which the care provided at each level is evidence-based.

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^{[231][232][233]} 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^[223] 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.

Key Info

Benefits and harms

Evidence from 4 RCTs ^{[223][231][232][233]} 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.

Certainty of evidence for a stepped care model was LOW due to very serious imprecision for PTSD diagnosis.

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 scarce 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
Intervention: Stepped/collaborative care
Comparator: Waitlist/ treatment as usual

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ treatment as usual	Stepped/ collaborative care		
PTSD diagnosis 3-6 months post trauma	Relative risk 0.37 (CI 95% 0.1 - 1.39) Based on data from 144 patients in 2 studies. (Randomized controlled)	391 per 1000	145 per 1000	Low Due to very serious imprecision ¹	Stepped/collaborative care may decrease PTSD diagnosis
PTSD symptom severity 3-6 months	Lower better Based on data from: 370 patients in 3 studies. (Randomized controlled)	Difference: SMD 0.45 lower (CI 95% 0.65 lower - 0.24 lower)		Moderate Due to serious imprecision ²	Stepped/ collaborative care probably decreases PTSD symptom severity slightly

- Inconsistency: No serious** . The magnitude of statistical heterogeneity was high, with I²:68% however both studies showed positive effects and therefore not important ; **Indirectness: No serious** . **Imprecision: Very Serious** . Low number of events (events =40), Wide confidence intervals (CI includes important benefit and important harm) ; **Publication bias: No serious** .
- Inconsistency: No serious** . **Indirectness: No serious** . **Imprecision: Serious** . Low number of patients (n=370), Wide confidence intervals (CI includes important benefit and unimportant benefit) ; **Publication bias: No serious** .

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[250] Stepped Collaborative Care vs WLTAU (Sx). [Website](#)

Trauma-focussed CBT (TF-CBT)

Conditional Recommendation

For adults with PTSD symptoms in the first three months after exposure to a traumatic event, we suggest offering trauma-focussed CBT (includes Prolonged Exposure, Cognitive Processing Therapy, Cognitive Therapy) in preference to doing nothing.

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.

Key Info

Benefits and harms

Evidence from 16 RCTs suggests a clinically important benefit of TFCBT on PTSD symptom severity and diagnosis, relative to WL/TAU [205][210][214][215][224][226][227][228], supportive counselling [206][207][208][209][216][221][222], and relaxation [213].

Evidence from a single RCT [228] 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 [206][207][208][209][215][216] 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 [221] and unimportant benefit on PTSD symptom severity [221][222] 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.

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.

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.

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.

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.

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.

Certainty of evidence for Trauma-focused CBT vs Self-help program was VERY LOW due to serious risk of bias, and very serious imprecision for PTSD symptom severity, and LOW due to very serious imprecision for PTSD diagnosis.

Preference and values

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.

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 focused 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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ treatment as usual	Trauma-focused CBT		
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 ¹	Trauma-focused CBT may decrease PTSD diagnosis
PTSD symptom severity	Lower better Based on data from: 705 patients in 8 studies. (Randomized controlled)	Difference: SMD 0.54 lower (CI 95% 0.83 lower - 0.24 lower)		Low Due to serious risk of bias, Due to serious imprecision ²	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 I²:74% . ; **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** .

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Clinical Question/ PICO

Population: Adults within the first three months post-traumatic event
Intervention: Trauma-focused CBT
Comparator: Supportive counselling

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Supportive counselling	Trauma-focused CBT		

<p>PTSD diagnosis</p> <p>Relative risk 0.61 (CI 95% 0.36 - 1.04) Based on data from 281 patients in 6 studies. (Randomized controlled)</p>	<p>587 per 1000</p> <p>358 per 1000</p> <p>Difference: 229 fewer per 1000 (CI 95% 376 fewer - 23 more)</p>	<p>Very Low Due to serious risk of bias, Due to serious inconsistency, Due to serious imprecision ¹</p> <p>We are uncertain whether trauma-focused CBT is more beneficial than supportive counseling for PTSD diagnosis</p>
<p>PTSD symptom severity</p> <p>Lower better Based on data from: 333 patients in 8 studies. (Randomized controlled)</p>	<p>Difference: SMD 0.7 lower (CI 95% 1.08 lower - 0.33 lower)</p>	<p>Low Due to serious risk of bias, Due to serious imprecision ²</p> <p>Trauma-focused CBT may be more effective than supportive counselling for decreasing PTSD symptom severity</p>

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 I²:67% . ; **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 I²:65% 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** .

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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	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Supportive counselling	Brief prolonged exposure-based interventions		
PTSD diagnosis	Relative risk 0.56 (CI 95% 0.29 - 1.06) Based on data from 251 patients in 5 studies. (Randomized controlled)	604 per 1000	338 per 1000	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
PTSD symptom severity	Lower better Based on data from: 262 patients in 6 studies. (Randomized controlled)	Difference: SMD 0.78 lower (CI 95% 1.26 lower - 0.3 lower)		Low Due to serious risk of bias, Due to serious imprecision ²	Brief prolonged exposure-based interventions may be more effective than supportive counselling for decreasing PTSD symptom severity

- 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 I²:74% . ; **Imprecision: Serious** . Low number of events (events = 115), Wide confidence intervals (CI includes important benefit and unimportant harm) ;
- 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 I²:69% 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** .

References

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[244] Brief PE vs Supportive Counselling (Sx). [Website](#)

Clinical Question/ PICO

Population: Adults within the first three months post-traumatic event
Intervention: Brief CPT-based interventions
Comparator: Supportive counselling

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Supportive counselling	Brief CPT-based interventions		
PTSD diagnosis	Relative risk 0.76 (CI 95% 0.32 - 1.83) Based on data from 30 patients in 1 studies. (Randomized controlled)	462 per 1000	351 per 1000	Very Low Due to serious risk of bias, Due to very serious imprecision ¹	We are uncertain if there is a difference between brief CPT- based interventions and supportive counselling on PTSD diagnosis
PTSD symptom severity	Lower better Based on data from: 71 patients in 2 studies. (Randomized controlled)	Difference: SMD 0.47 lower (CI 95% 0.95 lower - 0 higher)		Low Due to serious risk of bias, Due to serious imprecision ²	Brief CPT-based interventions may be slightly more beneficial than supportive counselling in decreasing PTSD symptom severity

- 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** .
- 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** .

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[246] Brief CPT vs Supportive Counselling (Sx). [Website](#)

Clinical Question/ PICO

Population: Adults within the first three months post-traumatic event
Intervention: Trauma-focused CBT
Comparator: Relaxation

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Relaxation	Trauma-focused CBT		
PTSD diagnosis	Relative risk 0.4 (CI 95% 0.1 - 1.6) Based on data from 20 patients in 1 studies. (Randomized controlled)	500 per 1000	200 per 1000	Very Low Due to very serious risk of bias, Due to very serious imprecision ¹	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. (Randomized controlled)	Difference: SMD 0.79 lower (CI 95% 1.71 lower - 0.13 higher)		Very Low Due to very serious risk of bias, Due to very serious imprecision ²	We are uncertain if there is a difference between trauma- focused CBT and relaxation on PTSD symptom severity

- Risk of bias: Very Serious** . Inadequate sequence generation/ generation of comparable groups and 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, due to poorly documented intervention delivery ; **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** .
- Risk of bias: Very Serious** . Inadequate sequence generation/ generation of comparable groups and 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, due to poorly documented intervention delivery ; **Inconsistency: No serious** . **Indirectness: No serious** . **Imprecision: Very Serious** . Low number of patients (n=20), Wide confidence intervals (CI includes important benefit and unimportant harm) ; **Publication bias: No serious** .

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Clinical Question/ PICO

Population: Adults within the first three months post-traumatic event
Intervention: Trauma-focused CBT
Comparator: Structured writing therapy

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Structured writing therapy	Trauma-focused CBT		
PTSD diagnosis	Relative risk 1.57 (CI 95% 0.68 - 3.65) Based on data from 43 patients in 1 studies. (Randomized controlled)	273 per 1000	429 per 1000	Very Low Due to serious risk of bias, Due to very serious imprecision ¹	We are uncertain if there is a difference between trauma- focused CBT and structured writing therapy on PTSD diagnosis
PTSD symptom severity	Lower better Based on data from: 43 patients in 1 studies. (Randomized controlled)	Difference: SMD 0.11 lower (CI 95% 0.7 lower - 0.49 higher)		Very Low Due to serious risk of bias, Due to very serious imprecision ²	We are uncertain if there is a difference between trauma- focused CBT and structured writing therapy on PTSD symptom severity

- 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** .
- 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** .

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Clinical Question/ PICO

Population: Adults within the first three months post-traumatic event
Intervention: Trauma-focused CBT
Comparator: Self-help program

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Self-help program	Trauma-focused CBT		
PTSD diagnosis	Relative risk 0.22 (CI 95% 0.03 - 1.45) Based on data from 10 patients in 1 studies. (Randomized controlled)	167 per 1000	37 per 1000	Low Due to very serious imprecision ¹	Trauma-focused CBT may be more beneficial than self-help programs for PTSD diagnosis
PTSD symptom severity	Lower better Based on data from: 37 patients in 1 studies. (Randomized controlled)	Difference: SMD 0.39 lower (CI 95% 1.04 lower - 0.26 higher)		Very Low Due to serious risk of bias, Due to very serious imprecision ²	We are uncertain if there is a difference between trauma- focused CBT and self- help programs on PTSD symptom severity

- 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 .**
- 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 .**

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Brief EMDR

Conditional Recommendation

For adults with PTSD symptoms in the first three months after exposure to a traumatic event, we suggest offering brief 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.

Key Info

Benefits and harms

Evidence from 5 small RCTs [140][217][218][225] [234] 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 [140] 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 experience 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.

Certainty of evidence for Brief EMDR vs Critical Incident Stress Debriefing (CSID) was LOW due to very serious imprecision for PTSD diagnosis (3-6 months), and PTSD symptom severity (3-6months).

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

- Population:** Adults within the first three months post traumatic event
- Intervention:** Brief EMDR
- Comparator:** Critical Incident Stress Debriefing (CSID)

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Critical Incident Stress Debriefing (CSID)	Brief EMDR		
PTSD diagnosis 3-6 months	Relative risk 0.03 (CI 95% 0 - 0.51) Based on data from 42 patients in 1 studies. (Randomized controlled)	783 per 1000	23 per 1000	Low Due to very serious imprecision ¹	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 ²	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 .

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- [147] EMDR vs CISD (Dx). [Website](#)
- [148] EMDR vs CISD (Sx). [Website](#)

Clinical Question/ PICO

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ treatment as usual	Brief EMDR		
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 ¹	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** .

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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^[228] 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^[211] 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.

Key Info

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 [228][248][261].

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 [228][238].

Evidence from another RCT suggests no difference between structured writing intervention and psychoeducation on PTSD symptom severity [211][262].

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.

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.

Certainty for evidence for Structured writing therapy vs Psychoeducation was LOW due to serious risk of bias, and serious imprecision for PTSD symptom severity.

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Structured writing therapy	Trauma-focused CBT		
PTSD diagnosis	Relative risk 1.57 (CI 95% 0.68 - 3.65) Based on data from 43 patients in 1 studies. (Randomized controlled)	273 per 1000	429 per 1000	Very Low Due to serious risk of bias, Due to very serious imprecision ¹	We are uncertain if there is a difference between trauma- focused CBT and structured writing therapy on PTSD diagnosis
PTSD symptom severity	Lower better Based on data from: 43 patients in 1 studies. (Randomized controlled)	Difference: SMD 0.11 lower (CI 95% 0.7 lower - 0.49 higher)		Very Low Due to serious risk of bias, Due to very serious imprecision ²	We are uncertain if there is a difference between trauma- focused CBT and structured writing therapy on PTSD symptom severity

- 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** .
- 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** .

References

[228] van Emmerik AAP, Kamphuis JH, Emmelkamp PMG : Treating acute stress disorder and posttraumatic stress disorder with cognitive behavioral therapy or structured writing therapy: a randomized controlled trial.. *Psychotherapy and psychosomatics* 2008;77(2):93-100 [Pubmed Journal](#)

Clinical Question/ PICO

Population: Adults within the first three months post traumatic event
Intervention: Structured writing therapy
Comparator: Waitlist/ treatment as usual

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ treatment as usual	Structured writing therapy		
PTSD diagnosis	Relative risk 0.63 (CI 95% 0.27 - 1.43) Based on data from 45 patients in 1 studies. (Randomized controlled)	435 per 1000	274 per 1000	Very Low Due to serious risk of bias, Due to very serious imprecision ¹	We are uncertain whether structured writing therapy increases or decreases PTSD diagnosis
PTSD symptom severity	Lower better Based on data from: 45 patients in 1 studies. (Randomized controlled)	Difference: SMD 0.97 lower (CI 95% 1.59 lower - 0.35 lower)		Very Low Due to serious risk of bias, Due to very serious imprecision ²	We are uncertain whether structured writing therapy increases or decreases PTSD symptom severity

- 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 (events = 15), Wide confidence intervals (CI includes important benefit and important harm) ; **Publication bias: No serious** .
- 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=45), Wide confidence intervals (CI includes important benefit and unimportant benefit) ; **Publication bias: No serious** .

References

[228] van Emmerik AAP, Kamphuis JH, Emmelkamp PMG : Treating acute stress disorder and posttraumatic stress disorder with cognitive behavioral therapy or structured writing therapy: a randomized controlled trial.. *Psychotherapy and psychosomatics* 2008;77(2):93-100 [Pubmed Journal](#)

Clinical Question/ PICO

Population: Adults within the first three months post-traumatic event
Intervention: Structured writing therapy
Comparator: Psychoeducation

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Psychoeducation	Structured writing therapy		
PSTD symptom severity	Lower better Based on data from: 104 patients in 1 studies.	Difference: SMD 0.16 higher (CI 95% 0.23 lower - 0.55 higher)		Low Due to serious risk of bias, Due to serious	There may be little or no difference between structured writing therapy and

(Randomized controlled)		imprecision ¹	psychoeducation on PTSD symptom severity
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1. **Risk of bias: Serious** . Incomplete data and large loss to follow up, due to baseline differences ; **Inconsistency: No serious** . **Indirectness: No serious** . **Imprecision: Serious** . Low number of patients (N=104), Wide confidence intervals (CI includes unimportant benefit and important harm) ; **Publication bias: No serious** .

References

[211] Bugg A, Turpin G, Mason S, Scholes C : A randomised controlled trial of the effectiveness of writing as a self-help intervention for traumatic injury patients at risk of developing post-traumatic stress disorder.. Behaviour research and therapy 2009;47(1):6-12 [Pubmed Journal](#)

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 may 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.

Key Info

Benefits and harms

Evidence from a single RCT [212] 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.

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ treatment as usual	Internet-based guided self-help		
PTSD symptom severity	Lower better Based on data from: 58 patients in 1 studies. (Randomized controlled)	Difference: SMD 0.66 lower (CI 95% 1.19 lower - 0.13 lower)		Low Due to serious imprecision, Due to serious risk of bias ¹	Internet-based guided self-help may decrease PTSD symptom severity

1. **Risk of bias: Serious** . Incomplete data and/or large loss to follow up, due to (in many cases) both parents participated in the study. Both parents were randomised to the same intervention. This was not addressed in the analysis. ; **Inconsistency: No serious** . **Indirectness: No serious** . **Imprecision: Serious** . Low number of patients (n=58), Wide confidence intervals (CI includes important benefit and unimportant benefit) ; **Publication bias: No serious** .

References

[212] Cernvall M, Carlbring P, Ljungman L, Ljungman G, von Essen L : Internet-based guided self-help for parents of children on cancer treatment: a randomized controlled trial.. *Psycho-oncology* 2015;24(9):1152-8 [Pubmed Journal](#)

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^[219]) 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.^[220]

Key Info

Benefits and harms

Evidence from 2 RCTs [350] [349] 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.

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

Population: Adults within the first three months post-traumatic event
Intervention: Present centered therapy (HOPE)
Comparator: Waitlist/TAU

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ TAU	Present centered therapy (HOPE)		
PTSD symptom severity	Lower better Based on data from: 119 patients in 2 studies. (Randomized controlled)		Difference: SMD 0.63 lower (CI 95% 1 lower - 0.27 lower)	Moderate Due to serious imprecision ¹	Present centered therapy (HOPE) probably decreases PTSD symptom severity

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** .

