National Institute for Health and Care Excellence

Final

Post-traumatic stress disorder

[C] Evidence reviews for psychological, psychosocial and other non-pharmacological interventions for the prevention of PTSD in adults

NICE guideline NG116

Evidence reviews

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Final

These evidence reviews were developed by the National Guideline Alliance hosted by the Royal College of Obstetricians and Gynaecologists

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This evidence report contains information on 1 review relating to the prevention of PTSD.

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Review question For adults at risk of PTSD, what are the relative benefits and harms of psychological, psychosocial or other non-pharmacological interventions targeted at PTSD symptoms?

Introduction

People who experience traumatic events are at risk of developing PTSD. It is normal to experience traumatic stress symptoms, such as intrusive images and hyperarousal, in the days following such traumatic events. For most people these symptoms subside naturally with time. For a proportion the symptoms persist causing significant distress and/or interference, to the point of meeting criteria for PTSD. There are many reasons that may put people at increased risk of PTSD. These include experiences during the trauma, such as dissociation and/or high arousal, and importantly post-trauma experience, such as negative interpretations of initial traumatic stress symptoms and perceived social support. The identification of such risk factors has allowed the further development of interventions aimed at preventing the development of PTSD. This review aims to identify the most effective and cost-effective psychological and psychosocial interventions for the prevention of PTSD.

Summary of the protocol (PICO table)

Please see Table 1 for a summary of the Population, Intervention, Comparison and Outcome (PICO) characteristics of this review.

Table 1: Summary of the protocol (PICO table)

Population	Adults at risk of PTSD At risk of PTSD is defined (in accordance with DSM) as: Exposure to actual or threatened death, serious injury or sexual violation. The exposure must result from one or more of the following scenarios, in which the individual: • directly experiences the traumatic event; • witnesses the traumatic event in person; • learns that the traumatic event occurred to a close family member or close friend (with the actual or threatened death being either violent or accidental); or • experiences first-hand repeated or extreme exposure to aversive details of the traumatic event (not through media, pictures, television or movies unless work-related) This population includes people with a diagnosis of acute stress disorder/acute stress reaction (according to DSM, ICD or similar criteria), people with clinically important PTSD symptoms within a month of the traumatic event, and people with sub-threshold symptoms The at-risk population for this review will also include the following groups that may not be captured by the DSM criteria: • family members of people with PTSD • family members or carers of people with a life-threatening illness or injury

Intervention	**Psychological interventions** (psychological interventions listed below are examples of interventions which may be included either alone or in combination in an individual or group format): • Trauma-focused cognitive behavioural therapies (CBT), including cognitive therapy, cognitive processing therapy, compassion focused therapy, exposure therapy/prolonged exposure (PE), virtual reality exposure therapy (VRET), imagery rehearsal therapy, mindfulness-based cognitive therapy (MBCT) and narrative exposure therapy (NET) • Non-trauma-focused CBT, including stress inoculation training (SIT) • Psychologically-focused debriefing (including single session debriefing) • Eye movement desensitisation and reprocessing (EMDR) • Hypnotherapy • Psychodynamic therapies, including traumatic incident reduction (TIR) • Counselling, including non-directive/supportive/person-centred counselling • Human givens therapy • Combined somatic and cognitive therapies, including thought field therapy (TFT) and emotional freedom technique (EFT) • Couple interventions, including cognitive-behavioural conjoint therapy • Parent training/family interventions, including behavioural family therapy **Psychosocial interventions** (psychosocial interventions listed below are examples of interventions which may be included either alone or in combination): • Meditation • Mindfulness-based stress reduction (MBSR) • Supported employment (including individual placement and support [IPS] supported employment and Veterans Health Administration Vocational Rehabilitation Programme [VRP]) • Practical support (including financial and housing) • Psychoeducational interventions • Peer support (including self-help groups and support groups and Trauma Risk Management [TRiM]) **Other non-pharmacological interventions** (other non-pharmacological interventions listed below are examples of interventions which may be included either alone or in combination): • Acupuncture (including classical acupuncture, electroacupuncture, auricular acupuncture, laser acupuncture and acupoint stimulation [such as acupressure, moxibustion and tapping]) • Exercise (including anaerobic [such as heavy weight training, sprinting, high-intensity interval training] and aerobic [such as running/jogging, swimming, cycling and walking] exercise, both supervised and unsupervised) • Repetitive transcranial magnetic stimulation (rTMS)

	• Yoga (including all types of yoga)
Comparison	• Any other intervention • Treatment as usual • Waitlist • Placebo
Outcome	**Critical outcomes:** • Efficacy (PTSD symptoms/diagnosis) • Acceptability of the intervention (discontinuation for any reason used as a proxy) **Important outcomes:** • Dissociative symptoms • Personal/social/occupational functioning (including global functioning/functional impairment) • Sleeping difficulties • Quality of life • Symptoms of a coexisting condition (including anxiety, depression and substance misuse problems) • Acceptability/tolerability

For full details see review protocol in Appendix A.

Methods and processes

This evidence review was developed using the methods and process described in Developing NICE guidelines: the manual; see the methods chapter for further information.

Declarations of interest were recorded according to NICE's 2014 and 2018 conflicts of interest policies.

Psychological interventions for the prevention of PTSD in adults

Introduction to clinical evidence

Psychological interventions will be considered as classes of intervention (trauma-focused CBT; non-trauma-focused CBT; present-centred therapy; cognitive therapies; behavioural therapies; problem solving; psychologically-focused debriefing; eye movement desensitisation and reprocessing [EMDR]; hypnotherapy; interpersonal psychotherapy (IPT); counselling; combined somatic and cognitive therapies; couple interventions; parent training/family interventions; self-help with support and self-help (without support), and form the subsections below.

Evidence for interventions in the following classes was also searched for but none was found: psychodynamic therapies; human givens therapy.

Analysis was subdivided by the type and timing of prevention strategies, including: early prevention of PTSD for adults exposed to trauma (with the intervention initiated within 1 month of the traumatic event); prevention of PTSD in adults with ongoing exposure to trauma (for instance, in a war zone); early 'treatment' (initiated 1- 3 months after trauma) of non-significant PTSD symptoms in adults; and delayed 'treatment' (initiated more than 3 months after trauma) of non-significant PTSD symptoms in adults.

A planned sub-analysis aimed to compare effects by diagnostic status at baseline, however, findings were not meaningful as there was either only one subgroup or subgroups had no more than 1 study in each.

Trauma-focused cognitive behavioural therapies (CBT): clinical evidence

Included studies

Forty-six studies of trauma-focused CBT for the prevention of PTSD in adults were identified for full-text review. Of these 46 studies, 21 RCTs (N=2251) were included. Some of these RCTs were three- or four-armed trials and as such were included in more than one comparison. There were 8 comparisons for trauma-focused CBT.

For the early prevention (intervention initiated within 1 month of traumatic event) of PTSD in adults, there was evidence for 3 relevant comparison: 3 RCTs (N=452) compared trauma-focused CBT (alone or in addition to psychoeducation) with waitlist or no treatment (Bryant 2008a; Rothbaum 2012; Wijesinghe 2015); 5 RCTs (N=545) compared trauma-focused CBT (alone or in addition to treatment as usual [TAU] or psychoeducation) with TAU, attention-placebo or a psychoeducational session (Foa 2006; Nixon 2016; O'Donnell 2012; Price 2014; Wijesinghe 2015); 7 RCTs (N=356) compared trauma-focused CBT with supportive counselling (Bryant unpublished; Bryant 1998/ Bryant 2003b [1 study reported across 2 papers]; Bryant 1999/Bryant 2003b [1 study reported across 2 papers]; Bryant 2005/2006 [1 study reported across 2 papers]; Foa 2006; Kangas 2013; Nixon 2012b).

For prevention of PTSD in adults with ongoing exposure to trauma (for instance, war zone), there were no included studies.

For the early treatment (1-3 months) of non-significant PTSD symptoms in adults, there was evidence for 1 relevant comparison: 1 RCT (N=60) compared trauma-focused CBT with self-help (without support) (Wu 2014).

For the delayed treatment (>3 months) of non-significant PTSD symptoms in adults, there was evidence for 4 relevant comparisons: 4 RCTs (N=667) compared trauma-focused CBT with waitlist (Bolton 2014b; Classen 2011; DuHamel 2010; Maercker 2006); 2 RCTs (N=423) compared trauma-focused CBT with attention-placebo or psychoeducation (Berger 2016; Chambers 2014); 1 RCT (N=166) compared trauma-focused CBT with present-centred therapy (Classen 2011); 1 RCT (N=63) compared a trauma-focused CBT group with a peer support group (Deblinger 2001).

Excluded studies

Twenty-five studies were reviewed at full text and excluded from this review. The most common reasons for exclusion were that efficacy or safety data could not be extracted, group assignment was non-randomised, the study was a subgroup or secondary analysis of an RCT already included, or the paper was a systematic review with no new useable data and any meta-analysis results not appropriate to extract.

Studies not included in this review with reasons for their exclusions are provided in Appendix K.

Summary of clinical studies included in the evidence review

Table 2, Table 3 and Table 4 provide brief summaries of the included studies and evidence from these are summarised in the clinical GRADE evidence profiles below (Table 5, Table 6, Table 7, Table 8, Table 9, Table 10, Table 11 and Table 12).

See also the study selection flow chart in Appendix C, forest plots in Appendix E and study evidence tables in Appendix D.

Table 2: Summary of included studies: Trauma-focused CBT for early prevention (<1 month)

Comparison	TF-CBT (+/- psychoeducation) versus waitlist/no treatment	TF-CBT (+/- TAU/psychoeducation) versus TAU/attention-placebo/ psychoeducational session	TF-CBT versus supportive counselling
Total no. of studies (N randomised)	3 (452)	5 (545)	7 (356)
Study ID	Bryant 2008a[1] Rothbaum 2012[2] Wijesinghe 2015[3]	Foa 2006[4] Nixon 2016[5] O'Donnell 2012[6] Price 2014[7] Wijesinghe 2015[3]	Bryant unpublished[8] Bryant 1998/2003b[9] Bryant 1999/Bryant 2003b[10] Bryant 2005/2006[11] Foa 2006[12] Kangas 2013[13] Nixon 2012b[14]
Country	Australia[1] US[2] Sri Lanka[3]	US[4,7] Australia[5,6] Sri Lanka[3]	Australia[8,9,10,11,13,14] US[12]
Diagnostic status	Acute stress disorder/acute stress reaction diagnosis according to ICD/DSM criteria[1]	Clinically important PTSD symptoms (scoring above a threshold on validated scale) [4,6]	Acute stress disorder/acute stress reaction diagnosis according to ICD/DSM criteria[8,9,10,11,14]

Comparison	TF-CBT (+/- psychoeducation) versus waitlist/no treatment	TF-CBT (+/- TAU/psychoeducation) versus TAU/attention-placebo/ psychoeducational session	TF-CBT versus supportive counselling
	Clinically important PTSD symptoms (scoring above a threshold on validated scale) [2] Unclear[3]	Acute stress disorder/acute stress reaction diagnosis according to ICD/DSM criteria[5] Non-significant symptoms (below threshold and <50% maximum score on scale) [7] Unclear[3]	Clinically important PTSD symptoms (scoring above a threshold on validated scale) [12] Non-significant symptoms (below threshold and <50% maximum score on scale) [13]
Mean age (range)	35.4 (range NR) [1] 31.5 (18-65) [2] 42.1 (range NR) [3]	33.7 (range NR) [4] 31 (range NR) [5] 35.9 (18-70) [6] 31.5 (range NR) [7] 42.1 (range NR) [3]	31 (18-60) [8] 32.6 (range NR) [9] 34 (range NR) [10] 33.6 (range NR) [11] 33.7 (range NR) [12] 54.8 (range NR) [13] 40.6 (range NR) [14]
Sex (% female)	58[1] 65[2] 25[3]	100[4] 98[5] 39[6] 65[7] 25[3]	67[8] 58[9] 51[10] 61[11] 100[12] 20[13] 47[14]
Ethnicity (% BME)	13[1] 87[2] NR[3]	69[4] 13[5] NR[3,6] 78[7]	NR[8,9,10,11,13] 69[12] 3[14]
Coexisting conditions	47% MDD; 4% anxiety disorder; 2% substance use disorder[1] NR[2] 0.02% treated in intensive care[3]	NR[4,7] 86% had at least one other comorbid diagnosis: Mood disorder (61%), Anxiety disorder (52%), Substance (28%)[5] 48% mild traumatic brain injury; 67% major depressive episode; 39% other (not PTSD) anxiety disorder[6] 0.02% treated in intensive care[3]	NR[8,9,10,11,12] 17% met criteria for MDD; 9% social anxiety; 26% adjustment disorder[13] 63% mood disorder; 27% anxiety disorder; 3% substance disorder[14]
Mean months since traumatic event	0.7[1] 0.02 (mean 11.79 hours) [2] Mean NR (intervention initiated 1-month post-discharge) [3]	0.67[4] NR (≤4 weeks) [5] Mean NR (intervention initiated at 4-weeks post-injury) [6] 0 (first intervention session began in the emergency	Mean NR (treatment delivered within two weeks of trauma) [8] 0.5[9,10,11] 0.67[12] NR ('newly diagnosed')[13] Mean NR (≤4 weeks)[14]

Comparison	TF-CBT (+/- psychoeducation) versus waitlist/no treatment	TF-CBT (+/- TAU/psychoeducation) versus TAU/attention-placebo/ psychoeducational session	TF-CBT versus supportive counselling
		department after the patient was medically stable) [7] Mean NR (intervention initiated 1-month post-discharge) [3]	
Type of traumatic event	Exposure to non-sexual violence: Nonsexual assault (63%); motor vehicle accident (37%)[1] Mixed: Rape (34%); Nonsexual assault (27%); Motor vehicle accident (34%); Other (5%)[2] Unintentional injury/illness/medical emergency: Snakebite[3]	Exposure to sexual abuse or assault: Sexual assault (63%) or non-sexual assault (37%)[4] Exposure to sexual abuse or assault: Rape or sexual assault. Relationship to perpetrator: stranger (46%); acquaintance or friend (43%); ex-intimate or relative (11%)[5] Motor Vehicle Collision: Motor vehicle accident (67%); Assault (22%) - data not reported for mechanism of injury for all participants (N=41 rather than 46) [6] Mixed: 35% sexual assault[7] Unintentional injury/illness/medical emergency: Snakebite[3]	Mixed: Nonsexual assault or motor vehicle accident[8] Motor Vehicle Collision: 58% motor vehicle accidents; 42% industrial accident[9] Exposure to non-sexual violence: Nonsexual assault (53%); motor vehicle accidents (47%)[10] Exposure to non-sexual violence: Non-sexual assault (55%); motor vehicle accident (45%)[11] Exposure to sexual abuse or assault: Sexual assault (63%) or non-sexual assault (37%)[12] Diagnosis of life-threatening condition: Patients diagnosed with a primary, first-onset head and neck cancer[13] Exposure to non-sexual violence: 93% physical assault; 7% sexual assault[14]
Single or multiple incident index trauma	Single	Single[3,4,5,6] Unclear[7]	Single
Lifetime experience of trauma	NR[1,3] 46% had previous trauma. Prior trauma exposure: Rape (12%); Nonsexual assault (13%); Motor vehicle accident (16%); Other (4%)[2]	NR[3,4,6,7] 91% prior trauma: sexual (74%); physical (54%); other (89%)[5]	NR[8,9,10,11,12,13] 83% previous trauma[14]
Intervention details	Combined two arms (prolonged exposure and cognitive restructuring;	Brief individual CBT (based on Foa 1991 protocol) [4]	CBT individual[8] Cognitive therapy[9] Two arms combined (prolonged exposure and

Comparison	TF-CBT (+/- psychoeducation) versus waitlist/no treatment	TF-CBT (+/- TAU/psychoeducation) versus TAU/attention-placebo/ psychoeducational session	TF-CBT versus supportive counselling
	following unpublished manual) [1] Prolonged exposure (modified version of Foa et al. 2007 and Rothbaum et al. 2007 protocol) [2] Trauma-focused CBT session following psychoeducation session[3]	Cognitive processing therapy (Nixon 2012) abbreviated 6-session format (modified framework and materials of Resick et al. 2007 manual) + TAU (35% taking psychotropic medication) [5] Trauma-focused CBT (following an unpublished manual) [6] Prolonged exposure (modified version of Foa 2007 manual) [7] Trauma-focused CBT session following psychoeducation session[3]	prolonged exposure + anxiety management; following unpublished manual) [10] CBT individual (following unpublished manual) [11] Brief individual CBT (based on Foa 1991 protocol) [12] Brief early CBT programme[13] Cognitive processing therapy (following manual by Resick & Schnicke 1993) [14]
Intervention format	Individual	Individual	Individual
Intervention intensity	5x weekly 90-min sessions (7.5 hours) [1] 3x weekly 1-hour sessions (3 hours) [2] 1x 15-min psychoeducation session + 1x 20-min TF-CBT session (0.6 hours) [3]	4x 2-hour sessions (8 hours) [4] 6x weekly 90min sessions. Mean attended 3.5 sessions[5] 4-10x 90-min sessions (6-15 hours). Mean attended 7.6 sessions[6] 3x weekly 1-hour sessions (3 hours) [7] 1x 15-min psychoeducation session + 1x 20-min TF-CBT session (0.6 hours)[3]	5x 1.5-hour sessions (7.5 hours) [8,9,10,11] 4x 2-hour sessions (8 hours) [12] 6x weekly 90-min sessions + 1x booster session at 4 week follow-up[13] 6x weekly 90-min sessions (9 hours) [14]
Comparator	Waitlist[1] No treatment[2,3]	Attention-placebo[4] TAU (46% were taking psychotropic medication) [5] TAU (57% received treatment) [6] TAU (no further detail reported) [7] Single psychoeducation session (psychological first-aid) prior to discharge[3]	Supportive counselling
Intervention length (weeks)	5[1] 3[2] 1[3]	1[3,4] 6[5] 10[6] 3[7]	5[8,9,10,11] 1[12] 10[13] 6[14]

BME, Black and Minority Ethnic; NR, Not reported; DSM, Diagnostic and Statistical Manual of Mental Disorders; ICD, International Classification of Disease; PTSD, Post-traumatic stress disorder; TAU, Treatment as usual; TF-CBT, Trauma-focused cognitive behavioural therapy
[1]Bryant 2008a; [2]Rothbaum 2012; [3]Wijesinghe 2015; [4]Foa 2006; [5]Nixon 2016; [6]O'Donnell 2012; [7]Price 2014; [8]Bryant unpublished; [9]Bryant 1998/2003b; [10]Bryant 1999/Bryant 2003b; [11]Bryant 2005/2006; [12]Foa 2006; [13]Kangas 2013; [14]Nixon 2012b

Table 3: Summary of included studies: Trauma-focused CBT for early treatment (1-3 months) of non-significant PTSD symptoms

Comparison	Trauma-focused CBT versus self-help (without support)
Total no. of studies (N randomised)	1 (60)
Study ID	Wu 2014
Country	China
Diagnostic status	Subthreshold symptoms (below threshold but ≥50% maximum score on scale)
Mean age (range)	39.6 (range NR)
Sex (% female)	32
Ethnicity (% BME)	NR
Coexisting conditions	NR
Mean months since traumatic event	Mean NR (participants received and completed the intervention within a period of 1–3 months after the MVC)
Type of traumatic event	Motor Vehicle Collision: Attended A&E after a motor vehicle collision
Single or multiple incident index trauma	Single
Lifetime experience of trauma	NR
Intervention details	Brief trauma-focused CBT (adapted from manual by Bisson 2004)
Intervention format	Individual
Intervention intensity	4x weekly 1.5-hour sessions (6 hours)
Comparator	Self-help booklet based on the brief trauma-focused CBT manual used in the study and a published PTSD self-help workbook (Williams and Poijula 2002)
Intervention length (weeks)	4

A&E, Accident and Emergency; BME, black and minority ethnic; CBT, cognitive behavioural therapy; MVC, Motor Vehicle Crashes; NR, not reported; PTSD, post-traumatic stress disorder

Table 4: Summary of included studies: Trauma-focused CBT for delayed treatment (>3 months) of non-significant PTSD symptoms

Comparison	Trauma-focused CBT versus waitlist/no treatment	Trauma-focused CBT versus attention-placebo/ psychoeducation	Trauma-focused CBT versus present-centred therapy	Trauma-focused CBT group versus peer support group
Total no. of studies (N randomised)	4 (667)	2 (423)	1 (166)	1 (63)
Study ID	Bolton 2014b[1] Classen 2011[2] DuHamel 2010[3] Maercker 2006[4]	Berger 2016[5] Chambers 2014[6]	Classen 2011	Deblinger 2001
Country	Thailand[1] US and Canada[2]	New Zealand[5] Australia[6]	US and Canada	US

Comparison	Trauma-focused CBT versus waitlist/no treatment	Trauma-focused CBT versus attention-placebo/ psychoeducation	Trauma-focused CBT versus present-centred therapy	Trauma-focused CBT group versus peer support group
	US[3] Germany[4]			
Diagnostic status	Non-significant symptoms (below threshold and <50% maximum score on scale) [1,3] Subthreshold symptoms (below threshold but ≥50% maximum score on scale) [2,4]	Non-significant symptoms (below threshold and <50% maximum score on scale) [5] Subthreshold symptoms (below threshold but ≥50% maximum score on scale) [6]	Subthreshold symptoms (below threshold but ≥50% maximum score on scale)	Non-significant symptoms (below threshold and <50% maximum score on scale)
Mean age (range)	35.6 (18-85) [1] 36.2 (range NR) [2] 51 (19-74) [3] 40.4[4]	44.6 (22-69) [5] 58.3 (range NR) [6]	36.2 (range NR)	33.1 (range NR)
Sex (% female)	63[1] 100[2] 51[3] 76[4]	77[5] 83[6]	100	100
Ethnicity (% BME)	NR[1,4] 27[2] 19[3]	25[5] NR[6]	27	NR
Coexisting conditions	10% harmful alcohol use (score ≥8 on AUDIT) [1] 52% met DSM–IV criteria for abuse or dependence (any substance) [2] NR[3,4]	NR	52% met DSM–IV criteria for abuse or dependence (any substance)	NR
Mean months since traumatic event	NR (mean 5.5 years in Thailand) [1] 246.6[2] 274 (since transplantation) [3] 56.1[4]	11[5] 20.9 (for patients and caregivers combined) [6]	246.6	11.4 (based on mothers estimation of age at first sexual abuse)
Type of traumatic event	Witnessing war as a civilian: Burmese survivors of imprisonment, torture, and related traumas[1] Childhood sexual abuse: Participants experienced childhood sexual	Natural disaster: Christchurch Earthquake, February 2011. 97% present during the earthquake; 40% lost friends or acquaintances; 59% had a family member or a friend injured; 52%	Childhood sexual abuse: Participants experienced childhood sexual abuse between age 4 and 17 years and the perpetrator was at least 5 years older. Mean age of first abuse	Non-offending mothers of children who had made a credible disclosure of contact sexual abuse

Comparison	Trauma-focused CBT versus waitlist/no treatment	Trauma-focused CBT versus attention-placebo/ psychoeducation	Trauma-focused CBT versus present-centred therapy	Trauma-focused CBT group versus peer support group
	abuse between age 4 and 17 years and the perpetrator was at least 5 years older. Mean age of first abuse experience 6.7 (SD=3.1); mean duration of abuse 7.7 years (SD=6.6) [2] Diagnosis of life-threatening condition: Survivors of hematopoietic stem-cell transplantation (HSCT) who had undergone HSCT 1-3 years earlier[3] Motor Vehicle Collision: Continuing medical treatment after MVA in days: 21.5 as inpatient; 245.1 as outpatient[4]	witnessed building falling[5] Diagnosis of life-threatening condition: Patients with cancer who had called cancer helplines seeking support. The most frequent cancer types were breast (31%), colorectal (9%), prostate (9%), hematologic (8%), lung (8%), and gynaecologic (7%)[6]	experience 6.7 (SD=3.1); mean duration of abuse 7.7 years (SD=6.6)	
Single or multiple incident index trauma	Multiple[1,2] Single[3,4]	Single	Multiple	Multiple
Lifetime experience of trauma	Mean number of traumatic events either witnessed or experienced: 12.0 (range 1-24) [1] NR[2,3,4]	NR	NR	27% of the mothers reported sexual abuse as an adult and 45% mothers reported sexual abuse as child
Intervention details	Cognitive Processing Therapy (CPT) [1] Trauma-focused group psychotherapy (TFGT), following manual by Classen et al. 2001[2] Telephone-administered Cognitive-	ERASE-Stress New Zealand (ES-NZ) [5] CBT individual (following unpublished manual) [6]	Trauma-focused group psychotherapy (TFGT), following manual by Classen et al. 2001	Trauma-focused CBT parent group (therapy based on individual therapy approach of Deblinger & Heflin, 1996)

Comparison	Trauma-focused CBT versus waitlist/no treatment	Trauma-focused CBT versus attention-placebo/ psychoeducation	Trauma-focused CBT versus present-centred therapy	Trauma-focused CBT group versus peer support group
	Behavioural Therapy, following an unpublished manual[3] Cognitive behavioural treatment (CBT) based on translated, modified, and extended version of protocol by Blanchard and Hickling (2003)[4]			
Intervention format	Individual[1,3,4] Group[2]	Group[5] Individual[6]	Group	Group
Intervention intensity	12 sessions (length of session not reported)[1] 24x weekly 90-min sessions (36 hours). 29% attended no therapy sessions; 56% attended ≥75% sessions[2] 10 sessions (1x 90-min and 9x 60-min; 10.5 hours in total). Mean attended 8.4 (SD=3.3) sessions[3] 8-12x weekly sessions (length of session not reported). Mean attended 11.4 (SD= 3.2) sessions[4]	3-day workshop (24 hours)[5] 5x sessions. Median 4 attended sessions[6]	24x weekly 90-min sessions (36 hours). 29% attended no therapy sessions; 56% attended ≥75% sessions	11x 2 hour sessions (22 hours). Mean number of sessions attended was 8.5 (SD=1.9) for completer sample across both arms
Comparator	Waitlist[1,2,4] No treatment[3]		Waitlist	Supportive group for parents
Intervention length (weeks)	NR[1] 26[2] 10-16[3] 12[4]		26	11x 1.75 hour sessions (19.25 hours)

AUDIT, Alcohol Use Disorders Identification Test; A&E, Accident and Emergency; BME, black and minority ethnic; CBT, cognitive behavioural therapy; DSM-IV, Diagnostic and Statistical Manual of Mental Disorders-IV; ERASE-Stress, a school-based, teacher-medicated prevention program; HSCT, Haemopoietic stem cell transplantation; MVA, Motor Vehicle Accidents; MVC, Motor Vehicle Crashes; NR, not reported; PTSD, post-traumatic stress disorder; SD, standard deviation
[1]Bolton 2014b; [2]Classen 2011; [3]DuHamel 2010; [4]Maercker 2006; [5]Berger 2016; [6]Chambers 2014

See appendix D for full evidence tables.

Quality assessment of clinical studies included in the evidence review

The clinical evidence profiles for this review (trauma-focused CBT for the prevention of PTSD in adults) are presented in Table 5, Table 6, Table 7, Table 8, Table 9, Table 10, Table 11 and Table 12.