References

[219] Johnson D, Zlotnick C, Perez S : Johnson, D. M., Zlotnick, C., & Perez, S. (2011). Cognitive behavioral treatment of PTSD in residents of battered women's shelters: Results of a randomized clinical trial. *Journal of consulting and clinical psychology*, 79(4), 542.. [Pubmed](#)

[220] Johnson D, Johnson N, Perez S, Palmieri P, Zlotnick C : Johnson, D. M., Johnson, N. L., Perez, S. K., Palmieri, P. A., & Zlotnick, C. (2016). Comparison of adding treatment of PTSD during and after shelter stay to standard care in residents of

battered women's shelters: Results of a randomized clinical trial. Journal of traumatic stress, 29(4), 365-373.. [Pubmed](#)

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

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ treatment as usual	Behavioural activation		
PTSD symptom severity	Lower better Based on data from: 8 patients in 1 studies. (Randomized controlled)	Difference: SMD 0.9 lower (CI 95% 2.42 lower - 0.62 higher)		Very Low Due to serious risk of bias, Due to very serious imprecision ¹	We are uncertain whether behavioural activation increases or decreases PTSD symptom severity

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** .

References

[229] Wagner A, Zatzick D, Ghesquiere A, Jurkovich G : Wagner, Amy W., et al. "Behavioral activation as an early intervention for posttraumatic stress disorder and depression among physically injured trauma survivors." Cognitive and Behavioral Practice 14.4 (2007): 341-349.. [Journal](#)

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Supportive counselling	Trauma-focused CBT		
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 ¹	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)		Low Due to serious risk of bias, Due to serious imprecision ²	Trauma-focused CBT may be more effective than supportive counseling for decreasing PTSD symptom severity

- 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 I²:67% . ; **Imprecision: Serious** . Low number of events (events = 127), Wide confidence intervals (CI includes important benefit and unimportant harm) ;
- 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 I²:65% 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** .

References

[206] Bryant RA, Harvey AG, Dang ST, Sackville T, Basten C : Treatment of acute stress disorder: a comparison of cognitive-behavioral therapy and supportive counseling.. Journal of consulting and clinical psychology 1998;66(5):862-6 [PubMed](#)

[207] Bryant RA, Sackville T, Dang ST, Moulds M, Guthrie R : Treating acute stress disorder: an evaluation of cognitive behavior therapy and supportive counseling techniques.. The American journal of psychiatry 1999;156(11):1780-6 [Pubmed](#)

[208] Bryant RA, Moulds M, Guthrie R, Nixon RDV : Treating acute stress disorder following mild traumatic brain injury.. The American journal of psychiatry 2003;160(3):585-7 [Pubmed](#)

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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	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ treatment as usual	Supportive counselling		
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 ¹	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)		Low Due to serious imprecision, Due to serious risk of bias ²	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 .**

References

[215] Foa EB, Zoellner LA, Feeny NC : An evaluation of three brief programs for facilitating recovery after assault.. Journal of traumatic stress 2006;19(1):29-43 [Pubmed](#)

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

Population: Adults within the first three months post-traumatic event
Intervention: Computerised neurobehavioural training
Comparator: Computerised games control condition

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Computerised games control condition	Computerised neurobehavioural training		
PTSD symptom severity	Lower better Based on data from: 59 patients in 1 studies. (Randomized controlled)			Low Due to serious risk of bias, Due to serious imprecision ¹	There may be little or no difference between Computerised neurobehavioural training and Computerised games control condition on PTSD symptom severity

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** .

References

[204] Ben-Zion Z, Fine N, Keynan N, Admon R, Green N, Halevi M, Fonzo G, Achituv M, Merin O, Sharon H, Halpern P, Liberzon I, Etkin A, Hendler T, Shalev A : Ben-Zion, Z., Fine, N. B., Keynan, J. N., Admon, R., Green, N., Halevi, M., ... & Halpern, P. (2018). Cognitive flexibility predicts PTSD symptoms: observational and interventional studies. *Frontiers in psychiatry*, 9, 477.. [Pubmed Journal](#)

Clinical Question/ PICO

Population: Adults within the first three months post-traumatic event
Intervention: Computerised neurobehavioural training
Comparator: Reading tasks control condition

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Reading tasks control condition	Computerised neurobehavioural training		
PTSD symptom severity	Lower better Based on data from: 49 patients in 1 studies. (Randomized controlled)	Difference: SMD 0.09 lower (CI 95% 0.71 lower - 0.53 higher)		Very Low Due to serious risk of bias, Due to very serious imprecision ¹	We are uncertain if there is a difference between computerised neurobehavioural training and a reading task control condition on PTSD symptom severity

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** .

References

[204] Ben-Zion Z, Fine N, Keynan N, Admon R, Green N, Halevi M, Fonzo G, Achituv M, Merin O, Sharon H, Halpern P, Liberzon I, Etkin A, Hendler T, Shalev A : Ben-Zion, Z., Fine, N. B., Keynan, J. N., Admon, R., Green, N., Halevi, M., ... & Halpern, P. (2018). Cognitive flexibility predicts PTSD symptoms: observational and interventional studies. *Frontiers in psychiatry*, 9, 477.. [Pubmed Journal](#)

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates TAU Nurse-led psychological intervention	Certainty of the Evidence (Quality of evidence)	Plain text summary
PTSD symptom severity	Lower better Based on data from: 85 patients in 1 studies. (Randomized controlled)	Difference: SMD 0.15 higher (CI 95% 0.28 lower - 0.58 higher)	Low Due to serious risk of bias, Due to serious imprecision ¹	Nurse-led psychological intervention may have little or no difference on PTSD symptom severity

1. **Risk of bias: Serious** . Incomplete data and/or large loss to follow up ; **Inconsistency: No serious** . **Indirectness: No serious** . **Imprecision: Serious** . Low number of patients (n=85), Wide confidence intervals (CI includes important benefit and unimportant harm) ; **Publication bias: No serious** .

References

- [206] Bryant RA, Harvey AG, Dang ST, Sackville T, Basten C : Treatment of acute stress disorder: a comparison of cognitive-behavioral therapy and supportive counseling.. *Journal of consulting and clinical psychology* 1998;66(5):862-6 [Pubmed](#)
- [207] Bryant RA, Sackville T, Dang ST, Moulds M, Guthrie R : Treating acute stress disorder: an evaluation of cognitive behavior therapy and supportive counseling techniques.. *The American journal of psychiatry* 1999;156(11):1780-6 [Pubmed](#)
- [208] Bryant RA, Moulds M, Guthrie R, Nixon RDV : Treating acute stress disorder following mild traumatic brain injury.. *The American journal of psychiatry* 2003;160(3):585-7 [Pubmed](#)
- [209] Bryant R, Moulds M, Guthrie R, Nixon R : Bryant, R. A., Moulds, M. L., Guthrie, R. M., & Nixon, R. D. (2005). The additive benefit of hypnosis and cognitive-behavioral therapy in treating acute stress disorder. *Journal of consulting and clinical psychology*, 73(2), 334.. [Pubmed](#)
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- [252] CBT-T vs Supportive Counselling (Dx). [Website](#)
- [253] CBT-T vs Supportive Counselling (Sx). [Website](#)

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 may 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.

Key Info

Benefits and harms

Evidence from 3 RCTs [271][282][283] 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.

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

Population: Adults within the first three months post traumatic event

Intervention: Hydrocortisone
Comparator: Placebo

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Placebo	Hydrocortisone		
PTSD diagnosis 3-6 months	Relative risk 0.21 (CI 95% 0.05 - 0.89) Based on data from 88 patients in 3 studies. (Randomized controlled)	196 per 1000	41 per 1000	Very Low Due to serious risk of bias, Due to very serious imprecision ¹	We are uncertain whether hydrocortisone improves or worsen PTSD diagnosis
PTSD symptom severity 3-6 months	Lower better Based on data from: 43 patients in 1 studies. (Randomized controlled)	Difference: SMD 0.63 lower (CI 95% 1.25 lower - 0.02 lower)		Very Low Due to serious risk of bias, Due to very serious imprecision ²	We are uncertain whether hydrocortisone improves or worsen PTSD symptom severity

- 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 ;
- 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** .

References

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- [282] Weis F, Kilger E, Rozenendaal B, de Quervain DJ-F, Lamm P, Schmidt M, Schmölz M, Briegel J, Schelling G : Stress doses of hydrocortisone reduce chronic stress symptoms and improve health-related quality of life in high-risk patients after cardiac surgery: a randomized study.. *The Journal of thoracic and cardiovascular surgery* 2006;131(2):277-82 [Pubmed](#)
- [283] Zohar J, Yahalom H, Kozlovsky N, Cwikel-Hamzany S, Matar MA, Kaplan Z, Yehuda R, Cohen H : High dose hydrocortisone immediately after trauma may alter the trajectory of PTSD: interplay between clinical and animal studies.. *European neuropsychopharmacology : the journal of the European College of Neuropsychopharmacology* 2011;21(11):796-809 [Pubmed Journal](#)
- [289] Hydrocortisone vs Placebo (Dx). [Website](#)
- [290] Hydrocortisone vs Placebo (Sx). [Website](#)

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Placebo	Docosahexaenoic Acid		
PTSD diagnosis 3-6 months	Relative risk 2.15 (CI 95% 0.2 - 23.04) Based on data from 110 patients in 1 studies. (Randomized controlled)	18 per 1000	39 per 1000	Low Due to very serious imprecision ¹	Docosahexaenoic acid may increase PTSD diagnosis
PTSD symptom severity 3-6 months	Lower better Based on data from: 110 patients in 1 studies. (Randomized controlled)	Difference: SMD 0.11 higher (CI 95% 0.26 lower - 0.49 higher)		Moderate Due to serious imprecision ²	Docosahexaenoic acid probably has little or no difference on PTSD symptom severity.

- 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 .**
- Inconsistency: No serious . Indirectness: No serious . Imprecision: Serious .** Low number of patients (n= 110) ; **Publication bias: No serious .**

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[274] Matsuoka Y, Nishi D, Hamazaki K, Yonemoto N, Matsumura K, Noguchi H, Hashimoto K, Hamazaki T : Docosahexaenoic acid for selective prevention of posttraumatic stress disorder among severely injured patients: a randomized, placebo-controlled trial.. The Journal of clinical psychiatry 2015;76(8):e1015-22 [Pubmed](#) [Journal](#)

[284] Docosahexaenoic Acid vs Placebo (Dx). [Website](#)

[285] Docosahexaenoic Acid vs Placebo (Sx) . [Website](#)

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

Population: Adults within the first three months of a traumatic event
Intervention: Escitalopram
Comparator: Placebo

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Placebo	Escitalopram		
PTSD diagnosis 3-6 months	Relative risk 1.05 (CI 95% 0.61 - 1.79) Based on data from 68 patients in 2 studies. (Randomized controlled)	314 per 1000	330 per 1000	Very Low Due to very serious risk of bias, Due to very serious imprecision ¹	Escitalopram may have little or no difference on PTSD diagnosis
PTSD symptom severity 3-6 months	Lower better Based on data from: 68 patients in 2 studies. (Randomized controlled)	Difference: SMD 0.01 lower (CI 95% 0.49 lower - 0.47 higher)		Very Low Due to very serious risk of bias, Due to serious imprecision ²	We are uncertain whether escitalopram increases or decreases PTSD symptom severity

- 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** .
- 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** . Mostly commercially funded studies ;

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disorder: a pilot randomized controlled trial.. BMC psychiatry 2015;15 24 [Pubmed Journal](#)

[286] Escitalopram vs Placebo (Dx). [Website](#)

[287] Escitalopram vs Placebo (Sx). [Website](#)

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Placebo	Oxytocin		
PTSD symptom severity 3-6 months	Lower better Based on data from: 107 patients in 1 studies. (Randomized controlled)	Difference: SMD 0.24 lower (CI 95% 0.62 lower - 0.14 higher)		Low Due to serious risk of bias, Due to serious imprecision ¹	Oxytocin may decrease PTSD symptom severity slightly

1. **Risk of bias: Serious** . Incomplete data and/or large loss to follow up (34%) ; **Inconsistency: No serious** . **Indirectness: No serious** . **Imprecision: Serious** . Low number of patients (n= 107), Wide confidence intervals (CI includes important benefit and unimportant harm) ; **Publication bias: No serious** .

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[291] Oxytocin vs Placebo (Sx). [Website](#)

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	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Placebo	Propranolol		
PTSD diagnosis 3-6 months	Relative risk 0.72 (CI 95% 0.29 - 1.77) Based on data from 82 patients in 3 studies. (Randomized controlled)	222 per 1000	160 per 1000	Very Low Due to serious risk of bias, Due to very serious imprecision ¹	We are uncertain whether propranolol increases or decreases PTSD diagnosis
PTSD symptom severity 3-6 months	Lower better Based on data from: 52 patients in 2 studies. (Randomized controlled)	Difference: SMD 0.06 higher (CI 95% 0.49 lower - 0.61 higher)		Low Due to serious risk of bias, Due to serious imprecision ²	Propranolol may have little or no difference on PTSD symptom severity

- Risk of bias: Serious** . Incomplete data and/or large loss to follow up, Missing intention-to-treat analysis, due to difficulties reaching recruitment targets, poor drug adherence ; **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** . Some authors disclosed prior funding from pharmaceutical company ;
- Risk of bias: Serious** . Incomplete data and/or large loss to follow up, Selective outcome reporting, difficulties reaching recruitment targets, poor adrug 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 pharmacological company ;

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controlled proof-of-concept trial in physically injured patients.. Journal of traumatic stress 2007;20(6):923-32 [Pubmed](#)

[292] Propranolol vs Placebo (Dx). [Website](#)

[293] Propranolol vs Placebo (Sx). [Website](#)

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

Population: Adults within the first three months post traumatic event
Intervention: Gabapentin
Comparator: Placebo

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Placebo	Gabapentin		
PTSD diagnosis 3-6 months	Relative risk 0.8 (CI 95% 0.18 - 3.59) Based on data from 26 patients in 1 studies. (Randomized controlled)	250 per 1000	200 per 1000	Very Low Due to serious risk of bias, Due to very serious imprecision ¹	We are uncertain whether gabapentin increases or decreases PTSD diagnosis
		Difference: 50 fewer per 1000 (CI 95% 205 fewer - 648 more)			

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** .

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[279] Stein MB, Kerridge C, Dimsdale JE, Hoyt DB : Pharmacotherapy to prevent PTSD: Results from a randomized controlled proof-of-concept trial in physically injured patients.. Journal of traumatic stress 2007;20(6):923-32 [Pubmed](#)

[288] Gabapentin vs Placebo (Dx). [Website](#)

Adults with clinically relevant post-traumatic stress symptoms

Psychological treatments 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.

Key Info

Benefits and harms

Evidence from 4 RCTs [333][336][368][385] 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 [385] suggests no important difference in benefit between CPT and prolonged exposure.

Evidence from a single study [310] 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.

Certainty of evidence for Trauma-focused CBT (CPT) vs Dialogical exposure therapy (DET) was LOW due to serious risk of bias, and serious imprecision.

Certainty of evidence for Cognitive processing therapy (CPT) vs Prolonged exposure (PE) was LOW due to serious imprecision, and serious risk of bias.

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

Population: Adults with PTSD
Intervention: Trauma-focused CBT (CPT)
Comparator: Dialogical exposure therapy (DET)

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Dialogical exposure therapy (DET)	Trauma-focused CBT (CPT)		
PTSD symptom severity	Lower better Based on data from: 138 patients in 1 studies. (Randomized controlled)	Difference: SMD 0.39 lower (CI 95% 0.73 lower - 0.05 lower)		Low Due to serious risk of bias, Due to serious imprecision ¹	Trauma-focused CBT (CPT) may be more beneficial than DET for PTSD symptom severity

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** .

References

[310] Butollo W, Karl R, König J, Rosner R : A Randomized Controlled Clinical Trial of Dialogical Exposure Therapy versus Cognitive Processing Therapy for Adult Outpatients Suffering from PTSD after Type I Trauma in Adulthood.. Psychotherapy

and psychosomatics 2016;85(1):16-26 [Pubmed Journal](#)

[414] CBT-T (CPT) vs DET. [Website](#)

Clinical Question/ PICO

Population: Adults with PTSD
Intervention: Cognitive Processing Therapy
Comparator: Waitlist/ treatment as usual

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ as usual	Cognitive Processing Therapy		
PTSD symptom severity	Lower better Based on data from: 298 patients in 4 studies. (Randomized controlled)		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** .