Table 5: Summary clinical evidence profile: Trauma-focused CBT (+/- psychoeducation) versus waitlist or no treatment for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist or no treatment	Corresponding risk Trauma-focused CBT (+/- psychoeducation)			
PTSD symptomatology self-rated PDS change score Follow-up: mean 3 weeks		The mean PTSD symptomatology self-rated in the intervention groups was 2.79 standard deviations lower (3.26 to 2.32 lower)		137 (1 study)	very low[1,2]
PTSD symptomatology clinician-rated at endpoint CAPS change score/PSS-I endpoint score Follow-up: 3-5 weeks		The mean PTSD symptomatology clinician-rated at endpoint in the intervention groups was 2.2 standard deviations lower (3.9 to 0.51 lower)		227 (2 studies)	very low[1,2,3]
PTSD symptomatology clinician-rated at 2-month follow-up PSS-I endpoint score Follow-up: mean 2 months		The mean PTSD symptomatology clinician-rated at 2-month follow-up in the intervention groups was 2.55 standard deviations		137 (1 study)	very low[1,2]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist or no treatment	Corresponding risk Trauma-focused CBT (+/- psychoeducation)			
		lower (3.01 to 2.1 lower)			
PTSD at endpoint Number of people who met criteria for PTSD Follow-up: mean 3 weeks	515 per 1000	463 per 1000 (329 to 654)	RR 0.9 (0.64 to 1.27)	137 (1 study)	very low[1,4]
PTSD at 2-month follow-up Number of people who met criteria for PTSD Follow-up: mean 2 months	471 per 1000	259 per 1000 (165 to 419)	RR 0.55 (0.35 to 0.89)	137 (1 study)	very low[1,5]
PTSD at 6-month follow-up Number of people who met criteria for PTSD Follow-up: mean 6 months	187 per 1000	106 per 1000 (47 to 239)	RR 0.57 (0.25 to 1.28)	150 (1 study)	very low[1,4]
Anxiety symptoms BAI change score Follow-up: mean 5 weeks		The mean anxiety symptoms in the intervention groups was 0.43 standard deviations lower (0.87 lower to 0.01 higher)		90 (1 study)	very low[1,6]
Depression symptoms BDI-II change score Follow-up: 3-5 weeks		The mean depression symptoms in the intervention groups was 1.94 standard deviations lower (4.47 lower to 0.6 higher)		227 (2 studies)	very low[1,3,4]
Discontinuation Number of participants lost to follow-up	168 per 1000	174 per 1000 (94 to 324)	RR 1.04 (0.56 to 1.93)	377 (3 studies)	very low[1,4]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist or no treatment	Corresponding risk Trauma-focused CBT (+/- psychoeducation)			
Follow-up: 3-26 weeks					

BAI=Beck Anxiety Inventory; BDI=Beck Depression Inventory; CAPS=clinician-administered PTSD scale; CBT=cognitive behavioural therapy; CI=confidence interval: PDS=posttraumatic diagnostic scale; PSS-I=PTSD symptom scale-Interview; PTSD=post-traumatic stress disorder; RR=relative risk; SMD=standardised mean difference

[1] *Risk of bias is high or unclear across multiple domains*
[2] *OIS not met (N<400)*
[3] *Considerable heterogeneity (I2>80%)*
[4] *95% CI crosses line of no effect and thresholds for both clinically important benefit and harm*
[5] *OIS not met (events<300)*
[6] *95% CI crosses both line of no effect and threshold for clinically important benefit*

Table 6: Summary clinical evidence profile: Trauma-focused CBT (+/- TAU/psychoeducation) versus TAU, attention-placebo or psychoeducational session for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk TAU, attention-placebo or psychoeducational session	Corresponding risk Trauma-focused CBT (+/- TAU/psychoeducation)			
PTSD symptomatology self-rated at endpoint PCL/PSS-SR change score Follow-up: 1-6 weeks		The mean PTSD symptomatology self-rated at endpoint in the intervention groups was 0.25 standard deviations lower (0.87 lower to 0.38 higher)		87 (2 studies)	very low[1,2,3]
PTSD symptomatology self-rated at 3-month follow-up PCL/PSS-SR change score Follow-up: mean 3 months		The mean PTSD symptomatology self-rated at 3-month follow-up in the intervention groups was 0.36 standard deviations lower (0.79 lower to 0.07 higher)		84 (2 studies)	low[1,3]
PTSD symptomat		The mean PTSD symptomatology		46 (1 study)	low[1,3]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk TAU, attention-placebo or psychoeducational session	Corresponding risk Trauma-focused CBT (+/- TAU/psychoeducation)			
ology self-rated at 6-month follow-up PCL change score Follow-up: mean 6 months		self-rated at 6-month follow-up in the intervention groups was 0.3 standard deviations lower (0.88 lower to 0.28 higher)			
PTSD symptomatology self-rated at 1-year follow-up PCL/PSS-SR change score Follow-up: mean 1 years		The mean PTSD symptomatology self-rated at 1-year follow-up in the intervention groups was 0.39 standard deviations lower (0.82 lower to 0.03 higher)		88 (2 studies)	low[1,3]
PTSD symptomatology clinician-rated at endpoint CAPS/PSS-I change score Follow-up: 1-10 weeks		The mean PTSD symptomatology clinician-rated at endpoint in the intervention groups was 0.29 standard deviations lower (0.63 lower to 0.04 higher)		232 (4 studies)	low[1,3]
PTSD symptomatology clinician-rated at 2-3 month follow-up CAPS/PSS-I change score Follow-up: 2-3 months		The mean PTSD symptomatology clinician-rated at 2-3 month follow-up in the intervention groups was 0.18 standard deviations lower (0.47 lower to 0.11 higher)		188 (3 studies)	low[1,4]
PTSD symptomatology clinician-rated at 6-		The mean PTSD symptomatology clinician-rated at 6-month follow-up in the intervention		77 (2 studies)	very low[1,2,3]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk TAU, attention-placebo or psychoeducational session	Corresponding risk Trauma-focused CBT (+/- TAU/psychoeducation)			
month follow-up CAPS change score Follow-up: mean 6 months		groups was 0.81 standard deviations lower (1.88 lower to 0.26 higher)			
PTSD symptomatology clinician-rated at 1-year follow-up CAPS/PSS-I change score Follow-up: mean 1 years		The mean PTSD symptomatology clinician-rated at 1-year follow-up in the intervention groups was 0.05 standard deviations lower (0.47 lower to 0.37 higher)		88 (2 studies)	low[1,4]
PTSD at endpoint Number meeting criteria for PTSD Follow-up: 6-10 weeks	591 per 1000	278 per 1000 (118 to 668)	RR 0.47 (0.2 to 1.13)	93 (2 studies)	very low[1,2,3]
PTSD at 2-3 month follow-up Number meeting criteria for PTSD Follow-up: 2-3 months	615 per 1000	437 per 1000 (326 to 585)	RR 0.71 (0.53 to 0.95)	184 (2 studies)	low[1,5]
PTSD at 6-month follow-up Number meeting criteria for PTSD Follow-up: mean 6 months	289 per 1000	214 per 1000 (81 to 557)	RR 0.74 (0.28 to 1.93)	197 (2 studies)	very low[1,2,6]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk TAU, attention-placebo or psychoeducational session	Corresponding risk Trauma-focused CBT (+/- TAU/psychoeducation)			
PTSD at 1-year follow-up Number meeting criteria for PTSD Follow-up: mean 1 years	455 per 1000	518 per 1000 (286 to 941)	RR 1.14 (0.63 to 2.07)	47 (1 study)	very low[1,6]
Response at endpoint Number of people showing improvement of at least 12 points on CAPS Follow-up: mean 6 weeks	682 per 1000	723 per 1000 (498 to 1000)	RR 1.06 (0.73 to 1.54)	47 (1 study)	very low[1,6]
Response at 3-month follow-up Number of people showing improvement of at least 12 points on CAPS Follow-up: mean 3 months	364 per 1000	520 per 1000 (265 to 1000)	RR 1.43 (0.73 to 2.79)	47 (1 study)	very low[1,6]
Response at 6-month follow-up Number of people showing improvement of at least 12 points on CAPS Follow-up:	500 per 1000	480 per 1000 (270 to 860)	RR 0.96 (0.54 to 1.72)	47 (1 study)	very low[1,6]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk TAU, attention-placebo or psychoeducational session	Corresponding risk Trauma-focused CBT (+/- TAU/psychoeducation)			
mean 6 months					
Response at 1-year follow-up Number of people showing improvement of at least 12 points on CAPS Follow-up: mean 1 years	500 per 1000	560 per 1000 (325 to 965)	RR 1.12 (0.65 to 1.93)	47 (1 study)	very low[1,6]
Anxiety symptoms at endpoint BAI/HADS-A change score Follow-up: 1-10 weeks		The mean anxiety symptoms at endpoint in the intervention groups was 0.98 standard deviations lower (2.1 lower to 0.14 higher)		82 (2 studies)	very low[1,3,7]
Anxiety symptoms at 3-month follow-up BAI change score Follow-up: mean 3 months		The mean anxiety symptoms at 3-month follow-up in the intervention groups was 0.60 standard deviations lower (1.25 lower to 0.06 higher)		38 (1 study)	very low[1,3,7]
Anxiety symptoms at 6-month follow-up HADS-A change score Follow-up: mean 6 months		The mean anxiety symptoms at 6-month follow-up in the intervention groups was 0.8 standard deviations lower (1.55 to 0.04 lower)		31 (1 study)	low[1,4]
Anxiety symptoms at 1-year follow-up BAI change score		The mean anxiety symptoms at 1-year follow-up in the intervention groups was 0.7 standard		42 (1 study)	very low[1,4]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk TAU, attention-placebo or psychoeducational session	Corresponding risk Trauma-focused CBT (+/- TAU/psychoeducation)			
Follow-up: mean 1 years		deviations lower (1.32 to 0.07 lower)			
Depression symptoms at endpoint BDI/BDI-II change score Follow-up: 1-10 weeks		The mean depression symptoms at endpoint in the intervention groups was 0.76 standard deviations lower (2.37 lower to 0.86 higher)		129 (3 studies)	very low[1,6,7]
Depression symptoms at 3-month follow-up BDI/BDI-II change score Follow-up: mean 3 months		The mean depression symptoms at 3-month follow-up in the intervention groups was 0.03 standard deviations lower (0.73 lower to 0.66 higher)		84 (2 studies)	very low[1,2,6]
Depression symptoms at 6-month follow-up BDI/BDI-II change score Follow-up: mean 6 months		The mean depression symptoms at 6-month follow-up in the intervention groups was 1.32 standard deviations lower (2.72 lower to 0.08 higher)		77 (2 studies)	very low[1,3,7]
Depression symptoms at 1-year follow-up BDI/BDI-II change score Follow-up: mean 1 years		The mean depression symptoms at 1-year follow-up in the intervention groups was 0.01 standard deviations higher (1.15 lower to 1.18 higher)		88 (2 studies)	very low[1,6,7]
Discontinuation Number of participants lost to follow-up	211 per 1000	249 per 1000 (177 to 350)	RR 1.18 (0.84 to 1.66)	441 (5 studies)	Moderate[8]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk TAU, attention-placebo or psychoeducational session	Corresponding risk Trauma-focused CBT (+/- TAU/psychoeducation)			
Follow-up: 1-10 weeks					

BAI=Beck Anxiety Inventory; BDI=Beck Depression Inventory; CAPS=Clinician-administered PTSD scale; CBT=cognitive behavioural therapy; CI=confidence interval; HADS-A=Hospital Anxiety and Depression Scale-Anxiety; PCL=PTSD Checklist; PSS-I/SR=PTSD symptom scale-interview/self-report; PTSD=post-traumatic stress disorder; RR=risk ratio; SMD=standard mean difference; TAU=treatment as usual

[1] Risk of bias is high or unclear across multiple domains
[2] Substantial heterogeneity (I2>50%)
[3] 95% CI crosses both line of no effect and threshold for clinically important benefit
[4] OIS not met (N<400)
[5] OIS not met (events<300)
[6] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm
[7] Considerable heterogeneity (I2>80%)
[8] 95% CI crosses both line of no effect and threshold for clinically important harm

Table 7: Summary clinical evidence profile: Trauma-focused CBT versus supportive counselling for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Supportive counselling	Corresponding risk Trauma-focused CBT			
PTSD symptomatology self-rated at endpoint IES-R endpoint/PCL/PDS/PSS-SR change score Follow-up: 1-10 weeks		The mean PTSD symptomatology self-rated at endpoint in the intervention groups was 0.71 standard deviations lower (1.14 to 0.28 lower)		133 (4 studies)	low[1,2]
PTSD symptomatology self-rated at 3-month follow-up PSS-SR change score Follow-up: mean 3 months		The mean PTSD symptomatology self-rated at 3-month follow-up in the intervention groups was 0.66 standard deviations lower (1.32 to 0.01 lower)		38 (1 study)	very low[1,2]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Supportive counselling	Corresponding risk Trauma-focused CBT			
PTSD symptomatology self-rated at 5-6 month follow-up IES-R endpoint/PCL change score Follow-up: 5-6 months		The mean PTSD symptomatology self-rated at 5-6 month follow-up in the intervention groups was 0.61 standard deviations lower (1.14 to 0.08 lower)		59 (2 studies)	low[1,2]
PTSD symptomatology self-rated at 11-12 month follow-up PCL/PSS-SR change score Follow-up: 11-12 months		The mean PTSD symptomatology self-rated at 11-12 month follow-up in the intervention groups was 0.5 standard deviations lower (0.95 to 0.06 lower)		81 (2 studies)	very low[1,2]
PTSD symptomatology clinician-rated at endpoint CAPS/PSS-I endpoint/change score Follow-up: 1-6 weeks		The mean PTSD symptomatology clinician-rated at endpoint in the intervention groups was 0.58 standard deviations lower (1 to 0.17 lower)		94 (3 studies)	low[1,2]
PTSD symptomatology clinician-rated at 3-6 month follow-up PSS-I/CAPS change score Follow-up: 3-6 months		The mean PTSD symptomatology clinician-rated at 3-6 month follow-up in the intervention groups was 0.38 standard deviations lower (0.87 lower to 0.11 higher)		66 (2 studies)	low[1,3]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Supportive counselling	Corresponding risk Trauma-focused CBT			
PTSD symptomatology clinician-rated at 1-3 year follow-up PSS-I/CAPS change score Follow-up: 1-3 years		The mean PTSD symptomatology clinician-rated at 1-3 year follow-up in the intervention groups was 0.21 standard deviations lower (1.2 lower to 0.78 higher)		81 (2 studies)	very low[1,4,5]
Diagnosis of PTSD at endpoint Number of people who met diagnostic criteria for PTSD Follow-up: 5-6 weeks	531 per 1000	313 per 1000 (186 to 521)	RR 0.59 (0.35 to 0.98)	86 (2 studies)	moderate[6]
Diagnosis of PTSD at 1-month follow-up Number of people who met criteria for PTSD Follow-up: mean 1 months	611 per 1000	196 per 1000 (24 to 1000)	RR 0.32 (0.04 to 2.64)	81 (2 studies)	very low[1,4,5]
Diagnosis of PTSD at 6-month follow-up Number of people who met criteria for PTSD Follow-up: mean 6 months	642 per 1000	366 per 1000 (250 to 533)	RR 0.57 (0.39 to 0.83)	161 (4 studies)	moderate[6]
Diagnosis of PTSD at 3-4 year follow-up Number of people who met criteria for PTSD Follow-up: 3-4 years	481 per 1000	332 per 1000 (221 to 501)	RR 0.69 (0.46 to 1.04)	137 (2 studies)	low[1,3]
Anxiety symptoms at endpoint BAI endpoint or change score/STAI State change score Follow-up: 1-10 weeks		The mean anxiety symptoms at endpoint in the intervention groups was 0.5 standard deviations lower (1.2 lower to 0.19 higher)		147 (4 studies)	very low[1,3,4]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Supportive counselling	Corresponding risk Trauma-focused CBT			
Anxiety symptoms at 1-3 month follow-up BAI/STAI State change score Follow-up: 1-3 months		The mean anxiety symptoms at 1-3 month follow-up in the intervention groups was 0.71 standard deviations lower (1.41 lower to 0 higher)		119 (3 studies)	very low[1,2,4]
Anxiety symptoms at 5-6 month follow-up STAI State change score/BAI endpoint/change score Follow-up: 5-6 months		The mean anxiety symptoms at 5-6 month follow-up in the intervention groups was 0.47 standard deviations lower (1.07 lower to 0.13 higher)		181 (5 studies)	very low[1,3,4]
Anxiety symptoms at 11-12 month follow-up BAI/STAI State change score Follow-up: 11-12 months		The mean anxiety symptoms at 11-12 month follow-up in the intervention groups was 0.52 standard deviations lower (1.32 lower to 0.29 higher)		80 (2 studies)	very low[1,3,4]
Depression symptoms at endpoint BDI/BDI-II endpoint/change score Follow-up: 1-10 weeks		The mean depression symptoms at endpoint in the intervention groups was 0.47 standard deviations lower (0.78 to 0.16 lower)		173 (5 studies)	low[1,2]
Depression symptoms at 1-3 month follow-up BDI/BDI-II change score		The mean depression symptoms at 1-3 month follow-up in the		119 (3 studies)	very low[1,3]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Supportive counselling	Corresponding risk Trauma-focused CBT			
Follow-up: 1-3 months		intervention groups was 0.19 standard deviations lower (0.67 lower to 0.29 higher)			
Depression symptoms at 5-6 month follow-up BDI/BDI-II endpoint/change score Follow-up: 5-6 months		The mean depression symptoms at 5-6 month follow-up in the intervention groups was 0.49 standard deviations lower (0.89 to 0.1 lower)		181 (5 studies)	low[1,2]
Depression symptoms at 11-12 month follow-up BDI/BDI-II change score Follow-up: 11-12 months		The mean depression symptoms at 11-12 month follow-up in the intervention groups was 0.53 standard deviations lower (1.48 lower to 0.42 higher)		81 (2 studies)	very low[1,3,4]
Depression symptoms at 3-year follow-up BDI-II change score Follow-up: mean 3 years		The mean depression symptoms at 3-year follow-up in the intervention groups was 0.76 standard deviations lower (1.45 to 0.06 lower)		35 (1 study)	very low[1,2]
Quality of life at endpoint FACT-G change score Follow-up: mean 10 weeks Better indicated by higher values		The mean quality of life at endpoint in the intervention groups was 0.31 standard deviations lower		35 (1 study)	low[1,7]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Supportive counselling	Corresponding risk Trauma-focused CBT			
		(0.99 lower to 0.37 higher)			
Quality of life at 5-month follow-up FACT-G change score Follow-up: mean 5 months Better indicated by higher values		The mean quality of life at 5-month follow-up in the intervention groups was 0.51 standard deviations higher (0.17 lower to 1.2 higher)		35 (1 study)	low[1,3]
Quality of life at 11-month follow-up FACT-G change score Follow-up: mean 11 months Better indicated by higher values		The mean quality of life at 11-month follow-up in the intervention groups was 0.78 standard deviations higher (0.07 to 1.48 higher)		35 (1 study)	low[1,2]
Discontinuation Number of participants lost to follow-up Follow-up: 1-10 weeks	163 per 1000	198 per 1000 (120 to 327)	RR 1.22 (0.74 to 2.01)	286 (7 studies)	low[5]

BAI=Beck Anxiety Inventory; BDI=Beck Depression Inventory; CAPS=clinician administered PTSD scale; CBT=cognitive behavioural therapy; CI=confidence interval; FACT-G=Functional Assessment of Cancer Therapy-General; IES-R=Impact of Event Scale-Revised; PCL=PTSD Checklist; PDS=PTSD diagnostic scale; PSS-I/SR=PTSD symptom scale-interview/self-report; PTSD=post-traumatic stress disorder; RR=risk ratio; SMD=standardised mean difference; STAI=State-Trait Anxiety Inventory

[1] Risk of bias is high or unclear across multiple domains
[2] OIS not met (N<400)
[3] 95% CI crosses both line of no effect and threshold for clinically important benefit
[4] Substantial heterogeneity (I2>50%)
[5] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm
[6] OIS not met (events<300)
[7] 95% CI crosses both line of no effect and threshold for clinically important harm

Table 8: Summary clinical evidence profile: Trauma-focused CBT versus self-help (without support) for the early treatment (1-3 months) of below threshold PTSD symptoms in adults

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Self-help (without support)	Corresponding risk Trauma-focused CBT			
PTSD symptomatology self-rated at 1-month follow-up IES-R change score Follow-up: mean 1 months		The mean PTSD symptomatology self-rated at 1-month follow-up in the intervention groups was 0.75 standard deviations lower (1.42 to 0.08 lower)		37 (1 study)	very low[1,2]
PTSD symptomatology self-rated at 4-month follow-up IES-R change score Follow-up: mean 4 months		The mean PTSD symptomatology self-rated at 4-month follow-up in the intervention groups was 0.67 standard deviations lower (1.29 to 0.05 lower)		43 (1 study)	very low[1,2]
Anxiety symptoms at 1-month follow-up HADS-A change score Follow-up: mean 1 months		The mean anxiety symptoms at 1-month follow-up in the intervention groups was 1.44 standard deviations lower (2.17 to 0.7 lower)		37 (1 study)	very low[1,2]
Anxiety symptoms at 4-month follow-up HADS-A change score Follow-up: mean 4 months		The mean anxiety symptoms at 4-month follow-up in the intervention groups was 1.32 standard deviations lower (1.99 to 0.65 lower)		43 (1 study)	very low[1,2]
Depression symptoms at 1-month follow-up HADS-D change score Follow-up: mean 1 months		The mean depression symptoms at 1-month follow-up in the intervention groups was 0.75 standard deviations lower (1.42 to 0.08 lower)		37 (1 study)	very low[1,2]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Self-help (without support)	Corresponding risk Trauma-focused CBT			
Depression symptoms at 4-month follow-up HADS-D change score Follow-up: mean 4 months		The mean depression symptoms at 4-month follow-up in the intervention groups was 1.28 standard deviations lower (1.95 to 0.62 lower)		43 (1 study)	very low[1,2]
Discontinuation Number of participants lost to follow-up Follow-up: mean 4 weeks	355 per 1000	415 per 1000 (216 to 788)	RR 1.17 (0.61 to 2.22)	60 (1 study)	very low[1,3]

CBT=cognitive behavioural therapy; CI=confidence interval; HADS-A/D=Hospital Anxiety and Depression Scale-Anxiety/Depression; IES-R=Impact of Event Scale-Revised; PTSD=post-traumatic stress disorder; RR=relative risk; SMD=standardised mean difference

[1] Risk of bias is high or unclear across multiple domains

[2] OIS not met (N<400)

[3] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm

Table 9: Summary clinical evidence profile: Trauma-focused CBT versus waitlist/no treatment for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist/no treatment	Corresponding risk Trauma-focused CBT			
PTSD symptomatology self-rated at endpoint PCL change score Follow-up: mean 26 weeks		The mean PTSD symptomatology self-rated at endpoint in the intervention groups was 0.14 standard deviations lower (0.55 lower to 0.27 higher)		90 (1 study)	very low[1,2]
PTSD symptomatology self-rated at 1-2 month follow-up PCL/HTQ change score Follow-up: 1-2 months		The mean PTSD symptomatology self-rated at 1-2 month follow-up in the intervention groups was 1 standard		428 (2 studies)	very low[1,3]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist/no treatment	Corresponding risk Trauma-focused CBT			
		deviations lower (1.88 to 0.12 lower)			
PTSD symptomatology self-rated at 5-6 month follow-up PCL change score Follow-up: 5-6 months		The mean PTSD symptomatology self-rated at 5-6 month follow-up in the intervention groups was 0.49 standard deviations lower (0.8 to 0.18 lower)		168 (2 studies)	very low[1,4]
PTSD symptomatology self-rated at 8-month follow-up PCL change score Follow-up: mean 8 months		The mean PTSD symptomatology self-rated at 8-month follow-up in the intervention groups was 0.52 standard deviations lower (0.97 to 0.07 lower)		81 (1 study)	low[1,4]
PTSD symptomatology clinician-rated CAPS change score Follow-up: mean 12 weeks		The mean PTSD symptomatology clinician-rated in the intervention groups was 1.55 standard deviations lower (2.25 to 0.86 lower)		42 (1 study)	low[1,4]
PTSD at endpoint Number who met criteria for PTSD Follow-up: mean 12 weeks	381 per 1000	145 per 1000 (46 to 465)	RR 0.38 (0.12 to 1.22)	42 (1 study)	low[1,2]
Anxiety symptoms at 1-month follow-up HSCL-25 Anxiety change score Follow-up: mean 1 months		The mean anxiety symptoms at 1-month follow-up in the intervention groups was 0.87 standard deviations lower (1.09 to 0.65 lower)		347 (1 study)	low[1,4]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist/no treatment	Corresponding risk Trauma-focused CBT			
Depression symptoms at 1-2 month follow-up HSCL-25/BSI Depression change score Follow-up: 1-2 months		The mean depression symptoms at 1-2 month follow-up in the intervention groups was 0.99 standard deviations lower (1.86 to 0.12 lower)		428 (2 studies)	very low[1,3]
Depression symptoms at 5-month follow-up BSI Depression change score Follow-up: mean 5 months		The mean depression symptoms at 5-month follow-up in the intervention groups was 0.64 standard deviations lower (1.09 to 0.18 lower)		81 (1 study)	low[1,4]
Depression symptoms at 8-month follow-up BSI Depression change score Follow-up: mean 8 months		The mean depression symptoms at 8-month follow-up in the intervention groups was 0.54 standard deviations lower (0.99 to 0.09 lower)		81 (1 study)	low[1,4]
Alcohol use disorder symptoms at 1-month follow-up AUDIT change score Follow-up: mean 1 months		The mean alcohol use disorder symptoms at 1-month follow-up in the intervention groups was 0.06 standard deviations higher (0.62 lower to 0.75 higher)		33 (1 study)	very low[1,5]
Alcohol use at endpoint Drug and Alcohol Use Interview: Total drinks in last 3 months change score		The mean alcohol use at endpoint in the intervention groups was 0.07 standard deviations lower		89 (1 study)	very low[1,4]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist/no treatment	Corresponding risk Trauma-focused CBT			
Follow-up: mean 26 weeks		(0.48 lower to 0.35 higher)			
Alcohol use at 6-month follow-up Drug and Alcohol Use Interview: Total drinks in last 3 months change score Follow-up: mean 6 months		The mean alcohol use at 6-month follow-up in the intervention groups was 0.21 standard deviations higher (0.22 lower to 0.64 higher)		83 (1 study)	very low[1,6]
Drug use at endpoint Drug and Alcohol Use Interview: Total joints in last 3 months change score Follow-up: mean 26 weeks		The mean drug use at endpoint in the intervention groups was 0.26 standard deviations lower (0.68 lower to 0.15 higher)		89 (1 study)	very low[1,2]
Drug use at 6-month follow-up Drug and Alcohol Use Interview: Total joints in last 3 months change score Follow-up: mean 6 months		The mean drug use at 6-month follow-up in the intervention groups was 0.25 standard deviations higher (0.18 lower to 0.69 higher)		83 (1 study)	very low[1,6]
Relationship difficulties at endpoint IIP change score Follow-up: mean 26 weeks		The mean relationship difficulties at endpoint in the intervention groups was 0.15 standard deviations lower (0.57 lower to 0.27 higher)		88 (1 study)	very low[1,2]
Relationship difficulties at 6-month follow-up IIP change score Follow-up: mean 6 months		The mean relationship difficulties at 6-month follow-up in the intervention groups was 0.36 standard deviations lower (0.78 lower to 0.07 higher)		88 (1 study)	very low[1,2]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist/no treatment	Corresponding risk Trauma-focused CBT			
Discontinuation Number of participants lost to follow-up Follow-up: 10-26 weeks	198 per 1000	262 per 1000 (109 to 625)	RR 1.32 (0.55 to 3.15)	546 (3 studies)	very low[5,7]

AUDIT=alcohol use disorder identification test; BSI=brief symptom inventory; CAPS=clinician-administered PTSD scale; CBT=cognitive behavioural therapy; CI=confidence interval: HSCL-25=Hopkins Symptom Checklist; HTQ=Harvard trauma questionnaire; IIP=inventory of interpersonal problems; PCL=PTSD checklist; RR=risk ratio; SMD=standardised mean difference

[1] Risk of bias is high or unclear across multiple domains
[2] 95% CI crosses both line of no effect and threshold for clinically important benefit
[3] Considerable heterogeneity (I2>80%)
[4] OIS not met (N<400)
[5] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm
[6] 95% CI crosses both line of no effect and threshold for clinically important harm
[7] Substantial heterogeneity (I2>50%)

Table 10: Summary clinical evidence profile: Trauma-focused CBT versus attention-placebo/psychoeducation for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Attention-placebo/psychoeducation	Corresponding risk Trauma-focused CBT			
PTSD symptomatology self-rated at endpoint PCL/IES change score Follow-up: 0.4-13 weeks		The mean PTSD symptomatology self-rated at endpoint in the intervention groups was 0.03 standard deviations lower (0.36 lower to 0.3 higher)		355 (2 studies)	low[1,2]
PTSD symptomatology self-rated at 3-month follow-up IES change score Follow-up: mean 3 months		The mean PTSD symptomatology self-rated at 3-month follow-up in the intervention groups was 0.13 standard deviations lower (0.37 lower to 0.1 higher)		272 (1 study)	low[1,2]
PTSD symptomatology self-rated at 6-8 month follow-up		The mean PTSD symptomatology self-rated at 6-8 month follow-up in the intervention		317 (2 studies)	very low[1,3,4]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Attention-placebo/psychoeducation	Corresponding risk Trauma-focused CBT			
PCL/IES change score Follow-up: 6-8 months		groups was 0.35 standard deviations lower (1.14 lower to 0.43 higher)			
Discontinuation Number of participants lost to follow-up Follow-up: mean 13 weeks	165 per 1000	186 per 1000 (119 to 292)	RR 1.13 (0.72 to 1.77)	354 (1 study)	low[5]

CI=confidence interval; IES=impact of event scale; PCL=PTSD checklist; PTSD=post-traumatic stress disorder; RR=risk ratio; SMD=standardised mean difference
[1] Risk of bias is high or unclear across multiple domains
[2] OIS not met (N<400)
[3] Considerable heterogeneity (I2>80%)
[4] 95% CI crosses both line of no effect and threshold for clinically important benefit
[5] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm

Table 11: Summary clinical evidence profile: Trauma-focused CBT versus present-centred therapy for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Present-centred therapy	Corresponding risk Trauma-focused CBT			
PTSD symptomatology self-rated at endpoint PCL change score Follow-up: mean 26 weeks		The mean PTSD symptomatology self-rated at endpoint in the intervention groups was 0.08 standard deviations higher (0.34 lower to 0.49 higher)		90 (1 study)	very low[1,2]
PTSD symptomatology self-rated at 6-month follow-up PCL change score Follow-up: mean 6 months		The mean PTSD symptomatology self-rated at 6-month follow-up in the intervention groups was 0.08 standard deviations lower (0.5 lower to 0.34 higher)		87 (1 study)	very low[1,3]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Present-centred therapy	Corresponding risk Trauma-focused CBT			
Alcohol use at endpoint Drug and Alcohol Use Interview: Total drinks in last 3 months change score Follow-up: mean 26 weeks		The mean alcohol use at endpoint in the intervention groups was 0.06 standard deviations higher (0.35 lower to 0.48 higher)		90 (1 study)	very low[1,2]
Alcohol use at 6-month follow-up Drug and Alcohol Use Interview: Total drinks in last 3 months change score Follow-up: mean 6 months		The mean alcohol use at 6-month follow-up in the intervention groups was 0.03 standard deviations lower (0.46 lower to 0.41 higher)		82 (1 study)	very low[1,2]
Drug use at endpoint Drug and Alcohol Use Interview: Total joints in last 3 months change score Follow-up: mean 26 weeks		The mean drug use at endpoint in the intervention groups was 0.25 standard deviations lower (0.66 lower to 0.17 higher)		90 (1 study)	very low[1,3]
Drug use at 6-month follow-up Drug and Alcohol Use Interview: Total joints in last 3 months change score Follow-up: mean 6 months		The mean drug use at 6-month follow-up in the intervention groups was 0.23 standard deviations higher (0.2 lower to 0.67 higher)		82 (1 study)	very low[1,4]
Relationship difficulties at endpoint IIP change score Follow-up: mean 26 weeks		The mean relationship difficulties at endpoint in the intervention groups was 0.06 standard deviations lower (0.48 lower to 0.36 higher)		88 (1 study)	very low[1,2]
Relationship difficulties at 6-month follow-up IIP change score		The mean relationship difficulties at 6-month follow-up in		88 (1 study)	very low[1,2]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Present-centred therapy	Corresponding risk Trauma-focused CBT			
Follow-up: mean 6 months		the intervention groups was 0.01 standard deviations higher (0.41 lower to 0.42 higher)			
Discontinuation Number of participants lost to follow-up Follow-up: mean 26 weeks	321 per 1000	418 per 1000 (257 to 685)	RR 1.3 (0.8 to 2.13)	111 (1 study)	low[1,4]

CBT=cognitive behavioural therapy; CI=confidence interval; IIP=inventory of interpersonal problems; PCL=PTSD Checklist; PTSD=post-traumatic stress disorder; RR=risk ratio; SMD=standardised mean difference
[1] Risk of bias was high or unclear across multiple domains
[2] OIS not met (N<400)
[3] 95% CI crosses both line of no effect and threshold for clinically important benefit
[4] 95% CI crosses both line of no effect and threshold for clinically important harm

Table 12: Summary clinical evidence profile: Trauma-focused CBT group versus peer support group for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Peer support group	Corresponding risk Trauma-focused CBT group			
PTSD symptomatology self-rated at endpoint SCL-90-R Posttraumatic Symptom Scale change score		The mean PTSD symptomatology self-rated at endpoint in the intervention groups was 0.37 standard deviations lower (0.97 lower to 0.22 higher)		44 (1 study)	very low[1,2]
PTSD symptomatology self-rated at 3-month follow-up SCL-90-R Posttraumatic Symptom Scale change score Follow-up: mean 3 months		The mean PTSD symptomatology self-rated at 3-month follow-up in the intervention groups was 0.73 standard deviations lower (1.35 to 0.12 lower)		44 (1 study)	very low[1,3]

CBT=cognitive behavioural therapy; CI=confidence interval; PTSD=post-traumatic stress disorder; SCL-90-R=Symptom Checklist-90-Revised; SMD=standardised mean difference
[1] Risk of bias is high or unclear across multiple outcomes
[2] 95% CI crosses both line of no effect and threshold for clinically important benefit
[3] OIS not met (N<400)

See appendix F for full GRADE tables.

Non-trauma-focused cognitive behavioural therapies (CBT): clinical evidence

Included studies

Thirteen studies of non-trauma-focused CBT for the prevention of PTSD in adults were identified for full-text review. Of these 13 studies, 2 RCTs (N=109) were included in a single comparison: Non-trauma-focused CBT in addition to TAU relative to TAU-only for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults (Nakamura 2011; Potter 2016).

Excluded studies

Eleven studies were reviewed at full text and excluded from this review. The most common reasons for exclusion were that the intervention was not targeted at PTSD symptoms, and efficacy or safety data could not be extracted

Studies not included in this review with reasons for their exclusions are provided in Appendix K.

Summary of clinical studies included in the evidence review

Table 13 provides a brief summary of the included studies and evidence from these are summarised in the clinical GRADE evidence profile below (Table 14).

See also the study selection flow chart in Appendix C, forest plots in Appendix E and study evidence tables in Appendix D.