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- [416] CPT vs WLTAU. [Website](#)

Clinical Question/ PICO

Population: Adults with PTSD
Intervention: Cognitive processing therapy (CPT)
Comparator: Prolonged exposure (PE)

Outcome Timeframe	Study results and measurements	Absolute effect estimates Prolonged exposure (PE) Cognitive processing therapy (CPT)	Certainty of the Evidence (Quality of evidence)	Plain text summary
PTSD symptom severity	Based on data from: 124 patients in 1 studies. (Randomized controlled)	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** .

References

[385] Resick PA, Nishith P, Weaver TL, Astin MC, Feuer CA : A comparison of cognitive-processing therapy with prolonged exposure and a waiting condition for the treatment of chronic posttraumatic stress disorder in female rape victims.. Journal of consulting and clinical psychology 2002;70(4):867-79 [Pubmed](#)

[415] CPT vs PE. [Website](#)

Cognitive therapy (CT)

Strong Recommendation

For adults with PTSD we recommend Cognitive Therapy (CT).

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 min for the initial sessions, and 60 minutes for the following sessions).^[324]

Key Info

Benefits and harms

Evidence from 4 RCTs [321][323][324][325] 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

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 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 the judgement of the Guideline Development Group that cognitive therapy has shown large clinically important benefits, has no associated harms, and has been widely used in clinical practice over several years. It was the Group'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.

Clinical Question/ PICO

Population: Adults with PTSD
Intervention: Cognitive Therapy
Comparator: Waitlist

Outcome Timeframe	Study results and measurements	Absolute effect estimates Waitlist Cognitive Therapy	Certainty of the Evidence (Quality of evidence)	Plain text summary
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<p>PTSD symptom severity</p> <p>Lower better Based on data from: 189 patients in 4 studies. (Randomized controlled)</p>	<p>Difference: SMD 1.32 lower (CI 95% 1.78 lower - 0.85 lower)</p>	<p>Low Due to serious imprecision, Due to serious risk of bias ¹</p> <p>Cognitive therapy may decrease PTSD symptom severity</p>
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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** .

References

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- [324] Ehlers A, Clark DM, Hackmann A, McManus F, Fennell M : Cognitive therapy for post-traumatic stress disorder: development and evaluation.. Behaviour research and therapy 2005;43(4):413-31 [Pubmed](#)
- [466] Cognitive Therapy vs WLTAU. [Website](#)

EMDR

Strong Recommendation

For adults with PTSD we recommend EMDR.

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.

Key Info

Benefits and harms

Evidence from 11 RCTs [295][297][313][318][343][348][362][381][388][389][403]) 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 [311][319][345][356][357][377][381][389][401][403], supportive counselling [391] and relaxation training [312][313][401][403].

Evidence suggests trivial unimportant differences between EMDR and EFT [351] or REM desensitisation [296].

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.

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.

Certainty of certainty of evidence for EMDR vs Supportive counselling was MODERATE due to serious imprecision.

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.

Certainty of certainty of evidence for EMDR vs Relaxation training was MODERATE due to serious imprecision.

Certainty of certainty of evidence for EMDR vs REM desensitization was VERY LOW due to serious risk of bias, and very serious imprecision.

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 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 EMDR due to the extensive 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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ treatment as usual	EMDR		
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 I²:70% 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** .

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[295] Acarturk C, Konuk E, Cetinkaya M, Senay I, Sijbrandij M, Gulen B, Cuijpers P : The efficacy of eye movement desensitization and reprocessing for post-traumatic stress disorder and depression among Syrian refugees: results of a randomized controlled trial.. *Psychological medicine* 2016;46(12):2583-93 [Pubmed](#) [Journal](#)

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posttraumatic stress disordered sexual assault victims.. Bulletin of the Menninger Clinic 1997;61(3):317-34 [Pubmed](#)

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[423] EMDR vs WLTAU. [Website](#)

Clinical Question/ PICO

Population: Adults with PTSD
Intervention: EMDR
Comparator: Trauma-focused CBT

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Trauma-focused CBT	EMDR		
PTSD symptom severity	Lower better Based on data from: 337 patients in 10 studies. (Randomized controlled)			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 EMDR and CBT-T on PTSD symptom severity

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 I²:60% ; **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** .

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[418] EMDR vs CBT-T. [Website](#)

Clinical Question/ PICO

Population: Adults with PTSD
Intervention: EMDR
Comparator: Supportive counselling

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Supportive counselling	EMDR		
PTSD symptom severity	Lower better Based on data from: 57 patients in 1 studies. (Randomized controlled)		Difference: SMD 0.75 lower (CI 95% 1.29 lower - 0.21 lower)	Moderate Due to serious imprecision ¹	EMDR is probably more beneficial than supportive counselling on PTSD symptom severity

1. **Inconsistency: No serious . Indirectness: No serious . Imprecision: Serious .** Low number of patients (n=57), Only data from one study ; **Publication bias: No serious .**

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[422] EMDR vs Supportive counselling. [Website](#)

Clinical Question/ PICO

Population: Adults with PTSD
Intervention: EMDR
Comparator: Emotional freedom techniques (EFT)

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Emotional freedom techniques (EFT)	EMDR		
PTSD symptom severity	Lower better Based on data from: 46 patients in 1 studies. (Randomized controlled)	Difference: SMD 0.08 higher (CI 95% 0.5 lower - 0.65 higher)		Very Low Due to serious risk of bias, Due to very serious imprecision ¹	We are uncertain if there is a difference between EMDR and EFT on PTSD symptom severity

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** .

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[419] EMDR vs Emotional freedom techniques. [Website](#)

Clinical Question/ PICO

Population: Adults with PTSD
Intervention: EMDR
Comparator: Relaxation training

Outcome Timeframe	Study results and measurements	Absolute effect estimates Relaxation training EMDR		Certainty of the Evidence (Quality of evidence)	Plain text summary
PTSD symptom severity	Lower better Based on data from: 117 patients in 4 studies. (Randomized controlled)	Difference: SMD 0.24 lower (CI 95% 0.61 lower - 0.13 higher)		Moderate Due to serious imprecision ¹	EMDR is probably more beneficial than relaxation training on PTSD symptom severity

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 .**

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- [420] EMDR vs Relaxation training. [Website](#)

Clinical Question/ PICO

Population: Adults with PTSD
Intervention: EMDR
Comparator: REM desensitisation

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		REM desensitisation	EMDR		
PTSD symptom severity	Lower better Based on data from: 21 patients in 1 studies. (Randomized controlled)	Difference: SMD 0.06 higher (CI 95% 0.8 lower - 0.91 higher)		Very Low Due to serious risk of bias, Due to very serious imprecision ¹	We are uncertain if there is a difference between EMDR and REM desensitization on PTSD symptom severity

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** .

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[421] EMDR vs REM Desensitization . [Website](#)

Prolonged exposure (PE)

Strong Recommendation

For adults with PTSD we recommend Prolonged Exposure.

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).

Key Info

Benefits and harms

Evidence from 12 RCTs [298][328][329][330][331][332][372][378][384][385][389][405] suggests a large clinically important benefit from PE on PTSD symptom severity in adults with PTSD.

Evidence from a single RCT [376] suggests a small unimportant difference between PE and a group psychoeducation intervention in adult veterans with PTSD

Certainty of the Evidence

Overall certainty of evidence for Prolonged Exposure was HIGH.

Certainty of evidence for Prolonged Exposure vs waitlist/treatment as usual was HIGH

Certainty of evidence for Prolonged Exposure vs Health Education was MODERATE due to serious imprecision.

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 high certainty evidence showing 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

- Population:** Adults with PTSD
- Intervention:** Prolonged Exposure
- Comparator:** Waitlist/ treatment as usual

Outcome Timeframe	Study results and measurements	Absolute effect estimates Waitlist/ treatment Prolonged Exposure	Certainty of the Evidence	Plain text summary
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			(Quality of evidence)	
PTSD symptom severity	Lower better Based on data from: 716 patients in 12 studies. (Randomized controlled)	Difference: SMD 1.51 lower (CI 95% 1.99 lower - 1.03 lower)	High 1	Prolonged exposure decreases PTSD symptom severity

1. **Risk of bias: No serious** . Completer data in 2 studies unlikely to impact effect size, 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 I²:85% 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** .

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[438] PE vs WLTAU. [Website](#)

Clinical Question/ PICO

Population: Adults with PTSD
Intervention: Prolonged exposure
Comparator: Health Education

Outcome Timeframe	Study results and measurements	Absolute effect estimates Health Education Prolonged exposure	Certainty of the Evidence (Quality of evidence)	Plain text summary
PTSD symptom severity	Lower better Based on data from: 134 patients in 1 studies. (Randomized controlled)	Difference: SMD 0.19 lower (CI 95% 0.53 lower - 0.15 higher)	Moderate Due to serious imprecision ¹	There is probably little or no difference between Prolonged exposure and health education on PTSD symptom severity

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 .**

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[464] Prolonged Exposure vs Health Education. [Website](#)

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.

Key Info

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) ([208][308][322][364][365][381][412]).

Certainty of the Evidence

Certainty of evidence for Trauma-focussed CBT vs waitlist/treatment as usual was MODERATE due to serious imprecision.

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 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 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.

Clinical Question/ PICO

Population: Adults with PTSD
Intervention: Trauma focused-CBT
Comparator: Waitlist/ treatment as usual

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ as usual	Trauma focused- CBT		
PTSD symptom severity	Lower better Based on data from: 291 patients in 7 studies. (Randomized controlled)		Difference: SMD 0.97 lower (CI 95% 1.32 lower - 0.63 lower)	Moderate Due to serious imprecision ¹	Trauma focused-CBT probably decreases PTSD symptom severity

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 ;

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PTSD in the context of chronic whiplash.. The Clinical journal of pain 28(9):755-65 [Pubmed Journal](#)

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.^[358] 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^{[346][358]}, 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.^[361] An example of the latter is DESTRESS-PC, a variant of CBT and stress inoculation training designed for symptoms resulting from military trauma.^[361]

Key Info

Benefits and harms

Evidence from 3 RCTs suggests large clinically important benefit from guided internet-based CBT-T relative to waitlist ^{[358][411]} or attention control ^[346].

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 ^[361].

Evidence from a single RCT suggests no important difference between guided internet-based CBT-T and internet-based psychotherapy ^[360].

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ treatment as usual	Guided internet- based trauma focused CBT		
PTSD symptom severity	Lower better Based on data from: 84 patients in 2 studies. (Randomized controlled)		Difference: SMD 1.12 lower (CI 95% 2.47 lower - 0.22 higher)	Low Due to serious imprecision, Due to serious inconsistency, Due to serious inconsistency ¹	Guided internet-based trauma focused CBT may decrease PTSD symptom severity

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 I²:87% 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 .

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[429] Guided internet-based CBT vs WLTAU. [Website](#)

Clinical Question/ PICO

Population: Adults with PTSD
Intervention: Guided internet-based trauma focused CBT
Comparator: Attention control

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Attention control	Guided internet-based trauma focused CBT		
PTSD symptom severity	Lower better Based on data from: 62 patients in 1 studies. (Randomized controlled)		Difference: SMD 1.05 lower (CI 95% 1.59 lower - 0.52 lower)	Moderate Due to serious imprecision ¹	Guided internet-based trauma focused CBT is probably more beneficial than attention control for decreasing PTSD symptom severity

1. **Inconsistency:** No serious . **Indirectness:** No serious . **Imprecision:** Serious . Low number of patients (n=62) ; **Publication bias:** No serious .

References

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[429] Guided internet-based CBT vs WLTAU. [Website](#)

Clinical Question/ PICO

Population: Adults with PTSD
Intervention: Guided internet-based trauma-focused CBT
Comparator: Internet-based non-trauma-focused supportive counselling

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Internet-based non- trauma-focused supportive counselling	Guided internet- based trauma- focused CBT		
PTSD symptom severity	Lower better Based on data from: 31 patients in 1 studies. (Randomized controlled)	Difference: SMD 0.4 lower (CI 95% 1.12 lower - 0.31 higher)		Very Low Due to serious risk of bias, Due to very serious imprecision ¹	We are uncertain if there is a difference between guided internet-based trauma- focused CBT and Internet-based non- trauma-focused supportive counselling on PTSD symptom severity

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**

References

[361] Litz BT, Engel CC, Bryant RA, Papa A : A randomized, controlled proof-of-concept trial of an Internet-based, therapist-assisted self-management treatment for posttraumatic stress disorder.. The American journal of psychiatry 2007;164(11):1676-83 [Pubmed](#)

[430] Internet-based CBT-T vs Internet based non-trauma-focused supportive counselling. [Website](#)

Clinical Question/ PICO

Population: Adults with PTSD

Intervention: Guided internet-based trauma-focused CBT
Comparator: Internet-based psychoeducation

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Internet-based psychoeducation	Guided internet- based trauma- focused CBT		
PTSD symptom severity	Lower better Based on data from: 51 patients in 1 studies. (Randomized controlled)	Difference: SMD 0.11 higher (CI 95% 0.45 lower - 0.66 higher)		Very Low Due to serious risk of bias, Due to very serious imprecision ¹	We are uncertain if there is a difference between guided internet-based trauma- focused CBT and Internet-based psychoeducation on PTSD symptom severity

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** .

References

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- [431] Internet-based CBT-T vs Internet-based psychoeducation . [Website](#)

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.[347][399]

Key Info

Benefits and harms

Evidence from 7 RCTs [296][303][347][370][375][399][407][408] 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.

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

Population: Adults with PTSD
Intervention: Narrative Exposure Therapy (NET)
Comparator: Waitlist/ treatment as usual

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ treatment as usual	Narrative Exposure Therapy (NET)		
PTSD symptom severity	Lower better Based on data from: 252 patients in 7 studies. (Randomized controlled)			Low Due to serious risk of bias, Due to serious imprecision ¹	Narrative exposure therapy (NET) may decrease PTSD symptom severity

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 I²:77% 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** .

References

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[303] Bichescu D, Neuner F, Schauer M, Elbert T : Narrative exposure therapy for political imprisonment-related chronic posttraumatic stress disorder and depression.. Behaviour research and therapy 2007;45(9):2212-20 [Pubmed](#)

[347] Jacob N, Neuner F, Maedl A, Schaal S, Elbert T : Dissemination of psychotherapy for trauma spectrum disorders in postconflict settings: a randomized controlled trial in Rwanda.. Psychotherapy and psychosomatics 2014;83(6):354-63 [Pubmed Journal](#)

[370] Morath J, Gola H, Sommershof A, Hamuni G, Kolassa S, Catani C, Adenauer H, Ruf-Leuschner M, Schauer M, Elbert T, Groettrup M, Kolassa I-T : The effect of trauma-focused therapy on the altered T cell distribution in individuals with PTSD: evidence from a randomized controlled trial.. Journal of psychiatric research 2014;54 1-10 [Pubmed Journal](#)

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[399] Stenmark H, Catani C, Neuner F, Elbert T, Holen A : Treating PTSD in refugees and asylum seekers within the general health care system. A randomized controlled multicenter study.. *Behaviour research and therapy* 2013;51(10):641-7 [Pubmed Journal](#)

[408] Zang Y, Hunt N, Cox T : Adapting narrative exposure therapy for Chinese earthquake survivors: a pilot randomised controlled feasibility study.. *BMC psychiatry* 2014;14 262 [Pubmed Journal](#)

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.

Key Info

Benefits and harms

Evidence from 3 RCTs suggests moderate clinically important benefit of PCT on PTSD symptom severity relative to waitlist [334][365] and no difference between PCT and non-trauma-focused CBT [334].

Evidence from 5 RCTs suggests CBT-T is more beneficial than PCT on PTSD symptom severity [331][365][382][393][400].

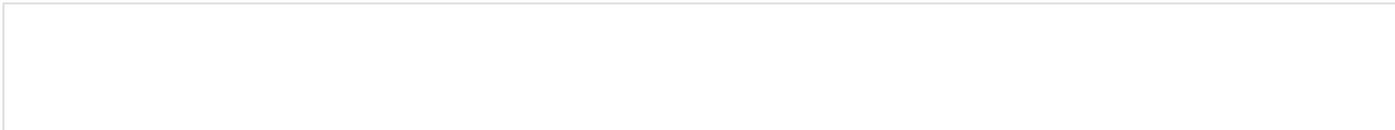
Certainty of the Evidence

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.

Certainty of evidence for Present Centred Therapy vs Trauma-focused CBT was LOW due to serious inconsistency and serious imprecision.

Certainty of evidence for Present Centred Therapy vs Non-trauma-focused CBT was LOW due to very serious imprecision.



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.

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.