Table 13: Summary of included studies: Non-trauma-focused CBT for delayed treatment (>3 month) of non-significant PTSD symptoms

Comparison	Non-trauma-focused CBT (+ TAU) versus TAU
Total no. of studies (N randomised)	2 (109)
Study ID	Nakamura 2011[1] Potter 2016[2]
Country	US[1] UK[2]
Diagnostic status	Subthreshold symptoms (below threshold but ≥50% maximum score on scale) [1] Non-significant symptoms (below threshold and <50% maximum score on scale) [2]
Mean age (range)	52.1 (range NR) [1] 41.4 (range NR) [2]
Sex (% female)	5[1] 46[2]
Ethnicity (% BME)	NR
Coexisting conditions	All participants had sleep disturbance[1]

Comparison	Non-trauma-focused CBT (+ TAU) versus TAU
	NR[2]
Mean months since traumatic event	NR[1] NR (medians 23/28 months [range 6-175]) [2]
Type of traumatic event	Military combat: 'Veterans' (no further detail reported) [1] Motor Vehicle Collision: Road traffic accident (59%); assault (11%); other (30%)[2]
Single or multiple incident index trauma	Multiple[1] Single[2]
Lifetime experience of trauma	NR
Intervention details	Mind–body bridging (MBB) program for sleep management, following protocol used by Tollefson et al. (2009) [1] CBT for postconcussional symptoms, using an individualised and formulation-driven approach[2]
Intervention format	Individual
Intervention intensity	2x weekly 90-min sessions (3 hours) [1] 12x weekly 1-hour sessions (12 hours) [2]
Comparator	TAU: Sleep hygiene program[1] TAU; Psychoactive medications were permitted[2]
Intervention length (weeks)	2[1] 12[2]

BME, black and minority ethnic; CBT, cognitive behavioural therapy; NR, not reported; PTSD, post-traumatic stress disorder; SD, standard deviation; TAU, treatment as usual
[1]Nakamura 2011; [2]Potter 2016

See appendix D for full evidence tables.

Quality assessment of clinical studies included in the evidence review

The clinical evidence profile for this review (non-trauma-focused CBT for the prevention of PTSD in adults) is presented in Table 14.

Table 14: Summary clinical evidence profile: Non-trauma-focused CBT (+ TAU) versus TAU for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk TAU	Corresponding risk Non-trauma-focused CBT (+ TAU)			
PTSD symptomatology self-rated PCL/IES-R change score Follow-up: 2-12 weeks		The mean PTSD symptomatology self-rated in the intervention groups was 0.31 standard deviations		103 (2 studies)	low[1,2]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk TAU	Corresponding risk Non-trauma-focused CBT (+ TAU)			
		lower (0.7 lower to 0.09 higher)			
PTSD at endpoint Number who criteria for PTSD Follow-up: mean 12 weeks	400 per 1000	308 per 1000 (140 to 676)	RR 0.77 (0.35 to 1.69)	46 (1 study)	very low[1,3]
Anxiety symptoms HADS-A change score Follow-up: mean 12 weeks		The mean anxiety symptoms in the intervention groups was 0.06 standard deviations lower (0.65 lower to 0.53 higher)		45 (1 study)	very low[1,3]
Depression symptoms CES-D/HADS-D change score Follow-up: 2-12 weeks		The mean depression symptoms in the intervention groups was 0.36 standard deviations lower (0.74 lower to 0.02 higher)		108 (2 studies)	low[1,2]
Anger STAXI-2 change score Follow-up: mean 12 weeks		The mean anger in the intervention groups was 0.29 standard deviations lower (0.88 lower to 0.3 higher)		45 (1 study)	very low[1,2]
Sleeping difficulties MOS-SS: Sleep Problems Index II change score Follow-up: mean 2 weeks		The mean sleeping difficulties in the intervention groups was 0.96		58 (1 study)	low[1,4]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk TAU	Corresponding risk Non-trauma-focused CBT (+ TAU)			
		standard deviations lower (1.51 to 0.41 lower)			
Quality of life SF-36 total/EuroQol change score Follow-up: 2-12 weeks Better indicated by higher values		The mean quality of life in the intervention groups was 0.24 standard deviations higher (0.14 lower to 0.63 higher)		107 (2 studies)	low[1,2]
Discontinuation Number of participants lost to follow-up Follow-up: 2-12 weeks	62 per 1000	47 per 1000 (11 to 211)	RR 0.75 (0.17 to 3.38)	109 (2 studies)	low[3]

CBT=cognitive behavioural therapy; CES-D=Center for Epidemiological Studies Depression; CI=confidence interval; EuroQoL=an instrument for measuring quality of life; HADS-A/D=Hospital Anxiety and Depression Inventory-Anxiety/Depression; IES-R=Impact of Event Scale-Revised; MOS-SS=Medical Outcomes Study-Sleep Scale; PTSD=post-traumatic stress disorder; RR=risk ratio; SF-36=short form survey-36; SMD=standardised mean difference; STAXI-2=State Trait Anger Expression Inventory-2; TAU=treatment as usual

[1] Risk of bias was high or unclear across multiple domains

[2] 95% CI crosses both line of no effect and threshold for clinically important benefit

[3] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm

[4] OIS not met (N<400)

See appendix F for full GRADE tables.

Present-centred therapy: clinical evidence

Included studies

One study of present-centred therapy for the prevention of PTSD in adults was identified for full-text review. This RCT (N=166) was included in a single comparison: present-centred therapy compared with waitlist for the delayed treatment (>3 months) of non-significant PTSD symptoms in adults (Classen 2011).

Excluded studies

No studies were reviewed at full text and excluded from this review

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Summary of clinical studies included in the evidence review

Table 15 provides a brief summary of the included studies and evidence from these are summarised in the clinical GRADE evidence profile below (Table 16).

See also the study selection flow chart in Appendix C, forest plots in Appendix E and study evidence tables in Appendix D.

Table 15: Summary of included studies: Present-centred therapy for delayed treatment (>3 months) of non-significant PTSD symptoms

Comparison	Present-centred therapy versus waitlist
Total no. of studies (N randomised)	1 (166)
Study ID	Classen 2011
Country	US and Canada
Diagnostic status	Subthreshold symptoms (below threshold but ≥50% maximum score on scale)
Mean age (range)	36.2 (range NR)
Sex (% female)	100
Ethnicity (% BME)	27
Coexisting conditions	52% met DSM–IV criteria for abuse or dependence (any substance)
Mean months since traumatic event	246.6
Type of traumatic event	Childhood sexual abuse: Participants experienced childhood sexual abuse between age 4 and 17 years and the perpetrator was at least 5 years older. Mean age of first abuse experience 6.7 (SD=3.1); mean duration of abuse 7.7 years (SD=6.6)
Single or multiple incident index trauma	Multiple
Lifetime experience of trauma	NR
Intervention details	Present-focused group psychotherapy (PFGT), following manual by Classen 2001
Intervention format	Group
Intervention intensity	24x weekly 90-min sessions (36 hours). 29% attended no therapy sessions; 56% attended ≥75% sessions
Comparator	Waitlist
Intervention length (weeks)	26

BME, black and minority ethnic; DSM-IV, Diagnostic and Statistical Manual of Mental Disorders-IV; NR, not reported; PTSD, post-traumatic stress disorder; SD, standard deviation

See appendix D for full evidence tables.

Quality assessment of clinical studies included in the evidence review

The clinical evidence profile for this review (present-centred therapy for the prevention of PTSD in adults) is presented in Table 16.

Table 16: Summary clinical evidence profile: Present-centred therapy versus waitlist for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist	Corresponding risk Present-centred therapy			
PTSD symptomatology self-rated at endpoint PCL change score Follow-up: mean 26 weeks		The mean PTSD symptomatology self-rated at endpoint in the intervention groups was 0.23 standard deviations lower (0.65 lower to 0.18 higher)		90 (1 study)	very low[1,2]
PTSD symptomatology self-rated at 6-month follow-up PCL change score Follow-up: mean 6 months		The mean PTSD symptomatology self-rated at 6-month follow-up in the intervention groups was 0.31 standard deviations lower (0.74 lower to 0.11 higher)		86 (1 study)	very low[1,2]
Alcohol use at endpoint Drug and Alcohol Use Interview: Total drinks in last 3 months change score Follow-up: mean 26 weeks		The mean alcohol use at endpoint in the intervention groups was 0.12 standard deviations lower (0.54 lower to 0.3 higher)		89 (1 study)	very low[1,2]
Alcohol use at 6-month follow-up Drug and Alcohol Use Interview: Total drinks in last 3 months change score Follow-up: mean 6 months		The mean alcohol use at 6-month follow-up in the intervention groups was 0.24 standard deviations higher (0.18 lower to 0.66 higher)		87 (1 study)	very low[1,3]
Drug use at endpoint Drug and Alcohol Use Interview: Total		The mean drug use at endpoint in the intervention groups was 0.02 standard		89 (1 study)	very low[1,4]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist	Corresponding risk Present-centred therapy			
joints in last 3 months change score Follow-up: mean 26 weeks		deviations higher (0.4 lower to 0.43 higher)			
Drug use at 6-month follow-up Drug and Alcohol Use Interview: Total joints in last 3 months change score Follow-up: mean 6 months		The mean drug use at 6-month follow-up in the intervention groups was 0.02 standard deviations higher (0.4 lower to 0.44 higher)		87 (1 study)	very low[1,4]
Relationship difficulties at endpoint IIP change score Follow-up: mean 26 weeks		The mean relationship difficulties at endpoint in the intervention groups was 0.1 standard deviations lower (0.51 lower to 0.32 higher)		88 (1 study)	very low[1,2]
Relationship difficulties at 6-month follow-up IIP change score Follow-up: mean 6 months		The mean relationship difficulties at 6-month follow-up in the intervention groups was 0.36 standard deviations lower (0.78 lower to 0.07 higher)		86 (1 study)	very low[1,2]
Discontinuation Number of participants lost to follow-up Follow-up: mean 26 weeks	164 per 1000	321 per 1000 (159 to 653)	RR 1.96 (0.97 to 3.99)	111 (1 study)	low[1,3]

CI=confidence interval; IIP=Inventory of Interpersonal Problems; PCL=PTSD Checklist; PTSD=post-traumatic stress disorder; RR=risk ratio; SMD=standardised mean difference

[1] Risk of bias is high or unclear across multiple domains

[2] 95% CI crosses both line of no effect and threshold for clinically important benefit

[3] 95% CI crosses both line of no effect and threshold for clinically important harm

[4] OIS not met (N<400)

See appendix F for full GRADE tables.

Cognitive therapies: clinical evidence

Included studies

Eighteen studies of cognitive therapies for the prevention of PTSD in adults were identified for full-text review. None of these studies could be included.

Excluded studies

Eighteen studies were reviewed at full text and excluded from this review. The most common reasons for exclusion were non-randomised group assignment, population outside scope (trials of soldiers on active service), or the paper was a systematic review with no new useable data and any meta-analysis results not appropriate to extract.

Studies not included in this review with reasons for their exclusions are provided in Appendix K.

Behavioural therapies: clinical evidence

Included studies

Seven studies of behavioural therapies for the prevention of PTSD in adults were identified for full-text review. Of these 7 studies, 4 RCTs (N=864) were included. One of these RCTs was a three--armed trial and included in more than one comparison. There were 4 comparisons for behavioural therapies.

For the early prevention (intervention initiated within 1 month of trauma) there were no included studies.

For prevention of PTSD in adults with ongoing exposure to trauma (for instance, war zone), there was evidence for 1 relevant comparison: 1 RCT (N=346) compared a brief behavioural intervention with enhanced TAU (Rahman 2016).

For the early treatment (1-3 months) of non-significant PTSD symptoms in adults, there were no included studies.

For the delayed treatment (>3 months) of non-significant PTSD symptoms in adults, there was evidence for 3 relevant comparisons: 1 RCT (N=421) compared a brief behavioural intervention with enhanced TAU (Bryant 2017); 2 RCTs (N=97) compared a behavioural sleep intervention with pill placebo or attention-placebo (Germain 2012; Germain 2014); 1 RCT (N=57) compared a behavioural sleep intervention with prazosin (Germain 2012).

Excluded studies

Three studies were reviewed at full text and excluded from this review due to small sample size (N<10 per arm), because the paper was a non-systematic review, or a preliminary report of an RCT already included.

Studies not included in this review with reasons for their exclusions are provided in Appendix K.

Summary of clinical studies included in the evidence review

Table 17 and Table 18 provide brief summaries of the included studies and evidence from these are summarised in the clinical GRADE evidence profiles below ().

See also the study selection flow chart in Appendix C, forest plots in Appendix E and study evidence tables in Appendix D.

Table 17: Summary of included studies: Behavioural therapies for ongoing exposure to trauma

Comparison	Brief behavioural intervention versus enhanced TAU
Total no. of studies (N randomised)	1 (346)
Study ID	Rahman 2016
Country	Pakistan
Diagnostic status	Non-significant symptoms (below threshold and <50% maximum score on scale)
Mean age (range)	33 (range NR)
Sex (% female)	79
Ethnicity (% BME)	NR
Coexisting conditions	NR
Mean months since traumatic event	NR
Type of traumatic event	Adults living in conflict-affected areas of Pakistan. Witnessed or experienced in past year: Armed conflict or war (61%); Natural disaster (20%); Serious road accident (52%); Physical assault (26%); Unnatural death of family or friend (11%); Serious injury to self (8%); Ill health with no access to medical care (6%)
Single or multiple incident index trauma	Multiple
Lifetime experience of trauma	NR
Intervention details	Brief multicomponent intervention, Problem Management Plus (PM+, following manual by Dawson 2015 and WHO 2016), based on established problem solving and behavioural techniques
Intervention format	Individual
Intervention intensity	5x weekly 90-min sessions (7.5 hours). Mean sessions attended 4.2 (SD=1.70)
Comparator	Enhanced TAU: seen at least once by their primary care physician. Study participants and their accompanying family member were provided psychoeducation and the opportunity to talk about their health in a supportive environment. Participants were given the option of a repeated consultation
Intervention length (weeks)	5

BME, black and minority ethnic; NR, not reported; PTSD, post-traumatic stress disorder; SD, standard deviation

Table 18: Summary of included studies: Behavioural therapies for delayed treatment (>3 months) of non-significant PTSD symptoms

Comparison	Brief behavioural intervention versus enhanced TAU	Behavioural sleep intervention versus pill placebo or attention-placebo	Behavioural sleep intervention versus prazosin
Total no. of studies (N randomised)	1 (421)	2 (97)	1 (57)
Study ID	Bryant 2017	Germain 2012[1] Germain 2014[2]	Germain 2012
Country	Kenya	US	US
Diagnostic status	Non-significant symptoms (below threshold and <50% maximum score on scale)	Non-significant symptoms (below threshold and <50% maximum score on scale)	Non-significant symptoms (below threshold and <50% maximum score on scale)
Mean age (range)	35.6 (range NR)	40.9 (range NR) [1] 38.4 (range NR) [2]	40.9 (range NR)
Sex (% female)	100	101 152	10
Ethnicity (% BME)	NR	181 222	18
Coexisting conditions	NR	All participants had sleep complaints. SCID primary diagnosis: GAD 4%; Major depressive disorder, recurrent episode, unspecified 2%; Primary Insomnia or Insomnia related to another disorder 30%[1] All participants had primary or comorbid insomnia. 25% met diagnostic criteria for current PTSD; 13% for current mood/anxiety disorder[2]	All participants had sleep complaints. SCID primary diagnosis: GAD 4%; Major depressive disorder, recurrent episode, unspecified 2%; Primary Insomnia or Insomnia related to another disorder 30%
Mean months since traumatic event	NR	NR	NR
Type of traumatic event	Domestic violence: Prior or current experience of interpersonal violence	Military combat: Combat Theatre: 48% Operations Iraqi/Enduring Freedom; 18% Persian Gulf War; 12% Vietnam; 6% Other theatre of operations; 15% No conflict[1]	Military combat: Combat Theatre: 48% Operations Iraqi/Enduring Freedom; 18% Persian Gulf War; 12% Vietnam; 6% Other theatre of operations; 15% No conflict

Comparison	Brief behavioural intervention versus enhanced TAU	Behavioural sleep intervention versus pill placebo or attention-placebo	Behavioural sleep intervention versus prazosin
		Military combat: Operations Enduring/Iraqi Freedom or Operation New Dawn (OEF/OIF/OND) [2]	
Single or multiple incident index trauma	Multiple	Multiple	Multiple
Lifetime experience of trauma	Mean lifetime traumas 6.9 (3.3). Lifetime trauma experienced: Disaster (52%); Fire (57%); Road accident (55%); Serious accident (48%); Chemical exposure (33%); Physical assault (73%); Assault with weapon (47%); Sexual assault (31%); Unwanted sexual contact (29%); War exposure (28%); Kidnapped (19%); Life-threatening illness (50%); Witness violent death (48%); Unexpected death of loved one (75%); Intimate partner violence (72%)	NR	NR
Intervention details	Problem Management Plus (PM+)	Behavioural sleep intervention[1] Brief behavioural treatment of insomnia (BBTI-MV). BBTI-MV was adapted from a manualized behavioural treatment that was initially developed for chronic insomnia in older adults (Buysse 2011; Germain 2006; Troxel 2012) [2]	Behavioural sleep intervention
Intervention format	Individual	Individual	Individual
Intervention intensity	5x weekly sessions (length of session NR)	8x weekly 45-min sessions (6 hours; at least 5 face-to-face sessions and up to 3 telephone contacts) [1]	8x weekly 45-min sessions (6 hours; at least 5 face-to-face sessions and up to 3 telephone contacts)

Comparison	Brief behavioural intervention versus enhanced TAU	Behavioural sleep intervention versus pill placebo or attention-placebo	Behavioural sleep intervention versus prazosin
		4 sessions (up to 1.9 hours in total) [2]	
Comparator	Enhanced TAU: referred to primary healthcare centres, where nurses provided non-specific counselling. 62% sought assistance from a community nurse, attending a mean of 2.1 (SD = 1.8) visits. In terms of the strategies reported by the community, 66% reported non-specific counselling, 27% provided psychosocial advice, 7% encouraged activity, 7% encouraged social support, and 3% instructed in coping strategies	Pill placebo, 4 capsules 30mins before bedtime[1] Attention-placebo: received two brochures created by the American Academy of Sleep Medicine (AASM) on insomnia and healthy sleep practices[2]	Prazosin, 1-15mg/day
Intervention length (weeks)	5	8[1] 4[2]	8

BME, black and minority ethnic; GAD, Generalised Anxiety Disorders; NR, not reported; PTSD, post-traumatic stress disorder; SCID, Structured Clinical Interview for DSM-IV (Diagnostic and Statistical Manual of Mental Disorders); SD, standard deviation, TAU, Treatment as usual
[1]Germain 2012; [2]Germain 2014

See appendix D for full evidence tables.

Quality assessment of clinical studies included in the evidence review

The clinical evidence profiles for this review (behavioural therapies for the prevention of PTSD in adults) are presented in Table 18.

Table 19: Summary clinical evidence profile: Brief behavioural intervention versus enhanced TAU for the prevention of PTSD in adults exposed to ongoing trauma (e.g. in a war zone)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Enhanced TAU	Corresponding risk Brief behavioural intervention			
PTSD symptomatology self-rated at endpoint PCL change score		The mean PTSD symptomatology self-rated at endpoint in the intervention		209 (1 study)	very low[1,2]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Enhanced TAU	Corresponding risk Brief behavioural intervention			
Follow-up: mean 5 weeks		groups was 0.78 standard deviations lower (1.06 to 0.5 lower)			
PTSD symptomatology self-rated at 2-month follow-up PCL change score Follow-up: mean 2 months		The mean PTSD symptomatology self-rated at 2-month follow-up in the intervention groups was 0.77 standard deviations lower (1 to 0.53 lower)		306 (1 study)	very low[1,2]
Anxiety symptoms at endpoint HADS-A change score Follow-up: mean 5 weeks		The mean anxiety symptoms at endpoint in the intervention groups was 1.3 standard deviations lower (1.6 to 1 lower)		209 (1 study)	very low[1,2]
Anxiety symptoms at 2-month follow-up HADS-A change score Follow-up: mean 2 months		The mean anxiety symptoms at 2-month follow-up in the intervention groups was 1.31 standard deviations lower (1.56 to 1.06 lower)		306 (1 study)	very low[1,2]
Depression symptoms at endpoint PHQ-9 change score Follow-up: mean 5 weeks		The mean depression symptoms at endpoint in the intervention groups was 1.4 standard deviations lower (1.7 to 1.09 lower)		209 (1 study)	very low[1,2]
Depression symptoms at 2-month follow-up PHQ-9 change score Follow-up: mean 2 months		The mean depression symptoms at 2-month follow-up in the intervention groups was 1.16 standard deviations lower (1.41 to 0.92 lower)		303 (1 study)	very low[1,2]
Functional impairment at		The mean functional		210 (1 study)	very low[1,2]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Enhanced TAU	Corresponding risk Brief behavioural intervention			
endpoint WHODAS change score Follow-up: mean 5 weeks		impairment at endpoint in the intervention groups was 0.49 standard deviations lower (0.77 to 0.22 lower)			
Functional impairment at 2-month follow-up WHODAS change score Follow-up: mean 2 months		The mean functional impairment at 2-month follow-up in the intervention groups was 0.3 standard deviations lower (0.53 to 0.08 lower)		303 (1 study)	very low[1,2]
Discontinuation Number of participants lost to follow-up Follow-up: mean 5 weeks	557 per 1000	652 per 1000 (546 to 775)	RR 1.17 (0.98 to 1.39)	346 (1 study)	low[1,3]

CI=confidence interval; HADS-A=Hospital Anxiety and Depression Scale-Anxiety; PCL=PTSD Checklist; PHQ-9=Patient Health Questionnaire-9; PTSD=post-traumatic stress disorder; RR=risk ratio; SMD=standardised mean difference; TAU=treatment as usual; WHODAS=WHO disability assessment schedule

[1] Risk of bias is high or unclear across multiple domains

[2] OIS not met (N<400)

[3] 95% CI crosses both line of no effect and threshold for clinically important harm

Table 20: Summary clinical evidence profile: Brief behavioural intervention versus enhanced TAU for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Enhanced TAU	Corresponding risk Brief behavioural intervention			
PTSD symptomatology self-rated at endpoint PCL change score Follow-up: mean 5 weeks		The mean PTSD symptomatology self-rated at endpoint in the intervention groups was 0.95 standard deviations lower (1.15 to 0.75 lower)		421 (1 study)	moderate[1]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Enhanced TAU	Corresponding risk Brief behavioural intervention			
PTSD symptomatology self-rated at 3-month follow-up PCL change score Follow-up: mean 3 months		The mean PTSD symptomatology self-rated at 3-month follow-up in the intervention groups was 0.54 standard deviations lower (0.74 to 0.35 lower)		421 (1 study)	moderate[1]
Functional impairment at endpoint WHODAS change score Follow-up: mean 5 weeks		The mean functional impairment at endpoint in the intervention groups was 1.09 standard deviations lower (1.29 to 0.88 lower)		421 (1 study)	moderate[1]
Functional impairment at 3-month follow-up WHODAS change score Follow-up: mean 3 months		The mean functional impairment at 3-month follow-up in the intervention groups was 0.69 standard deviations lower (0.89 to 0.5 lower)		421 (1 study)	moderate[1]
Discontinuation Number of participants lost to follow-up Follow-up: mean 5 weeks	175 per 1000	195 per 1000 (131 to 293)	RR 1.12 (0.75 to 1.68)	421 (1 study)	low[2]

CI=confidence interval; PCL=PTSD Checklist; PTSD=post-traumatic stress disorder; RR=risk ratio; SMD=standardised mean difference; TAU=treatment as usual; WHODAS=WHO disability assessment schedule

[1] Risk of bias is high or unclear across multiple domains

[2] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm

Table 21: Summary clinical evidence profile: Behavioural sleep intervention versus pill placebo or attention-placebo for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Pill placebo or attention-placebo	Corresponding risk Behavioural sleep intervention			
PTSD symptomatology self-rated at endpoint PCL change score Follow-up: 4-8 weeks		The mean PTSD symptomatology self-rated at endpoint in the intervention groups was 0.23 standard deviations lower (1.57 lower to 1.1 higher)		61 (2 studies)	very low[1,2,3]
PTSD symptomatology self-rated at 4-month follow-up PCL change score Follow-up: mean 4 months		The mean PTSD symptomatology self-rated at 4-month follow-up in the intervention groups was 0.68 standard deviations lower (1.53 lower to 0.16 higher)		23 (1 study)	low[1,4]
Anxiety symptoms at endpoint BAI change score Follow-up: 4-8 weeks		The mean anxiety symptoms at endpoint in the intervention groups was 0.41 standard deviations higher (0.1 lower to 0.92 higher)		60 (2 studies)	low[1,5]
Anxiety symptoms at 4-month follow-up BAI change score Follow-up: mean 4 months		The mean anxiety symptoms at 4-month follow-up in the intervention groups was 0.07 standard deviations lower (0.88 lower to 0.75 higher)		23 (1 study)	very low[1,3]
Depression symptoms at endpoint BDI change score Follow-up: 4-8 weeks		The mean depression symptoms at endpoint in the intervention groups was 0.38 standard		61 (2 studies)	low[1,4]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Pill placebo or attention -placebo	Corresponding risk Behavioural sleep intervention			
		deviations lower (0.89 lower to 0.13 higher)			
Depression symptoms at 4-month follow-up BDI change score Follow-up: mean 4 months		The mean depression symptoms at 4-month follow-up in the intervention groups was 0.37 standard deviations lower (1.2 lower to 0.46 higher)		23 (1 study)	low[1,4]
Functional impairment at endpoint SDS change score Follow-up: mean 8 weeks		The mean functional impairment at endpoint in the intervention groups was 0.12 standard deviations lower (0.91 lower to 0.66 higher)		25 (1 study)	very low[1,3]
Functional impairment at 4-month follow-up SDS change score Follow-up: mean 4 months		The mean functional impairment at 4-month follow-up in the intervention groups was 0.3 standard deviations higher (0.52 lower to 1.13 higher)		23 (1 study)	very low[1,3]
Sleeping difficulties at endpoint PSQI change score Follow-up: 4-8 weeks		The mean sleeping difficulties at endpoint in the intervention groups was 1.12 standard deviations lower (1.67 to 0.58 lower)		62 (2 studies)	low[1,6]
Sleeping difficulties at 4-month follow-up PSQI change score		The mean sleeping difficulties at 4-month follow-up in the intervention groups was		23 (1 study)	low[1,4]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Pill placebo or attention -placebo	Corresponding risk Behavioural sleep intervention			
Follow-up: mean 4 months		0.66 standard deviations lower (1.51 lower to 0.18 higher)			
Discontinuation Number of participants lost to follow-up Follow-up: 4-8 weeks	222 per 1000	256 per 1000 (113 to 582)	RR 1.15 (0.51 to 2.62)	75 (2 studies)	low[3]

BAI=Beck Anxiety Inventory; BDI=Beck Depression Inventory; CI=confidence interval; PCL=PTSD Checklist; PSQI=Pittsburgh Sleep Quality Index; PTSD=post-traumatic stress disorder; RR=risk ratio; SDS=Sheehan Disability Scale; SMD=standardised mean difference
[1] Risk of bias is high or unclear across multiple domains
[2] Considerable heterogeneity (I2>80%)
[3] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm
[4] 95% CI crosses both line of no effect and threshold for clinically important benefit
[5] 95% CI crosses both line of no effect and threshold for clinically important harm
[6] OIS not met (N<400)

Table 22: Summary clinical evidence profile: Behavioural sleep intervention versus prazosin for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Prazosin	Corresponding risk Behavioural sleep intervention			
PTSD symptomatology self-rated at endpoint PCL change score Follow-up: mean 8 weeks		The mean PTSD symptomatology self-rated at endpoint in the intervention groups was 0.11 standard deviations higher (0.65 lower to 0.87 higher)		27 (1 study)	very low[1,2]
PTSD symptomatology self-rated at 4-month follow-up PCL change score Follow-up: mean 4 months		The mean PTSD symptomatology self-rated at 4-month follow-up in the intervention groups was 0.52 standard deviations higher		24 (1 study)	low[1,3]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Prazosin	Corresponding risk Behavioural sleep intervention			
		(0.29 lower to 1.34 higher)			
Anxiety symptoms at endpoint BAI change score Follow-up: mean 8 weeks		The mean anxiety symptoms at endpoint in the intervention groups was 0.65 standard deviations higher (0.14 lower to 1.43 higher)		27 (1 study)	low[1,3]
Anxiety symptoms at 4-month follow-up BAI change score Follow-up: mean 4 months		The mean anxiety symptoms at 4-month follow-up in the intervention groups was 0.75 standard deviations higher (0.09 lower to 1.58 higher)		24 (1 study)	low[1,3]
Depression symptoms at endpoint BDI change score Follow-up: mean 8 weeks		The mean depression symptoms at endpoint in the intervention groups was 0.24 standard deviations higher (0.52 lower to 1 higher)		27 (1 study)	very low[1,2]
Depression symptoms at 4-month follow-up BDI change score Follow-up: mean 4 months		The mean depression symptoms at 4-month follow-up in the intervention groups was 0.8 standard deviations higher (0.04 lower to 1.63 higher)		24 (1 study)	low[1,3]
Functional impairment at endpoint SDS change score Follow-up: mean 8 weeks		The mean functional impairment at endpoint in the intervention groups was 0.14 standard deviations higher (0.62 lower to 0.9 higher)		27 (1 study)	very low[1,2]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Prazosin	Corresponding risk Behavioural sleep intervention			
Functional impairment at 4-month follow-up SDS change score Follow-up: mean 4 months		The mean functional impairment at 4-month follow-up in the intervention groups was 0.9 standard deviations higher (0.04 to 1.77 higher)		23 (1 study)	low[1,4]
Sleeping difficulties at endpoint PSQI change score Follow-up: mean 8 weeks		The mean sleeping difficulties at endpoint in the intervention groups was 0.35 standard deviations lower (1.11 lower to 0.41 higher)		27 (1 study)	low[1,5]
Sleeping difficulties at 4-month follow-up PSQI change score Follow-up: mean 4 months		The mean sleeping difficulties at 4-month follow-up in the intervention groups was 0.36 standard deviations higher (0.45 lower to 1.17 higher)		24 (1 study)	low[1,3]
Discontinuation Number of participants lost to follow-up Follow-up: mean 8 weeks	278 per 1000	369 per 1000 (142 to 953)	RR 1.33 (0.51 to 3.43)	37 (1 study)	low[2]

BAI=Beck Anxiety Inventory; BDI=Beck Depression Inventory; CI=confidence interval; PCL=PTSD checklist; PSQI=Pittsburgh Sleep Quality Assessment; PTSD=post-traumatic stress disorder; RR=risk ratio; SDS=Sheehan Disability Scale; SMD=standardised mean difference

[1] Risk of bias is high or unclear across multiple domains

[2] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm

[3] 95% CI crosses both line of no effect and threshold for clinically important harm

[4] OIS not met (N<400)

[5] 95% CI crosses both line of no effect and threshold for clinically important benefit

See appendix F for full GRADE tables.

Problem solving: clinical evidence

Included studies

Two studies of problem solving for the prevention of PTSD in adults were identified for full-text review. Neither of these studies could be included.

Excluded studies

Two studies were reviewed at full text and excluded from this review because the population was outside scope (trials of soldiers on active service), or efficacy or safety data could not be extracted.

Studies not included in this review with reasons for their exclusions are provided in Appendix K.

Psychologically-focused debriefing: clinical evidence

Included studies

Thirty-five studies of psychologically-focused debriefing for the prevention of PTSD in adults were identified for full-text review. Of these 35 studies, 9 RCTs (N=967) were included. Two of these RCTs are three-armed trials and included in more than one comparison. There were 4 comparisons for psychologically-focused debriefing.