Clinical Question/ PICO

- Population:** Adults with PTSD
- Intervention:** Trauma-focused CBT
- Comparator:** Present Centred Therapy

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Present Centred Therapy	Trauma-focused CBT		
PTSD symptom severity	Lower better Based on data from: 649 patients in 5 studies. (Randomized controlled)			Low Due to serious inconsistency, Due to serious imprecision ¹	Trauma-focused CBT may be more beneficial than PCT on PTSD symptom severity

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 I²:74% . ; **Imprecision: Serious** . Wide confidence intervals (CI includes important benefit and unimportant benefit) ;

References

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[382] Rauch SAM, King AP, Abelson J, Tuerk PW, Smith E, Rothbaum BO, Clifton E, Defever A, Liberzon I : Biological and symptom changes in posttraumatic stress disorder treatment: a randomized clinical trial.. Depression and anxiety 2015;32(3):204-12 [Pubmed Journal](#)

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[454] CBT-T vs PCT. [Website](#)

Clinical Question/ PICO

Population: Adults with PTSD
Intervention: Non-trauma-focused CBT
Comparator: Present centred therapy (PCT)

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Present centred therapy (PCT)	Non-trauma-focused CBT		
PTSD symptom severity	Lower better Based on data from: 101 patients in 1 studies. (Randomized controlled)		Difference: SMD 0.04 lower (CI 95% 0.43 lower - 0.35 higher)	Low Due to very serious imprecision ¹	There may be little or no difference between Non-trauma focused CBT and PCT on PTSD symptom severity

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** .

References

[334] Ford JD, Steinberg KL, Zhang W : A randomized clinical trial comparing affect regulation and social problem-solving

psychotherapies for mothers with victimization-related PTSD.. Behavior therapy 2011;42(4):560-78 [Pubmed Journal](#)
 [434] Non-CBT-T vs PCT. [Website](#)

Clinical Question/ PICO

Population: Adults with PTSD
Intervention: Present centred therapy
Comparator: Waitlist/ treatment as usual

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ treatment as usual	Present centred therapy		
PTSD symptom severity	Lower better Based on data from: 138 patients in 2 studies. (Randomized controlled)			Moderate Due to serious imprecision ¹	Present centred therapy probably decreases PTSD symptom severity

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** .

References

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 [365] McDonagh A, Friedman M, McHugo G, Julian F, Sengupta A, Mueser K, Demment C, Fournier D, Schnurr P, Descamps M : McDonagh, A., Friedman, M., McHugo, G., Ford, J., Sengupta, A., Mueser, K., ... & Descamps, M. (2005). Randomized trial of cognitive-behavioral therapy for chronic posttraumatic stress disorder in adult female survivors of childhood sexual abuse. Journal of consulting and clinical psychology, 73(3), 515.. [Pubmed Journal](#)

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.^[329]

Key Info

Benefits and harms

Evidence from 2 RCTs suggests large clinically important benefit of SIT on PTSD symptom severity relative to waitlist [328][329] or supportive counselling [328].

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.

Certainty of evidence for Stress inoculation training vs Supportive counselling was VERY LOW due to serious risk of bias, and very serious imprecision.

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

Population: Adults with PTSD
Intervention: Stress inoculation training (SIT)
Comparator: Supportive counselling

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Supportive counselling	Stress inoculation training (SIT)		
PTSD symptom severity	Lower better Based on data from: 25 patients in 1 studies. (Randomized controlled)	Difference: SMD 1.22 lower (CI 95% 2.09 lower - 0.35 lower)		Very Low Due to serious risk of bias, Due to very serious imprecision ¹	We are uncertain if there is a difference between SIT and supportive counselling on PTSD symptom severity

1. **Risk of bias: Serious** . Incomplete data and large loss to follow up ; **Imprecision: Very Serious** . Low number of patients (n=25) ;

References

[328] Foa EB, Rothbaum BO, Riggs DS, Murdock TB : Treatment of posttraumatic stress disorder in rape victims: a comparison between cognitive-behavioral procedures and counseling.. Journal of consulting and clinical psychology 1991;59(5):715-23 [PubMed](#)

Clinical Question/ PICO

Population: Adults with PTSD
Intervention: Stress Inoculation Therapy
Comparator: Waitlist/ treatment as usual

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ treatment as usual	Stress Inoculation Therapy		
PTSD symptom severity	Lower better Based on data from: 58 patients in 2 studies. (Randomized controlled)	Difference: SMD 1.53 lower (CI 95% 2.13 lower - 0.93 lower)		Low Due to serious risk of bias, Due to serious imprecision ¹	Stress inoculation therapy may decrease PTSD symptom severity

1. **Risk of bias: Serious** . Incomplete data and/or large loss to follow up ; **Inconsistency: No serious** . **Indirectness: No serious** . **Imprecision: Serious** . Low number of patients (n=58) ; **Publication bias: No serious** .

References

[328] Foa EB, Rothbaum BO, Riggs DS, Murdock TB : Treatment of posttraumatic stress disorder in rape victims: a comparison between cognitive-behavioral procedures and counseling.. Journal of consulting and clinical psychology 1991;59(5):715-23 [Pubmed](#)

[329] Foa EB, Dancu CV, Hembree EA, Jaycox LH, Meadows EA, Street GP : A comparison of exposure therapy, stress inoculation training, and their combination for reducing posttraumatic stress disorder in female assault victims.. Journal of consulting and clinical psychology 1999;67(2):194-200 [Pubmed](#)

[461] SIT vs WLTAU. [Website](#)

Trauma-focussed CBT (group)

Conditional Recommendation

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

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 [397][387], Beck's CBT and other protocols^[314]. All treatment interventions require (to varying degrees) engagement with the traumatic memory, opportunities for cognitive restructuring, and skills aiming to reduce avoidance.

Key Info

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 [298][302][314][326][410] or applied muscle relaxation [342].

Evidence from 3 RCTs found no important difference between group CBT-T and Group CPT [386][392][397].

Evidence from a single RCT found individual CBT-T had a small important benefit above that of Group CBT-T [387].

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.

Certainty of evidence for Group Trauma-Focused CBT vs Group present centred therapy was LOW due to serious risk of bias, and serious imprecision

Certainty of evidence for Group Trauma-Focused CBT vs Individual trauma-focused CBT was MODERATE due to serious imprecision.

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.

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.

Clinical Question/ PICO

- Population:** Adults with PTSD
- Intervention:** Group trauma-focused CBT
- Comparator:** Waitlist/ treatment as usual

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ treatment as usual	Group trauma-focused CBT		
PTSD symptom severity	Lower better	Difference: SMD 1.01 lower		Low Due to serious	Group trauma-focused CBT may decrease PTSD

Based on data from: 247 patients in 5 studies. (Randomized controlled)	(CI 95% 1.28 lower - 0.74 lower)	risk of bias, Due to serious imprecision ¹	symptom severity
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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** .

References

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[410] Hollifield M, Sinclair-Lian N, Warner T, Hammerschlag R : Hollifield, M., Sinclair-Lian, N., Warner, T. D., & Hammerschlag, R. (2007). Acupuncture for posttraumatic stress disorder: a randomized controlled pilot trial. *The Journal of nervous and mental disease*, 195(6), 504-513.. [Pubmed](#)

Clinical Question/ PICO

Population: Adults with PTSD
Intervention: Group trauma-focused CBT
Comparator: Group present centred therapy

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Group present centred therapy	Group trauma-focused CBT		
PTSD symptom severity	Lower better Based on data from: 617 patients in 3 studies. (Randomized controlled)		Difference: SMD 0.14 lower (CI 95% 0.3 lower - 0.02 higher)	Low Due to serious risk of bias, Due to serious imprecision ¹	Group trauma-focused CBT may have little or no difference on PTSD symptom severity

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 I²:96% . ; **Imprecision: Serious** . Wide confidence intervals (CIs include important benefit and

unimportant harm) ;

References

[386] Resick PA, Wachen JS, Mintz J, Young-McCaughan S, Roache JD, Borah AM, Borah EV, Dondanville KA, Hembree EA, Litz BT, Peterson AL : A randomized clinical trial of group cognitive processing therapy compared with group present-centered therapy for PTSD among active duty military personnel.. Journal of consulting and clinical psychology 2015;83(6):1058-1068 [Pubmed Journal](#)

[392] Schnurr PP, Friedman MJ, Foy DW, Shea MT, Hsieh FY, Lavori PW, Glynn SM, Wattenberg M, Bernardy NC : Randomized trial of trauma-focused group therapy for posttraumatic stress disorder: results from a department of veterans affairs cooperative study.. Archives of general psychiatry 2003;60(5):481-9 [Pubmed](#)

[397] Sloan DM, Unger W, Lee DJ, Beck JG : A Randomized Controlled Trial of Group Cognitive Behavioral Treatment for Veterans Diagnosed With Chronic Posttraumatic Stress Disorder.. Journal of traumatic stress 2018;31(6):886-898 [Pubmed Journal](#)

[425] Group CBT-T vs Group PCT. [Website](#)

Clinical Question/ PICO

Population: Adults with PTSD
Intervention: Group trauma-focused CBT
Comparator: Individual trauma-focused CBT

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Individual trauma-focused CBT	Group trauma-focused CBT		
PTSD symptom severity	Lower better Based on data from: 268 patients in 1 studies. (Randomized controlled)	Difference: SMD 0.35 higher (CI 95% 0.11 higher - 0.59 higher)		Moderate Due to serious imprecision ¹	Group trauma-focused CBT is probably not as effective as individual trauma-focused CBT on PTSD symptom severity

1. **Inconsistency: No serious . Indirectness: No serious . Imprecision: Serious .** Low number of patients (n=268), Wide confidence intervals (CIs include unimportant harm and important hard), Only data from one study ; **Publication bias: No serious**

References

[387] Resick PA, Wachen JS, Dondanville KA, Pruiksma KE, Yarvis JS, Peterson AL, Mintz J, , Borah EV, Brundige A, Hembree EA, Litz BT, Roache JD, Young-McCaughan S : Effect of Group vs Individual Cognitive Processing Therapy in Active-Duty Military Seeking Treatment for Posttraumatic Stress Disorder: A Randomized Clinical Trial.. JAMA psychiatry 2017;74(1):28-36 [Pubmed Journal](#)

[426] Group CBT-T vs Individual CBT-T. [Website](#)

Couples trauma-focused 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 may be used in a research context.

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.^[369]

Key Info

Benefits and harms

Evidence from a single RCT [369] suggests large clinically important benefit from couples CBT-T on PTSD symptom severity relative to waitlist.

Certainty of the Evidence

Certainty of evidence is LOW due to very serious imprecision.

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	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ treatment as usual	Couples CBT with a trauma focus		
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 .

References

[369] Monson CM, Fredman SJ, Macdonald A, Pukay-Martin ND, Resick PA, Schnurr PP : Effect of cognitive-behavioral couple therapy for PTSD: a randomized controlled trial.. JAMA 2012;308(7):700-9 [Pubmed Journal](#)

[413] Couples CBT-T vs WLTAU. [Website](#)

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 may 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.^[315]

Key Info

Benefits and harms

Evidence from a single RCT suggests a large, clinically important benefit on PTSD symptom severity compared to waitlist controls [315].

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 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

Population: Adults with PTSD
Intervention: Group and individual CBT with a trauma focus
Comparator: Waitlist/ treatment as usual

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ treatment as usual	Group and individual CBT with a trauma focus		
PTSD symptom severity	Lower better Based on data from: 55 patients in 1 studies. (Randomized controlled)	Difference: SMD 2.32 lower (CI 95% 3.02 lower - 1.63 lower)		Low Due to serious risk of bias, Due to serious imprecision ¹	Group and individual CBT with a trauma focus may decrease PTSD symptom severity

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** .

References

- [315] Chard KM : An evaluation of cognitive processing therapy for the treatment of posttraumatic stress disorder related to childhood sexual abuse.. Journal of consulting and clinical psychology 2005;73(5):965-71 [Pubmed](#)
- [424] Group and individual CBT-T (combined) vs WLTAU. [Website](#)

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.[405]

Key Info

Benefits and harms

Evidence from 2 RCTs suggests large clinically important benefit of meta-cognitive therapy on PTSD symptom severity relative to waitlist [404][405].

Certainty of the Evidence

Certainty of evidence is VERY LOW for meta-cognitive therapy due to serious risk of bias, and very serious imprecision.

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

Population: Adults with PTSD
Intervention: Metacognitive Therapy
Comparator: Waitlist/ treatment as usual

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ treatment as usual	Metacognitive Therapy		
PTSD symptom severity	Lower better Based on data from: 40 patients in 2 studies. (Randomized controlled)	Difference: SMD 2.36 lower (CI 95% 4.22 lower - 0.51 lower)		Very Low Due to serious risk of bias, Due to very serious imprecision ¹	We are uncertain whether metacognitive therapy increases or decreases PTSD symptom severity

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 I²: 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** .

References

[338] Gersons BP, Carlier IV, Lamberts RD, van der Kolk BA : Randomized clinical trial of brief eclectic psychotherapy for police officers with posttraumatic stress disorder.. Journal of traumatic stress 2000;13(2):333-47 [Pubmed](#)

[394] Schnyder U, Muller J, Maercker A, Wittmann L : Schnyder, U., Müller, J., Maercker, A., & Wittmann, L. (2011, April). Brief eclectic psychotherapy for PTSD: a randomized controlled trial. In National conference on psychotherapy, 3rd, May, 2010, Jakarta, Indonesia; Presented at the aforementioned conference, and the 20th IFP World Congress of Psychotherapy, June 16-19, 2010, Lucerne, Switzerland.. Physicians Postgraduate Press.. [Pubmed](#)

[404] Wells A, Colbear JS : Treating posttraumatic stress disorder with metacognitive therapy: a preliminary controlled trial.. Journal of clinical psychology 2012;68(4):373-81 [Pubmed](#) [Journal](#)

[405] Wells A, Walton D, Lovell K, Proctor D : Wells, A., Walton, D., Lovell, K., & Proctor, D. (2015). Metacognitive therapy versus prolonged exposure in adults with chronic post-traumatic stress disorder: A parallel randomized controlled trial. Cognitive Therapy and Research, 39(1), 70-80.. [Journal](#)

[460] Metacognitive Therapy vs WLTAU. [Website](#)

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.^{[409][334]}

Key Info

Benefits and harms

Evidence from 2 RCTs suggests large clinically important benefit of Non-trauma-focussed CBT on PTSD symptom severity relative to waitlist [334][409].

No clinically important difference was found between Non-trauma-focussed CBT and PCT [334].

Certainty of the Evidence

Overallly 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.

Certainty of evidence for non-trauma-focused CBT vs Present centred therapy (PCT) was LOW due to very serious imprecision.

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist	Non-trauma-focused CBT		
PTSD symptom severity	Lower better Based on data from: 126 patients in 2 studies. (Randomized controlled)	Difference: SMD 0.93 lower (CI 95% 1.3 lower - 0.56 lower)		Low Due to serious imprecision, Due to serious risk of bias ¹	Non-CBT-T may decrease PTSD symptom severity

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** .

References

[334] Ford JD, Steinberg KL, Zhang W : A randomized clinical trial comparing affect regulation and social problem-solving psychotherapies for mothers with victimization-related PTSD.. Behavior therapy 2011;42(4):560-78 [Pubmed](#) [Journal](#)

[404] Wells A, Colbear JS : Treating posttraumatic stress disorder with metacognitive therapy: a preliminary controlled trial.. Journal of clinical psychology 2012;68(4):373-81 [Pubmed](#) [Journal](#)

[405] Wells A, Walton D, Lovell K, Prcotor D : Wells, A., Walton, D., Lovell, K., & Proctor, D. (2015). Metacognitive therapy versus prolonged exposure in adults with chronic post-traumatic stress disorder: A parallel randomized controlled trial. Cognitive Therapy and Research, 39(1), 70-80.. [Journal](#)

[409] Zlotnick C, Shea TM, Rosen K, Simpson E, Mulrenin K, Begin A, Pearlstein T : An affect-management group for women with posttraumatic stress disorder and histories of childhood sexual abuse.. Journal of traumatic stress 1997;10(3):425-36 [Pubmed](#)

[462] Non-CBT-T vs WLTAU. [Website](#)

Clinical Question/ PICO

Population: Adults with PTSD
Intervention: Non-trauma-focused CBT
Comparator: Present centred therapy (PCT)

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Present centred therapy (PCT)	Non-trauma-focused CBT		
PTSD symptom	Lower better			Low	There may be little or no difference between

severity	Based on data from: 101 patients in 1 studies. (Randomized controlled)	Difference: SMD 0.04 lower (CI 95% 0.43 lower - 0.35 higher)	Due to very serious imprecision ¹	Non-trauma focused CBT and PCT on PTSD symptom severity
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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** .

References

- [334] Ford JD, Steinberg KL, Zhang W : A randomized clinical trial comparing affect regulation and social problem-solving psychotherapies for mothers with victimization-related PTSD.. Behavior therapy 2011;42(4):560-78 [Pubmed Journal](#)
- [434] Non-CBT-T vs PCT. [Website](#)

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.^{[402][339]}

Key Info

Benefits and harms

Evidence from 2 RCTs [339][402] 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.

Rationale

The Guideline Development Group considered the evidence showing clinically important benefit of Reconsolidation of Trauma 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

Outcome Timeframe	Study results and measurements	Absolute effect estimates Waitlist/ treatment as usual Reconsolidation of traumatic memories (RTM)		Certainty of the Evidence (Quality of evidence)	Plain text summary
PTSD symptom severity	Lower better Based on data from: 99 patients in 2 studies. (Randomized controlled)	Difference: SMD 2.69 lower (CI 95% 4 lower - 1.37 lower)		Moderate Due to serious imprecision ¹	Reconsolidation of traumatic memories (RTM) probably decreases PTSD symptom severity

1. **Inconsistency: No serious** . The magnitude of statistical heterogeneity was high, with I²:75% 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** .

References

[339] Gray R, Budden-Potts D, Bourke F : Reconsolidation of Traumatic Memories for PTSD: A randomized controlled trial of 74 male veterans.. *Psychotherapy research : journal of the Society for Psychotherapy Research* 2019;29(5):621-639 [Pubmed Journal](#)

[402] Tylee D, Gray R, Glatt S, Bourke F : Tylee, D. S., Gray, R., Glatt, S. J., & Bourke, F. (2017). Evaluation of the reconsolidation of traumatic memories protocol for the treatment of PTSD: a randomized, wait-list-controlled trial. *Journal of Military, Veteran and Family Health*, 3(1), 21-33.. [Journal](#)

[442] RTM vs WLTAU. [Website](#)

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 may 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. [301][300]

Key Info

Benefits and harms

Evidence from 2 RCTs [300][301] 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

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

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.

Clinical Question/ PICO

- Population:** Adults with PTSD
Intervention: Single Session CBT-T
Comparator: Waitlist/ treatment as usual

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ treatment as usual	Single Session CBT- T		
PTSD symptom severity	Lower better Based on data from: 90 patients in 2 studies. (Randomized controlled)	Difference: SMD 0.57 lower (CI 95% 1 lower - 0.15 lower)		Low Due to serious risk of bias, Due to serious imprecision ¹	Single session CBT-T may decrease PTSD symptom severity slightly

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** .

References

[300] Basoglu M, Salcioglu E, Livanou M, Kalender D, Acar G : Single-session behavioral treatment of earthquake-related posttraumatic stress disorder: A randomised waiting list controlled trial. [Pubmed Journal](#)

[301] Başoglu M, Salcioglu E, Livanou M : A randomized controlled study of single-session behavioural treatment of earthquake-related post-traumatic stress disorder using an earthquake simulator.. Psychological medicine 2007;37(2):203-13 [Pubmed](#)

[443] Single session CBT vs WLTAU. [Website](#)

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 may be used in a research context.

Virtual Reality therapies, such as virtual reality exposure (VRE^[384]) and VR-graded exposure therapy (VR-GET^[366]) 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.

Key Info

Benefits and harms

Evidence from three RCTs [337][366][384] suggest small clinically unimportant benefit of virtual reality therapy on PTSD symptoms in active military soldiers relative to waitlist.

Evidence from 2 RCTs [384][367] found no difference between virtual reality therapy and control exposure.

Evidence from a single RCT [383] 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.

Certainty of evidence for Virtual Reality Therapy vs Control exposure was VERY LOW due to serious inconsistency, and very serious imprecision.

Certainty of evidence for Virtual Reality Therapy vs Present centred therapy was LOW due to very serious imprecision.

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 Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ treatment as usual	Virtual Reality Therapy		
PTSD symptom severity	Lower better Based on data from: 104 patients in 3 studies. (Randomized controlled)			Low Due to serious risk of bias, Due to serious imprecision ¹	Virtual reality therapy may decrease PTSD symptom severity slightly

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** .

References

[337] Gamito P, Oliveira J, Rosa P, Morais D, Duarte N, Oliveira S, Saraiva T : PTSD elderly war veterans: a clinical controlled pilot study.. *Cyberpsychology, behavior and social networking* 2010;13(1):43-8 [Pubmed](#)

[366] McLay RN, Wood DP, Webb-Murphy JA, Spira JL, Wiederhold MD, Pyne JM, Wiederhold BK : A randomized, controlled trial of virtual reality-graded exposure therapy for post-traumatic stress disorder in active duty service members with combat-related post-traumatic stress disorder.. *Cyberpsychology, behavior and social networking* 2011;14(4):223-9 [Pubmed](#) [Journal](#)

[384] Reger GM, Koenen-Woods P, Zetocha K, Smolenski DJ, Holloway KM, Rothbaum BO, Difede J, Rizzo AA, Edwards-Stewart A, Skopp NA, Mishkind M, Reger MA, Gahm GA : Randomized controlled trial of prolonged exposure using imaginal exposure vs. virtual reality exposure in active duty soldiers with deployment-related posttraumatic stress disorder (PTSD).. *Journal of consulting and clinical psychology* 2016;84(11):946-959 [Pubmed](#) [Journal](#)

[450] VR-exposure vs WLTAU. [Website](#)

Clinical Question/ PICO

Population: Adults with PTSD
Intervention: Virtual reality therapy
Comparator: Control exposure

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Control exposure	Virtual reality therapy		
PTSD symptom severity	Lower better Based on data from: 147 patients in 2 studies. (Randomized controlled)	Difference: SMD 0.01 higher (CI 95% 0.68 lower - 0.71 higher)		Very Low Due to serious inconsistency, Due to very serious imprecision ¹	We are uncertain whether virtual reality therapy increases or decreases PTSD symptom severity

1. **Inconsistency: Serious** . The magnitude of statistical heterogeneity was high, with $I^2:78\%$. ; **Indirectness: No serious** .
Imprecision: Very Serious . Low number of patients (n=147), Wide confidence intervals (CIs include important benefit and important harm) ; **Publication bias: No serious** .

References

[367] McLay RN, Baird A, Webb-Murphy J, Deal W, Tran L, Anson H, Klam W, Johnston S : A Randomized, Head-to-Head Study of Virtual Reality Exposure Therapy for Posttraumatic Stress Disorder.. *Cyberpsychology, behavior and social networking* 2017;20(4):218-224 [Pubmed](#) [Journal](#)

[384] Reger GM, Koenen-Woods P, Zetocha K, Smolenski DJ, Holloway KM, Rothbaum BO, Difede J, Rizzo AA, Edwards-Stewart A, Skopp NA, Mishkind M, Reger MA, Gahm GA : Randomized controlled trial of prolonged exposure using imaginal exposure vs. virtual reality exposure in active duty soldiers with deployment-related posttraumatic stress disorder (PTSD).. *Journal of consulting and clinical psychology* 2016;84(11):946-959 [Pubmed](#) [Journal](#)

[448] VR-Exposure vs Control exposure therapy. [Website](#)

Clinical Question/ PICO

Population: Adults with PTSD
Intervention: Virtual reality therapy
Comparator: Present centred therapy

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Present centred therapy	Virtual reality therapy		
PTSD symptom severity	Lower better Based on data from: 9 patients in 1 studies. (Randomized controlled)	Difference: SMD 0.51 lower (CI 95% 1.86 lower - 0.84 higher)		Low Due to very serious imprecision ¹	Virtual reality therapy may be more beneficial than PCT on PTSD symptom severity

1. **Inconsistency: No serious . Indirectness: No serious . Imprecision: Very Serious .** Low number of patients (n=9), Wide confidence intervals (CIs include important benefit and important harm), Only data from one study ; **Publication bias: No serious**

References

[383] Ready D, Geradi R, Backscheider A, Mascaro N, Rothbaum B : Comparing Virtual Reality Exposure Therapy to Present-Centered Therapy with 11 U.S. Vietnam Veterans with PTSD. [Pubmed](#)

[449] VR-Exposure vs Present centred therapy. [Website](#)

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 may be used in a research context.

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.

Key Info

Benefits and harms

Evidence from a single RCT [395] suggests a large clinically important benefit from written exposure therapy on PTSD symptom severity relative to waitlist.

Evidence from a single RCT [397] 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.

Certainty of evidence for Written exposure therapy vs Trauma-focused CBT was LOW due to very serious imprecision.

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ treatment as usual	Written exposure therapy		
PTSD symptom severity	Lower better Based on data from: 46 patients in 1 studies. (Randomized controlled)		Difference: SMD 3.35 lower (CI 95% 4.27 lower - 2.43 lower)	Low Due to very serious imprecision ¹	Written exposure therapy may decrease PTSD symptom severity

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 .**

References

[395] Sloan DM, Marx BP, Bovin MJ, Feinstein BA, Gallagher MW : Written exposure as an intervention for PTSD: a randomized clinical trial with motor vehicle accident survivors.. Behaviour research and therapy 2012;50(10):627-35
[Pubmed Journal](#)

[452] WET vs WLTAU. [Website](#)

Clinical Question/ PICO

Population: Adults with PTSD
Intervention: Written exposure therapy
Comparator: Trauma-focused CBT

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Trauma-focused CBT	Written exposure therapy		
PTSD symptom severity	Lower better Based on data from: 126 patients in 1 studies. (Randomized controlled)	Difference: SMD 0.13 higher (CI 95% 0.21 lower - 0.48 higher)		Low Due to very serious imprecision ¹	There may be little or no difference between Written exposure therapy and Trauma- focused CBT on PTSD symptom severity

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**

References

[396] Sloan DM, Marx BP, Lee DJ, Resick PA : A Brief Exposure-Based Treatment vs Cognitive Processing Therapy for Posttraumatic Stress Disorder: A Randomized Noninferiority Clinical Trial.. JAMA psychiatry 2018;75(3):233-239 [Pubmed Journal](#)

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ treatment as usual	Brief Eclectic Psychotherapy		
PTSD symptom severity	Lower better Based on data from: 72 patients in 2 studies. (Randomized controlled)	Difference: SMD 0.38 lower (CI 95% 0.85 lower - 0.09 higher)		Moderate Due to serious imprecision ¹	Brief eclectic psychotherapy probably decreases PTSD symptom severity slightly

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 .**

References

[338] Gersons BP, Carlier IV, Lamberts RD, van der Kolk BA : Randomized clinical trial of brief eclectic psychotherapy for police officers with posttraumatic stress disorder.. Journal of traumatic stress 2000;13(2):333-47 [Pubmed](#)

[394] Schnyder U, Muller J, Maercker A, Wittmann L : Schnyder, U., Müller, J., Maercker, A., & Wittmann, L. (2011, April). Brief eclectic psychotherapy for PTSD: a randomized controlled trial. In National conference on psychotherapy, 3rd, May, 2010, Jakarta, Indonesia; Presented at the aforementioned conference, and the 20th IFP World Congress of Psychotherapy, June 16-19, 2010, Lucerne, Switzerland.. Physicians Postgraduate Press.. [Pubmed](#)

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ treatment as usual	Supportive counselling		
PTSD symptom severity	Lower better Based on data from: 72 patients in 2 studies. (Randomized controlled)	Difference: SMD 0.43 lower (CI 95% 0.9 lower - 0.04 higher)		Low Due to serious risk of bias, Due to serious imprecision ¹	Supportive counselling may decrease PTSD symptom severity slightly

1. **Risk of bias: Serious** . Inadequate sequence generation, resulting in potential for selection bias, Incomplete data and large unbalanced loss to follow up, Missing intention-to-treat analysis ; **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** .

References

[304] Blanchard EB, Hickling EJ, Devineni T, Veazey CH, Galovski TE, Mundy E, Malta LS, Buckley TC : A controlled evaluation of cognitive behavioural therapy for posttraumatic stress in motor vehicle accident survivors.. Behaviour research and therapy 2003;41(1):79-96 [Pubmed](#)

[328] Foa EB, Rothbaum BO, Riggs DS, Murdock TB : Treatment of posttraumatic stress disorder in rape victims: a comparison between cognitive-behavioral procedures and counseling.. Journal of consulting and clinical psychology 1991;59(5):715-23 [Pubmed](#)

[446] Supportive counselling vs WLTAU. [Website](#)

Clinical Question/ PICO

Population: Adults with PTSD
Intervention: Supportive counselling
Comparator: Psychoeducation

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Psychoeducation	Supportive counselling		
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** .

References

[373] Neuner F, Schauer M, Klaschik C, Karunakara U, Elbert T : Neuner, F., Schauer, M., Klaschik, C., Karunakara, U., & Elbert, T. (2004). A comparison of narrative exposure therapy, supportive counseling, and psychoeducation for treating posttraumatic stress disorder in an african refugee settlement. *Journal of consulting and clinical psychology*, 72(4), 579.. [Pubmed](#)

[445] Supportive Counselling vs Psychoeducation. [Website](#)

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
Comparator: Waitlist/ treatment as usual

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ treatment as usual	Psychodynamic therapy		
PTSD symptom severity	Lower better Based on data from: 52 patients in 1 studies. (Randomized controlled)		Difference: SMD 0.41 lower (CI 95% 0.96 lower - 0.14 higher)	Low Due to serious risk of bias, Due to serious imprecision ¹	Psychodynamic therapy may decrease PTSD symptom severity slightly

1. **Risk of bias: Serious** . Incomplete data and/or large loss to follow up There were no reported reasons for drop-out. Inadequate statistical correction for these drop-outs. Inadequate reporting of baseline characteristics. Each treatment arm had its own dedicated therapists (i.e. differences in outcome may have been attributable to expertise as opposed to the intervention). ; **Inconsistency: No serious** . **Indirectness: No serious** . **Imprecision: Serious** . Low number of patients (n=52), Wide confidence intervals (CIs include important benefit and unimportant harm), Only data from one study ; **Publication bias: No serious** .

References

- [306] Brom D, Kleber R, Defares P : Brom, D., Kleber, R. J., & Defares, P. B. (1989). Brief psychotherapy for posttraumatic stress disorders. *Journal of consulting and clinical psychology*, 57(5), 607.. [Pubmed](#)
- [440] Psychodynamic therapy vs WLTAU. [Website](#)

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

- Population:** Adults with PTSD
- Intervention:** Observed and experiential integration (OEI)
- Comparator:** Waitlist/ treatment as usual

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ treatment as usual	Observed and experiential integration (OEI)		
PTSD symptom severity	Lower better Based on data from: 10 patients in 1 studies. (Randomized controlled)		Difference: SMD 2.86 lower (CI 95% 4.9 lower - 0.83 lower)	Very Low Due to serious risk of bias, Due to very serious imprecision ¹	We are uncertain whether observed and experiential integration (OEI) increases or decreases PTSD symptom severity

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 ; **Publication bias: No serious** .

References

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[437] OEI vs WLTAU. [Website](#)

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ treatment as usual	Relaxation training		
PTSD symptom severity	Lower better Based on data from: 53 patients in 2 studies. (Randomized controlled)		Difference: SMD 0.09 lower (CI 95% 0.91 lower - 0.73 higher)	Low Due to serious inconsistency, Due to serious imprecision ¹	Relaxation training may have little or no difference on PTSD symptom severity

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** .

References

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- [441] Relaxation training vs WLTAU. [Website](#)

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 [409] 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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ treatment as usual	Stabilising group treatment		
PTSD symptom severity	Lower better Based on data from: 71 patients in 1 studies. (Randomized controlled)		Difference: SMD 0.11 higher (CI 95% 0.36 lower - 0.57 higher)	Low Due to serious risk of bias, Due to serious imprecision ¹	Stabilising group treatment may have little or no difference on PTSD symptom severity

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** .

References

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- [444] Stabilising group treatment vs WLTAU. [Website](#)

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.

Clinical Question/ PICO

Population: Adults with PTSD
Intervention: Group interpersonal therapy (IPT)
Comparator: Waitlist/ treatment as usual

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ treatment as usual	Group interpersonal therapy (IPT)		
PTSD symptom severity	Lower better Based on data from: 48 patients in 1 studies. (Randomized controlled)		Difference: SMD 1.19 lower (CI 95% 1.84 lower - 0.54 lower)	Very Low Due to serious risk of bias, Due to very serious imprecision ¹	We are uncertain whether group interpersonal therapy (IPT) increases or decreases PTSD symptom severity

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** .