All 4 comparisons were for the early prevention (intervention initiated within 1 month of trauma) of PTSD in adults: 7 RCTs (N=847) compared single/two session debriefing (alone or in addition to psychoeducation) with no treatment (Bisson 1997; Conlon 1999; Dolan. unpublished; Hobbs 1996; Marchand 2006; Rose 1999; Sijbrandij 2006); 1 RCT (N=67) compared group debriefing with no treatment (Tuckey 2014); 2 RCTs (N=120) compared group debriefing with an attention-placebo or psychoeducational session (Grundlingh 2017; Tuckey 2014); 1 RCT (N= 157) compared a combined single session debriefing and psychoeducation intervention with single psychoeducation session (Rose 1999).

Excluded studies

Twenty-six studies were reviewed at full text and excluded from this review. The most common reason for exclusion was non-randomised group assignment.

Studies not included in this review with reasons for their exclusions are provided in Appendix K.

Summary of clinical studies included in the evidence review

Table 23 and Table 24 provide brief summaries of the included studies and evidence from these are summarised in the clinical GRADE evidence profiles below (Table 25, Table 26, Table 27 and Table 28).

See also the study selection flow chart in Appendix C, forest plots in Appendix E and study evidence tables in Appendix D.

Table 23: Summary of included studies: Psychologically-focused debriefing for early prevention (<1 month)-part 1

Comparison	Single/two session debriefing (+/- psychoeducation) versus no treatment	Single session debriefing + psychoeducation versus single psychoeducation session
Total no. of studies (N randomised)	7 (847)	1 (157)
Study ID	Bisson 1997[1] Conlon 1999[2] Dolan (unpublished)[3] Hobbs 1996[4] Marchand 2006[5] Rose 1999[6] Sijbrandi 2006[7]	Rose 1999
Country	UK[1,3,4,6] Ireland[2] Canada[5] Netherlands[7]	UK
Diagnostic status	Non-significant symptoms (below threshold and <50% maximum score on scale)[1,3,4,5,7] Subthreshold symptoms (below threshold but ≥50% maximum score on scale)[2] Clinically important PTSD symptoms (scoring above a threshold on validated scale)[6]	Clinically important PTSD symptoms (scoring above a threshold on validated scale)
Mean age (range)	37.4 (16-65)[1] 33.9 (16-65)[2] 35 (18-65)[3] Median: 26-29 (17-69)[4] 21.8 (16-53)[5] 35.9 (18-76)[6] 40.4 (range NR)[7]	35.9 (18-76)
Sex (% female)	25[1,6] 53[2] 54[3] 38[4] 52[5] 47[7]	25
Ethnicity (% BME)	NR	NR
Coexisting conditions	NR	NR
Mean months since traumatic event	0.2[1,2] Mean NR (6-12 days after trauma)[3] Median 0.06 (within 24-48 hours of accident in most cases)[4] 0.3[5] 0.7[6] Median 15 days (range 11–19)[7]	0.7

Comparison	Single/two session debriefing (+/- psychoeducation) versus no treatment	Single session debriefing + psychoeducation versus single psychoeducation session
Type of traumatic event	Unintentional injury/illness/medical emergency: Burn trauma (length of hospital admission 16.1 [16.5] days) [1] Motor Vehicle Collision: Ambulant trauma clinic attenders with minor road traffic accident (RTA) injuries[2] Mixed: Motor vehicle accident, assault, house fire or industrial accident[3] Motor Vehicle Collision: Victims of road accidents admitted to hospital. 87% driver; 13% passengers. 67% car; 25% motorcycle; 8% lorry or van[4] Exposure to mugging or robbery: Armed robbery[5] Exposure to non-sexual violence: Actual physical assault (94%); Threatened physical assault (4%); Actual or threatened sexual assault (4%)[6] Mixed: Assault (52%) or accident (48%)[7]	Exposure to non-sexual violence: Actual physical assault (94%); Threatened physical assault (4%); Actual or threatened sexual assault (4%)
Single or multiple incident index trauma	Single	Single
Lifetime experience of trauma	19% had past significant trauma[1] NR[2,3,4,7] Mean 2.5 prior traumatic events[5] 41% had a history of child abuse[6]	41% had a history of child abuse
Intervention details	Single session debriefing (following structure of Mitchell 1983) delivered to individual (72%) or couple (28%)[1] Single session debriefing[2,4,7] Critical incident stress debriefing[3] Critical Incident Stress Debriefing, adapted form (CISD-A; adapted from Mitchell & Everly, 1995) [5] Single session debriefing (following unpublished manual loosely based on based on Mitchell's [1983] protocol) followed by psychoeducation[6]	Single session debriefing (following unpublished manual loosely based on based on Mitchell's [1983] protocol) followed by psychoeducation
Intervention format	Individual/Family[1] Individual[2,3,4,5,6,7]	Individual
Intervention intensity	1x 30-120 min session (0.5-2 hours). Mean 0.7 (0.3) hours[1] 1x 30-min session (0.5 hours) [2] 1x 0.75-2 hour session[3] 1x 1-hour session[4] 2x 1-hour sessions (2 hours) [5] 1x 1.5 hour session (1-hour debriefing + 30-min psychoeducation) [6]	1x 1.5 hour session (1-hour debriefing + 30-min psychoeducation)

Comparison	Single/two session debriefing (+/- psychoeducation) versus no treatment	Single session debriefing + psychoeducation versus single psychoeducation session
	1x 0.75-1 hour session[7]	
Comparator	No treatment	Single psychoeducation session based on a specially prepared leaflet that included information on normal reactions to traumatic events and where and when to find help. Information was related to participants' own experiences and was tailored to the nature of the assault
Intervention length (weeks)	0.1[1,2,3,4,6,7] 1[5]	0.1

BME, Black and Minority Ethnic; NR, not reported; PTSD, Post-traumatic stress disorder;
[1]Bisson 1997; [2]Conlon 1999; [3]Dolan (unpublished); [4]Hobbs 1996; [5]Marchand 2006; [6]Rose 1999; [7]Sijbrandi 2006

Table 24: Summary of included studies: Psychologically-focused debriefing for early prevention (<1 month)-part 2

Comparison	Group debriefing versus no treatment	Group debriefing versus attention-placebo or psychoeducational session
Total no. of studies (N randomised)	1 (67)	2 (120)
Study ID	Tuckey 2014	Grundlingh 2017[1] Tuckey 2014[2]
Country	Australia	Uganda[1] Australia[2]
Diagnostic status	Non-significant symptoms (below threshold and <50% maximum score on scale)	Non-significant symptoms (below threshold and <50% maximum score on scale)
Mean age (range)	NR	29.8 (range NR) [1] NR[2]
Sex (% female)	9	65[1] 9[2]
Ethnicity (% BME)	NR	NR
Coexisting conditions	NR	NR
Mean months since traumatic event	0.1 (within 3 days)	NR (<5 weeks) [1] 0.1 (within 3 days) [2]
Type of traumatic event	Being an emergency responder in a traumatic event: Firemen responding to a potentially traumatic event (PTE). All but one of these PTEs were motor vehicle accidents that resulted in fatalities or serious injuries to the vehicle occupants. The remaining PTE was a failed resuscitation attempt. All events involved secondary exposure (i.e., the fire-fighters provided fire and rescue services to primary victims)	Indirect exposure through profession: Ugandan researchers employed by the Good Schools Study to interview children who experienced violence[1] Being an emergency responder in a traumatic event: Firemen responding to a potentially traumatic event (PTE). All but one of these PTEs were motor vehicle accidents that resulted in fatalities or serious injuries to the vehicle occupants. The remaining

Comparison	Group debriefing versus no treatment	Group debriefing versus attention-placebo or psychoeducational session
	rather than primary exposure (where in fire-fighters' lives were directly threatened, by a burnover for example)	PTE was a failed resuscitation attempt. All events involved secondary exposure (i.e., the fire-fighters provided fire and rescue services to primary victims) rather than primary exposure (where in fire-fighters' lives were directly threatened, by a burnover for example) [2]
Single or multiple incident index trauma	Unclear	Unclear
Lifetime experience of trauma	NR	Personal experience of violence (lifetime): Intimate partner violence (emotional, sexual or physical; 23%); sexual violence from others (6%)[1] NR[2]
Intervention details	Group critical incident stress debriefing (CISD, following the protocol by Mitchell 1983 and Mitchell & Everly 1993)	Group Debriefings for Secondary Distress, intervention designed specifically for the study[1] Group critical incident stress debriefing (CISD, following the protocol by Mitchell 1983 and Mitchell & Everly 1993) [2]
Intervention format	Group	Group
Intervention intensity	1x 90-min session (1.5 hours)	3x 1.5-2 hour sessions (4.5-6 hours) [1] 1x 90-min session (1.5 hours) [2]
Comparator	No treatment	Attention-placebo: During the same time slot the control group was assigned to a leisure activity (film showing), for every session of debriefing undergone by the intervention group. The films were chosen for their light-hearted uplifting content and presented as a fun and relaxing activity[1] Single psychoeducation session[2]
Intervention length (weeks)	0.1	5[1] 0.1[2]

BME, Black and Minority Ethnic; NR, not reported; PTSD, Post-traumatic stress disorder;
[1]Grundlingh 2017; [2]Tuckey 2014

See appendix D for full evidence tables.

Quality assessment of clinical studies included in the evidence review

The clinical evidence profiles for this review (psychologically-focused debriefing for the prevention of PTSD in adults) are presented in Table 25, Table 26, Table 27 and Table 28.

Table 25: Summary clinical evidence profile: Single/two session debriefing (+/- psychoeducation) versus no treatment for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk No treatment	Corresponding risk Single/two session debriefing (+/- psychoeducation)			
PTSD symptomatology self-rated at 1-4 month follow-up IES endpoint/change score Follow-up: 1-4 months		The mean PTSD symptomatology self-rated at 1-4 month follow-up in the intervention groups was 0.13 standard deviations higher (0.11 lower to 0.37 higher)		392 (5 studies)	low[1,2]
PTSD symptomatology self-rated at 6-month follow-up IES endpoint score/PSS-SR change score Follow-up: mean 6 months		The mean PTSD symptomatology self-rated at 6-month follow-up in the intervention groups was 0.02 standard deviations higher (0.29 lower to 0.32 higher)		162 (2 studies)	very low[1,2]
PTSD symptomatology self-rated at 1-year follow-up IES change score Follow-up: mean 1 years		The mean PTSD symptomatology self-rated at 1-year follow-up in the intervention groups was 0.65 standard deviations higher (0.25 to 1.05 higher)		103 (1 study)	very low[1,2]
PTSD symptomatology clinician-rated at endpoint SI–PTSD change score Follow-up: mean 0.1 weeks		The mean PTSD symptomatology clinician-rated at endpoint in the intervention groups was 0.11 standard deviations lower (0.42 lower to 0.19 higher)		189 (1 study)	very low[1,2]
PTSD symptomatology clinician-rated at 1-3 month follow-up SI–PTSD/CAPS		The mean PTSD symptomatology clinician-rated at 1-3 month follow-up in the intervention groups was		217 (2 studies)	very low[1,3,4]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk No treatment	Corresponding risk Single/two session debriefing (+/- psychoeducation)			
change score Follow-up: 1-3 months		0.44 standard deviations lower (1.52 lower to 0.64 higher)			
PTSD symptomatology clinician-rated at 6-month follow-up SI–PTSD change score Follow-up: mean 6 months		The mean PTSD symptomatology clinician-rated at 6-month follow-up in the intervention groups was 0.25 standard deviations lower (0.57 lower to 0.06 higher)		169 (1 study)	very low[1,5]
Diagnosis of PTSD at 1-month follow-up Number of participants who met diagnostic criteria Follow-up: mean 1 months	24 per 1000	91 per 1000 (10 to 834)	RR 3.82 (0.42 to 35.04)	75 (1 study)	low[4]
Diagnosis of PTSD at 3-6 month follow-up Number of participants who met diagnostic criteria Follow-up: 3-6 months	235 per 1000	284 per 1000 (200 to 406)	RR 1.21 (0.85 to 1.73)	313 (3 studies)	very low[1,6]
Diagnosis of PTSD at 1-year follow-up Number of participants who met diagnostic criteria Follow-up: mean 1 years	250 per 1000	468 per 1000 (280 to 780)	RR 1.87 (1.12 to 3.12)	133 (1 study)	very low[1,7]
Anxiety symptoms at endpoint HAM-A change score Follow-up: mean 0.1 weeks		The mean anxiety symptoms at endpoint in the intervention groups was 0.1 standard deviations higher (0.2 lower to 0.4 higher)		190 (1 study)	very low[1,2]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk No treatment	Corresponding risk Single/two session debriefing (+/- psychoeducation)			
Anxiety symptoms at 1-3 month follow-up HADS-A endpoint/change score; HAM-A change score Follow-up: 1-3 months		The mean anxiety symptoms at 1-3 month follow-up in the intervention groups was 0.08 standard deviations higher (0.13 lower to 0.29 higher)		376 (3 studies)	very low[1,2]
Anxiety symptoms at 6-month follow-up HADS-A endpoint/HAM-A change score Follow-up: mean 6 months		The mean anxiety symptoms at 6-month follow-up in the intervention groups was 0.03 standard deviations lower (0.29 lower to 0.22 higher)		245 (2 studies)	low[1,2]
Anxiety symptoms at 1-year follow-up HADS-A change score Follow-up: mean 1 years		The mean anxiety symptoms at 1-year follow-up in the intervention groups was 0.56 standard deviations higher (0.16 to 0.96 higher)		103 (1 study)	very low[1,2]
Depression symptoms at endpoint HAM-D change score Follow-up: mean 0.1 weeks		The mean depression symptoms at endpoint in the intervention groups was 0.09 standard deviations higher (0.21 lower to 0.39 higher)		188 (1 study)	low[1,2]
Depression symptoms at 1-3 month follow-up HADS-D endpoint/change score; HAM-D change score Follow-up: 1-3 months		The mean depression symptoms at 1-3 month follow-up in the intervention groups was 0.04 standard deviations lower (0.25 lower to 0.17 higher)		376 (3 studies)	very low[1,2]
Depression symptoms at 6-		The mean depression		337 (3 studies)	very low[1,2]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk No treatment	Corresponding risk Single/two session debriefing (+/- psychoeducation)			
month follow-up HADS-D/BDI endpoint score/HAM-D change score Follow-up: mean 6 months		symptoms at 6-month follow-up in the intervention groups was 0.06 standard deviations lower (0.28 lower to 0.16 higher)			
Depression symptoms at 1-year follow-up HADS-D change score Follow-up: mean 1 years		The mean depression symptoms at 1-year follow-up in the intervention groups was 0.39 standard deviations higher (0 to 0.79 higher)		103 (1 study)	very low[1,2]
Discontinuation Number of participants lost to follow-up Follow-up: 0.1-1 weeks	161 per 1000	233 per 1000 (162 to 337)	RR 1.45 (1.01 to 2.1)	795 (7 studies)	low[1,7]

CI=confidence interval; CAPS=Clinician administered PTSD scale; HADS-A/D=Hospital Anxiety and Depression-Anxiety/Depression; HAM-A =Hamilton Anxiety Rating Scale; HAM-D=Hamilton Depression Scale; IES=Impact of Event Scale; PSS-SR=PTSD symptom scale-self-report; PTSD=post-traumatic stress disorder; RR=risk ratio; SI-PTSD=Structured Interview-PTSD; SMD=standardised mean difference

[1] Risk of bias is high or unclear across multiple domains
[2] OIS not met (N<400)
[3] Considerable heterogeneity (I2>80%)
[4] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm
[5] 95% CI crosses both line of no effect and threshold for clinically important benefit
[6] 95% CI crosses both line of no effect and threshold for clinically important harm
[7] OIS not met (events<300)

Table 26: Summary clinical evidence profile: Group debriefing versus no treatment for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk No treatment	Corresponding risk Group debriefing			
PTSD symptomatology self-rated IES-R change score		The mean PTSD symptomatology self-rated in the intervention groups was 0.28 standard		39 (1 study)	low[1,2]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk No treatment	Corresponding risk Group debriefing			
Follow-up: mean 0.1 weeks		deviations lower (0.91 lower to 0.35 higher)			
Discontinuation Number of participants lost to follow-up Follow-up: mean 0.1 weeks	500 per 1000	445 per 1000 (275 to 720)	RR 0.89 (0.55 to 1.44)	74 (1 study)	low[3]

CI=confidence interval; IES-R=Impact of Event Scale-Revised; PTSD=post-traumatic stress disorder; RR=risk ratio; SMD=standardised mean difference
[1] Risk of bias is high or unclear across multiple domains
[2] 95% CI crosses both line of no effect and threshold for clinically important benefit
[3] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm

Table 27: Summary clinical evidence profile: Group debriefing versus attention-placebo or psychoeducational session for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Attention-placebo or psychoeducational session	Corresponding risk Group debriefing			
PTSD symptomatology self-rated IES-R endpoint/change score Follow-up: 0.1-5 weeks		The mean PSTD symptomatology self-rated in the intervention groups was 0.08 standard deviations higher (0.95 lower to 1.12 higher)		100 (2 studies)	very low[1,2,3]
Discontinuation Number of participants lost to follow-up Follow-up: 0.1-5 weeks	267 per 1000	549 per 1000 (69 to 1000)	RR 2.06 (0.26 to 16.58)	137 (2 studies)	very low[3,4]

CI=confidence interval; IES-R=Impact of event scale-revised; PTSD=post-traumatic stress disorder; RR=risk ratio; SMD=standardised mean difference
[1] Risk of bias is high or unclear across multiple domains
[2] Considerable heterogeneity (I2>80%)
[3] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm
[4] Substantial heterogeneity (I2>50%)

Table 28: Summary clinical evidence profile: Single session debriefing + psychoeducation versus single psychoeducation session for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Single psychoeducation session	Corresponding risk Single session debriefing + psychoeducation			
PTSD symptomatology self-rated at 6-month follow-up PSS-SR change score Follow-up: mean 6 months		The mean PTSD symptomatology self-rated at 6-month follow-up in the intervention groups was 0.23 standard deviations higher (0.18 lower to 0.64 higher)		92 (1 study)	very low[1,2]
Diagnosis of PTSD at 6-month follow-up Number of people who met diagnostic criteria Follow-up: mean 6 months	231 per 1000	332 per 1000 (178 to 621)	RR 1.44 (0.77 to 2.69)	106 (1 study)	very low[1,3]
Depression symptoms at 6-month follow-up BDI endpoint score Follow-up: mean 6 months		The mean depression symptoms at 6-month follow-up in the intervention groups was 0.2 standard deviations higher (0.21 lower to 0.61 higher)		92 (1 study)	very low[1,2]
Discontinuation Number of participants lost to follow-up Follow-up: mean 6 months	135 per 1000	129 per 1000 (48 to 345)	RR 0.96 (0.36 to 2.56)	106 (1 study)	very low[1,3]

BDI=Beck Depression Inventory; CI=confidence interval; PSS-SR=PTSD symptom scale-self-report; PTSD=post-traumatic stress disorder; RR=risk ratio; SMD=standardised mean difference

[1] Risk of bias is high or unclear across multiple domains

[2] 95% CI crosses both line of no effect and threshold for clinically important harm

[3] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm

See appendix F for full GRADE tables.

Eye movement desensitisation and reprocessing (EMDR): clinical evidence

Included studies

Seven studies of eye movement desensitisation and reprocessing (EMDR) for the prevention of PTSD in adults were identified for full-text review. Of these 7 studies, 2 RCTs (N=131) were included in 4 relevant comparisons for EMDR (1 RCT had 3 arms and was included in 3 relevant comparisons).

For the early prevention (intervention initiated within 1 month of trauma) of PTSD there was evidence for 1 relevant comparison: 1 RCT (N=83) compared a brief EMDR intervention with TAU (Gil-Jardine 2018).

For prevention of PTSD in adults with ongoing exposure to trauma (for instance, war zone), there were no included studies.

For the early treatment (1-3 months) of non-significant PTSD symptoms in adults, there were no included studies.

For the delayed treatment (>3 months) of non-significant PTSD symptoms in adults, there was evidence from 1 RCT (N=48) for 3 relevant comparisons (Lytle 2002): EMDR versus supportive counselling; EMDR versus eye fixation desensitisation (EFD); EFD versus supportive counselling.

Excluded studies

Five studies were reviewed at full text and excluded from this review due to non-randomised group assignment, because the population was outside scope, or due to small sample size (N<10 per arm).

Studies not included in this review with reasons for their exclusions are provided in Appendix K.

Summary of clinical studies included in the evidence review

Table 29 and Table 30 provide brief summaries of the included studies and evidence from these are summarised in the clinical GRADE evidence profiles below (Table 31, Table 32, Table 33 and Table 34).

See also the study selection flow chart in Appendix C, forest plots in Appendix E and study evidence tables in Appendix D.

Table 29: Summary of included studies: Eye movement desensitisation and reprocessing (EMDR) for early prevention (<1 month)

Comparison	EMDR versus TAU
Total no. of studies (N randomised)	1 (83)
Study ID	Gil-Jardine 2018
Country	France
Diagnostic status	Unclear

Comparison	EMDR versus TAU
Mean age (range)	Mean NR. Medians 46 & 49 (range NR)
Sex (% female)	85
Ethnicity (% BME)	NR
Coexisting conditions	NR
Mean months since traumatic event	NR (within 24 hours of injury)
Type of traumatic event	Emergency room admissions: 63% medical emergency (35% neurology; 11% abdominal; 17% other); 37% injury (10% road traffic crash; 18% fall; 7% other accidents; 1% assault)
Single or multiple incident index trauma	Single
Lifetime experience of trauma	NR
Intervention details	EMDR recent traumatic episode protocol (R-TEP; Shapiro & Laub 2013)
Intervention format	Individual
Intervention intensity	1x 1-hour session
Comparator	TAU (medically and psychologically attended to by ER staff with no intervention of the study psychologist)
Intervention length (weeks)	0.1

BME, Black and Minority Ethnic; NR, Not reported; TAU, Treatment as usual

Table 30: Summary of included studies: Eye movement desensitisation and reprocessing (EMDR) for delayed treatment (>3 months) of non-significant PTSD symptoms

Comparison	EMDR versus supportive counselling	EMDR versus EFD	EFD versus supportive counselling
Total no. of studies (N randomised)	1 (48)	1 (48)	1 (48)
Study ID	Lytle 2002	Lytle 2002	Lytle 2002
Country	US	US	US
Diagnostic status	Subthreshold symptoms (below threshold but ≥50% maximum score on scale)	Subthreshold symptoms (below threshold but ≥50% maximum score on scale)	Subthreshold symptoms (below threshold but ≥50% maximum score on scale)
Mean age (range)	18.9 (range NR)	18.9 (range NR)	18.9 (range NR)
Sex (% female)	80	80	80
Ethnicity (% BME)	7	7	7
Coexisting conditions	NR	NR	NR
Mean months since traumatic event	Mean NR (exclusion criteria <2 months)	Mean NR (exclusion criteria <2 months)	Mean NR (exclusion criteria <2 months)

Comparison	EMDR versus supportive counselling	EMDR versus EFD	EFD versus supportive counselling
Type of traumatic event	Mixed: The most commonly reported trauma types were automobile accidents (24%), witnessing or suffering serious physical injury (20%) and rape (13%)	Mixed: The most commonly reported trauma types were automobile accidents (24%), witnessing or suffering serious physical injury (20%) and rape (13%)	Mixed: The most commonly reported trauma types were automobile accidents (24%), witnessing or suffering serious physical injury (20%) and rape (13%)
Single or multiple incident index trauma	Single	Single	Single
Lifetime experience of trauma	NR	NR	NR
Intervention details	Eye movement desensitisation and reprocessing (EMDR; following unpublished manual based on Shapiro 1989 [and approved by Shapiro])	Eye movement desensitisation and reprocessing (EMDR; following unpublished manual based on Shapiro 1989 [and approved by Shapiro])	Eye fixation desensitisation (EFD). Identical treatment to EMDR but with the exception that participants were asked to gaze at a 3 inch square of light blue paper placed at eye level on a wall directly in front of them
Intervention format	Individual	Individual	Individual
Intervention intensity	1x 1-hour session	1x 1-hour session	1x 1-hour session
Comparator	Non-directive verbal psychotherapy (based on Generalized Anxiety Disorder Treatment Protocol Manual of Borkovec & Costello 1993)	Eye fixation desensitisation (EFD). Identical treatment to EMDR but with the exception that participants were asked to gaze at a 3 inch square of light blue paper placed at eye level on a wall directly in front of them	Non-directive verbal psychotherapy (based on Generalized Anxiety Disorder Treatment Protocol Manual of Borkovec & Costello 1993)
Intervention length (weeks)	0.1	0.1	0.1

BME, Black and Minority Ethnic; EFD, Eye fixation desensitisation; EMDR, Eye movement desensitisation and reprocessing; NR, Not reported;

See appendix D for full evidence tables.

Quality assessment of clinical studies included in the evidence review

The clinical evidence profiles for this review (EMDR for the prevention of PTSD in adults) are presented in Table 31, Table 32, Table 33 and Table 34.

Table 31: Summary clinical evidence profile: Eye movement desensitisation and reprocessing (EMDR) versus TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk TAU	Corresponding risk Eye movement desensitisation and reprocessing (EMDR)			
PTSD at 3-month follow-up Number of participants who met DSM-IV criteria for PTSD Follow-up: mean 13 months	189 per 1000	30 per 1000 (4 to 227)	RR 0.16 (0.02 to 1.2)	71 (1 study)	low[1,2]
Discontinuation Number of participants lost to follow-up Follow-up: mean 13 weeks	98 per 1000	190 per 1000 (62 to 584)	RR 1.95 (0.64 to 5.99)	83 (1 study)	very low[1,3]

DSM-IV= Diagnostic and Statistical Manual of Mental Disorders, 4th Edition; CI=confidence interval; PTSD=post-traumatic stress disorder; RR=risk ratio
[1] Risk of bias was high across multiple outcomes
[2] 95% CI crosses both line of no effect and threshold for clinically important benefit
[3] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm

Table 32: Summary clinical evidence profile: Eye movement desensitisation and reprocessing (EMDR) versus supportive counselling for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Supportive counselling	Corresponding risk Eye movement desensitisation and reprocessing (EMDR)			
PTSD symptomatology self-rated IES change score Follow-up: mean 0.1 weeks		The mean PTSD symptomatology self-rated in the intervention groups was 0.22 standard deviations lower (0.94 lower to 0.49 higher)		30 (1 study)	very low[1,2]
Depression symptoms BDI change score Follow-up: mean 0.1 weeks		The mean depression symptoms in the intervention groups was 0.37 standard deviations higher		30 (1 study)	very low[1,3]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Supportive counselling	Corresponding risk Eye movement desensitisation and reprocessing (EMDR)			
		(0.35 lower to 1.1 higher)			

BDI=Beck Depression Inventory; CI=confidence interval; IES=Impact of event scale; PTSD=post-traumatic stress disorder; RR=risk ratio; SMD=standardised mean difference
[1] Risk of bias is high or unclear across multiple domains
[2] 95% CI crosses both line of no effect and threshold for clinically important benefit
[3] 95% CI crosses both line of no effect and threshold for clinically important harm

Table 33: Summary clinical evidence profile: Eye movement desensitisation and reprocessing (EMDR) versus eye fixation desensitisation (EFD) for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Eye fixation desensitisation (EFD)	Corresponding risk Eye movement desensitisation and reprocessing (EMDR)			
PTSD symptomatology self-rated IES change score Follow-up: mean 0.1 weeks		The mean PTSD symptomatology self-rated in the intervention groups was 0.5 standard deviations higher (0.23 lower to 1.23 higher)		30 (1 study)	very low[1,2]
Depression symptoms BDI change score Follow-up: mean 0.1 weeks		The mean depression symptoms in the intervention groups was 0.06 standard deviations lower (0.78 lower to 0.65 higher)		30 (1 study)	very low[1,3]

BDI=Beck Depression Inventory; CI=confidence interval; IES=Impact of event scale; PTSD=post-traumatic stress disorder; RR=risk ratio; SMD=standardised mean difference
[1] Risk of bias is high or unclear across multiple domains
[2] 95% CI crosses both line of no effect and threshold for clinically important harm
[3] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm

Table 34: Summary clinical evidence profile: Eye fixation desensitisation (EFD) versus supportive counselling for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Supportive counselling	Corresponding risk Eye fixation desensitisation (EFD)			
PTSD symptomatology self-rated IES change score Follow-up: mean 0.1 weeks		The mean PTSD symptomatology self-rated in the intervention groups was 0.81 standard deviations lower (1.56 to 0.06 lower)		30 (1 study)	very low[1,2]
Depression symptoms BDI change score Follow-up: mean 0.1 weeks		The mean depression symptoms in the intervention groups was 0.49 standard deviations higher (0.24 lower to 1.21 higher)		30 (1 study)	very low[1,3]

BDI=Beck Depression Inventory; CI=confidence interval; IES=Impact of event scale; PTSD=post-traumatic stress disorder; RR=risk ratio; SMD=standardised mean difference
[1] Risk of bias is high or unclear across multiple domains
[2] OIS not met (N<400)
[3] 95% CI crosses both line of no effect and threshold for clinically important harm

See appendix F for full GRADE tables.

Hypnotherapy: clinical evidence

Included studies

Two studies of hypnotherapy for the prevention of PTSD in adults were identified for full-text review. Of these 2 studies, 1 RCT (N=87) was included (Bryant 2005/2006 [1 study reported across 2 papers]). This RCT had 3 arms and was included in 2 relevant comparisons for the early prevention (intervention initiated within 1 month of trauma) of PTSD in adults: combined hypnotherapy and trauma-focused CBT intervention compared with trauma-focused CBT-only; combined hypnotherapy and trauma-focused CBT intervention compared with supportive counselling.

Excluded studies

One study was reviewed at full text and excluded from this review because the outcome measures were not validated.

Studies not included in this review with reasons for their exclusions are provided in Appendix K.

Summary of clinical studies included in the evidence review

Table 35 provides a brief summary of the included studies and evidence from these are summarised in the clinical GRADE evidence profile below (Table 36 and Table 37).

See also the study selection flow chart in Appendix C, forest plots in Appendix E and study evidence tables in Appendix D.

Table 35: Summary of included studies: Hypnotherapy for early prevention (<1 month)

Comparison	Hypnotherapy + trauma-focused CBT versus trauma-focused CBT	Hypnotherapy + trauma-focused CBT versus supportive counselling
Total no. of studies (N randomised)	1 (87)	1 (87)
Study ID	Bryant 2005/2006	Bryant 2005/2006
Country	Australia	Australia
Diagnostic status	Acute stress disorder/acute stress reaction diagnosis according to ICD/DSM criteria	Acute stress disorder/acute stress reaction diagnosis according to ICD/DSM criteria
Mean age (range)	33.6 (range NR)	33.6 (range NR)
Sex (% female)	61	61
Ethnicity (% BME)	NR	NR
Coexisting conditions	NR	NR
Mean months since traumatic event	0.5	0.5
Type of traumatic event	Exposure to non-sexual violence: Non-sexual assault (55%); motor vehicle accident (45%)	Exposure to non-sexual violence: Non-sexual assault (55%); motor vehicle accident (45%)
Single or multiple incident index trauma	Single	Single
Lifetime experience of trauma	NR	NR
Intervention details	CBT (following unpublished manual) + hypnotherapy	CBT (following unpublished manual) + hypnotherapy
Intervention format	Individual	Individual
Intervention intensity	5x weekly 90-min sessions (7.5 hours)	5x weekly 90-min sessions (7.5 hours)
Comparator	CBT individual	Supportive counselling (following unpublished manual)
Intervention length (weeks)	5	5

BME, Black and Minority Ethnic; CBT, Cognitive Behavioural Therapy; DSM, Diagnostic and Statistical Manual of Mental Disorders; ICD, International Classification of Diseases; NR, Not reported

See appendix D for full evidence tables.