References

[353] Krupnick JL, Green BL, Stockton P, Miranda J, Krause E, Mete M : Group interpersonal psychotherapy for low-income women with posttraumatic stress disorder.. *Psychotherapy research : journal of the Society for Psychotherapy Research* 2008;18(5):497-507 [Pubmed Journal](#)

[428] Group IPT vs WLTAU. [Website](#)

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

Population: Adults with PTSD
Intervention: Trauma-focused CBT
Comparator: Dialogical exposure therapy (DET)

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Dialogical exposure therapy (DET)	Trauma-focused CBT		
PTSD symptom severity	Lower better Based on data from: 138 patients in 1 studies. (Randomized controlled)			Low Due to serious risk of bias, Due to serious imprecision ¹	Trauma-focused CBT may be more beneficial than DET on PTSD symptom severity

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** .

References

[310] Butollo W, Karl R, König J, Rosner R : A Randomized Controlled Clinical Trial of Dialogical Exposure Therapy versus Cognitive Processing Therapy for Adult Outpatients Suffering from PTSD after Type I Trauma in Adulthood.. Psychotherapy and psychosomatics 2016;85(1):16-26 [Pubmed Journal](#)

[414] CBT-T (CPT) vs DET. [Website](#)

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

- Population:** Adults with PTSD
- Intervention:** Trauma-focused CBT
- Comparator:** Interpersonal Therapy (IPT)

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Interpersonal Therapy (IPT)	Trauma-focused CBT		
PTSD symptom severity	Lower better			Very Low Due to serious	We are uncertain if there is a difference

Based on data from: 64 patients in 1 studies. (Randomized controlled)	(CI 95% 0.58 lower - 0.41 higher)	risk of bias, Due to very serious imprecision ¹	between trauma-focused CBT and IPT on PTSD symptom severity
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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 ;

References
 [363] Markowitz JC, Petkova E, Neria Y, Van Meter PE, Zhao Y, Hembree E, Lovell K, Biyanova T, Marshall RD : Is Exposure Necessary? A Randomized Clinical Trial of Interpersonal Psychotherapy for PTSD.. The American journal of psychiatry 2015;172(5):430-40 [Pubmed Journal](#)
 [457] CBT-T (PE) vs IPT. [Website](#)

Clinical Question/ PICO

Population: Adults with PTSD
Intervention: Interpersonal therapy
Comparator: Relaxation training

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Relaxation training	Interpersonal therapy		
PTSD symptom severity	Lower better Based on data from: 60 patients in 1 studies. (Randomized controlled)		Difference: SMD 0.15 lower (CI 95% 0.67 lower - 0.38 higher)	Very Low Due to serious risk of bias, Due to very serious imprecision ¹	We are uncertain if there is a difference between interpersonal therapy and relaxation training on PTSD symptom severity

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** .

References
 [363] Markowitz JC, Petkova E, Neria Y, Van Meter PE, Zhao Y, Hembree E, Lovell K, Biyanova T, Marshall RD : Is Exposure Necessary? A Randomized Clinical Trial of Interpersonal Psychotherapy for PTSD.. The American journal of psychiatry 2015;172(5):430-40 [Pubmed Journal](#)

Pharmacological treatments 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)

Conditional Recommendation

For adults with PTSD we suggest SSRIs (sertraline, paroxetine or fluoxetine) in circumstances where:

- a) the person is unwilling or not in a position to engage in or access recommended psychological therapy (TF-CBT, PE, CT, CPT or EMDR); or
- b) the person has a comorbid condition or associated symptoms (e.g., clinically significant depression and high levels of dissociation) where SSRIs are indicated; or
- c) 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); or
- d) the person has not gained significant benefit from recommended psychological therapy; or
- e) 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.

Key Info

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 [474][487][493][494][507].

Evidence from 4 RCTs suggests a small, clinically important benefit from Paroxetine for PTSD symptoms relative to placebo [491][492][504][502].

Evidence from 9 RCTs suggests a small, clinically unimportant benefit from Sertraline for PTSD symptoms relative to placebo [470][471][476][478][485][490][497][510][498]. Evidence from a single RCT suggests that sertraline was more effective than citalopram in reducing PTSD symptoms [505] while evidence from 2 RCTs found a small unimportant difference in favour of Nefazadone relative to Sertraline [496][500].

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.

Certainty of evidence for Sertraline vs Citalopram was VERY LOW due to serious publication bias, and very serious imprecision.

Certainty of evidence for Sertraline vs Nefazadone was LOW due to serious risk of bias, and serious imprecision.

Certainty of evidence for Sertraline vs Venlafaxine was VERY LOW due to serious imprecision, serious publication bias, and serious risk of bias.

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

Population: Adults with PTSD
Intervention: Selective serotonin re-uptake inhibitors (SSRIs)
Comparator: Placebo

Outcome Timeframe	Study results and measurements	Absolute effect estimates Placebo SSRIs		Certainty of the Evidence (Quality of evidence)	Plain text summary
PTSD symptom severity	Lower better Based on data from: 3,185 patients in 18 studies. (Randomized controlled)	Difference: SMD 0.32 lower (CI 95% 0.43 lower - 0.2 lower)		Low Due to serious imprecision. Due to serious risk of bias ¹	SSRIs may decrease PTSD symptom severity slightly

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 ;

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- [476] Davidson JR, Rothbaum BO, van der Kolk BA, Sikes CR, Farfel GM : Multicenter, double-blind comparison of sertraline and placebo in the treatment of posttraumatic stress disorder.. *Archives of general psychiatry* 2001;58(5):485-92 [Pubmed](#)
- [478] Davidson J, Rothbaum BO, Tucker P, Asnis G, Benattia I, Musngnung JJ : Venlafaxine extended release in posttraumatic stress disorder: a sertraline- and placebo-controlled study.. *Journal of clinical psychopharmacology* 2006;26(3):259-67 [Pubmed](#)
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- [494] Martenyi F, Brown EB, Caldwell CD : Failed efficacy of fluoxetine in the treatment of posttraumatic stress disorder: results of a fixed-dose, placebo-controlled study.. *Journal of clinical psychopharmacology* 2007;27(2):166-70 [Pubmed](#)
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- [498] Pfizer 588 (unpublished data) 12 week, double-blind comparison of flexible doses of Lustral (sertraline) versus placebo (primarily female physical/sexual assault population).
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[510] Zohar J, Amital D, Miodownik C, Kotler M, Bleich A, Lane RM, Austin C : Double-blind placebo-controlled pilot study of sertraline in military veterans with posttraumatic stress disorder.. Journal of clinical psychopharmacology 2002;22(2):190-5 [Pubmed](#)

[511] SSRIs vs Placebo. [Website](#)

Clinical Question/ PICO

Population: Adults with PTSD
Intervention: Citalopram
Comparator: Sertraline

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Sertraline	Citalopram		
PTSD symptom severity	Lower better Based on data from: 48 patients in 1 studies. (Randomized controlled)	Difference: SMD 0.65 higher (CI 95% 0.07 higher - 1.23 higher)		Very Low Due to serious publication bias, Due to very serious imprecision ¹	We are uncertain if there is a difference between citalopram and sertraline on PTSD symptom severity

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 ;

References

[505] Tucker P, Potter-Kimball R, Wyatt DB, Parker DE, Burgin C, Jones DE, Masters BK : Can physiologic assessment and side effects tease out differences in PTSD trials? A double-blind comparison of citalopram, sertraline, and placebo.. Psychopharmacology bulletin 2003;37(3):135-49 [Pubmed](#)

Clinical Question/ PICO

Population: Adults with PTSD

Intervention: Sertraline
Comparator: Nefazadone

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Nefazadone	Sertraline		
PTSD symptom severity	Lower better Based on data from: 80 patients in 2 studies. (Randomized controlled)	Difference: SMD 0.19 higher (CI 95% 0.25 lower - 0.63 higher)		Low Due to serious risk of bias, Due to serious imprecision ¹	There may be little or no difference between Sertraline and Nefazadone on PTSD symptom severity

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** .

References

- [496] McRae AL, Brady KT, Mellman TA, Sonne SC, Killeen TK, Timmerman MA, Bayles-Dazet W : Comparison of nefazodone and sertraline for the treatment of posttraumatic stress disorder.. Depression and anxiety 2004;19(3):190-6 [Pubmed](#)
- [500] Saygin M, Sungur M, Sabol E, Cetinkaya P : Sabol, E. U., & Çetinkaya, P. (2002). Nefazodone versus sertraline in treatment of posttraumatic stress disorder. Bull Clin Psychopharmacol, 12, 1-5.. [Website](#)

Clinical Question/ PICO

Population: Adults with PTSD
Intervention: Venlafaxine
Comparator: Sertraline

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Sertraline	Venlafaxine		
PTSD symptom severity	Lower better Based on data from: 352 patients in 1 studies. (Randomized controlled)	Difference: SMD 0.07 lower (CI 95% 0.28 lower - 0.14 higher)		Very Low Due to serious imprecision, Due to serious publication bias, Due to serious risk of bias ¹	We are uncertain if there is a difference between venlafaxine and sertraline on PTSD symptom severity

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 ;

References

[478] Davidson J, Rothbaum BO, Tucker P, Asnis G, Benattia I, Musgnung JJ : Venlafaxine extended release in posttraumatic stress disorder: a sertraline- and placebo-controlled study.. Journal of clinical psychopharmacology 2006;26(3):259-67
[Pubmed](#)

Venlafaxine

Conditional Recommendation

For adults with PTSD we suggest venlafaxine in circumstances where:

- the person is unwilling or not in a position to engage in or access recommended psychological therapy (TF-CBT, PE, CT, CPT or EMDR); or
- the person has a comorbid condition or associated symptoms (e.g., clinically significant depression and high levels of dissociation) where SSRIs are indicated; or
- 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); or
- the person has not gained significant benefit from recommended psychological therapy; or
- 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.^{[478][479]}

Key Info

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 [479] [478] and no difference between venlafaxine and sertraline [478].

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.

Certainty of evidence for Venlafaxine vs Sertraline was VERY LOW due to serious imprecision, serious publication bias, and serious risk of bias.

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.

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 SSRI's 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

- Population:** Adults with PTSD
- Intervention:** Serotonin and nor-adrenaline re-uptake inhibitors- Venlafaxine
- Comparator:** Placebo

Outcome Timeframe	Study results and measurements	Absolute effect estimates Placebo Serotonin and nor-adrenaline re-uptake inhibitors- Venlafaxine	Certainty of the Evidence (Quality of evidence)	Plain text summary
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<p>PTSD symptom severity</p> <p>Lower better Based on data from: 687 patients in 2 studies. (Randomized controlled)</p>	<p>Difference: SMD 0.24 lower (CI 95% 0.39 lower - 0.09 lower)</p>	<p>Moderate Due to serious risk of bias ¹</p>	<p>Venlafaxine probably decreases PTSD symptom severity slightly</p>
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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: No serious** . **Publication bias: No serious** .

References

[478] Davidson J, Rothbaum BO, Tucker P, Asnis G, Benattia I, Musgnung JJ : Venlafaxine extended release in posttraumatic stress disorder: a sertraline- and placebo-controlled study.. Journal of clinical psychopharmacology 2006;26(3):259-67 [Pubmed](#)

[479] Davidson J, Baldwin D, Stein DJ, Kuper E, Benattia I, Ahmed S, Pedersen R, Musgnung J : Treatment of posttraumatic stress disorder with venlafaxine extended release: a 6-month randomized controlled trial.. Archives of general psychiatry 2006;63(10):1158-65 [Pubmed](#)

[530] Venlafaxine vs Placebo. [Website](#)

Clinical Question/ PICO

Population: Adults with PTSD
Intervention: Venlafaxine
Comparator: Sertraline

Outcome Timeframe	Study results and measurements	Absolute effect estimates Sertraline Venlafaxine		Certainty of the Evidence (Quality of evidence)	Plain text summary
<p>PTSD symptom severity</p>	<p>Lower better Based on data from: 352 patients in 1 studies. (Randomized controlled)</p>	<p>Difference: SMD 0.07 lower (CI 95% 0.28 lower - 0.14 higher)</p>		<p>Very Low Due to serious imprecision, Due to serious publication bias, Due to serious risk of bias ¹</p>	<p>We are uncertain if there is a difference between venlafaxine and sertraline on PTSD symptom severity</p>

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 ;

References

[478] Davidson J, Rothbaum BO, Tucker P, Asnis G, Benattia I, Musgnung JJ : Venlafaxine extended release in posttraumatic stress disorder: a sertraline- and placebo-controlled study.. *Journal of clinical psychopharmacology* 2006;26(3):259-67
[Pubmed](#)

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 but this needs further research.

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

Key Info

Benefits and harms

Evidence from a single RCT suggests a moderate, clinically important benefit from ketamine on PTSD symptom severity relative to placebo [484].

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.

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

Population: Adults with PTSD
Intervention: Ketamine
Comparator: Placebo

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Placebo	Ketamine		
PTSD symptom severity	Lower better Based on data from: 35 patients in 1 studies. (Randomized controlled)			Very Low Due to very serious imprecision, Due to serious publication bias, Due to serious risk of bias ¹	We are uncertain whether ketamine increases or decreases PTSD symptom severity

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 on patent for ketamine for PTSD (would benefit financially from positive findings) ;

References

[484] Feder A, Parides MK, Murrough JW, Perez AM, Morgan JE, Saxena S, Kirkwood K, Aan Het Rot M, Lapidus KAB, Wan L-B, Iosifescu D, Charney DS : Efficacy of intravenous ketamine for treatment of chronic posttraumatic stress disorder: a randomized clinical trial.. JAMA psychiatry 2014;71(6):681-8 [Pubmed Journal](#)

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 but this needs further research.

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

Key Info

Benefits and harms

Evidence from a single RCT suggests a moderate, clinically important benefit of quetiapine on PTSD symptom severity [508].

Certainty of the Evidence

Certainty of the evidence is VERY LOW due to serious risk of bias, serious publication bias and serious imprecision.

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Placebo	Antipsychotics- Quetiapine		
PTSD symptom severity	Lower better Based on data from: 80 patients in 1 studies. (Randomized controlled)		Difference: SMD 0.49 lower (CI 95% 0.93 lower - 0.04 lower)	Very Low Due to serious risk of bias, Due to serious imprecision, Due to serious publication bias ¹	We are uncertain whether quetiapine increases or decreases PTSD symptom severity

1. **Risk of bias: Serious** . Large loss to follow up, due to [baseline differences and differential attrition] ; **Inconsistency: No serious** . **Indirectness: No serious** . **Imprecision: Serious** . Low number of patients (n=80), Wide confidence intervals (CIs include important benefit and unimportant benefit), Only data from one study ; **Publication bias: Serious** . Mostly commercially funded studies ;

References

[508] Villarreal G, Hamner MB, Cañive JM, Robert S, Calais LA, Durklaski V, Zhai Y, Qualls C : Efficacy of Quetiapine Monotherapy in Posttraumatic Stress Disorder: A Randomized, Placebo-Controlled Trial.. The American journal of psychiatry 2016;173(12):1205-1212 [Pubmed](#)

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Placebo	Nor-adrenergic and specific serotonin antidepressant- Mirtazapin		
PTSD symptom severity	Lower better Based on data from: 21 patients in 1 studies. (Randomized controlled)		Difference: SMD 1.89 lower (CI 95% 3 lower - 0.78 lower)	Very Low Due to very serious imprecision, Due to serious publication bias, Due to serious risk of bias ¹	We are uncertain whether Mirtazapine increases or decreases PTSD symptom severity.

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 ;

References

[477] Davidson JRT, Weisler RH, Butterfield MI, Casat CD, Connor KM, Barnett S, van Meter S : Mirtazapine vs. placebo in posttraumatic stress disorder: a pilot trial.. Biological psychiatry 2003;53(2):188-91 [PubMed](#)

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Placebo	Tricyclic antidepressant- Amitriptyline		
PTSD symptom severity	Lower better Based on data from: 33 patients in 1 studies. (Randomized controlled)	Difference: SMD 0.9 lower (CI 95% 1.62 lower - 0.18 lower)		Very Low Due to serious risk of bias, Due to very serious imprecision ¹	We are uncertain whether amitriptyline increases or decreases PTSD symptom severity

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** .