Quality assessment of clinical studies included in the evidence review

The clinical evidence profiles for this review (hypnotherapy for the prevention of PTSD in adults) are presented in Table 36 and Table 37.

Table 36: Summary clinical evidence profile: Hypnotherapy + trauma-focused CBT versus trauma-focused CBT for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Trauma-focused CBT	Corresponding risk Hypnotherapy + trauma-focused CBT			
PTSD symptomatology clinician-rated at 3-year follow-up CAPS endpoint score Follow-up: mean 3 years		The mean PTSD symptomatology clinician-rated at 3-year follow-up in the intervention groups was 0.03 standard deviations higher (0.62 lower to 0.67 higher)		37 (1 study)	very low[1,2]
PTSD at 1-month follow-up Number of people who met criteria for PTSD Follow-up: mean 1 months	364 per 1000	298 per 1000 (149 to 611)	RR 0.82 (0.41 to 1.68)	63 (1 study)	very low[1,2]
PTSD at 6-month follow-up Number of people who met criteria for PTSD Follow-up: mean 6 months	424 per 1000	399 per 1000 (221 to 721)	RR 0.94 (0.52 to 1.7)	63 (1 study)	very low[1,2]
PTSD at 3-year follow-up Number of people who met criteria for PTSD Follow-up: mean 3 years	394 per 1000	465 per 1000 (264 to 827)	RR 1.18 (0.67 to 2.1)	63 (1 study)	very low[1,2]
Anxiety symptoms a 1-month follow-up BAI change score Follow-up: mean 1 months		The mean anxiety symptoms a 1-month follow-up in the intervention groups was 0.26 standard		63 (1 study)	very low[1,3]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Trauma-focused CBT	Corresponding risk Hypnotherapy + trauma-focused CBT			
		deviations lower (0.76 lower to 0.24 higher)			
Anxiety symptoms at 6-month follow-up BAI change score Follow-up: mean 6 months		The mean anxiety symptoms at 6-month follow-up in the intervention groups was 0.17 standard deviations lower (0.66 lower to 0.33 higher)		63 (1 study)	very low[1,3]
Depression symptoms at 1-month follow-up BDI-II change score Follow-up: mean 1 months		The mean depression symptoms at 1-month follow-up in the intervention groups was 0.04 standard deviations lower (0.54 lower to 0.45 higher)		63 (1 study)	very low[1,3]
Depression symptoms at 6-month follow-up BDI-II change score Follow-up: mean 6 months		The mean depression symptoms at 6-month follow-up in the intervention groups was 0.07 standard deviations higher (0.42 lower to 0.57 higher)		63 (1 study)	very low[1,4]
Depression symptoms at 3-year follow-up BDI-II change score Follow-up: mean 3 years		The mean depression symptoms at 3-year follow-up in the intervention groups was 0.43 standard deviations lower		37 (1 study)	very low[1,3]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Trauma-focused CBT	Corresponding risk Hypnotherapy + trauma-focused CBT			
		(1.08 lower to 0.23 higher)			
Discontinuation Number of participants lost to follow-up Follow-up: mean 0.1 weeks	273 per 1000	235 per 1000 (98 to 548)	RR 0.86 (0.36 to 2.01)	63 (1 study)	very low[1,2]

BAI=Beck Anxiety Inventory; BDI=Beck Depression Inventory; CI=confidence interval; CAPS=clinician-administered PTSD scale; PTSD=post-traumatic stress disorder; RR=risk ratio; SMD=standardised mean difference

[1] Risk of bias is high or unclear across multiple domains

[2] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm

[3] 95% CI crosses both line of no effect and threshold for clinically important benefit

[4] 95% CI crosses both line of no effect and threshold for clinically important harm

Table 37: Summary clinical evidence profile: Hypnotherapy + trauma-focused CBT versus supportive counselling for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Supportive counselling	Corresponding risk Hypnotherapy + trauma-focused CBT			
PTSD symptomatology clinician-rated at 3-year follow-up CAPS endpoint score Follow-up: mean 3 years		The mean PTSD symptomatology clinician-rated at 3-year follow-up in the intervention groups was 0.68 standard deviations lower (1.37 lower to 0.02 higher)		34 (1 study)	low[1,2]
PTSD at 1-month follow-up Number of people who met criteria for PTSD Follow-up: mean 1 months	500 per 1000	300 per 1000 (150 to 590)	RR 0.6 (0.3 to 1.18)	54 (1 study)	low[1,2]
PTSD at 6-month follow-up Number of people who met criteria for PTSD Follow-up: mean 6 months	583 per 1000	402 per 1000 (227 to 694)	RR 0.69 (0.39 to 1.19)	54 (1 study)	low[1,2]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Supportive counselling	Corresponding risk Hypnotherapy + trauma-focused CBT			
PTSD at 3-year follow-up Number of people who met criteria for PTSD Follow-up: mean 3 years	667 per 1000	467 per 1000 (287 to 753)	RR 0.7 (0.43 to 1.13)	54 (1 study)	low[1,2]
Anxiety symptoms at 1-month follow-up BAI change score Follow-up: mean 1 months		The mean anxiety symptoms at 1-month follow-up in the intervention groups was 0.36 standard deviations lower (0.9 lower to 0.18 higher)		54 (1 study)	very low[1,2]
Anxiety symptoms at 6-month follow-up BAI change score Follow-up: mean 6 months		The mean anxiety symptoms at 6-month follow-up in the intervention groups was 0.28 standard deviations lower (0.82 lower to 0.26 higher)		54 (1 study)	very low[1,2]
Depression symptoms at 1-month follow-up BDI-II change score Follow-up: mean 1 months		The mean depression symptoms at 1-month follow-up in the intervention groups was 0.01 standard deviations higher (0.53 lower to 0.54 higher)		54 (1 study)	very low[1,3]
Depression symptoms at 6-month follow-up BDI-II change score Follow-up: mean 6 months		The mean depression symptoms at 6-month follow-up in the intervention groups was 0.13 standard deviations higher (0.41 lower to 0.66 higher)		54 (1 study)	very low[1,4]
Depression symptoms at 3-year follow-up BDI-II change score		The mean depression symptoms at 3-year follow-up in the intervention		34 (1 study)	very low[1,5]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Supportive counselling	Corresponding risk Hypnotherapy + trauma-focused CBT			
Follow-up: mean 3 years		groups was 1.14 standard deviations lower (1.87 to 0.41 lower)			
Discontinuation Number of participants lost to follow-up Follow-up: mean 0.1 weeks	83 per 1000	233 per 1000 (53 to 1000)	RR 2.8 (0.64 to 12.26)	54 (1 study)	very low[1,3]

BAI=Beck Anxiety Inventory; BDI=Beck Depression Inventory; CAPS=Clinician administered PTSD scale; CBT=cognitive behavioural therapy; CI=confidence interval; PTSD=post-traumatic stress disorder; RR=risk ratio; SMD=standardised mean difference

[1] Risk of bias is high or unclear across multiple domains

[2] 95% CI crosses both line of no effect and threshold for clinically important benefit

[3] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm

[4] 95% CI crosses both line of no effect and threshold for clinically important harm

[5] OIS not met (N<400)

See appendix F for full GRADE tables.

Interpersonal psychotherapy (IPT): clinical evidence

Included studies

Three studies of interpersonal psychotherapy (IPT) for the prevention of PTSD in adults were identified for full-text review. Of these 3 studies, 1 RCT (N=90) was included in a single relevant comparison for the early prevention (intervention initiated within 1 month of trauma) of PTSD in adults: IPT versus TAU (Holmes 2007).

Excluded studies

Two studies were reviewed at full text and excluded from this review because the intervention was not targeted at PTSD symptoms or the paper was a subgroup/secondary analysis that is not relevant.

Studies not included in this review with reasons for their exclusions are provided in Appendix K.

Summary of clinical studies included in the evidence review

Table 38 provides a brief summary of the included study and evidence from this study is summarised in the clinical GRADE evidence profile below (Table 39).

See also the study selection flow chart in Appendix C, forest plots in Appendix E and study evidence tables in Appendix D.

Table 38: Summary of included studies: Interpersonal psychotherapy (IPT) for early prevention (<1 month)

Comparison	IPT versus TAU
Total no. of studies (N randomised)	1 (90)
Study ID	Holmes 2007
Country	Australia
Diagnostic status	Non-significant symptoms (below threshold and <50% maximum score on scale)
Mean age (range)	38.4 (range NR)
Sex (% female)	30
Ethnicity (% BME)	NR
Coexisting conditions	10% any DSM-IV psychiatric disorder: 3% MDD; 3% alcohol abuse/dependence; 5% substance abuse/dependence
Mean months since traumatic event	0.5
Type of traumatic event	Motor Vehicle Collision: 62.5% road traffic accidents, 17.5% falls or collisions and 13.8% non-accidental injury
Single or multiple incident index trauma	Single
Lifetime experience of trauma	NR
Intervention details	Interpersonal counselling (based on manual by Klerman 1987)
Intervention format	Individual
Intervention intensity	Planned intensity NR. Mean 5.9 sessions attended (SD=1.1)
Comparator	TAU: In the case of psychological distress participants in TAU group were recommended to seek assessment through their primary practitioner, but were also able to contact the study coordinator
Intervention length (weeks)	13

BME, Black and Minority Ethnic; DSM-IV, Diagnostic and Statistical Manual of Mental Disorders-IV; IPT, Interpersonal psychotherapy; MDD, Major Depressive Disorders; NR, Not reported; SD, Standard deviation; TAU, Treatment as usual

See appendix D for full evidence tables.

Quality assessment of clinical studies included in the evidence review

The clinical evidence profile for this review (IPT for the prevention of PTSD in adults) is presented in Table 39.

Table 39: Summary clinical evidence profile: Interpersonal psychotherapy (IPT) versus TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk TAU	Corresponding risk Interpersonal psychotherapy (IPT)			
PTSD symptomatology		The mean PTSD symptomatology		58 (1 study)	very low[1,2]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk TAU	Corresponding risk Interpersonal psychotherapy (IPT)			
self-rated at endpoint PCL change score Follow-up: mean 13 weeks		self-rated at endpoint in the intervention groups was 0.24 standard deviations lower (0.76 lower to 0.27 higher)			
PTSD symptomatology self-rated at 3-month follow-up PCL change score Follow-up: mean 3 months		The mean PTSD symptomatology self-rated at 3-month follow-up in the intervention groups was 0.04 standard deviations lower (0.55 lower to 0.48 higher)		58 (1 study)	very low[1,2]
PTSD diagnosis at 3-month follow-up Number of people who met diagnostic criteria Follow-up: mean 3 months	282 per 1000	550 per 1000 (313 to 959)	RR 1.95 (1.11 to 3.4)	90 (1 study)	very low[1,3]
Anxiety symptoms at endpoint HADS-A change score Follow-up: mean 13 weeks		The mean anxiety symptoms at endpoint in the intervention groups was 0.57 standard deviations higher (0.04 to 1.09 higher)		58 (1 study)	very low[1,4]
Anxiety symptoms at 3-month follow-up HADS-A change score Follow-up: mean 3 months		The mean anxiety symptoms at 3-month follow-up in the intervention groups was 0.36 standard deviations higher (0.16 lower to 0.88 higher)		58 (1 study)	very low[1,5]
Depression symptoms at endpoint BDI change score Follow-up: mean 13 weeks		The mean depression symptoms at endpoint in the intervention groups was 0.5 standard		58 (1 study)	very low[1,5]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk TAU	Corresponding risk Interpersonal psychotherapy (IPT)			
		deviations higher (0.02 lower to 1.02 higher)			
Depression symptoms at 3-month follow-up BDI change score Follow-up: mean 3 months		The mean depression symptoms at 3-month follow-up in the intervention groups was 0.05 standard deviations higher (0.46 lower to 0.57 higher)		58 (1 study)	very low1,5
Alcohol use disorder symptoms at endpoint AUDIT change score Follow-up: mean 13 weeks		The mean alcohol use disorder symptoms at endpoint in the intervention groups was 0.03 standard deviations higher (0.48 lower to 0.55 higher)		58 (1 study)	very low[1,5]
Alcohol use disorder symptoms at 3-month follow-up AUDIT change score Follow-up: mean 3 months		The mean alcohol use disorder symptoms at 3-month follow-up in the intervention groups was 0.43 standard deviations higher (0.1 lower to 0.95 higher)		58 (1 study)	very low[1,5]
Discontinuation Number of participants lost to follow-up Follow-up: mean 13 weeks	205 per 1000	470 per 1000 (238 to 931)	RR 2.29 (1.16 to 4.54)	90 (1 study)	moderate[3]

AUDIT=Alcohol use disorder identification test; BDI=Beck Depression Inventory; CI=confidence interval; HADS-A=Hospital Anxiety and Depression Scale-Anxiety; PCL=PTSD Checklist; PTSD=post-traumatic stress disorder; RR=risk ratio; SMD=standardised mean difference; TAU=treatment as usual

[1] Risk of bias is high or unclear across multiple domains

[2] 95% CI crosses both line of no effect and threshold for clinically important benefit

[3] OIS not met (events<300)

[4] OIS not met (N<400)

[5] 95% CI crosses both line of no effect and threshold for clinically important harm

See appendix F for full GRADE tables.

Counselling: clinical evidence

Included studies

Twelve studies of counselling for the prevention of PTSD in adults were identified for full-text review. Of these 12 studies, 2 RCTs (N=241) were included. There were 2 comparisons for counselling.

For the early prevention (intervention initiated within 1 month of trauma) of PTSD in adults, there was evidence for 1 relevant comparison: 1 RCT (N=90) compared supportive counselling compared with attention-placebo (Foa 2006)

For prevention of PTSD in adults with ongoing exposure to trauma (for instance, war zone), there were no included studies

For the early treatment (1-3 months) of non-significant PTSD symptoms in adults, there was evidence for 1 relevant comparison: 1 RCT (N=151) compared counselling with no treatment (Brom 1993).

For the delayed treatment (>3 months) of non-significant PTSD symptoms in adults, there were no included studies.

Excluded studies

Ten studies were reviewed at full text and excluded from this review. The most common reasons for exclusion was that the intervention was not targeted at PTSD symptoms.

Studies not included in this review with reasons for their exclusions are provided in Appendix K.

Summary of clinical studies included in the evidence review

Table 40 and Table 41 provide brief summaries of the included studies and evidence from these are summarised in the clinical GRADE evidence profiles below (Table 42 and Table 43).

See also the study selection flow chart in Appendix C, forest plots in Appendix E and study evidence tables in Appendix D.

Table 40: Summary of included studies: Counselling for early prevention (<1 month)

Comparison	Supportive counselling versus attention-placebo
Total no. of studies (N randomised)	1 (90)
Study ID	Foa 2006
Country	US
Diagnostic status	Clinically important PTSD symptoms (scoring above a threshold on validated scale)
Mean age (range)	33.7 (range NR)
Sex (% female)	100
Ethnicity (% BME)	69
Coexisting conditions	NR
Mean months since traumatic event	0.67

Comparison	Supportive counselling versus attention-placebo
Type of traumatic event	Exposure to sexual abuse or assault: Sexual assault (63%) or non-sexual assault (37%)
Single or multiple incident index trauma	Single
Lifetime experience of trauma	NR
Intervention details	Supportive counselling, active listening
Intervention format	Individual
Intervention intensity	4x 2-hour sessions (8 hours)
Comparator	Attention-placebo
Intervention length (weeks)	1

BME, Black and Minority Ethnic; NR, Not reported; PTSD, Post-traumatic stress disorders

Table 41: Summary of included studies: Counselling for early treatment (1-3 months) of non-significant PTSD symptoms

Comparison	Counselling versus no treatment
Total no. of studies (N randomised)	1 (151)
Study ID	Brom 1993
Country	Netherlands
Diagnostic status	Non-significant symptoms (below threshold and <50% maximum score on scale)
Mean age (range)	37.7 (range NR)
Sex (% female)	41
Ethnicity (% BME)	NR
Coexisting conditions	NR
Mean months since traumatic event	1-3 months
Type of traumatic event	Motor Vehicle Collision: Road accidents judged moderately serious to serious
Single or multiple incident index trauma	Single
Lifetime experience of trauma	NR
Intervention details	Supportive counselling (Brom & Kleber 1989)
Intervention format	Individual
Intervention intensity	3-6 sessions
Comparator	No treatment
Intervention length (weeks)	22

BME, Black and Minority Ethnic; NR, Not reported

See appendix D for full evidence tables.

Quality assessment of clinical studies included in the evidence review

The clinical evidence profiles for this review (counselling for the prevention of PTSD in adults) are presented in Table 42 and Table 43.

Table 42: Summary clinical evidence profile: Supportive counselling versus attention-placebo for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Attention-placebo	Corresponding risk Supportive counselling			
PTSD symptomatology self-rated at endpoint PSS-SR change score Follow-up: mean 1 weeks		The mean PTSD symptomatology self-rated at endpoint in the intervention groups was 0.93 standard deviations higher (0.29 to 1.56 higher)		43 (1 study)	very low[1,2]
PTSD symptomatology self-rated at 3-month follow-up PSS-SR change score Follow-up: mean 3 months		The mean PTSD symptomatology self-rated at 3-month follow-up in the intervention groups was 0.36 standard deviations higher (0.28 lower to 1.01 higher)		38 (1 study)	very low[1,3]
PTSD symptomatology self-rated at 1-year follow-up PSS-SR change score Follow-up: mean 1 years		The mean PTSD symptomatology self-rated at 1-year follow-up in the intervention groups was 0.24 standard deviations higher (0.35 lower to 0.84 higher)		44 (1 study)	very low[1,3]
PTSD symptomatology clinician-rated at endpoint PSS-I change score Follow-up: mean 1 weeks		The mean PTSD symptomatology clinician-rated at endpoint in the intervention groups was 0.32 standard deviations higher (0.28 lower to 0.93 higher)		43 (1 study)	low[1,3]
PTSD symptomatology clinician-rated at 3-month follow-up PSS-I change score Follow-up: mean 3 months		The mean PTSD symptomatology clinician-rated at 3-month follow-up in the intervention groups was 0.2 standard deviations higher		40 (1 study)	low[1,3]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Attention -placebo	Corresponding risk Supportive counselling			
		(0.42 lower to 0.83 higher)			
PTSD symptomatology clinician-rated at 1-year follow-up PSS-I change score Follow-up: mean 1 years		The mean PTSD symptomatology clinician-rated at 1-year follow-up in the intervention groups was 0.3 standard deviations lower (0.89 lower to 0.3 higher)		44 (1 study)	low[1,3]
Anxiety symptoms at endpoint BAI change score Follow-up: mean 1 weeks		The mean anxiety symptoms at endpoint in the intervention groups was 0.57 standard deviations higher (0.04 lower to 1.19 higher)		43 (1 study)	very low[1,3]
Anxiety symptoms at 3-month follow-up BAI change score Follow-up: mean 3 months		The mean anxiety symptoms at 3-month follow-up in the intervention groups was 0.6 standard deviations higher (0.05 lower to 1.25 higher)		38 (1 study)	very low[1,3]
Anxiety symptoms at 1-year follow-up BAI change score Follow-up: mean 1 years		The mean anxiety symptoms at 1-year follow-up in the intervention groups was 0.35 standard deviations higher (0.26 lower to 0.95 higher)		43 (1 study)	very low[1,3]
Depression symptoms at endpoint BDI change score Follow-up: mean 1 weeks		The mean depression symptoms at endpoint in the intervention groups was 0.79 standard deviations higher (0.16 to 1.41 higher)		43 (1 study)	very low[1,2]
Depression symptoms at 3-		The mean depression		38 (1 study)	very low[1,3]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Attention-placebo	Corresponding risk Supportive counselling			
month follow-up BDI change score Follow-up: mean 3 months		symptoms at 3-month follow-up in the intervention groups was 0.38 standard deviations higher (0.26 lower to 1.03 higher)			
Depression symptoms at 1-year follow-up BDI change score Follow-up: mean 1 years		The mean depression symptoms at 1-year follow-up in the intervention groups was 0.65 standard deviations higher (0.04 to 1.26 higher)		44 (1 study)	very low[1,2]
Discontinuation Number of participants lost to follow-up Follow-up: mean 1 weeks	333 per 1000	173 per 1000 (67 to 443)	RR 0.52 (0.2 to 1.33)	59 (1 study)	very low[1,4]

BAI=Beck Anxiety Inventory; BDI=Beck Depression Inventory; CI=confidence interval; PSS-I/SR=PTSD symptom scale-interview/self-report; RR=risk ratio; SMD=standardised mean difference
[1] Risk of bias is high or unclear across multiple domains
[2] OIS not met (N<400)
[3] 95% CI crosses both line of no effect and threshold for clinically important harm
[4] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm

Table 43: Summary clinical evidence profile: Counselling versus no treatment for the early treatment (1-3 months) of below threshold PTSD symptoms in adults

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk No treatment	Corresponding risk Counselling			
PTSD symptomatology self-rated IES change score Follow-up: mean 22 weeks		The mean PTSD symptomatology self-rated in the intervention groups was 0.25 standard deviations lower (0.57 lower to 0.07 higher)		151 (1 study)	very low[1,2]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk No treatment	Corresponding risk Counselling			
Discontinuation Number of participants lost to follow-up Follow-up: mean 22 weeks	241 per 1000	161 per 1000 (84 to 313)	RR 0.67 (0.35 to 1.3)	151 (1 study)	very low[1,3]

CI=confidence interval; IES=Impact of event scale; PTSD=post-traumatic stress disorder; RR=risk ratio; SMD=standardised mean difference
[1] Risk of bias is high or unclear across multiple domains
[2] 95% CI crosses both line of no effect and threshold for clinically important benefit
[3] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm

See appendix F for full GRADE tables.

Combined somatic and cognitive therapies: clinical evidence

Included studies

Two studies of combined somatic and cognitive therapies for the prevention of PTSD in adults were identified for full-text review. Neither of these studies could be included.

Excluded studies

Two studies were reviewed at full text and excluded from this review due to small sample size (N<10 per arm) or because outcomes were not of interest.

Studies not included in this review with reasons for their exclusions are provided in Appendix K.

Couple interventions: clinical evidence

Included studies

Two studies of couple interventions for the prevention of PTSD in adults were identified for full-text review. Of these 2 studies, 1 RCT (N=83) was included in a single comparison for the early prevention (intervention initiated within 1 month of trauma) of PTSD in adults: brief cognitive-behavioural conjoint therapy compared with waitlist (Brunet 2013/ Des Groseilliers 2013 [1 study reported across 2 papers]).

Excluded studies

One study was reviewed at full text and excluded from this review because the intervention was not targeted at PTSD symptoms.

Studies not included in this review with reasons for their exclusions are provided in Appendix K.

Summary of clinical studies included in the evidence review

Table 44 provides a brief summary of the included study and evidence from this study is summarised in the clinical GRADE evidence profile below (Table 45).

See also the study selection flow chart in Appendix C, forest plots in Appendix E and study evidence tables in Appendix D.

Table 44: Summary of included studies: Couple interventions for early prevention (<1 month)

Comparison	Brief cognitive-behavioural conjoint therapy versus waitlist
Total no. of studies (N randomised)	1 (83)
Study ID	Brunet 2013/Des Groseilliers 2013
Country	Canada
Diagnostic status	Clinically important PTSD symptoms (scoring above a threshold on validated scale)
Mean age (range)	36.3 (19-63)
Sex (% female)	46
Ethnicity (% BME)	NR
Coexisting conditions	NR
Mean months since traumatic event	0.9
Type of traumatic event	Motor Vehicle Collision: Motor vehicle accident (55%), work accident (16%), leisure accident (14%), or physical assault (15%)
Single or multiple incident index trauma	Single
Lifetime experience of trauma	NR
Intervention details	Brief dyadic cognitive-behavioural intervention
Intervention format	Family
Intervention intensity	1x 90-min session followed by 1x 75-min session (2.75 hours)
Comparator	Waitlist
Intervention length (weeks)	2

BME, Black and Minority Ethnic; NR, Not reported; PTSD, Post-traumatic stress disorders

See appendix D for full evidence tables.

Quality assessment of clinical studies included in the evidence review

The clinical evidence profile for this review (couple interventions for the prevention of PTSD in adults) is presented in Table 45.

Table 45: Summary clinical evidence profile: Brief cognitive-behavioural conjoint therapy versus waitlist for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist	Corresponding risk Brief cognitive-behavioural conjoint therapy			
PTSD symptomatology self-rated at 2-month follow-up IES-R change score Follow-up: mean 2 months		The mean PTSD symptomatology self-rated at 2-month follow-up in the intervention groups was 0.56 standard deviations lower (1.02 to 0.09 lower)		74 (1 study)	low[1,2]
PTSD symptomatology self-rated at 2-year follow-up IES-R change score Follow-up: mean 2 years		The mean PTSD symptomatology self-rated at 2-year follow-up in the intervention groups was 0.52 standard deviations lower (1.11 lower to 0.08 higher)		46 (1 study)	low[1,3]
Discontinuation Number of participants lost to follow-up Follow-up: mean 2 weeks	179 per 1000	228 per 1000 (95 to 540)	RR 1.27 (0.53 to 3.01)	83 (1 study)	low[4]

CI=confidence interval; IES-R=Impact of event scale-revised; PTSD=post-traumatic stress disorder; RR=risk ratio; SMD=standardised mean difference
[1] Risk of bias is high or unclear across multiple domains
[2] OIS not met (N<400)
[3] 95% CI crosses both line of no effect and threshold for clinically important benefit
[4] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm

See appendix F for full GRADE tables.

Parent training/family interventions: clinical evidence

Included studies

Two studies of parent training or family interventions for the prevention of PTSD in adults were identified for full-text review. Of these 2 studies, 1 RCT (N=152) was included in a single comparison for the early prevention (intervention initiated within 1 month of trauma) of PTSD in adults: family therapy in addition to TAU compared with TAU-only (Stehl 2009).

Excluded studies

One study was reviewed at full text and excluded from this review because the intervention was not targeted at PTSD symptoms.

Studies not included in this review with reasons for their exclusions are provided in Appendix K.

Summary of clinical studies included in the evidence review

Table 46 provides a brief summary of the included study and evidence from this study is summarised in the clinical GRADE evidence profile below (Table 47).

See also the study selection flow chart in Appendix C, forest plots in Appendix E and study evidence tables in Appendix D.

Table 46: Summary of included studies: Parent training/family therapy for early prevention (<1 month)

Comparison	Family therapy (+ TAU) versus TAU
Total no. of studies (N randomised)	1 (152)
Study ID	Stehl 2009
Country	US
Diagnostic status	Subthreshold symptoms (below threshold but ≥50% maximum score on scale)
Mean age (range)	Medians: 35-40 (range NR)
Sex (% female)	69
Ethnicity (% BME)	23
Coexisting conditions	NR
Mean months since traumatic event	Mean NR (goal was to initiate intervention 4–6 weeks after diagnosis)
Type of traumatic event	Parent/caregiver of child (aged 0-17 years) with cancer who was receiving chemotherapy and/or radiation treatment
Single or multiple incident index trauma	Single
Lifetime experience of trauma	NR
Intervention details	Surviving Cancer Competently Intervention Program— Newly Diagnosed (SCCIP-ND; following an unpublished manual) is an adaptation of an integrated cognitive behavioural and family therapy intervention developed and tested with adolescent survivors of childhood cancer and their families (Kazak 1999) + TAU
Intervention format	Family
Intervention intensity	3x 45-min sessions (2.25 hours)
Comparator	TAU: All families in study (and in the Division of Oncology) were assigned a social worker who attended the initial family meeting, provided resources and supplemental information about diagnosis and treatment, and offered support
Intervention length (weeks)	NR

BME, Black and Minority Ethnic; NR, Not reported; TAU, Treatment as usual

See appendix D for full evidence tables.

Quality assessment of clinical studies included in the evidence review

The clinical evidence profile for this review (family therapy for the prevention of PTSD in adults) is presented in Table 47.

Table 47: Summary clinical evidence profile: Family therapy (+ TAU) versus TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk TAU	Corresponding risk Family therapy (+ TAU)			
PTSD symptomatology self-rated at 1-month follow-up IES-R endpoint score Follow-up: mean 1 months		The mean PTSD symptomatology self-rated at 1-month follow-up in the intervention groups was 0.1 standard deviations higher (0.22 lower to 0.41 higher)		152 (1 study)	low[1,2]
Anxiety symptoms at 1-month follow-up STAI State endpoint score Follow-up: mean 1 months		The mean anxiety symptoms at 1-month follow-up in the intervention groups was 0.01 standard deviations higher (0.31 lower to 0.32 higher)		152 (1 study)	low[1,2]
Discontinuation Number of participants lost to follow-up Follow-up: mean 4 weeks	184 per 1000	184 per 1000 (94 to 359)	RR 1 (0.51 to 1.95)	152 (1 study)	low[3]

CI=confidence interval; IES-R=Impact of event scale-revised; RR=risk ratio; SMD=standardised mean difference; STAI=State-Trait Anxiety Inventory; TAU=treatment as usual
[1] Risk of bias is high or unclear across multiple outcomes
[2] OIS not met (N<400)
[3] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm

See appendix F for full GRADE tables.

Self-help (without support): clinical evidence

Included studies

Nineteen studies of self-help (without support) for the prevention of PTSD in adults were identified for full-text review. Of these 19 studies, 11 RCTs (N=1653) were included. There were 4 comparisons for self-help (without support).

For the early prevention (intervention initiated within 1 month of trauma) of PTSD in adults, there was evidence for 2 relevant comparisons: 1 RCT (N=85) compared self-help (without support) with waitlist (Cox 2009/Kenardy 2015 [1 study reported across 2 papers]); 5 RCTs

(N=857) compared self-help (without support) alone or in addition to TAU compared with TAU (Jones 2003; Kenardy 2008; Marsac 2013; Mouthaan 2013; Scholes 2007).

For prevention of PTSD in adults with ongoing exposure to trauma (for instance, war zone), there were no included studies.

For the early treatment (1-3 months) of non-significant PTSD symptoms in adults, there were no included studies.

For the delayed treatment (>3 months) of non-significant PTSD symptoms in adults, there was evidence for 2 relevant comparisons: 2 RCTs (N=345) compared self-help (without support) with waitlist (Beatty 2010a; Hobfoll 2016); 3 RCTs (N=366) compared self-help (without support) alone or in addition to TAU with attention-placebo or TAU (Ironson 2013; Koopman 2005; Short 2017).

Excluded studies

Eight studies were reviewed at full text and excluded from this review. The most common reasons for exclusion were that the comparison was outside protocol (within-class comparison), and efficacy or safety data could not be extracted.

Studies not included in this review with reasons for their exclusions are provided in Appendix K.

Summary of clinical studies included in the evidence review

Table 48 and Table 49 provide brief summaries of the included studies and evidence from these are summarised in the clinical GRADE evidence profiles below (Table 50, Table 51, Table 52 and Table 53).

See also the study selection flow chart in Appendix C, forest plots in Appendix E and study evidence tables in Appendix D.

Table 48: Summary of included studies: Self-help (without support) for early prevention (<1 month)

Comparison	Self-help (without support) versus waitlist	Self-help (without support; +/- TAU) versus TAU
Total no. of studies (N randomised)	1 (85)	5 (857)
Study ID	Cox 2009/Kenardy 2015	Jones 2003[1] Kenardy 2008[2] Marsac 2013[3] Mouthaan 2013[4] Scholes 2007[5]
Country	Australia	UK[1,5] Australia[2] US[3] Netherlands[4]
Diagnostic status	Non-significant symptoms (below threshold and <50% maximum score on scale)	Unclear[1] Non-significant symptoms (below threshold and <50% maximum score on scale)[2,3,4]

Comparison	Self-help (without support) versus waitlist	Self-help (without support; +/- TAU) versus TAU
		Clinically important PTSD symptoms (scoring above a threshold on validated scale) [5]
Mean age (range)	40.7 (range NR)	57.9 (17-84) [1] 39.9 (range NR) [2] 41 (23-59) [3] 43.8 (range NR) [4] 36.6 (range NR) [5]
Sex (% female)	NR	44[1] 86[2] 82[3] 40[4] 52[5]
Ethnicity (% BME)	NR	NR[1,2,4,5] 51[3]
Coexisting conditions	NR	NR
Mean months since traumatic event	NR (intervention initiated within 4-6 weeks of trauma)	NR (recruited to study within 1 week of ICU discharge) [1] 0.1[2,3] 0.23[4] Mean NR (intervention initiated within 1 month of their accident) [5]
Type of traumatic event	Family member or carer of child with unintentional injury caused by: falls (48%); sport injuries (15%); motor vehicle accidents as a passenger or pedestrian (7%); burns (7%); knock or blow (1%); other types of unintentional injury (14%)	Unintentional injury/illness/medical emergency: Patients who had been in ICU and ventilated. Mean ICU stay 13.6 days (range 2-114) [1] Family member of child with unintentional injury/illness/medical emergency. Cause of accident: 35% falls; 30% sporting injuries; 28% motor vehicle accidents; 7% other types of accidents. Type of injury: 53% Fractures and dislocations; 28% Lacerations or abrasions; 18% Other[2] Family member of child with unintentional injury/illness/medical emergency: Parent of children who incurred an injury and received medical treatment at a large urban Level I paediatric trauma centre. Children's injuries resulted primarily from recreation (31%), falls (31%), and motor vehicle crashes (16%)[3] Motor Vehicle Collision: Traffic accident (68%); Work-related accident (9%); Fall (14%); Interpersonal violence/physical abuse (2%); Other (7%)[4] Motor Vehicle Collision: Road traffic accident (65%): Assault (27%); Occupational injury (7%)[5]

Comparison	Self-help (without support) versus waitlist	Self-help (without support; +/- TAU) versus TAU
Single or multiple incident index trauma	Single	Single
Lifetime experience of trauma	NR	NR[1,2,3,5] Mean 2.9 prior traumatic events[4]
Intervention details	Psychoeducational materials (delivered to parents): Information booklet (''So your child has been in an accident . . . Information for parents about dealing with accidents?'')	Cognitive bibliotherapy: Routine Follow-Up Plus Rehabilitation Package[1] Psychoeducational materials (delivered to parents): Information booklet (''So your child has been in an accident…an information booklet for parents'') [2] Computerised psychoeducational intervention (delivered to parents): AfterTheInjury.org (ATI) [3] Computerised psychoeducational intervention: Trauma TIPS[4] Self-help information booklet[5]
Intervention format	Individual	Individual
Intervention intensity	Planned intensity NR. Majority read material once	NR[1,5] Planned intensity NR. 97% of parents reported that they read the booklets[2] 20-min directed use (encouraged to re-visit the ATI website as often as they wished after the initial introduction) [3] 0.5 hours. Mean 1.7 logins (average login time was 20.8 minutes) [4]
Comparator	Waitlist	TAU: Routine ICU Follow-Up[1] TAU (no further detail reported) [2.5] TAU: usual psychosocial care includes a social worker who provides services to patients with injuries and their families 4 days per week with 24-hr on-call coverage[3] TAU: incidental, nonstructured talks with trauma centre staff or with a patient's general practitioner (GP), either directly following injury or during the course of the trial[4]
Intervention length (weeks)	2-22	6[1] 4[2,4] NR[3] 13[5]

BME, Black and Minority Ethnic; ICU, Intensive care unit; NR, Not reported; TAU, Treatment as usual
[1]Jones 2003; [2]Kenardy 2008; [3]Marsac 2013; [4]Mouthaan 2013; [5]Scholes 2007

Table 49: Summary of included studies: Self-help (without support) for delayed treatment (>3 months) of non-significant PTSD symptoms

Comparison	Self-help (without support) versus waitlist	Self-help (without support; +/- TAU) versus attention-placebo or TAU
Total no. of studies (N randomised)	2 (345)	3 (366)
Study ID	Beatty 2010a[1] Hobfoll 2016[2]	Ironson 2013[3] Koopman 2005[4] Short 2017[5]
Country	Australia[1] US[2]	US
Diagnostic status	Subthreshold symptoms (below threshold but ≥50% maximum score on scale) [1] Non-significant symptoms (below threshold and <50% maximum score on scale) [2]	Non-significant symptoms (below threshold and <50% maximum score on scale)[3] Subthreshold symptoms (below threshold but ≥50% maximum score on scale)[4,5]
Mean age (range)	53.1 (29-79) [1] 34.4 (range NR) [2]	42.8 (range NR)[3] 36.5 (21-56) [4] 40.1 (19-66) [5]
Sex (% female)	100[1] 18[2]	39[3] 100[4] 51[5]
Ethnicity (% BME)	NR[1] 28[2]	83[3] 32[4] 51[5]
Coexisting conditions	NR	NR[3,4] 49% met criteria for a mood disorder, 75% for at least one anxiety disorder[5]
Mean months since traumatic event	NR	NR
Type of traumatic event	Diagnosis of life-threatening condition: Breast cancer[1] Military combat: Non–active-duty veterans who served since September 11, 2001[2]	Diagnosis of life-threatening condition: HIV-affected men and women[3] Domestic violence: 83% had been slapped, hit or punched; 79% had been pushed or shoved; 50% had been choked; 46% had been kicked; 46% had been raped; 16% had been threatened with a weapon. Women had left the abusive partner on average 5 years earlier (SD = 5.9) and had been in the relationship on average for 6.3 years (SD = 6.9) [4] Unclear[5]
Single or multiple incident index trauma	Single[1] Multiple[2]	Single[3] Multiple[4] Unclear[5]

Comparison	Self-help (without support) versus waitlist	Self-help (without support; +/- TAU) versus attention-placebo or TAU
Lifetime experience of trauma	NR	NR
Intervention details	Cognitive bibliotherapy. Workbook entitled 'Women Moving On: A workbook, journal for women moving forward after treatment for breast cancer'[1] Computerised non-trauma-focused CBT: Vets Prevail[2]	Expressive writing[3,4] Computerised cognitive training: Cognitive anxiety sensitivity treatment (CAST) protocol + TAU[5]
Intervention format	Individual	Individual
Intervention intensity	Planned intensity NR. At post-treatment 88% had read all the information, 81% had completed 25% or more of the suggestions and exercises, and 88% spent 1–15 min or more per week using the book[1] 7 online sessions. 73% completed ≥5 sessions; 13% completed 2-4; 5% completed 1; 5% completed no lessons[2]	4x 30-min writing sessions (2 hours)[3] 4x weekly 20-min sessions (1.3 hours)[4] 3x weekly sessions[5]
Comparator	Waitlist	Attention-placebo: Neutral writing[3,4] TAU: permitted to remain on psychotropic medication[5]
Intervention length (weeks)	13[1] 6[2]	2-4[3] 4[4] 3[5]

BME, Black and Minority Ethnic; CBT, Cognitive Behavioural Therapy; ICU, Intensive care unit; NR, Not reported; SD, Standard deviation; TAU, Treatment as usual
[1]Beatty 2010a; [2]Hobfoll 2016; [3]Ironson 2013; [4]Koopman 2005; [5]Short 2017

See appendix D for full evidence tables.

Quality assessment of clinical studies included in the evidence review

The clinical evidence profiles for this review (self-help without support for the prevention of PTSD in adults) are presented in Table 50, Table 51, Table 52 and Table 53.

Table 50: Summary clinical evidence profile: Self-help (without support) versus waitlist for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist	Corresponding risk Self-help (without support)			
PTSD symptomatology self-rated at endpoint IES-R change score		The mean PTSD symptomatology self-rated at endpoint in the intervention groups was		56 (1 study)	very low[1,2]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist	Corresponding risk Self-help (without support)			
Follow-up: 2-22 weeks		0.06 standard deviations lower (0.58 lower to 0.47 higher)			
PTSD symptomatology self-rated at 5-month follow-up IES-R change score Follow-up: mean 5 months		The mean PTSD symptomatology self-rated at 5-month follow-up in the intervention groups was 0.13 standard deviations lower (0.65 lower to 0.4 higher)		56 (1 study)	very low[1,2]
Discontinuation Number of participants lost to follow-up Follow-up: 2-22 weeks	244 per 1000	317 per 1000 (159 to 634)	RR 1.3 (0.65 to 2.6)	85 (1 study)	very low[1,3]

CI=confidence interval; IES-R=Impact of Event Scale-Revised; PTSD=post-traumatic stress disorder; RR=risk ratio; SMD=standardised mean difference
[1] Risk of bias is high or unclear across multiple domains
[2] 95% CI crosses both line of no effect and threshold for clinically important benefit
[3] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm

Table 51: Summary clinical evidence profile: Self-help (without support; +/- TAU) versus TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk TAU	Corresponding risk Self-help (without support; +/- TAU)			
PTSD symptomatology self-rated at endpoint PDS/IES/IES-R change score Follow-up: 4-13 weeks		The mean PTSD symptomatology self-rated at endpoint in the intervention groups was 0.00 standard deviations lower (0.32 lower to 0.32 higher)		483 (3 studies)	low[1,5]
PTSD symptomatology self-rated at 6-8 week follow-up PCL/IES-R change score		The mean PTSD symptomatology self-rated at 6-8 week follow-up in the intervention groups was 0.12 standard		400 (2 studies)	moderate[1]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk TAU	Corresponding risk Self-help (without support; +/- TAU)			
Follow-up: 6-8 weeks		deviations higher (0.08 lower to 0.32 higher)			
PTSD symptomatology self-rated at 5-6 month follow-up PDS/IES/IES-R change score Follow-up: mean 5-6 months		The mean PTSD symptomatology self-rated at 5-6 month follow-up in the intervention groups was 0.08 standard deviations higher (0.14 lower to 0.31 higher)		462 (3 studies)	moderate [1]
PTSD symptomatology self-rated at 11-month follow-up IES-R change score Follow-up: mean 11 months		The mean PSTD symptomatology self-rated at 11-month follow-up in the intervention groups was 0.22 standard deviations higher (0 to 0.45 higher)		300 (1 study)	low[1,2]
PTSD symptomatology clinician-rated at endpoint CAPS endpoint score Follow-up: mean 4 weeks		The mean PTSD symptomatology clinician-rated at endpoint in the intervention groups was 0.76 standard deviations lower (0.99 to 0.53 lower)		300 (1 study)	low[1,2]
PTSD symptomatology clinician-rated at 2-month follow-up CAPS endpoint score Follow-up: mean 2 months		The mean PTSD symptomatology clinician-rated at 2-month follow-up in the intervention groups was 0.54 standard deviations lower (0.77 to 0.31 lower)		300 (1 study)	low[1,2]
PTSD symptomatology clinician-rated at 5-month follow-up CAPS endpoint score Follow-up: mean 5 months		The mean PTSD symptomatology clinician-rated at 5-month follow-up in the intervention groups was 0.28 standard deviations lower (0.51 to 0.06 lower)		300 (1 study)	low[1,2]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk TAU	Corresponding risk Self-help (without support; +/- TAU)			
PTSD symptomatology clinician-rated at 11-month follow-up CAPS endpoint score Follow-up: mean 11 months		The mean PTSD symptomatology clinician-rated at 11-month follow-up in the intervention groups was 0 standard deviations higher (0.23 lower to 0.23 higher)		300 (1 study)	low[1,2]
PTSD at 5-month follow-up Number scoring above clinical cut-off on scale Follow-up: mean 5 months	368 per 1000	449 per 1000 (291 to 689)	RR 1.22 (0.79 to 1.87)	126 (1 study)	very low[1,3]
Anxiety symptoms at endpoint HADS-A/DASS Anxiety change score Follow-up: 4-13 weeks		The mean anxiety symptoms at endpoint in the intervention groups was 0.05 standard deviations lower (0.31 lower to 0.20 higher)		485 (3 studies)	moderate[1]
Anxiety symptoms at 2-month follow-up HADS-A change score Follow-up: mean 2 months		The mean anxiety symptoms at 2-month follow-up in the intervention groups was 0.07 standard deviations higher (0.16 lower to 0.29 higher)		300 (1 study)	low[1,2]
Anxiety symptoms at 5-6 month follow-up HADS-A/DASS Anxiety change score Follow-up: 5-6 months		The mean anxiety symptoms at 5-6 month follow-up in the intervention groups was 0.05 standard deviations lower (0.24 lower to 0.13 higher)		464 (3 studies)	moderate[1]
Anxiety symptoms at 11-month follow-up HADS-A change score		The mean anxiety symptoms at 11-month follow-up in the intervention groups was 0.31 standard		300 (1 study)	low[1,2]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk TAU	Corresponding risk Self-help (without support; +/- TAU)			
Follow-up: mean 11 months		deviations higher (0.08 to 0.54 higher)			
Depression symptoms at endpoint HADS-D/DASS Depression change score Follow-up: 4-13 weeks		The mean depression symptoms at endpoint in the intervention groups was 0.19 standard deviations lower (0.47 lower to 0.09 higher)		485 (3 studies)	moderate [1]
Depression symptoms at 2-month follow-up HADS-D change score Follow-up: mean 2 months		The mean depression symptoms at 2-month follow-up in the intervention groups was 0.01 standard deviations higher (0.21 lower to 0.24 higher)		300 (1 study)	low[1,2]
Depression symptoms at 5-6 month follow-up HADS-D/DASS Depression change score Follow-up: 5-6 months		The mean depression symptoms at 5-6 month follow-up in the intervention groups was 0.09 standard deviations lower (0.33 lower to 0.15 higher)		464 (3 studies)	moderate [1]
Depression symptoms at 11-month follow-up HADS-D change score Follow-up: mean 11 months		The mean depression symptoms at 11-month follow-up in the intervention groups was 0.28 standard deviations higher (0.05 to 0.51 higher)		300 (1 study)	low[1,2]
Discontinuation Number of participants lost to follow-up Follow-up: 4-13 weeks	286 per 1000	320 per 1000 (263 to 395)	RR 1.12 (0.92 to 1.38)	753 (4 studies)	low[1,4]

CAPS=clinician administered PTSD scale; CI=confidence interval; HADS-A=Hospital Anxiety and Depression Scale-Anxiety/Depression; IES-R=Impact of event scale-revised; PCL=PTSD Checklist; PTSD=post-traumatic stress disorder; RR=risk ratio; SMD=standardised mean difference

[1] Risk of bias is high or unclear across multiple outcomes
[2] OIS not met (N<400)
[3] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm
[4] 95% CI crosses both line of no effect and threshold for clinically important harm
[5] Substantial heterogeneity (I2>50%)

Table 52: Summary clinical evidence profile: Self-help (without support) versus waitlist for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist	Corresponding risk Self-help (without support)			
PTSD symptomatology self-rated at endpoint PSS-SR endpoint score/PCL change score Follow-up: 6-13 weeks		The mean PTSD symptomatology self-rated at endpoint in the intervention groups was 0.78 standard deviations lower (1.03 to 0.53 lower)		288 (2 studies)	low[1,2]
PTSD symptomatology self-rated at 1-3 month follow-up PSS-SR endpoint score/PCL change score Follow-up: 1-3 months		The mean PTSD symptomatology self-rated at 1-3 month follow-up in the intervention groups was 0.33 standard deviations lower (1.56 lower to 0.9 higher)		296 (2 studies)	very low[1,3,4]
Response at 3-month follow-up Number of people showing clinically significant improvement based on reliable change indices (RCI on PSS-SR) Follow-up: mean 3 months	91 per 1000	100 per 1000 (15 to 645)	RR 1.1 (0.17 to 7.09)	42 (1 study)	very low[1,4]
Depression symptoms at endpoint CES-D change score Follow-up: mean 6 weeks		The mean depression symptoms at endpoint in the intervention groups was 0.29 standard deviations lower		248 (1 study)	low[1,2]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist	Corresponding risk Self-help (without support)			
		(0.55 to 0.03 lower)			
Depression symptoms at 6-week follow-up CES-D change score Follow-up: mean 6 weeks		The mean depression symptoms at 6-week follow-up in the intervention groups was 0.81 standard deviations lower (1.08 to 0.55 lower)		256 (1 study)	low[1,2]
Quality of life at endpoint EORTC QLQ endpoint score Follow-up: mean 13 weeks Better indicated by higher values		The mean quality of life at endpoint in the intervention groups was 0.01 standard deviations lower (0.63 lower to 0.61 higher)		40 (1 study)	very low[1,4]
Quality of life at 3-month follow-up EORTC QLQ endpoint score Follow-up: mean 3 months Better indicated by higher values		The mean quality of life at 3-month follow-up in the intervention groups was 0.11 standard deviations higher (0.51 lower to 0.73 higher)		40 (1 study)	very low[1,4]
Discontinuation Number of participants lost to follow-up Follow-up: 6-13 weeks	60 per 1000	213 per 1000 (91 to 500)	RR 3.53 (1.5 to 8.29)	345 (2 studies)	moderate[5]

CES-D=Center for epidemiologic studies depression Scale; CI=confidence interval; EORTC QLQ=an integrated system for assessing health-related quality of life questionnaire; PCL=PTSD Checklist; PSS-SR=PTSD symptom scale-self-report: PTSD=post-traumatic stress disorder; RR=risk ratio; SMD=standardised mean difference

[1] Risk of bias is high or unclear across multiple outcomes

[2] OIS not met (N<400)

[3] Considerable heterogeneity (I2>80%)

[4] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm

[5] OIS not met (events<300)

Table 53: Summary clinical evidence profile: Self-help (without support; +/- TAU) versus attention-placebo or TAU for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk attention-placebo or TAU	Corresponding risk Self-help (without support; +/- TAU)			
PTSD symptomatology self-rated at endpoint PCL/DTS change score Follow-up: 2-4 weeks		The mean PTSD symptomatology self-rated at endpoint in the intervention groups was 0.28 standard deviations lower (0.66 lower to 0.1 higher)		275 (2 studies)	very low[1,2]
PTSD symptomatology self-rated at 1-5 month follow-up PCL/DTS change score Follow-up: 1-5 months		The mean PTSD symptomatology self-rated at 1-5 month follow-up in the intervention groups was 0.26 standard deviations lower (0.67 lower to 0.16 higher)		299 (3 studies)	very low[1,2,3]
PTSD symptomatology self-rated at 11-month follow-up DTS change score Follow-up: mean 11 months		The mean PTSD symptomatology self-rated at 11-month follow-up in the intervention groups was 0.07 standard deviations higher (0.23 lower to 0.37 higher)		173 (1 study)	very low[1,4]
Depression symptoms at endpoint HAM-D change score Follow-up: 2-4 weeks		The mean depression symptoms at endpoint in the intervention groups was 0.03 standard deviations higher (0.24 lower to 0.3 higher)		211 (1 study)	very low[1,4]
Depression symptoms at 4-5 month follow-up BDI/HAMD change score Follow-up: 4-5 months		The mean depression symptoms at 4-5 month follow-up in the intervention groups was 0.05 standard		238 (2 studies)	very low[1,3,4]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk attention-placebo or TAU	Corresponding risk Self-help (without support; +/- TAU)			
		deviations lower (0.49 lower to 0.39 higher)			
Depression symptoms at 11-month follow-up HAM-D change score Follow-up: mean 11 months		The mean depression symptoms at 11-month follow-up in the intervention groups was 0.26 standard deviations higher (0.04 lower to 0.56 higher)		171 (1 study)	very low[1,5]
Discontinuation Number of participants lost to follow-up Follow-up: 2-4 weeks	114 per 1000	132 per 1000 (67 to 258)	RR 1.16 (0.59 to 2.27)	244 (1 study)	very low[1,6]

BDI=Beck Depression Inventory; CI=confidence interval; DTS= Davidson Trauma Scale; HAM-D= Hamilton Rating Scale for Depression; PCL=PTSD Checklist; PTSD=post-traumatic stress disorder; RR=risk ratio; SMD=standardised mean difference; TAU=treatment as usual[1] Risk of bias is high or unclear across multiple outcomes
[2] 95% CI crosses line of no effect and threshold for clinically important benefit
[3] Substantial heterogeneity (I2>50%)
[4] OIS not met (N<400)
[5] 95% CI crosses both line of no effect and threshold for clinically important harm
[6] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm

See appendix F for full GRADE tables.

Self-help with support: clinical evidence

Included studies

Seven studies of self-help with support for the prevention of PTSD in adults were identified for full-text review. Of these 7 studies, 5 RCTs (N=404) were included. There were 5 comparisons for self-help with support.

For the early prevention (intervention initiated within 1 month of trauma) of PTSD in adults, there was evidence for 2 relevant comparisons: 1 RCT (N=71) compared self-help with support with attention-placebo (Iyadurai 2017); 1 RCT (N=148) compared self-help with support in addition to TAU with TAU-only (Bugg 2009).

For prevention of PTSD in adults with ongoing exposure to trauma (for instance, war zone), there were no included studies

For the early treatment (1-3 months) of non-significant PTSD symptoms in adults, there was evidence for 1 relevant comparison: 1 RCT (N=58) compared self-help with support with waitlist (Cernvall 2015).

For the delayed treatment (>3 months) of non-significant PTSD symptoms in adults, there was evidence for 2 relevant comparisons: 1 RCT (N=104) compared self-help with support with waitlist (Sveen 2017); 1 RCT (N=23) compared self-help with support with attention-placebo (Carrico 2015).

Excluded studies

Two studies were reviewed at full text and excluded from this review because the population was outside scope (trial of soldiers on active service), and efficacy or safety data could not be extracted.

Studies not included in this review with reasons for their exclusions are provided in Appendix K.

Summary of clinical studies included in the evidence review

Table 54, Table 55 and Table 56 provide brief summaries of the included studies and evidence from these are summarised in the clinical GRADE evidence profiles below (Table 57, Table 58, Table 59, Table 60 and Table 61).

See also the study selection flow chart in Appendix C, forest plots in Appendix E and study evidence tables in Appendix D.

Table 54: Summary of included studies: Self-help with support for early prevention (<1 month)

Comparison	Self-help with support versus attention-placebo	Self-help with support (+ TAU) versus TAU
Total no. of studies (N randomised)	1 (71)	1 (148)
Study ID	Iyadurai 2017	Bugg 2009
Country	UK	UK
Diagnostic status	Unclear	Clinically important PTSD symptoms (scoring above a threshold on validated scale)
Mean age (range)	39.7 (range NR)	37.5 (18-65)
Sex (% female)	52	72
Ethnicity (% BME)	21	NR
Coexisting conditions	NR	NR
Mean months since traumatic event	201.1 mins since trauma	1.3 (first intervention session within 5-6 weeks of trauma)
Type of traumatic event	Motor Vehicle Collision: All participants experienced motor vehicle accident (rather than witnessed). 76% were brought in by ambulance. Type of motor vehicle accident: Car/van/bus driver (45%); Car/van passenger (6%);	Motor Vehicle Collision: Motor vehicle accident (79%), occupational injury (3%) or assault (18%)

Comparison	Self-help with support versus attention-placebo	Self-help with support (+ TAU) versus TAU
	Motorcyclist (15%); Cyclist (28%); Pedestrian (6%). 28% admitted as inpatient	
Single or multiple incident index trauma	Single	Single
Lifetime experience of trauma	73% prior trauma	NR
Intervention details	Tetris computer game + memory reminder cue	Expressive writing with support + TAU (self-help information booklet)
Intervention format	Individual	Individual
Intervention intensity	1x 20-min session. All participants allocated to the intervention condition completed the memory reminder cue, and only one participant did not play Tetris for the minimum required duration of 10 min uninterrupted (they were moved by staff to a different bay)	3x 20min writing sessions (+ telephone support after each writing session)
Comparator	Attention-placebo: participants filled in a simple activity log to note down each activity they had already engaged in during their time in the emergency department	TAU: Self-help information booklet one-month post-injury
Intervention length (weeks)	1	0.4

BME, Black and minority ethnic; NR, Not reported; PTSD, post-traumatic stress disorder; TAU, Treatment as usual

Table 55: Summary of included studies: Self-help with support for early treatment (1-3 months) of non-significant PTSD symptoms

Comparison	Self-help with support versus waitlist
Total no. of studies (N randomised)	1 (58)
Study ID	Cernvall 2015
Country	Sweden
Diagnostic status	Subthreshold symptoms (below threshold but ≥50% maximum score on scale)
Mean age (range)	38 (range NR)
Sex (% female)	67
Ethnicity (% BME)	NR
Coexisting conditions	NR
Mean months since traumatic event	Median months since diagnosis: 3
Type of traumatic event	Parents of children on cancer treatment (52% Leukaemia; 17% Sarcoma; 7% Lymphoma; 15% CNS tumour; 9% Other malignant disease)
Single or multiple incident index trauma	Single
Lifetime experience of trauma	45% had experience of previous traumatic events

Comparison	Self-help with support versus waitlist
Intervention details	Computerised CBT with support
Intervention format	Individual
Intervention intensity	NR
Comparator	Waitlist
Intervention length (weeks)	10

BME, Black and Minority Ethnic; CBT, Cognitive Behavioural therapy; CNS, Central Nervous System; NR, Not reported; PTSD, post-traumatic stress disorder

Table 56: Summary of included studies: Self-help with support for early treatment (>3 months) of non-significant PTSD symptoms

Comparison	Self-help with support versus waitlist	Self-help with support versus attention-placebo
Total no. of studies (N randomised)	1 (104)	1 (23)
Study ID	Sveen 2017	Carrico 2015
Country	Sweden	US
Diagnostic status	Non-significant symptoms (below threshold and <50% maximum score on scale)	Non-significant symptoms (below threshold and <50% maximum score on scale)
Mean age (range)	37.4 (range NR)	45.5 (range NR)
Sex (% female)	68	0
Ethnicity (% BME)	NR	64
Coexisting conditions	NR	All participants had used methamphetamine in the past 30 days
Mean months since traumatic event	34.3	163.2
Type of traumatic event	Parent of a child with severe burns admitted to a burn centre. Mean age of child at time of injury 3.0 years, mean length of stay in hospital 7.2 days. Cause of injury: scalds (76%); fire (4%); contact burns (14%); other, e.g. electrical or chemical (6%)	Diagnosis of life-threatening condition: HIV-positive
Single or multiple incident index trauma	Single	Single
Lifetime experience of trauma	NR	NR
Intervention details	Computerised trauma-focused CBT with support	Expressive writing with support
Intervention format	Individual	Individual
Intervention intensity	6x weekly modules (with written support from psychologist or psychotherapist)	7 sessions. All participants completed all 7 sessions

Comparison	Self-help with support versus waitlist	Self-help with support versus attention-placebo
Comparator	Waitlist	Attention-placebo: Control writing condition
Intervention length (weeks)	6	4

BME, Black and Minority Ethnic; CBT, Cognitive Behavioural therapy; NR, Not reported; PTSD, post-traumatic stress disorder

See appendix D for full evidence tables.

Quality assessment of clinical studies included in the evidence review

The clinical evidence profiles for this review (self-help with support for the prevention of PTSD in adults) are presented in Table 57, Table 58, Table 59, Table 60 and Table 61.