References

[475] Davidson J, Kudler H, Smith R, Mahorney SL, Lipper S, Hammett E, Saunders WB, Cavenar JO : Treatment of posttraumatic stress disorder with amitriptyline and placebo.. Archives of general psychiatry 1990;47(3):259-66 [Pubmed](#)

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Placebo	Tricyclic antidepressant- Imipramine		
PTSD symptom severity	Lower better Based on data from: 41 patients in 1 studies.	Difference: SMD 0.24 lower (CI 95% 0.86 lower - 0.38 higher)		Very Low Due to very serious imprecision, Due	We are uncertain whether imipramine increases or decreases PTSD symptom severity

(Randomized controlled)		to very serious risk of bias ¹
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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** . Low number of patients (n=41), Wide confidence intervals (CIs include important benefit and unimportant harm), Only data from one study ; **Publication bias: No serious** .

References

[489] Kosten TR, Frank JB, Dan E, McDougle CJ, Giller EL : Pharmacotherapy for posttraumatic stress disorder using phenelzine or imipramine.. The Journal of nervous and mental disease 1991;179(6):366-70 [Pubmed](#)

[519] Imipramine vs Placebo. [Website](#)

Brofaromine

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

Clinical Question/ PICO

Population: Adults with PTSD
Intervention: Monoamine oxidase inhibitors- Brofaromine
Comparator: Placebo

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Placebo	Monoamine oxidase inhibitors- Brofaromine		
PTSD symptom severity	Lower better Based on data from: 178 patients in 2 studies. (Randomized controlled)		Difference: SMD 0.22 lower (CI 95% 0.7 lower - 0.26 higher)	Very Low Due to serious risk of bias, Due to serious inconsistency, Due to serious imprecision, Due to serious publication bias ¹	We are uncertain whether brofaromine increases or decreases PTSD symptom severity

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 I²:59% . ; **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 ;

References

[469] Baker DG, Diamond BI, Gillette G, Hamner M, Katzelnick D, Keller T, Mellman TA, Pontius E, Rosenthal M, Tucker P : A double-blind, randomized, placebo-controlled, multi-center study of brofaromine in the treatment of post-traumatic stress disorder.. Psychopharmacology 1995;122(4):386-9 [Pubmed](#)

[488] Katz RJ, Lott MH, Arbus P, Crocq L, Herlobsen P, Lingjaerde O, Lopez G, Loughrey GC, MacFarlane DJ, McIvor R : Pharmacotherapy of post-traumatic stress disorder with a novel psychotropic.. Anxiety 1(4):169-74 [Pubmed](#)

[513] Brofaromine vs Placebo. [Website](#)

Phenelzine

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

Clinical Question/ PICO

Population: Adults with PTSD
Intervention: Monoamine oxidase inhibitors- Phenelzine
Comparator: Placebo

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Placebo	Monoamine oxidase inhibitors- Phenelzine		
PTSD symptom severity	Lower better Based on data from: 37 patients in 1 studies. (Randomized controlled)		Difference: SMD 1.06 lower (CI 95% 1.75 lower - 0.36 lower)	Very Low Due to very serious imprecision, Due to very serious risk of bias ¹	We are uncertain whether phenelzine increases or decreases PTSD symptom severity

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** .

References

[489] Kosten TR, Frank JB, Dan E, McDougale CJ, Giller EL : Pharmacotherapy for posttraumatic stress disorder using

phenelzine or imipramine.. The Journal of nervous and mental disease 1991;179(6):366-70 [Pubmed](#)

Clinical Question/ PICO

Population: Adults with PTSD
Intervention: Phenelzine
Comparator: Imipramine

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Imipramine	Phenelzine		
PTSD symptom severity	Lower better Based on data from: 42 patients in 1 studies. (Randomized controlled)	Difference: SMD 0.72 lower (CI 95% 1.34 lower - 0.09 lower)		Very Low Due to very serious imprecision, Due to very serious risk of bias ¹	We are uncertain if there is a difference between phenelzine and imipramine on PTSD symptom severity

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** . Low number of patients (n= 41), Wide confidence intervals (CIs include important benefit and unimportant benefit), Only data from one study ; **Publication bias: No serious** .

References
 [489] Kosten TR, Frank JB, Dan E, McDougle CJ, Giller EL : Pharmacotherapy for posttraumatic stress disorder using phenelzine or imipramine.. The Journal of nervous and mental disease 1991;179(6):366-70 [Pubmed](#)

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Placebo	Antipsychotics- Olanzapine		
PTSD symptom severity	Lower better Based on data from: 43 patients in 2 studies. (Randomized controlled)	Difference: SMD 0.44 lower (CI 95% 1.51 lower - 0.63 higher)		Very Low Due to serious inconsistency, Due to very serious imprecision, Due to serious publication bias, Due to serious risk of bias ¹	We are uncertain whether Olanzapine increases or decreases PTSD symptom severity.

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 ;

References

[472] Butterfield MI, Becker ME, Connor KM, Sutherland S, Churchill LE, Davidson JR : Olanzapine in the treatment of post-traumatic stress disorder: a pilot study.. International clinical psychopharmacology 2001;16(4):197-203 [Pubmed](#)

[473] Carey P, Suliman S, Ganesan K, Seedat S, Stein DJ : Olanzapine monotherapy in posttraumatic stress disorder: efficacy in a randomized, double-blind, placebo-controlled study.. Human psychopharmacology 2012;27(4):386-91 [Pubmed Journal](#)

[522] Olanzapine vs Placebo. [Website](#)

Divalproex

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

Clinical Question/ PICO

Population: Adults with PTSD
Intervention: Antiepileptics- Divalproex
Comparator: Placebo

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Placebo	Antiepileptics- Divalproex		

PTSD symptom severity	Lower better Based on data from: 82 patients in 1 studies. (Randomized controlled)	Difference: SMD 0.03 lower (CI 95% 0.46 lower - 0.41 higher)	Very Low Due to serious publication bias, Due to very serious imprecision ¹	We are uncertain whether divalproex increases or decreases PTSD symptom severity
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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 ;

References

[482] Davis LL, Davidson JRT, Ward LC, Bartolucci AL, Bowden CL, Petty F : Divalproex in the treatment of posttraumatic stress disorder: a randomized, double-blind, placebo-controlled trial in a veteran population.. Journal of clinical psychopharmacology 2008;28(1):84-8 [Pubmed Journal](#)

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Placebo	Antiepileptics- Lamotrigine		
PTSD symptom severity	Lower better Based on data from: 14 patients in 1 studies. (Randomized controlled)		Difference: SMD 0 lower (CI 95% 1.16 lower - 1.16 higher)	Very Low Due to very serious imprecision, Due to serious publication bias, Due to serious risk of bias ¹	We are uncertain whether Lamotrigine increases or decreases PTSD symptom severity.

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 ;

References

[486] Hertzberg MA, Butterfield MI, Feldman ME, Beckham JC, Sutherland SM, Connor KM, Davidson JR : A preliminary study of lamotrigine for the treatment of posttraumatic stress disorder.. Biological psychiatry 1999;45(9):1226-9 [Pubmed](#)

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Placebo	Antiepileptics- Tiagabine		
PTSD symptom severity	Lower better Based on data from: 202 patients in 1 studies. (Randomized controlled)		Difference: SMD 0.02 lower (CI 95% 0.3 lower - 0.26 higher)	Very Low Due to serious risk of bias, Due to serious publication bias, Due to serious imprecision ¹	We are uncertain whether tiagabine increases or decreases PTSD symptom severity

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 ;

References

[480] Davidson JRT, Brady K, Mellman TA, Stein MB, Pollack MH : The efficacy and tolerability of tiagabine in adult patients with post-traumatic stress disorder.. Journal of clinical psychopharmacology 2007;27(1):85-8 [Pubmed](#)

Topiramate

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

Clinical Question/ PICO

Population: Adults with PTSD
Intervention: Antiepileptics- Topiramate
Comparator: Placebo

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Placebo	Antiepileptics- Topiramate		
PTSD symptom severity	Lower better Based on data from: 31 patients in 1 studies. (Randomized controlled)	Difference: SMD 0.16 lower (CI 95% 0.87 lower - 0.55 higher)		Low Due to serious imprecision, Due to serious risk of bias ¹	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 ;

References

[509] Yeh MSL, Mari JJ, Costa MCP, Andreoli SB, Bressan RA, Mello MF : A double-blind randomized controlled trial to study the efficacy of topiramate in a civilian sample of PTSD.. CNS neuroscience & therapeutics 2011;17(5):305-10 [Pubmed Journal](#)

Ganaxolone

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

Clinical Question/ PICO

Population: Adults with PTSD
Intervention: Ganaxolone
Comparator: Placebo

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Placebo	Ganaxolone		
PTSD symptom severity	Lower better Based on data from: 99 patients in 1 studies. (Randomized controlled)	Difference: SMD 0.12 lower (CI 95% 0.51 lower - 0.28 higher)		Low Due to serious risk of bias, Due to serious imprecision ¹	Ganaxolone 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 [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** .

References
 [499] Rasmusson AM, Marx CE, Jain S, Farfel GM, Tsai J, Sun X, Geraciotti TD, Hamner MB, Lohr J, Rosse R, Summerall L, Naylor JC, Cusin C, Lang AJ, Raman R, Stein MB : A randomized controlled trial of ganaxolone in posttraumatic stress disorder.. *Psychopharmacology* 2017;234(15):2245-2257 [Pubmed Journal](#)

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	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Placebo	Neurokinin-1 antagonist		
PTSD symptom severity	Lower better Based on data from: 39 patients in 1 studies. (Randomized controlled)	Difference: SMD 0.27 lower (CI 95% 0.9 lower - 0.36 higher)		Very Low Due to serious risk of bias, Due to very serious imprecision, Due to serious	We are uncertain whether Neurokinin-1 antagonist increases or decreases PTSD symptom severity

publication bias ¹

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** . 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 ;

References

[495] Mathew SJ, Vythilingam M, Murrough JW, Zarate CA, Feder A, Luckenbaugh DA, Kinkead B, Parides MK, Trist DG, Bani MS, Bettica PU, Ratti EM, Charney DS : A selective neurokinin-1 receptor antagonist in chronic PTSD: a randomized, double-blind, placebo-controlled, proof-of-concept trial.. *European neuropsychopharmacology : the journal of the European College of Neuropsychopharmacology* 2011;21(3):221-9 [Pubmed Journal](#)

Non-psychological and non-pharmacological treatments 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 may 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.

Key Info

Benefits and harms

Evidence from a single RCT suggests clinically important benefit from acupuncture for PTSD symptom severity relative to waitlist and CBT-T [410].

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.

Certainty of evidence for Acupuncture vs Trauma-focused CBT was LOW due to very serious imprecision.

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

Population: Adults with PTSD
Intervention: Acupuncture
Comparator: Waitlist/ treatment as usual

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ treatment as usual	Acupuncture		
PTSD symptom severity	Lower better Based on data from: 48 patients in 1 studies. (Randomized controlled)		Difference: SMD 0.92 lower (CI 95% 1.51 lower - 0.32 lower)	Low Due to very serious imprecision ¹	Acupuncture may decrease PTSD symptom severity

1. **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 .**

References

- [548] Hollifield M, Sinclair-Lian N, Warner TD, Hammerschlag R : Acupuncture for posttraumatic stress disorder: a randomized controlled pilot trial.. The Journal of nervous and mental disease 2007;195(6):504-13 [Pubmed](#)
- [589] Acupuncture vs WL. [Website](#)

Clinical Question/ PICO

Population: Adults with PTSD
Intervention: Acupuncture
Comparator: Trauma-focused CBT

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Trauma-focused CBT	Acupuncture		
PTSD symptom severity	Lower better		Difference: SMD 0.35 lower	Low Due to very	Acupuncture may be more beneficial than

Based on data from: 49 patients in 1 studies. (Randomized controlled)	(CI 95% 0.91 lower - 0.22 higher)	serious imprecision ¹	CBT-T on PTSD symptom severity
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1. **Inconsistency: No serious** . Single study ; **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** .

References

[548] Hollifield M, Sinclair-Lian N, Warner TD, Hammerschlag R : Acupuncture for posttraumatic stress disorder: a randomized controlled pilot trial.. The Journal of nervous and mental disease 2007;195(6):504-13 [Pubmed](#)

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 this may 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.^[592] 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.^[566] This brief treatment was based on MBSR principles but was delivered in individual sessions and did not include the full program.

Key Info

Benefits and harms

Evidence from 2 RCTs suggests a small clinically unimportant benefit from MBSR for PTSD symptom severity relative to placebo [549][561].

Evidence from 2 RCTs suggests no difference in benefit between MBSR and PCT on PTSD symptom severity [565][553][541].

Evidence from a single RCT suggests a large, clinically important benefit of MBSR relative to psychoeducation on PTSD symptom severity [566].

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.

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.

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.

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ treatment as usual	Mindfulness-based stress reduction		
PTSD symptom severity	Lower better Based on data from: 99 patients in 2 studies. (Randomized controlled)		Difference: SMD 0.28 lower (CI 95% 0.67 lower - 0.12 higher)	Low Due to serious imprecision, Due to serious risk of bias ¹	Mindfulness-based stress reduction may decrease PTSD symptom severity slightly

1. **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** .

References

[549] Kearney DJ, McDermott K, Malte C, Martinez M, Simpson TL : Effects of participation in a mindfulness program for veterans with posttraumatic stress disorder: a randomized controlled pilot study.. Journal of clinical psychology 2013;69(1):14-27 [Pubmed Journal](#)

[561] Wahbeh H, Goodrich E, Goy E, Oken BS : Mechanistic Pathways of Mindfulness Meditation in Combat Veterans With Posttraumatic Stress Disorder.. Journal of clinical psychology 2016;72(4):365-83 [Pubmed Journal](#)

[580] Mindfulness based stress reduction vs WL. [Website](#)

Clinical Question/ PICO

Population: Adults with PTSD
Intervention: Mindfulness-based stress reduction
Comparator: Present centred therapy

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Present centred therapy	Mindfulness-based stress reduction		
PTSD symptom severity	Lower better Based on data from: 324 patients in 3 studies. (Randomized controlled)		Difference: SMD 0.11 lower (CI 95% 0.53 lower - 0.32 higher)	Very Low Due to serious risk of bias, Due to serious inconsistency, Due to very serious imprecision ¹	We are uncertain if there is a difference between mindfulness- based stress reduction and PCT on PTSD symptom severity

1. **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 I²:63 % . ; **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** .

References

[541] Bremner JD, Mishra S, Campanella C, Shah M, Kasher N, Evans S, Fani N, Shah AJ, Reiff C, Davis LL, Vaccarino V, Carmody J : A Pilot Study of the Effects of Mindfulness-Based Stress Reduction on Post-traumatic Stress Disorder Symptoms and Brain Response to Traumatic Reminders of Combat in Operation Enduring Freedom/Operation Iraqi Freedom Combat Veterans with Post-traumatic Stress Disorder.. Frontiers in psychiatry 2017;8 157 [Pubmed Journal](#)

[553] Polusny MA, Erbes CR, Thuras P, Moran A, Lamberty GJ, Collins RC, Rodman JL, Lim KO : Mindfulness-Based Stress Reduction for Posttraumatic Stress Disorder Among Veterans: A Randomized Clinical Trial.. JAMA 2015;314(5):456-65 [Pubmed Journal](#)

[565] Davis L, Whetsell C, Hamner M, Carmody J, Rothbaum B, Allen R, Bartolucci AL, Southwick S, Bremner D : Davis, L. L., Whetsell, C., Hamner, M. B., Carmody, J., Rothbaum, B. O., Allen, R. S., ... & Bremner, J. D. (2018). A Multisite Randomized Controlled Trial of Mindfulness-Based Stress Reduction in the Treatment of Posttraumatic Stress Disorder. Psychiatric Research and Clinical Practice. [Journal](#)

[578] Mindfulness based stress reduction vs PCT. [Website](#)

Clinical Question/ PICO

Population: Adults with PTSD
Intervention: Mindfulness-based stress reduction
Comparator: Psychoeducation

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Psychoeducation	Mindfulness-based stress reduction		
PTSD symptom severity	Lower better Based on data from: 27 patients in 1 studies. (Randomized controlled)	Difference: SMD 1.23 lower (CI 95% 2.07 lower - 0.4 lower)		Very Low Due to serious risk of bias, Due to very serious imprecision ¹	We are uncertain if there is a difference between mindfulness- based stress reduction and psychoeducation on PTSD symptom severity

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 ; **Inconsistency: No serious** . **Indirectness: No serious** . **Imprecision: Very Serious** . Low number of patients (n=27), Only data from one study ; **Publication bias: No serious** .