Table 57: Summary clinical evidence profile: Self-help with support versus attention-placebo for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Attention-placebo	Corresponding risk Self-help with support			
PTSD symptomatology self-rated at endpoint PDS endpoint score Follow-up: mean 1 weeks		The mean PTSD symptomatology self-rated at endpoint in the intervention groups was 0.28 standard deviations lower (0.75 lower to 0.19 higher)		71 (1 study)	low[1,2]
PTSD symptomatology self-rated at 1-month follow-up PDS endpoint score Follow-up: mean 1 months		The mean PTSD symptomatology self-rated at 1-month follow-up in the intervention groups was 0.06 standard deviations lower (0.53 lower to 0.4 higher)		71 (1 study)	low[1,2]
PTSD at 1-month follow-up Number above clinical threshold on PDS Follow-up: mean 1 months	88 per 1000	109 per 1000 (26 to 448)	RR 1.23 (0.3 to 5.08)	71 (1 study)	very low[1,3]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Attention-placebo	Corresponding risk Self-help with support			
Discontinuation Number of participants lost to follow-up Follow-up: mean 1 weeks	29 per 1000	81 per 1000 (9 to 743)	RR 2.76 (0.3 to 25.25)	71 (1 study)	low[3]

CI=confidence interval; PDS=PTSD Diagnostic Scale; PTSD=post-traumatic stress disorder; RR=risk ratio; SMD=standardised mean difference;
[1] Risk of bias is high or unclear across multiple outcomes
[2] 95% CI crosses both line of no effect and threshold for clinically important benefit
[3] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm

Table 58: Summary clinical evidence profile: Self-help with support (+ TAU) versus TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk TAU	Corresponding risk Self-help with support (+ TAU)			
PTSD symptomatology self-rated at 7-week follow-up PDS change score Follow-up: mean 7 weeks		The mean PTSD symptomatology self-rated at 7-week follow-up in the intervention groups was 0.13 standard deviations lower (0.61 lower to 0.35 higher)		67 (1 study)	very low[1,2]
PTSD symptomatology self-rated at 20-week follow-up PDS change score Follow-up: mean 20 weeks		The mean PTSD symptomatology self-rated at 20-week follow-up in the intervention groups was 0.43 standard deviations lower (0.99 lower to 0.13 higher)		51 (1 study)	very low[1,2]
Anxiety symptoms at 7-week follow-up HADS-A change score Follow-up: mean 7 weeks		The mean anxiety symptoms at 7-week follow-up in the intervention groups was 0.05 standard deviations higher (0.43 lower to 0.53 higher)		67 (1 study)	very low[1,3]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk TAU	Corresponding risk Self-help with support (+ TAU)			
Anxiety symptoms at 20-week follow-up HADS-A change score Follow-up: mean 20 weeks		The mean anxiety symptoms at 20-week follow-up in the intervention groups was 0.34 standard deviations lower (0.89 lower to 0.22 higher)		51 (1 study)	very low[1,2]
Depression symptoms at 7-week follow-up HADS-D change score Follow-up: mean 7 weeks		The mean depression symptoms at 7-week follow-up in the intervention groups was 0.16 standard deviations lower (0.64 lower to 0.32 higher)		67 (1 study)	very low[1,2]
Depression symptoms at 20-week follow-up HADS-D change score Follow-up: mean 20 weeks		The mean depression symptoms at 20-week follow-up in the intervention groups was 0.28 standard deviations lower (0.83 lower to 0.27 higher)		51 (1 study)	very low[1,2]
Quality of life at 7-week follow-up WHO-QoL-BREF endpoint score Follow-up: mean 7 weeks Better indicated by higher values		The mean quality of life at 7-week follow-up in the intervention groups was 0.14 standard deviations lower (0.62 lower to 0.34 higher)		67 (1 study)	very low[1,2]
Quality of life at 20-week follow-up WHO-QoL-BREF endpoint score Follow-up: mean 20 weeks Better indicated by higher values		The mean quality of life at 20-week follow-up in the intervention groups was 0.01 standard deviations lower (0.56 lower to 0.54 higher)		51 (1 study)	very low[1,4]
Discontinuation Number of participants lost to follow-up	526 per 1000	568 per 1000 (426 to 763)	RR 1.08 (0.81 to 1.45)	148 (1 study)	low[1,3]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk TAU	Corresponding risk Self-help with support (+ TAU)			
Follow-up: mean 7 weeks					

CI=confidence interval; HADS-A/D=Hospital Anxiety and Depression Scale-Anxiety/Depression; PDS=PTSD diagnostic scale; PTSD=post-traumatic stress disorder; RR=risk ratio; SMD=standardised mean difference; TAU=treatment as usual; WHO QoL BREF=WHO quality of life questionnaire

[1] Risk of bias is high or unclear across multiple outcomes

[2] 95% CI crosses both line of no effect and threshold for clinically important benefit

[3] 95% CI crosses both line of no effect and threshold for clinically important harm

[4] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm

Table 59: Summary clinical evidence profile: Self-help with support versus waitlist for the early treatment (1-3 months) of below threshold PTSD symptoms in adults

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist	Corresponding risk Self-help with support			
PTSD symptomatology self-rated PCL change score Follow-up: mean 10 weeks		The mean PTSD symptomatology self-rated in the intervention groups was 1.58 standard deviations lower (2.17 to 0.98 lower)		58 (1 study)	very low[1,2]
Anxiety symptoms BAI change score Follow-up: mean 10 weeks		The mean anxiety symptoms in the intervention groups was 1.02 standard deviations lower (1.57 to 0.47 lower)		58 (1 study)	very low[1,2]
Depression symptoms BDI-II change score Follow-up: mean 10 weeks		The mean depression symptoms in the intervention groups was 1.53 standard deviations lower (2.12 to 0.94 lower)		58 (1 study)	very low[1,2]
Discontinuation Number of participants lost to follow-up Follow-up: mean 10 weeks	259 per 1000	420 per 1000 (197 to 897)	RR 1.62 (0.76 to 3.46)	58 (1 study)	very low[1,3]

BAI=Beck Anxiety Inventory; BDI=Beck Depression Inventory; CI=confidence interval; PCL=PTSD Checklist; PTSD=post-traumatic stress disorders; RR=risk ratio; SMD=standardised mean difference
[1] Risk of bias is high or unclear across multiple outcomes
[2] OIS not met (N<400)
[3] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm

Table 60: Summary clinical evidence profile: Self-help with support versus waitlist for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist	Corresponding risk Self-help with support			
PTSD symptomatology self-rated at endpoint IES-R change score Follow-up: mean 6 weeks		The mean PTSD symptomatology self-rated at endpoint in the intervention groups was 0.64 standard deviations lower (1.32 lower to 0.04 higher)		40 (1 study)	very low[1,2]
PTSD symptomatology self-rated at 3-month follow-up IES-R change score Follow-up: mean 3 months		The mean PTSD symptomatology self-rated at 3-month follow-up in the intervention groups was 0.44 standard deviations lower (1.03 lower to 0.14 higher)		48 (1 study)	very low[1,2]
Depression symptoms at 3-month follow-up MADRS change score Follow-up: mean 3 months		The mean depression symptoms at 3-month follow-up in the intervention groups was 0.2 standard deviations lower (0.78 lower to 0.38 higher)		48 (1 study)	very low[1,2]
Relationship difficulties at endpoint Parenting Stress Index Short Form (PSI-SF) change score Follow-up: mean 6 weeks		The mean relationship difficulties at endpoint in the intervention groups was 0.4 standard deviations higher (0.27 lower to 1.07 higher)		40 (1 study)	very low[1,3]
Relationship difficulties at 3-month follow-up		The mean relationship difficulties at 3-		48 (1 study)	very low[1,3]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist	Corresponding risk Self-help with support			
Parenting Stress Index Short Form (PSI-SF) change score Follow-up: mean 3 months		month follow-up in the intervention groups was 0.45 standard deviations higher (0.14 lower to 1.03 higher)			
Discontinuation Number of participants lost to follow-up Follow-up: mean 6 weeks	481 per 1000	750 per 1000 (543 to 1000)	RR 1.56 (1.13 to 2.16)	104 (1 study)	moderate[4]

CI=confidence interval; IES-R=Impact of event scale-Revised; MADRS=Montgomery-Asberg Depression Rating Scale; PSI-SF=Parenting Stress Index-Short Form; PTSD=post-traumatic stress disorders; RR=risk ratio; SMD=standardised mean difference

[1] Risk of bias is high or unclear across multiple domains

[2] 95% CI crosses both line of no effect and threshold for clinically important benefit

[3] 95% CI crosses both line of no effect and threshold for clinically important harm

[4] OIS not met (events<300)

Table 61: Summary clinical evidence profile: Self-help with support versus attention-placebo for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk attention-placebo	Corresponding risk Self-help with support			
PTSD symptomatology self-rated at endpoint IES-R change score Follow-up: mean 4 weeks		The mean PTSD symptomatology self-rated at endpoint in the intervention groups was 0.47 standard deviations higher (0.38 lower to 1.33 higher)		22 (1 study)	low[1,2]
PTSD symptomatology self-rated at 2-month follow-up IES-R change score Follow-up: mean 2 months		The mean PTSD symptomatology self-rated at 2-month follow-up in the intervention groups was 0.54 standard deviations higher (0.32 lower to 1.39 higher)		22 (1 study)	low[1,2]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk attention-placebo	Corresponding risk Self-help with support			
Discontinuation Number of participants lost to follow-up Follow-up: mean 4 weeks	91 per 1000	28 per 1000 (1 to 623)	RR 0.31 (0.01 to 6.85)	23 (1 study)	low[3]

CI=confidence interval; IES-R=Impact of event scale-revised; PTSD=post-traumatic stress disorder; RR=risk ratio; SMD=standardised mean difference
[1] Risk of bias is high or unclear across multiple outcomes
[2] 95% CI crosses both line of no effect and threshold for clinically important harm
[3] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm

See appendix F for full GRADE tables.

Economic evidence

Included studies

One study assessing the cost effectiveness of psychological interventions for the prevention of PTSD in adults was identified (Chatterton 2016). The search strategy for economic studies is provided in Appendix B.

Excluded studies

No economic studies of psychological interventions for the prevention of PTSD in adults were reviewed at full text and excluded.

Summary of studies included in the economic evidence review

Chatterton and colleagues (2016) performed a cost-utility analysis alongside a RCT (Chambers 2009) that compared trauma-focused CBT with psychoeducation for adult patients with cancer and PTSD symptoms and their carers in Australia (N=690, patients n=336, carers n=354; 27% did not complete all follow-up assessments and multiple imputation was used to account for missing data). The authors conducted separate analyses for patients and for the carers. According to their mean impact of events scale (IES) score and a cut-off of 35, carers met the criteria for PTSD, whereas patients with cancer did not pass the threshold for PTSD and were at risk of developing PTSD. Therefore, the analysis on patients with cancer is described in this section, as the interventions effectively aimed at prevention of PTSD. All study participants were divided into low and high distress sub-groups, based on a cut-off point of BSI=63 (Brief Symptom Inventory), and separate analyses were carried out by the authors for low and high distress sub-groups. The perspective of the analysis was the Australian health sector including patient co-payments. Healthcare costs consisted of intervention and other health-care resources (medical and psychological; psychiatrist, psychologist, social worker, GP, nurse) used by cancer patients and carers including out of pocket expenses such as co-payments for medical care or prescription medications. National unit costs were used. The outcome measure was the QALY estimated based on the Assessment of Quality of Life (AQoL-4D) instrument, with utility scores having been elicited from the Australian population. The time horizon of the analysis was one year.

Trauma-focused CBT was found to be less costly and more effective than psychoeducation (i.e. it was dominant) in patients with high distress at risk of PTSD. In patients with low distress and at risk of PTSD, trauma-focused CBT was more costly and more effective than psychoeducation, with an ICER of $20,938/QALY (£9,945/QALY at 2016 prices). The probability of trauma-focused CBT being cost-effective compared with psychoeducation at a cost effectiveness threshold of $50,000/QALY (£23,750/QALY in 2016 prices) was 0.81 and for patients with cancer at risk of PTSD and high distress and 0.73 for patients with cancer at risk of PTSD and low distress. The study is partially applicable to the UK context as it was conducted in Australia, so unit costs and resource use reflect the Australian healthcare system; in addition, estimated QALYs reflect the Australian population's preferences. The study is characterised by minor limitations.

The reference of the study and the economic evidence table are provided in Appendix H. The economic evidence profile is shown in Appendix I.

Economic model

No economic modelling was conducted for this question because other topics were agreed as higher priorities for economic evaluation.

Resource impact

The recommendations made by the committee based on this review are not expected to have a substantial impact on resources. The committee's considerations that contributed to the resource impact assessment are included under the 'Cost effectiveness and resource use' in 'The committee's discussion of the evidence' section.

Clinical evidence statements

Trauma-focused CBT for early prevention (≤1 month)

- Very low quality evidence from 1-2 RCTs (N=137-227) suggests large and statistically significant benefits of trauma-focused CBT (alone or in addition to psychoeducation) relative to waitlist or no treatment on improving PTSD symptomatology (self-rated and clinician-rated), and this benefit appears to be maintained at 2 month follow-up, for adults who have been exposed to a traumatic event within the last month. Very low quality single-RCT (N=137-150) analyses suggest a clinically important and statistically significant benefit on the number of people who met criteria for PTSD at 2-month follow-up, however effects at endpoint and 6-month follow-up are not statistically significant. Very low quality evidence from 1-3 RCTs (N=90-377) suggests non-significant effects on anxiety and depression symptoms, and discontinuation.
- Very low to low quality evidence from 1-4 RCTs (N=46-232) suggests non-significant differences between trauma-focused CBT and TAU, attention-placebo or a psychoeducational session on PTSD symptomatology (self-rated and clinician-rated at endpoint and 2-3, 6 and 12-month follow-up) for adults who have been exposed to a traumatic event within the last month. Very low quality evidence from 2 RCTs (N=93-197) suggests clinically important but not statistically significant benefits of trauma-focused CBT on the number of people who met criteria at endpoint and 6-month follow-up, and low quality evidence from 2 RCTs (N=184) suggests this benefit is both clinically important and statistically significant at 2-3 month follow-up. Although very low quality single-RCT (N=47) evidence suggests this effect is neither clinically important nor statistically significant at 1-year follow-up. Very low quality evidence from this same RCT (N=47) also suggests non-significant effects on the rate of response. Low to very low quality evidence from 1-2 RCTs (N=31-82) suggests clinically important but not statistically significant benefits of trauma-focused CBT on improving anxiety symptoms at

endpoint and 3-month follow-up, and both clinically important and statistically significant benefits at 6-month and 1-year follow-up. Very low quality evidence from 2-3 RCTs (N=77-129) suggests clinically important but not statistically significant benefits of trauma-focused CBT on improving depression symptoms at endpoint and 6-month follow-up, however neither clinically important nor statistically significant effects are observed at 3-month and 1-year follow-up although this is largely driven by inconsistent findings from 1 study. Moderate quality evidence from 5 RCTs suggests non-significant differences between trauma-focused CBT and TAU, attention-placebo or a psychoeducational session on the rate of discontinuation.

- Low quality evidence from 4 RCTs (N=133) suggests a moderate and statistically significant benefit of trauma-focused CBT relative to supportive counselling on improving self-rated PTSD symptomatology for adults who have been exposed to a traumatic event within the last month. Low to very low quality evidence from 1-2 RCTs (N=38-81) suggests these benefits are maintained up to 11-12 month follow-up. Low quality evidence from 3 RCTs (N=94) also suggests a moderate and statistically significant benefit of trauma-focused CBT on improving clinician-rated PTSD symptomatology at endpoint, although effects at 3-6 month and 1-3 year follow-up are neither clinically important nor statistically significant. Moderate to very low quality evidence from 2-4 RCTs (N=81-161) suggests clinically important and statistically significant benefits of trauma-focused CBT on the number of people who meet criteria for PTSD at endpoint and 6-month follow-up, and clinically important but not statistically significant benefits at 1-month and 3-4 year follow-up. Very low quality evidence from 2-5 RCTs (N=80-181) suggests clinically important but not statistically significant benefits of trauma-focused CBT on improving anxiety symptoms at endpoint and 11-12 month follow-up, and both clinically important and statistically significant benefit at 1-3 month follow-up, although the effect at 5-6 month follow-up is non-significant. Low to very low quality evidence from 1-5 RCTs (N=35-181) suggests small-to-moderate but statistically significant benefits of trauma-focused CBT on improving depression symptoms at endpoint, 5-6 month follow-up and 3-year follow-up, and a clinically important but not statistically significant benefit at 11-12 month follow-up, although a non-significant effect is observed at 1-3 month follow-up. Low quality single-RCT (N=35) evidence suggests a moderate-to-large and delayed benefit of trauma-focused CBT on improving quality of life at 11-month follow-up (non-significant effect at endpoint and clinically important but not statistically significant effect at 5-month follow-up). Low quality evidence from 7 RCTs (N=286) suggests neither a clinically important nor statistically significant difference between trauma-focused CBT and supportive counselling on the rate of discontinuation.

Trauma-focused CBT for early treatment (1-3 months) of below threshold PTSD symptoms

- Very low quality single-RCT (N=37-43) evidence suggests clinically important and statistically significant benefits of brief trauma-focused CBT relative to a self-help booklet on improving self-rated PTSD symptomatology, anxiety and depression symptoms at 1-month and 4-month follow-up for adults who have been exposed to a traumatic event 1-3 months ago and have subthreshold PTSD symptoms (just below threshold) at baseline. Evidence from this same RCT (N=60) suggests neither clinically important nor statistically significant effects on discontinuation.

Trauma-focused CBT for delayed treatment (>3 months) of below threshold PTSD symptoms

- Low to very low quality evidence from 1-2 RCTs (N=81-428) suggests delayed, clinically important and statistically significant benefits of trauma-focused CBT relative to waitlist or no treatment on improving self-rated PTSD symptomatology at 1-2, 5-6 and 8-month follow-up (non-significant at treatment/study endpoint) for adults who have been exposed to a traumatic event more than 3 months ago and have below threshold PTSD symptoms

at baseline. Low quality single-RCT (N=42) evidence suggests a large and statistically significant benefit on clinician-rated PTSD symptomatology at endpoint (no follow-up available). This same RCT also suggests a clinically important but not statistically significant benefit on the number of people who met criteria for PTSD at endpoint. Low to very low quality evidence from single-RCT analyses (N=81-428) also suggests clinically important and statistically significant benefits of trauma-focused CBT on improving anxiety symptoms at 1-month follow-up, and depression symptoms at 1-2, 5 and 8-month follow-up. Conversely, very low quality single-RCT (N=33-89) analyses suggests non-significant effects on alcohol use disorder symptoms at 1-month follow-up, or alcohol or drug use or relationship difficulties at endpoint or 6-month follow-up. Very low quality evidence from 3 RCTs (N=546) suggests a higher rate of discontinuation may be associated with trauma-focused CBT, although this effect is not statistically significant.

- Very low to low quality evidence from 1-2 RCTs (N=272-355) suggests non-significant effects of trauma-focused CBT relative to attention-placebo on self-rated PTSD symptomatology at endpoint, 3- or 6-8 month follow-up, or on the rate of discontinuation, for adults who have been exposed to a traumatic event more than 3 months ago and have below threshold PTSD symptoms at baseline.
- Very low quality single-RCT (N=82-90) evidence suggests non-significant effects of trauma-focused CBT relative to present-centred therapy on self-rated PTSD symptomatology, alcohol or drug use, or relationship difficulties at endpoint or 6-month follow-up, for adults who have been exposed to a traumatic event more than 3 months ago and have subthreshold PTSD symptoms (just below threshold) at baseline. Low quality evidence from this same RCT (N=111) suggests there may be a higher rate of discontinuation associated with trauma-focused CBT, although this effect is not statistically significant.
- Very low quality single-RCT (N=44) evidence suggests a delayed moderate and statistically significant benefit of a trauma-focused CBT group relative to a peer support group on improving PTSD symptomatology at 3-month follow-up (non-significant at endpoint) for adults who have been exposed to a traumatic event more than 3 months ago and have below threshold PTSD symptoms at baseline. No evidence on discontinuation, or any other outcomes, are available.

Non-trauma-focused CBT for delayed treatment (>3 months) of below threshold PTSD symptoms

- Low quality single-RCT (N=58) evidence suggests a large and statistically significant benefit of a non-trauma-focused CBT for sleep management in addition to TAU relative to TAU-only on improving sleeping difficulties for adults who have been exposed to a traumatic event more than 3 months ago and have subthreshold PTSD symptoms (just below threshold) at baseline. However, very low to low quality evidence from 1-2 RCTs (N=45-108) suggests effects of non-trauma-focused CBT targeted at sleeping problems or postconcussional symptoms do not extend to PTSD symptomatology, PTSD caseness, anxiety or depression symptoms, anger or quality of life. Low quality evidence from both RCTs (N=109) also suggests a non-significant effect on discontinuation.

Present-centred therapy for delayed treatment (>3 months) of below threshold PTSD symptoms

- Very low quality single-RCT (N=86-90) suggests non-significant effects of present-centred therapy relative to waitlist on self-rated PTSD symptomatology, alcohol or drug use, or relationship difficulties at endpoint or 6-month follow-up, for adults who have been exposed to a traumatic event more than 3 months ago and have subthreshold PTSD symptoms (just below threshold) at baseline. Low quality evidence from this same RCT (N=111) suggests there may be a higher rate of discontinuation associated with present-centred therapy, although this effect is not statistically significant.

Behavioural therapies for adults exposed to ongoing trauma

- Very low quality single-RCT (N=209-306) evidence suggests clinically important and statistically significant benefits of a brief behavioural intervention relative to enhanced TAU on improving PTSD symptomatology and anxiety and depression symptoms at endpoint and 2-month follow-up for adults with ongoing exposure to trauma (in this instance, adults living in conflict-affected areas of Pakistan). Very low quality evidence from this same RCT (N=210-303) also suggests smaller but still statistically significant benefits on improving functional impairment at endpoint and 2-month follow-up. Low quality evidence from this RCT (N=346) suggests non-significant effects on the rate of discontinuation,

Behavioural therapies for delayed treatment (>3 months) of below threshold PTSD symptoms

- Moderate quality single-RCT (N=421) evidence suggests clinically important and statistically significant benefits of a brief behavioural intervention relative to enhanced TAU on improving PTSD symptomatology and functional impairment at endpoint and 3-month follow-up, for adults who have been exposed to a traumatic event more than 3 months ago and have non-significant PTSD symptoms at baseline. Low quality evidence from this same RCT (N=421) suggests a non-significant effect on the rate of discontinuation.
- Low quality evidence from 2 RCTs (N=62) suggests a large and statistically significant benefit of a behavioural sleep intervention relative to pill placebo or attention-placebo on improving sleeping difficulties at endpoint for adults who have been exposed to a traumatic event more than 3 months ago and have non-significant PTSD symptoms at baseline. However, low quality evidence from 1 of these RCTs (N=23) suggests the benefits on sleeping difficulties are short-term, as the effect at 4-month follow-up is not statistically significant. In addition, low to very low quality evidence from 1-2 RCTs (N=23-62) suggests benefits do not extend to PTSD symptomatology, anxiety or depression symptoms, or functional impairment at endpoint or 4-month follow-up. Low quality evidence from both RCTs (N=75) suggests neither a clinically important nor statistically significant effect on the rate of discontinuation.
- Low quality single-RCT (N=23) evidence suggests a large and statistically significant effect in favour of prazosin relative to a behavioural sleep intervention on improving functional impairment at 4-month follow-up for adults who have been exposed to a traumatic event more than 3 months ago and have non-significant PTSD symptoms at baseline. However, low to very low quality evidence from this same RCT (N=24-27) suggests non-significant effects on PTSD symptomatology, anxiety or depression symptoms, functional impairment at endpoint, or sleeping difficulties. Low quality evidence from this RCT (N=37) suggests there may be a higher rate of discontinuation associated with a behavioural sleep intervention relative to prazosin, however absolute numbers are small and this effect is not statistically significant.

Psychologically-focused debriefing for early prevention (≤1 month)

- Very low to low quality evidence from 2-5 RCTs (N=162-392) suggests a non-significant effect of single-session or two-session debriefing (alone or in addition to psychoeducation) relative to no treatment on self-rated PTSD symptomatology at 1-4 month or 6-month follow-up for adults who have been exposed to a traumatic event within the last month. Very low quality single-RCT (N=103) evidence suggests a clinically important and statistically significant harm associated with debriefing on self-rated PTSD symptomatology at 1-year follow-up with the debriefing arm showing an increase in symptoms and the no treatment arm showing a decrease. Low to very low quality evidence from 1-3 RCTs (N=75-313) suggests a similar pattern in effects on the number of people meeting diagnostic criteria for PTSD with non-significant effects observed at 1-month and 3-6 month follow-up, and a clinically important and statistically significant harm

observed at 1-year follow-up with nearly twice as many of the debriefing arm meeting criteria for PTSD relative to the no treatment arm. Low to very low quality evidence from 1-3 RCTs (N=103-376) also suggests the same pattern on anxiety symptoms with non-significant effects at endpoint, and 1-3 month and 6-month follow-up and a clinically important and statistically significant harm at 1-year follow-up with the debriefing arm showing a small increase in anxiety symptoms and the no treatment arm showing a small improvement. Very low quality evidence from 1-2 RCTs (N=169-217) suggests non-significant effects on clinician-rated PTSD symptomatology at endpoint, or 1-3 month or 6-month follow-up. Very low to low quality evidence from 1-3 RCTs (N=103-376) also suggests non-significant effects of debriefing on depression symptoms at endpoint or at 1-3 month, 6-month or 1-year follow-up. Low quality evidence from 7 RCTs (N=795) suggests a clinically important and statistically significant harm associated with debriefing on the rate of discontinuation with significantly more participants lost to follow-up in the debriefing relative to no treatment arm.

- Low quality single-RCT (N=39-74) evidence suggests a non-significant effect of group debriefing relative to no treatment on PTSD symptomatology and discontinuation for adults who have been exposed to a traumatic event within the last month.
- Very low quality evidence from 2 RCTs (N=100) suggests a non-significant effect of group debriefing relative to attention-placebo or a psychoeducational session on PTSD symptomatology for adults who have been exposed to a traumatic event within the last month. Evidence from these 2 RCTs (N=137) suggests a higher rate of discontinuation may be associated with debriefing, however this effect is not statistically significant.
- Very low quality single-RCT (N=92-106) evidence suggests non-significant effects of a combined single-session debriefing and psychoeducation intervention relative to a single psychoeducational session on PTSD symptomatology, diagnosis of PTSD and depression symptoms at 6-month follow-up (no other time point available) or on discontinuation, for adults who have been exposed to a traumatic event within the last month.

Eye movement desensitisation and reprocessing (EMDR) for early prevention (≤1 month)

- Low quality single-RCT (N=71) evidence suggests a clinically important but not statistically significant benefit of EMDR relative to TAU on the number of people who met criteria for PTSD at 3-month follow-up, for adults who have been exposed to a traumatic event within the last month. Very low quality evidence from this same RCT (N=83) suggests there may be a higher rate of discontinuation associated with EMDR relative to TAU, however this effect is not statistically significant.

Eye movement desensitisation and reprocessing (EMDR) for delayed treatment (>3 months) of below threshold PTSD symptoms

- Very low quality single-RCT (N=30) evidence suggests non-significant effects of EMDR relative to supportive counselling on PTSD symptomatology or depression symptoms for adults who have been exposed to a traumatic event more than 3 months ago and have subthreshold PTSD symptoms (just below threshold) at baseline. No evidence on discontinuation or any other outcomes is available.
- Very low quality single-RCT (N=30) evidence suggests non-significant effects of EMDR relative to eye fixation desensitisation (EFD) on PTSD symptomatology or depression symptoms for adults who have been exposed to a traumatic event more than 3 months ago and have subthreshold PTSD symptoms (just below threshold) at baseline. No evidence on discontinuation or any other outcomes is available.
- Very low quality single-RCT (N=30) evidence suggests a large and statistically significant benefit of eye fixation desensitisation (EFD) relative to supportive counselling on improving PTSD symptomatology for adults who have been exposed to a traumatic event more than 3 months ago and have subthreshold PTSD symptoms (just below threshold)

at baseline. However, evidence from this same RCT suggests non-significant effects on depression symptoms and no evidence on discontinuation or any other outcomes is available.

Hypnotherapy for early prevention (≤1 month)

- Very low quality single-RCT (N=37-63) evidence suggests non-significant effects of a combined hypnotherapy and trauma-focused CBT intervention relative to trauma-focused CBT-only on clinician-rated PTSD symptomatology at 3-year follow-up, the number of people who met criteria for PTSD or depression symptoms at 1-month, 6-month and 3-year follow-up, anxiety symptoms at 1-month and 6-month follow-up, and discontinuation for adults who have been exposed to a traumatic event within the last month.
- Very low quality single-RCT (N=34) evidence suggests a delayed large and statistically significant benefit of a combined hypnotherapy and trauma-focused CBT intervention relative to supportive counselling on improving depression symptoms at 3-year follow-up (non-significant effects at 1-and 6-month follow-up) for adults with acute stress disorder. However, low to very low quality evidence from this same RCT (N=34-54) suggests non-significant differences for clinician-rated PTSD symptomatology at 3-year follow-up, the number of people who met criteria for PTSD at 1-month, 6-month and 3-year follow-up, and anxiety symptoms at 1-month and 6-month follow-up. Very low quality evidence from this RCT suggests there may be a higher rate of discontinuation associated with the combined hypnotherapy and trauma-focused CBT intervention relative to supportive counselling, however this effect is not statistically significant.

Interpersonal psychotherapy (IPT) for early prevention (≤1 month)

- Very low quality single-RCT (N=58) evidence suggests non-significant effects of IPT relative to TAU on self-rated PTSD symptomatology, depression symptoms or alcohol use disorder symptoms at endpoint or 3-month follow-up for adults who have been exposed to a traumatic event within the last month. Evidence from the same RCT (N=90) suggests a clinically important and statistically significant harm of IPT relative to TAU on PTSD diagnosis at 3-month follow-up with participants in the IPT arm nearly twice as likely to meet diagnostic criteria for PTSD compared with those in the TAU arm. Evidence from this same RCT (N=58) also suggests a clinically important and statistically significant harm of IPT on anxiety symptoms with TAU participants showing greater improvement than those in the IPT arm at endpoint (effects are non-significant at 3-month follow-up). Moderate quality evidence from this RCT suggests significantly higher discontinuation associated with IPT relative to TAU.

Counselling for early prevention (≤1 month)

- Very low quality single-RCT (N=43) evidence suggests a large and statistically significant harm of supportive counselling relative to attention-placebo on self-rated PTSD symptomatology at endpoint for adults who have been exposed to a traumatic event within the last month, with significantly greater improvement for those in the attention-placebo arm (effects are non-significant at 3-month and 1-year follow-up). Very low quality evidence from this study (N=43-44) also suggests a clinically important and statistically significant harm on depression symptoms at endpoint and 1-year follow-up with greater improvement observed in the attention-placebo arm (non-significant effects at 3-month follow-up). Very low to low quality evidence from this RCT (N=38-59) suggests non-significant effects on clinician-rated PTSD symptomatology and anxiety symptoms at endpoint, 3-month or 1-year follow-up, and on discontinuation.

Counselling for early treatment (1-3 months) of below threshold PTSD symptoms

- Very low quality single-RCT (N=151) evidence suggests non-significant effects of counselling relative to no treatment on PTSD symptomatology or discontinuation at

treatment/study endpoint for adults who have been exposed to a traumatic event 1-3 months ago and have non-significant PTSD symptoms at baseline.

Couple interventions for early prevention (≤1 month)

- Low quality single RCT (N=46-74) evidence suggests a clinically important and statistically significant benefit of brief cognitive-behavioural conjoint therapy relative to waitlist on improving PTSD symptomatology at 2-month follow-up, and a clinically important benefit that just misses statistical significance at 2-year follow-up, for adults who have been exposed to a traumatic event within the last month. Evidence from this RCT (N=83) suggests a higher rate of discontinuation may be associated with cognitive-behavioural conjoint therapy, however this effect is not statistically significant.

Parent training/family interventions for early prevention (≤1 month)

- Low quality single-RCT (N=152) evidence suggests non-significant effects of family therapy in addition to TAU relative to TAU-only on PTSD symptomatology, anxiety symptoms and discontinuation, for adults who have been exposed to a traumatic event within the last month.

Self-help (without support) for early prevention (≤1 month)

- Very low quality single-RCT (N=56) evidence suggests non-significant effects of self-help (without support) relative to waitlist on PTSD symptomatology (at endpoint and 5-month follow-up) for adults who have been exposed to a traumatic event within the last month. Evidence from this same study (N=85) suggests a trend for a higher rate of discontinuation associated with self-help, although this effect is not statistically significant.
- Low quality single-RCT (N=300) evidence suggests a clinically important and statistically significant benefit of self-help (without support) alone or in addition to TAU relative to TAU on clinician-rated PTSD symptomatology for adults who have been exposed to a traumatic event within the last month. However, evidence from this RCT suggests effects may be relatively short-term with diminishing effect sizes over time and a non-significant effect at 11-month follow-up. Moderate to very low quality evidence from 1-3 RCTs (N=126-485) suggests non-significant effects on self-rated PTSD symptomatology, or anxiety and depression symptoms at endpoint, 6-8 week, 5-6 month or 11-month follow-up, or on the number of people meeting criteria for PTSD at 5-month follow-up. Low quality evidence from 4 RCTs (N=753) also suggests a non-significant effect on discontinuation.

Self-help (without support) for delayed treatment (>3 months) of below threshold PTSD symptoms

- Low quality evidence from 2 RCTs (N=288) suggests clinically important and statistically significant benefits of self-help (without support) relative to waitlist on improving PTSD symptomatology for adults who have been exposed to a traumatic event more than 3 months ago and have below threshold PTSD symptoms at baseline. However, very low quality evidence from both RCTs (N=296) suggests this benefit may be short-term as non-significant at 1-3 month follow-up. Very low quality evidence from 1 of these RCTs (N=40-42) suggests non-significant effects of self-help on the rate of response at 3-month follow-up, or on quality of life at endpoint or 3-month follow-up. Conversely low quality evidence from the other RCT (N=248-256) suggests a small but statistically significant benefit on improving depression symptoms at endpoint, and a large and statistically significant benefit at 6-week follow-up. Moderate quality evidence from 2 RCTs (N=345) suggests a clinically important and statistically significant harm of self-help (without support) on discontinuation, with over 3 and a half times more participants dropping out of the self-help arm.
- Very low quality evidence from 1-3 RCTs (N=171-299) suggests non-significant effects of self-help (without support) alone or in addition to TAU relative to TAU or attention-placebo

on PTSD symptomatology or depression symptoms at endpoint and up to 11-month follow-up or on discontinuation, for adults who have been exposed to a traumatic event more than 3 months ago and have below threshold PTSD symptoms at baseline.

Self-help with support for early prevention (≤1 month)

- Very low to low quality single-RCT (N=71) evidence suggests non-significant effects of self-help with support relative to attention-placebo on PTSD symptomatology at endpoint and 1-month follow-up, or on the number of people meeting criteria for PTSD at 1-month follow-up, for adults who have been exposed to a traumatic event within the last month. Low quality evidence from this RCT suggests a higher rate of discontinuation may be associated with self-help with support, however absolute numbers are relatively small and this effect is not statistically significant.
- Very low to low quality single-RCT (N=51-148) evidence suggests non-significant effects of self-help with support in addition to TAU relative to TAU-only on PTSD symptomatology, anxiety or depression symptoms, or quality of life at 7-week or 20-week follow-up or on discontinuation, for adults who have been exposed to a traumatic event within the last month.

Self-help with support for early treatment (1-3 months) of below threshold PTSD symptoms

- Very low quality single-RCT (N=58) evidence suggests large and statistically significant benefits of self-help with support relative to waitlist on improving PTSD symptomatology, anxiety and depression symptoms for adults who have been exposed to a traumatic event 1-3 months ago and have subthreshold PTSD symptoms (just below threshold) at baseline. Evidence from this same RCT suggests a higher rate of discontinuation may be associated with self-help with support, however this effect is not statistically significant.