References

[566] Niles B, Klunk-Gillis J, Ryngala D, Silberbogen A, Paysnick A, Wolf E : Niles, B. L., Klunk-Gillis, J., Ryngala, D. J., Silberbogen, A. K., Paysnick, A., & Wolf, E. J. (2012). Comparing mindfulness and psychoeducation treatments for combat-related PTSD using a telehealth approach. *Psychological Trauma: Theory, Research, Practice, and Policy*, 4(5), 538.. [Website](#)

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 this may be used in a research context.

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.[559]

Key Info

Benefits and harms

Evidence from 3 RCTs suggests large clinically important benefit of Neurofeedback for PTSD symptom severity relative to waitlist or usual care [559][558][567].

Certainty of the Evidence

Certainty of the evidence is MODERATE due to serious imprecision.

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

Population: Adults with PTSD
Intervention: Neurofeedback
Comparator: Waitlist/ treatment as usual

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ treatment as usual	Neurofeedback		
PTSD symptom severity	Lower better Based on data from: 94 patients in 3 studies. (Randomized controlled)		Difference: SMD 1.55 lower (CI 95% 2.94 lower - 0.15 lower)	Moderate Due to serious imprecision ¹	Neurofeedback probably decreases PTSD symptom severity

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** .

References

[558] Tan G, Dao TK, Farmer L, Sutherland RJ, Gevirtz R : Heart rate variability (HRV) and posttraumatic stress disorder (PTSD): a pilot study.. Applied psychophysiology and biofeedback 2011;36(1):27-35 [Pubmed Journal](#)

[559] van der Kolk BA, Hodgdon H, Gapen M, Musicaro R, Suvak MK, Hamlin ED, Spinazzola J : A Randomized Controlled Study of Neurofeedback for Chronic PTSD.. PloS one 2016;11(12):e0166752 [Pubmed Journal](#)

[567] Noohi S, Miraghaie A, Arabi A, Nooripour R : Noohi, S., Miraghaie, A. M., Arabi, A., & Nooripour, R. (2017). Effectiveness of neuro-feedback treatment with alpha/theta method on PTSD symptoms and their executing function. Biomedical Research, 28(5), 2019-2027. [Website](#)

[582] Neruofeedback vs WL. [Website](#)

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 this may 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.[555] In the integrated exercise study, veteran participants attended three one hour group sessions each week for 12 weeks, for a total of 36 sessions.[547] Exercise sessions included aerobic exercise, strength training with weights and resistance bands, and yoga movements and poses presented within a framework of mindfulness principles.

Key Info

Benefits and harms

Evidence from 2 RCTs [547][555] 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

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

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.

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.

Clinical Question/ PICO

Population: Adults with PTSD
Intervention: Physical exercise
Comparator: Waitlist/ treatment as usual

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ treatment as usual	Physical exercise		
PTSD symptom severity	Lower better Based on data from: 105 patients in 2 studies. (Randomized controlled)		Difference: SMD 0.36 lower (CI 95% 0.75 lower - 0.03 higher)	Low Due to serious imprecision, Due to serious risk of bias ¹	Physical exercise may decrease PTSD symptom severity slightly

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** .

References

- [547] Goldstein LA, Mehling WE, Metzler TJ, Cohen BE, Barnes DE, Choucroun GJ, Silver A, Talbot LS, Maguen S, Hlavin JA, Chesney MA, Neylan TC : Veterans Group Exercise: A randomized pilot trial of an Integrative Exercise program for veterans with posttraumatic stress.. Journal of affective disorders 2018;227 345-352 [Pubmed Journal](#)
- [555] Rosenbaum S, Sherrington C, Tiedemann A : Exercise augmentation compared with usual care for post-traumatic stress disorder: a randomized controlled trial.. Acta psychiatrica Scandinavica 2015;131(5):350-9 [Pubmed Journal](#)
- [590] Physical exercise vs WL. [Website](#)

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 may 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.

Key Info

Benefits and harms

Evidence from 3 RCTs suggest a large clinically important benefit of rTMS for PTSD symptom severity relative to waitlist [537][545][563].

Certainty of the Evidence

Certainty of the evidence is MODERATE due to serious imprecision.

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

Population: Adults with PTSD
Intervention: Repetitive transcranial magnetic stimulation (rTMS)
Comparator: Sham TMS

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Sham TMS	Repetitive transcranial magnetic stimulation (rTMS)		
PTSD symptom severity	Lower better Based on data from: 94 patients in 3 studies. (Randomized controlled)		Difference: SMD 1.43 lower (CI 95% 2.45 lower - 0.41 lower)	Moderate Due to serious imprecision ¹	Repetitive transcranial magnetic stimulation (rTMS) probably decreases PTSD symptom severity

1. **Risk of bias: No serious** . Incomplete data in one study ; **Inconsistency: No serious** . The magnitude of statistical heterogeneity was high ($I^2:74%$) however the difference was between studies with moderate and very large effects so not important ; **Indirectness: No serious** . **Imprecision: Serious** . Low number of patients (n=94) ; **Publication bias: No serious** .

References

[537] Ahmadzadeh M-J, Rezaei M : Unilateral right and bilateral dorsolateral prefrontal cortex transcranial magnetic stimulation in treatment post-traumatic stress disorder: A randomized controlled study.. Brain research bulletin 2018;140 334-340 [Pubmed Journal](#)

[545] Cohen H, Kaplan Z, Kotler M, Kouperman I, Moisa R, Grisaru N : Repetitive transcranial magnetic stimulation of the right dorsolateral prefrontal cortex in posttraumatic stress disorder: a double-blind, placebo-controlled study.. The American journal of psychiatry 2004;161(3):515-24 [Pubmed](#)

[563] Watts BV, Landon B, Groft A, Young-Xu Y : A sham controlled study of repetitive transcranial magnetic stimulation for posttraumatic stress disorder.. Brain stimulation 2012;5(1):38-43 [Pubmed Journal](#)

[583] rTMS vs WL. [Website](#)

Transcendental Meditation (TM)

RESEARCH RECOMMENDATION

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

There is emerging evidence for Transcendental Meditation and this may 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.

Key Info

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 [376].

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.

Certainty of evidence for Transcendental meditation vs Psychoeducation was MODERATE due to serious imprecision.

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Prolonged exposure	Transcendental meditation		
PTSD symptom severity	Lower better Based on data from: 136 patients in 1 studies. (Randomized controlled)	Difference: SMD 0.16 lower (CI 95% 0.49 lower - 0.18 higher)		Moderate Due to serious imprecision ¹	There is probably little or no difference between Transcendental meditation and Prolonged exposure on PTSD symptom severity

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 .**

References

[551] Nidich S, Mills PJ, Rainforth M, Heppner P, Schneider RH, Rosenthal NE, Salerno J, Gaylord-King C, Rutledge T : Non-trauma-focused meditation versus exposure therapy in veterans with post-traumatic stress disorder: a randomised controlled trial.. The lancet. Psychiatry 2018;5(12):975-986 [Pubmed Journal](#)

[587] Transcendental mediation vs Prolonged exposure. [Website](#)

Clinical Question/ PICO

Population: Adults with PTSD
Intervention: Transcendental meditation
Comparator: Psychoeducation

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Psychoeducation	Transcendental meditation		
PTSD symptom severity	Lower better Based on data from: 134 patients in 1 studies. (Randomized controlled)			Moderate Due to serious imprecision ¹	Transcendental meditation is probably more beneficial than psychoeducation on PTSD symptom severity

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 .**

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[570] Transcendental meditation vs Health education . [Website](#)

[586] Transcendental meditation vs Heath education. [Website](#)

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 this may 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,^{[564][557]} Kripalu,^{[550][554]} and trauma-informed yoga^[560].

Key Info

Benefits and harms

Evidence from 5 RCTs suggests a small, clinically unimportant benefit from yoga on PTSD symptom severity relative to waitlist ^{[550][554][560][564][557]}.

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

Population: Adults with PTSD
Intervention: Yoga
Comparator: Waitlist/ treatment as usual

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ treatment as usual	Yoga		
PTSD symptom severity	Lower better Based on data from: 162 patients in 5 studies. (Randomized controlled)		Difference: SMD 0.4 lower (CI 95% 0.72 lower - 0.09 lower)	Low Due to serious imprecision, Due to serious risk of bias ¹	Yoga may decrease PTSD symptom severity slightly

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 continue each stage] ; **Inconsistency: No serious** . **Indirectness: No serious** . Population comparable ; **Imprecision: Serious** . Low number of patients (n=162) ; **Publication bias: No serious** .

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- [588] Yoga vs WL. [Website](#)

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

Population: Adults with PTSD
Intervention: Mantram repetition
Comparator: Waitlist/ treatment as usual

Outcome Timeframe	Study results and measurements	Absolute effect estimates Waitlist/ treatment as usual Mantram repetition	Certainty of the Evidence (Quality of evidence)	Plain text summary
PTSD symptom severity	Lower better Based on data from: 175 patients in 2 studies. (Randomized controlled)	Difference: SMD 0.27 lower (CI 95% 0.57 lower - 0.02 higher)	Low Due to serious risk of bias, Due to serious imprecision ¹	Mantram repetition may decrease PTSD symptom severity slightly

1. **Risk of bias: Serious** . Missing intention-to-treat analysis ; **Inconsistency: No serious** . **Indirectness: No serious** . **Imprecision: Serious** . Low number of patients (n=175) ; **Publication bias: No serious** .

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- [577] Mantrum repetition vs WL. [Website](#)

Clinical Question/ PICO

Population: Adults with PTSD
Intervention: Mantram repetition
Comparator: Present centred therapy

Outcome	Study results and	Absolute effect estimates	Certainty of	Plain text summary
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Timeframe	measurements	Present centred therapy	Mantram repetition	the Evidence (Quality of evidence)	
PTSD symptom severity	Lower better Based on data from: 173 patients in 1 studies. (Randomized controlled)	Difference: SMD 0.37 lower (CI 95% 0.68 lower - 0.07 lower)		Moderate Due to serious imprecision ¹	Mantram repetition is probably more beneficial than PCT on PTSD symptom severity.

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 .**

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[576] Mantrum repetition vs PCT. [Website](#)

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

Population: Adults with PTSD
Intervention: Group music therapy
Comparator: Waitlist/ treatment as usual

Outcome Timeframe	Study results and measurements	Absolute effect estimates Waitlist/ treatment as usual	Group music therapy	Certainty of the Evidence (Quality of evidence)	Plain text summary
PTSD symptom severity	Lower better Based on data from: 16	Difference: SMD 2.12 lower (CI 95% 3.41 lower - 0.83 lower)		Very Low Due to very serious	We are uncertain whether group music therapy increases or

patients in 1 studies. (Randomized controlled)		imprecision, Due to serious risk of bias ¹	decreases PTSD symptom severity
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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** .

References

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- [574] Group music therapy vs WL. [Website](#)

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
- Intervention:** Nature adventure therapy
- Comparator:** Waitlist/ treatment as usual

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ treatment as usual	Nature adventure therapy		
PTSD symptom severity	Lower better Based on data from: 42 patients in 1 studies. (Randomized controlled)		Difference: SMD 0.4 lower (CI 95% 1.01 lower - 0.22 higher)	Very Low Due to serious risk of bias, Due to serious indirectness, Due to very serious imprecision ¹	We are uncertain whether nature adventure therapy increases or decreases PTSD symptom severity

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** .

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- [581] Nature adventure therapy vs WL. [Website](#)

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ treatment as usual	Somatic experiencing		
PTSD symptom severity	Lower better Based on data from: 60 patients in 1 studies. (Randomized controlled)	Difference: SMD 0.75 lower (CI 95% 1.28 lower - 0.22 lower)		Moderate Due to serious imprecision ¹	Somatic experiencing probably decreases PTSD symptom severity slightly

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** .

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Disorder: A Randomized Controlled Outcome Study.. Journal of traumatic stress 2017;30(3):304-312 [Pubmed Journal](#)
 [585] Somatic experiencing vs WL. [Website](#)

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

Population: Adults with PTSD
Intervention: Saikokaishikankyoto
Comparator: Waitlist/ treatment as usual

Outcome Timeframe	Study results and measurements	Absolute effect estimates Waitlist/ treatment Saikokaishikankyoto as usual	Certainty of the Evidence (Quality of evidence)	Plain text summary
PTSD symptom severity	Lower better Based on data from: 43 patients in 1 studies. (Randomized controlled)	Difference: SMD 0.91 lower (CI 95% 1.55 lower - 0.28 lower)	Very Low Due to serious risk of bias, Due to serious imprecision, Due to serious publication bias ¹	We are uncertain whether saikokaishikankyoto increases or decreases PTSD symptom severity

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 ;

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[584] Saikokeishikankyoto vs WL. [Website](#)

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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Attention control placebo	Attentional bias modification		
PTSD symptom severity	Lower better Based on data from: 102 patients in 1 studies. (Randomized controlled)			Moderate Due to serious imprecision ¹	Attentional bias modification probably decreases PTSD symptom severity slightly

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** .

References

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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

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Waitlist/ as usual	Hypnotherapy		
PTSD symptom severity	Lower better Based on data from: 52 patients in 1 studies. (Randomized controlled)		Difference: SMD 0.04 lower (CI 95% 0.58 lower - 0.51 higher)	Very Low Due to serious risk of bias, Due to serious imprecision, Due to serious indirectness ¹	We are uncertain whether hypnotherapy increases or 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/or large loss to follow up, Missing intention-to-treat analysis ; **Inconsistency: No serious** . **Indirectness: Serious** . Differences between the population of interest and those studied (80% of participants were bereaved) ; **Imprecision: Serious** . Low number of patients (n=52), Only data from one study ; **Publication bias: No serious** .

References

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Clinical Question/ PICO

Population: Adults with PTSD
Intervention: Hypnotherapy
Comparator: Trauma-focused CBT

Outcome Timeframe	Study results and measurements	Absolute effect estimates		Certainty of the Evidence (Quality of evidence)	Plain text summary
		Trauma-focused CBT	Hypnotherapy		

<p>PTSD symptom severity</p> <p>Lower better Based on data from: 56 patients in 1 studies. (Randomized controlled)</p>	<p>Difference: SMD 0.34 higher (CI 95% 0.19 lower - 0.86 higher)</p>	<p>Very Low Due to serious risk of bias, Due to serious imprecision, Due to serious indirectness ¹</p>	<p>We are uncertain if there is a difference between hypnotherapy and CBT-T on PTSD symptom severity</p>
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1. **Risk of bias: Serious** . Incomplete data and/or large loss to follow up, Inadequate/lack of blinding of outcome assessors, resulting in potential for detection bias, Use of unvalidated and/or subjective outcome measures, Incomplete data and/or large loss to follow up ; **Inconsistency: No serious** . **Indirectness: Serious** . Differences between the population of interest and those studied (80% of participants were bereaved) ; **Imprecision: Serious** . Low number of patients (n=56), Wide confidence intervals (CIs include important harm and unimportant benefit), Only data from one study ; **Publication bias: No serious** .

References

[542] Brom D, Kleber RJ, Defares PB : Brief psychotherapy for posttraumatic stress disorders.. Journal of consulting and clinical psychology 1989;57(5):607-12 [Pubmed](#)

Electroacupuncture

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.

Clinical Question/ PICO

- Population:** Adults with PTSD
- Intervention:** Electroacupuncture
- Comparator:** Paroxetine

Outcome Timeframe	Study results and measurements	Absolute effect estimates Paroxetine Electroacupuncture		Certainty of the Evidence (Quality of evidence)	Plain text summary
PTSD symptom severity	Lower better Based on data from: 127 patients in 1 studies. (Randomized controlled)	Difference: SMD 0.21 lower (CI 95% 0.56 lower - 0.14 higher)		Moderate Due to serious imprecision ¹	Electroacupuncture is probably more beneficial than paroxetine on PTSD symptom severity

1. **Inconsistency: No serious . Indirectness: No serious . Imprecision: Serious .** Low number of patients (n=127), Wide confidence intervals (CIs include important benefit and unimportant harm), Only data from one study, ; **Publication bias: No serious .**

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Development of the Guidelines

The development of the Guidelines is described on the [Phoenix Australia Public Consultation website](#) (see the Plain Language Statement, Executive Summary, and Chapter 1 - Introduction).

Guideline Development Group

The members of the Guideline Development Group and the Phoenix Australia project team are set listed in the Acknowledgments document on the [Phoenix Australia Public Consultation website](#).

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[21] Stepped Preventative Care vs WLTAU. [Website](#)

[22] TFCBT (NET) vs Meditation. [Website](#)

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[24] Propranolol vs Placebo. [Website](#)

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