Self-help with support for delayed treatment (>3 months) of below threshold PTSD symptoms

- Very low quality single-RCT (N=40) evidence suggests a clinically important but not statistically significant benefit of self-help with support relative to waitlist for improving PTSD symptomatology for adults who have been exposed to a traumatic event more than 3 months ago and have non-significant PTSD symptoms at baseline. However, evidence from the same study (N=48) suggests any potential benefit is short-term as neither a clinically important nor statistically significant effect is observed at 3-month follow-up. Evidence from this same study (N=40-48) also suggests non-significant effects of self-help with support on depression symptoms (at 3-month follow-up, no endpoint data available) or relationship difficulties (at endpoint or 3-month follow-up). Moderate quality evidence from this same RCT (N=104) suggests a significantly higher rate of discontinuation is associated with self-help with support relative to waitlist.
- Low quality single-RCT evidence (N=22) suggests a non-significant effect of self-help with support relative to attention-placebo on PTSD symptomatology at endpoint, and a clinically important but not statistically significant trend in favour of attention-placebo for PTSD symptomatology at 2-month follow-up, for adults who have been exposed to a traumatic event more than 3 months ago and have non-significant PTSD symptoms at baseline. This study also showed a trend for a lower rate of discontinuation associated with self-help with support, however, this effect is not statistically significant.

Economic evidence statements

Trauma-focused CBT

- Evidence from 1 Australian economic evaluation conducted alongside a RCT (N = 336; missing data on approximately 27% of participants were imputed by multiple imputation)

suggests that, compared with psychoeducation, trauma-focused CBT is likely to be cost-effective for the prevention of PTSD in people at risk for PTSD. This evidence is partially applicable to the UK context and is characterised by minor methodological limitations.

The committee's discussion of the evidence

Interpreting the evidence

The outcomes that matter the most

Critical outcomes were measures of PTSD symptom improvement on validated scales and prevention of PTSD (as measured by the number of adults with a diagnosis or scoring above clinical threshold on a validated scale at endpoint or follow-up). Attrition from treatment (for any reason) was also considered an important outcome, as a proxy for the acceptability and/or tolerability of treatment. The committee considered dissociative symptoms, personal/social/occupational functioning (including global functioning/functional impairment, sleeping difficulties, and quality of life), and symptoms of a coexisting condition (including anxiety, depression and substance misuse problems) as important but not critical outcomes. This distinction was based on the primacy of preventing PTSD, whilst acknowledging that broader symptom measures may be indicators of a general pattern of effect. The committee also acknowledged that these other measures are not routinely collected in trials. Generally change scores were favoured over final scores as although in theory randomisation should balance out any differences at baseline, this assumption can be violated by small sample sizes. The committee also expressed a general preference for self-rated PTSD symptomatology over clinician-rated measures. However, in considering psychological interventions (relative to pharmacological interventions) a greater emphasis was placed on triangulating effects on self-rated PTSD symptomatology with clinician-rated outcome measures, given that the latter but not the former could be blinded.

The quality of the evidence

With the exception of a few outcomes of moderate quality, all the evidence reviewed was of low or very low quality, reflecting the high risk of bias associated with the studies (including for instance, high risk of bias associated with randomisation method as reflected by significant group differences at baseline, and lack of/unclear blinding of outcome assessment), the small numbers in many trials and the imprecision of many of the results (in terms of both the width of the confidence intervals and the failure to meet the optimal information size). However, the committee agreed to make strong recommendations despite uncertainty in the evidence, as the breadth of outcomes considered allowed triangulation of effects, greater confidence was conferred where long-term follow-up was available and effects were consistent across different follow-up periods. The committee decided to make a weaker ('consider') recommendation for the informal consensus-based recommendation.

Consideration of clinical benefits and harms

The committee discussed the strength and breadth of the evidence for trauma-focused CBT, with benefits observed on both clinician-rated and self-rated measures of PTSD symptomatology, the rate of PTSD caseness at endpoint and follow-up, and on some other outcomes including depression and anxiety symptoms. Taken together with evidence suggesting that benefits are potentially long-lasting, the committee agreed that trauma-focused CBT should be offered to adults with clinically important PTSD symptoms or acute stress disorder within 1-month of the traumatic event in order to prevent the later development of PTSD.

There was no consistent evidence for any effective intervention for preventing PTSD in those with subthreshold PTSD symptoms within the first month of the traumatic event. The committee were mindful that for this group active monitoring may be a way of managing potential difficulties that may precede PTSD, whilst recognising that not all people exposed to a traumatic event go on to develop PTSD and thus early intervention is not necessary for all.

There is evidence suggesting that single-session (or two-session) psychological debriefing, offered as an individually structured intervention or as the intervention was originally conceived as a group intervention for teams of emergency workers who are used to working together, is unlikely to have a clinically important effect on preventing subsequent PTSD. There is also limited evidence of harmful effects of debriefing at 1-year follow-up, namely, clinically important and statistically significant effects on PTSD symptomatology and diagnosis of PTSD *in favour of no treatment* relative to debriefing. On the basis of the evidence suggesting that debriefing is at best ineffective, and that offering an ineffective intervention can be regarded as harmful as it means that people are being denied access to another intervention with greater evidence of benefits, the committee judged that the harms outweighed any potential benefits and a negative recommendation was made.

The committee considered single-study evidence for EMDR in adults exposed to trauma within the last month. Although evidence from this study suggested a trend for benefit in the number of participants with PTSD at 3-month follow-up, this effect was not statistically significant. Furthermore, this was a small single study and it only reported on one clinical outcome of interest. Given the lack of a statistically significant benefit and these additional considerations, the committee did not consider it appropriate to recommend EMDR within this time period.

The committee did not consider it appropriate to make any recommendations for the 'treatment' of non-significant PTSD symptoms more than 3 months after trauma as it was agreed that there was no clinical need for intervention for this group.

Cost effectiveness and resource use

Existing evidence suggests that trauma-focused CBT is likely to be cost-effective for the prevention of PTSD in people at risk for PTSD compared with psychoeducation. The committee took existing economic evidence into account but noted that, although it is characterised by minor methodological limitations, it is only partially applicable to the UK. No economic modelling was conducted in the area of prevention of PTSD. The committee considered the benefits of trauma-focused CBT in adults with clinically important symptoms of PTSD or a diagnosis of acute stress disorder within a month after a traumatic event, and the cost-savings further down the care pathway following symptom improvement, and agreed that the clinical benefits and anticipated future cost-savings are likely to outweigh costs associated with provision of trauma-focused CBT in this population, within the first month of trauma.

The committee also considered the potential benefits of active monitoring in a population exposed to trauma with subthreshold PTSD symptoms within a month after the traumatic event. They acknowledged that not all people exposed to a traumatic event go on to develop PTSD and therefore early intervention is not necessary for all and expressed the view that the modest costs of active monitoring of this population are likely to be offset by clinical benefits resulting from the management of potential difficulties that may precede PTSD.

The committee anticipated that the recommendations will result in a minor change in practice given that trauma-focused CBT is recommended by the previous guideline for adults within 1-month of a traumatic event, there is an existing negative recommendation for

psychologically-focused debriefing, and a previous recommendation for watchful waiting (analogous to active monitoring).

References for included studies

Trauma-focused CBT

Berger 2016

Berger R, Abu-Raiya H and Benatov J (2016) Reducing primary and secondary traumatic stress symptoms among educators by training them to deliver a resiliency program (ERASE-Stress) following the Christchurch earthquake in New Zealand. American Journal of Orthopsychiatry 86(2), 236

Bolton 2014b

Bolton P, Lee C, Haroz EE, et al. (2014) A transdiagnostic community-based mental health treatment for comorbid disorders: development and outcomes of a randomized controlled trial among Burmese refugees in Thailand. PLoS medicine 11(11):e1001757

Bryant 1998/2003b

Bryant RA, Harvey AG, Dang ST, et al. (1998) Treatment of acute stress disorder: A comparison of cognitive-behavioral therapy and supportive counseling. Journal of Consulting and Clinical Psychology 66(5), 862–866

Bryant RA, Moulds ML and Nixon VD (2003) Cognitive Behaviour Therapy of acute stress disorder: a four-year follow-up. Behaviour Research and Therapy 41, 489-494

Bryant 1999/Bryant 2003b

Bryant RA, Sackville T, Dang ST, et al. (1999) Treating acute stress disorder: An evaluation of cognitive behavior therapy and supportive counseling techniques. The American Journal of Psychiatry 156(11), 1780–1786

Bryant RA, Moulds ML and Nixon VD (2003) Cognitive Behaviour Therapy of acute stress disorder: a four-year follow-up. Behaviour Research and Therapy 41, 489-494

Bryant 2005/2006

Bryant RA, Moulds ML, Guthrie RM and Nixon RD (2005) The additive benefit of hypnosis and cognitive-behavioral therapy in treating acute stress disorder. Journal of consulting and clinical psychology 73(2), 334

Bryant RA, Moulds ML, Nixon RD, et al. (2006) Hypnotherapy and cognitive behaviour therapy of acute stress disorder: A 3-year follow-up. Behaviour Research and Therapy 44(9), 1331–1335

Bryant 2008a

Bryant RA, Mastrodomenico J, Felmingham KL, et al. (2008) Treatment of acute stress disorder: A randomized controlled trial. Archives of General Psychiatry, 65(6), 659–667

Bryant (unpublished)

Bryant RA, Moulds M, Guthrie R and Nixon RDV (unpublished) Treating acute stress disorder following mild traumatic brain injury.

Chambers 2014

Chambers SK, Girgis A, Occhipinti S, et al. (2014) A randomized trial comparing two low-intensity psychological interventions for distressed patients with cancer and their caregivers. In Oncology nursing forum 41(4):e257

Classen 2011

Classen CC, Palesh OG, Cavanaugh CE, et al. (2011) A comparison of trauma-focused and present-focused group therapy for survivors of childhood sexual abuse: A randomized controlled trial. Psychological Trauma: Theory, Research, Practice, and Policy 3(1), 84

Deblinger 2001

Deblinger, E., Stauffer, L. B., & Steer, R. A. (2001). Comparative efficacies of supportive and cognitive behavioral group therapies for young children who have been sexually abused and their nonoffending mothers. Child Maltreatment, 6(4), 332-343.

DuHamel 2010

DuHamel KN, Mosher CE, Winkel G, et al. (2010) Randomized clinical trial of telephone-administered cognitive-behavioral therapy to reduce post-traumatic stress disorder and distress symptoms after hematopoietic stem-cell transplantation. Journal of Clinical Oncology 28(23), 3754-61

Foa 2006

Foa EB, Zoellner LA and Feeny NC (2006) An evaluation of three brief programs for facilitating recovery after assault. Journal of traumatic stress 19(1), 29-43

Kangas 2013

Kangas M, Milross C, Taylor A and Bryant RA (2013) A pilot randomized controlled trial of a brief early intervention for reducing posttraumatic stress disorder, anxiety and depressive symptoms in newly diagnosed head and neck cancer patients. Psycho-Oncology 22(7), 1665-73

Maercker 2006

Maercker A, Zollner T, Menning H, et al. (2006) Dresden PTSD treatment study: randomized controlled trial of motor vehicle accident survivors. BMC Psychiatry 6

Nixon 2012b

Nixon RD (2012) Cognitive processing therapy versus supportive counseling for acute stress disorder following assault: A randomized pilot trial. Behavior therapy 43(4), 825-36

Nixon 2016

Nixon R, Best T, Wilksch S, Angelakis S, et al. (2016) Cognitive Processing Therapy for the Treatment of Acute Stress Disorder Following Sexual Assault: A Randomised Effectiveness Study. Behaviour Change 33, 232-250

O'Donnell 2012

O'Donnell ML, Lau W, Tipping S, et al. (2012) Stepped early psychological intervention for posttraumatic stress disorder, other anxiety disorders, and depression following serious injury. Journal of traumatic stress 25(2), 125-33

Price 2014

Price M, Kearns M, Houry D and Rothbaum B (2014) Emergency department predictors of posttraumatic stress reduction for trauma-exposed individuals with and without an early intervention. Journal of Consulting and Clinical Psychology 82, 336-341

Rothbaum 2012

Rothbaum BO, Kearns MC, Price M, et al. (2012) Early intervention may prevent the development of posttraumatic stress disorder: A randomized pilot civilian study with modified prolonged exposure. Biological Psychiatry 72(11), 957–963

Wijesinghe 2015

Wijesinghe CA, Williams SS, Kasturiratne A, et al. (2015) A Randomized controlled trial of a brief intervention for delayed psychological effects in snakebite victims. PLoS Negl Trop Dis 9(8):e0003989

Wu 2014

Wu KK, Li FW and Cho VW (2014) A randomized controlled trial of the effectiveness of brief-CBT for patients with symptoms of posttraumatic stress following a motor vehicle crash. Behavioural and cognitive psychotherapy 42(01), 31-47

Non-trauma focused CBT

Nakamura 2011

Nakamura Y, Lipschitz DL, Landward R, et al. (2011) Two sessions of sleep-focused mind–body bridging improve self-reported symptoms of sleep and PTSD in veterans: A pilot randomized controlled trial. Journal of psychosomatic research 70(4), 335-45

Potter 2016

Potter SD, Brown RG and Fleminger S (2016) Randomised, waiting list controlled trial of cognitive–behavioural therapy for persistent postconcussional symptoms after predominantly mild–moderate traumatic brain injury. Journal of Neurology, Neurosurgery & Psychiatry:jnnp-2015

Present-centered therapy

Classen 2011

Classen CC, Palesh OG, Cavanaugh CE, et al. (2011) A comparison of trauma-focused and present-focused group therapy for survivors of childhood sexual abuse: A randomized controlled trial. Psychological Trauma: Theory, Research, Practice, and Policy 3(1), 84

Behavioural therapies

Bryant 2017

Bryant RA, Schafer A, Dawson KS, et al. (2017) Effectiveness of a brief behavioural intervention on psychological distress among women with a history of gender-based violence in urban Kenya: A randomised clinical trial. PLoS medicine 14(8):e1002371

Germain 2012

Germain A, Richardson R, Moul DE, et al. (2012) Placebo-controlled comparison of prazosin and cognitive-behavioral treatments for sleep disturbances in US Military Veterans. Journal of psychosomatic research 72(2), 89-96

Germain 2014

Germain A, Richardson R, Stocker R, et al. (2014) Treatment for insomnia in combat-exposed OEF/OIF/OND military veterans: Preliminary randomized controlled trial. Behaviour research and therapy 61, 78-88

Rahman 2016

Rahman A, Hamdani SU, Awan NR, et al. (2016) Effect of a multicomponent behavioral intervention in adults impaired by psychological distress in a conflict-affected area of Pakistan: a randomized clinical trial. JAMA 316(24), 2609-17

Psychologically-focused debriefing

Bisson 1997

Bisson JI, Jenkins PL, Alexander J and Bannister C (1997) Randomised controlled trial of psychological debriefing for victims of acute burn trauma. The British journal of psychiatry 171(1), 78-81

Conlon 1999

Conlon L, Fahy TJ and Conroy R (1999) PTSD in ambulant RTA victims: a randomized controlled trial of debriefing. Journal of Psychosomatic Research 46, 37-44

Dolan (unpublished)

Dolan L, Bowyer D, Freeman C and Little K (unpublished) Critical Incident Stress Debriefing after Trauma: is it effective?

Grundlingh 2017

Grundlingh H, Knight L, Naker D and Devries K (2017) Secondary distress in violence researchers: a randomised trial of the effectiveness of group debriefings. BMC Psychiatry 17, 204

Hobbs 1996

Hobbs M, Mayou R, Harrison B and Worlock P (1996) A randomised controlled trial of psychological debriefing for victims of road traffic accidents. British Medical Journal 313, 1438-1439

Marchand 2006

Marchand A, Guay S, Boyer R, et al. (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

Rose 1999

Rose S, Brewin CR, Andrews B and Kirk M (1999) A randomized controlled trial of individual psychological debriefing for victims of violent crime. Psychological Medicine 29, 793-799

Sijbrandi 2006

Sijbrandij M, Olff M, Reitsma JB, et al. (2006) Emotional or educational debriefing after psychological trauma. Randomised controlled trial, The British journal of psychiatry: the journal of mental science 189, 150-155

Tuckey 2014

Tuckey MR and Scott JE (2014) Group critical incident stress debriefing with emergency services personnel: A randomized controlled trial. Anxiety, Stress and Coping 27, 38-54

Eye movement desensitisation and reprocessing (EMDR)

Gil-Jardine 2018

Gil-Jardiné, C., Evrard, G., Al Joboory, S., Saint Jammes, J. T., Masson, F., Ribéreau-Gayon, R., ... & Valdenaire, G. (2018). 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, 103, 229-236.

Lytle 2002

Lytle RA, Hazlett-Stevens H and Borkovec TD (2002) Efficacy of eye movement desensitization in the treatment of cognitive intrusions related to a past stressful event. Journal of Anxiety Disorders 16(3), 273-88

Hypnotherapy

Bryant 2005/2006

Bryant RA, Moulds ML, Guthrie RM and Nixon RD (2005) The additive benefit of hypnosis and cognitive-behavioral therapy in treating acute stress disorder. Journal of consulting and clinical psychology 73(2), 334

Bryant RA, Moulds ML, Nixon RD, et al. (2006) Hypnotherapy and cognitive behaviour therapy of acute stress disorder: A 3-year follow-up. Behaviour Research and Therapy 44(9), 1331–1335

Interpersonal psychotherapy (IPT)

Holmes 2007

Holmes A, Hodgins G, Adey S, et al. (2007) Trial of interpersonal counselling after major physical trauma. Australian and New Zealand Journal of Psychiatry 41(11), 926-33

Counselling

Brom 1993

Brom D, Kleber RJ and Hofman MC (1993) Victims of Traffic Accidents: Incidence and Prevention of Post-Traumatic Stress Disorder. Journal of Clinical Psychology 49(2), 131-139

Foa 2006

Foa EB, Zoellner LA and Feeny NC (2006) An evaluation of three brief programs for facilitating recovery after assault. Journal of traumatic stress 19(1), 29-43

Couple intervention

Brunet 2013/Des Groseilliers 2013

Brunet A, Des Groseilliers IB, Cordova MJ and Ruzek JI (2013) Randomized controlled trial of a brief dyadic cognitivebehavioral intervention designed to prevent PTSD. European Journal of Psychotraumatology 4, 21572

Des Groseilliers I, Marchand A, Cordova M, et al. (2013) Two-year follow-up of a brief dyadic cognitive-behavioral intervention designed to prevent PTSD. Psychological Trauma: Theory, Research, Practice, and Policy 5, 462-469

Parent training/family interventions

Stehl 2009

Stehl ML, Kazak AE, Alderfer MA, et al. (2009) Conducting a randomized clinical trial of an psychological intervention for parents/caregivers of children with cancer shortly after diagnosis. Journal of Pediatric Psychology 34, 803-16

Self-help without support

Beatty 2010a

Beatty L, Oxlad M, Koczwara B and Wade TD (2010) A randomised pilot of a self-help workbook intervention for breast cancer survivors. Supportive care in cancer 18(12), 1597-603

Cox 2009/Kenardy 2015

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. 2009 Nov 11;35(6):581-92.

Kenardy JA, Cox CM, Brown FL. A Web-Based Early Intervention Can Prevent Long-Term PTS Reactions in Children With High Initial Distress Following Accidental Injury. Journal of traumatic stress. 2015;28(4):366-9.

Hobfoll 2016

Hobfoll SE, Blais RK, Stevens NR, et al. (2016) Vets prevail online intervention reduces PTSD and depression in veterans with mild-to-moderate symptoms. Journal of consulting and clinical psychology 84(1), 31

Ironson 2013

Ironson G, O'cleirigh C, Leserman J, et al. (2013) Gender-specific effects of an augmented written emotional disclosure intervention on posttraumatic, depressive, and HIV-disease-related outcomes: a randomized, controlled trial. Journal of consulting and clinical psychology 81(2), 284

Koopman 2005

Koopman C, Ismailji T, Holmes D, et al. (2005) The effects of expressive writing on pain, depression and posttraumatic stress disorder symptoms in survivors of intimate partner violence. Journal of Health psychology 10(2), 211-21

Jones 2003

Jones C, Skirrow P, Griffiths R, et al. (2003) Rehabilitation after critical illness: a randomized, controlled trial. Critical Care Medicine 31, 2456–2461

Kenardy 2008

Kenardy J, Thompson K, Le Brocque R, Olsson K. Information–provision intervention for children and their parents following pediatric accidental injury. European Child & Adolescent Psychiatry. 2008 Aug 1;17(5):316-25.

Marsac 2013

Marsac ML, Hildenbrand AK, Kohser KL, et al. (2013) Preventing posttraumatic stress following pediatric injury: a randomized controlled trial of a web-based psycho-educational intervention for parents. Journal of pediatric psychology, jst053

Mouthaan 2013

Mouthaan J, Sijbrandij M, De Vries GJ, et al. (2013) Internet-based early intervention to prevent posttraumatic stress disorder in injury patients: randomized controlled trial. Journal of Medical Internet Research 15(8):e165

Scholes 2007

Scholes C, Turpin and Mason S (2007) 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 45, 2527-2536

Short 2017

Short NA, Boffa JW, Norr AM, et al. (2017) Randomized Clinical Trial Investigating the Effects of an Anxiety Sensitivity Intervention on Posttraumatic Stress Symptoms: A Replication and Extension. Journal of traumatic stress 30(3), 296-303

Self-help with support

Bugg 2009

Bugg A, Turpin G, Mason S and Scholes C (2009) 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 47(1), 6-12

Carrico 2015

Carrico AW, Nation A, Gómez W, et al. (2015) Pilot trial of an expressive writing intervention with HIV-positive methamphetamine-using men who have sex with men. Psychology of Addictive Behaviors 29(2), 277

Cernvall 2015

Cernvall M, Carlbring P, Ljungman L, et al. (2015) Internet-based guided self-help for parents of children on cancer treatment: a randomized controlled trial. Psycho-Oncology 24(9), 1152-8

Iyadurai 2017

Iyadurai L, Blackwell SE, Meiser-Stedman R, et al. (2017) 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

Sveen 2017

Sveen J, Andersson G, Buhrman B, Sjöberg F, Willebrand M. Internet-based information and support program for parents of children with burns: a randomized controlled trial. Burns. 2017 May 31;43(3):583-91

Psychosocial interventions for the prevention of PTSD in adults

Introduction to clinical evidence

Psychosocial interventions will be considered as classes of intervention (art therapy; meditation or mindfulness-based stress reduction [MBSR]; practical support; psychoeducational interventions; peer support; relaxation) and form the subsections below.

Evidence for interventions in the following classes was also searched for but none was found: supported employment.

Art therapy: clinical evidence

Included studies

One study of art therapy for the prevention of PTSD in adults was identified for full-text review. This study could not be included.

Excluded studies

One study was reviewed at full text and excluded from this review because efficacy or safety data could not be extracted.

Studies not included in this review with reasons for their exclusions are provided in Appendix K.

Meditation/ Mindfulness-based stress reduction (MBSR): clinical evidence

Included studies

Fifteen studies of meditation or mindfulness-based stress reduction (MBSR) for the prevention of PTSD in adults were identified for full-text review. Of these 15 studies, 3 RCTs (N=130) were included in a single comparison for the delayed treatment (>3 months) of non-significant PTSD symptoms in adults: meditation or MBSR (alone or in addition to TAU) compared with no treatment, waitlist or TAU (Kelly 2016; Kim 2013; Schellekens 2017).

Excluded studies

Twelve studies were reviewed at full text and excluded from this review. The most common reason for exclusion was that the intervention was not targeted at PTSD symptoms.

Studies not included in this review with reasons for their exclusions are provided in Appendix K.

Summary of clinical studies included in the evidence review

Table 62 provides a brief summary of the included studies and evidence from these are summarised in the clinical GRADE evidence profile below (Table 63).

See also the study selection flow chart in Appendix C, forest plots in Appendix E and study evidence tables in Appendix D.

Table 62: Summary of included studies: Meditation/MBSR for delayed treatment (>3 months) of non-significant PTSD symptoms

Comparison	Meditation/MBSR (+/- TAU) versus no treatment, waitlist or TAU
Total no. of studies (N randomised)	3 (130)
Study ID	Kelly 2016[1] Kim 2013[2] Schellekens 2017[3]
Country	US[1,2] Netherlands[3]
Diagnostic status	Subthreshold symptoms (below threshold but ≥50% maximum score on scale) [1,2] Non-significant symptoms (below threshold and <50% maximum score on scale) [3]
Mean age (range)	41.5 (19-69) [1] 46.3 (range NR) [2] 58.8 (range NR) [3]
Sex (% female)	100[1] 95[2] 52[3]
Ethnicity (% BME)	27[1] 41[2] NR[3]
Coexisting conditions	NR
Mean months since traumatic event	NR (3% <1 month; 5% 2-6 months; 18% 6 months-1 year; 28% 1-2 years; 23% 3-5 years; 23% >5 years) [1] NR[2] 7.1[3]
Type of traumatic event	Domestic violence: Female survivors of IPV[1] Unclear: Nurses with subthreshold PTSD symptoms[2] Diagnosis of life-threatening condition: Adults with nonsmall cell (86%) or small cell (11%) lung cancer (curative [51%] or palliative stage [49%])[3]
Single or multiple incident index trauma	Multiple[1] Unclear[2] Single[3]
Lifetime experience of trauma	Mean number of lifetime types of IPV-related traumatic experience was 2.1 (SD = 1.7, range 1–6) [1] NR[2,3]
Intervention details	Trauma-informed model of mindfulness-based stress reduction (TI-MBSR), following unpublished manual[1] Mindfulness-based stretching and deep breathing exercise (MBX) [2] Mindfulness-based stress reduction (MBSR) + TAU [3]
Intervention format	Group
Intervention intensity	8x weekly 2-2.5 hour sessions (16-20 hours). Mean attended sessions 7.0 (SD = 1.7) [1] 16x twice-weekly 1-hour sessions (16 hours). All participants attended at least 12 session[2] 8x weekly 2.5-hour sessions (20 hours) [3]

Comparison	Meditation/MBSR (+/- TAU) versus no treatment, waitlist or TAU
Comparator	Waitlist[1] No treatment[2] TAU: In both groups, care as usual (CAU) consisted of anticancer treatment (i.e., surgery, chemotherapy, radiotherapy), medical consultations, and supportive care, including psychosocial care (e.g., visits to psychiatrist/psychologist, participation in psychosocial programme) [3]
Intervention length (weeks)	8

BME, Black and Minority Ethnic; CBT, Cognitive Behavioural therapy; IPV, Intimate partner violence; MBSR, Mindfulness-based stress reduction; NR, Not reported; PTSD, post-traumatic stress disorder; SD, standard deviation; TAU, Treatment as usual
[1]Kelly 2016; [2]Kim 2013; [3]Schellekens 2017

See appendix D for full evidence tables.

Quality assessment of clinical studies included in the evidence review

The clinical evidence profile for this review (MBSR for the prevention of PTSD in adults) is presented in Table 63.

Table 63: Summary clinical evidence profile: Meditation/MBSR (+/- TAU) versus no treatment, waitlist or TAU for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk No treatment, waitlist or TAU	Corresponding risk Meditation/MBSR (+/- TAU)			
PTSD symptomatology self-rated at endpoint PCL/IES change score Follow-up: mean 8 weeks		The mean PTSD symptomatology self-rated at endpoint in the intervention groups was 0.75 standard deviations lower (1.16 to 0.35 lower)		105 (3 studies)	very low[1,2,3]
PTSD symptomatology self-rated at 3-month follow-up IES change score Follow-up: mean 3 months		The mean PTSD symptomatology self-rated at 3-month follow-up in the intervention groups was 0.37 standard deviations lower (1 lower to 0.27 higher)		39 (1 study)	very low[1,4]
Depression symptoms BDI-II change score		The mean depression symptoms in the intervention groups		39 (1 study)	low[1,3]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk No treatment, waitlist or TAU	Corresponding risk Meditation/MBSR (+/- TAU)			
Follow-up: mean 8 weeks		was 1.01 standard deviations lower (1.68 to 0.34 lower)			
Quality of life at endpoint QLQ-C30-GHS change score Follow-up: mean 8 weeks Better indicated by higher values		The mean quality of life at endpoint in the intervention groups was 0.32 standard deviations higher (0.28 lower to 0.91 higher)		44 (1 study)	very low[1,4]
Quality of life at 3-month follow-up QLQ-C30-GHS change score Follow-up: mean 3 months Better indicated by higher values		The mean quality of life at 3-month follow-up in the intervention groups was 0.39 standard deviations higher (0.25 lower to 1.03 higher)		39 (1 study)	very low[1,4]
Discontinuation Number of participants lost to follow-up Follow-up: mean 8 weeks	203 per 1000	201 per 1000 (104 to 390)	RR 0.99 (0.51 to 1.92)	130 (3 studies)	very low[1,5]

BDI=Beck Depression Inventory; CI=confidence interval; IES=Impact of event scale; MBSR=Mindfulness-based stress reduction; PCL=PTSD Checklist; PTSD=post-traumatic stress disorder; RR=risk ratio; SMD=standardised mean difference; TAU=treatment as usual; QLQ-C30-GHS=an instrument to measure quality of life of cancer patients

[1] Risk of bias is high or unclear across multiple outcomes
[2] Substantial heterogeneity (I2>50%)
[3] OIS not met (N<400)
[4] 95% CI crosses both line of no effect and threshold for clinically important benefit
[5] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm

See appendix F for full GRADE tables.

Practical support: clinical evidence

Included studies

Nine studies of practical support for the prevention of PTSD in adults were identified for full-text review. Of these 9 studies, 1 RCT (N=352) was included in a single comparison for the early treatment (1-3 months post-trauma) of non-significant PTSD symptoms in adults: intensive care diary compared with waitlist (Jones 2010/2012 [1 study reported across 2 papers]).

Excluded studies

Eight studies were reviewed at full text and excluded from this review. The most common reasons for exclusion were that the intervention was not targeted at PTSD symptoms, or the paper was a systematic review with no new useable data and any meta-analysis results not appropriate to extract.

Studies not included in this review with reasons for their exclusions are provided in Appendix K.

Summary of clinical studies included in the evidence review

Table 64 provides a brief summary of the included study and evidence from this study is summarised in the clinical GRADE evidence profile below (Table 65).

See also the study selection flow chart in Appendix C, forest plots in Appendix E and study evidence tables in Appendix D.

Table 64: Summary of included studies: Practical support for early treatment (1-3 months) of non-significant PTSD symptoms

Comparison	Intensive care diary versus waitlist
Total no. of studies (N randomised)	1 (352)
Study ID	Jones 2010/2012
Country	Denmark, Italy, Norway, Portugal, Sweden, UK
Diagnostic status	Non-significant symptoms (below threshold and <50% maximum score on scale)
Mean age (range)	Median: 59-60 (18-82)
Sex (% female)	36
Ethnicity (% BME)	NR
Coexisting conditions	NR
Mean months since traumatic event	1.5
Type of traumatic event	Unintentional injury/illness/medical emergency: Respiratory failure (22%); Sepsis (15%); Circulatory failure (13%); Multi-organ failure (14%); Multiple trauma without head injury (9%); Multiple trauma with head injury (3%); Isolated head injury (2%); Combined (pulmonary/circulatory) (11%); Gastrointestinal failure (6%); Neurological failure (3%); Other (2%). Median ICU stay 13 days (range 3-79)
Single or multiple incident index trauma	Single
Lifetime experience of trauma	20% had previous traumatic experiences
Intervention details	Intensive care diary kept whilst the patient was unconscious in the ICU; contained photographs and hand written text and was introduced to the patient by a research nurse or doctor who ensured that they understood its contents but did not give any advice on what to do with it
Intervention format	Individual
Intervention intensity	Planned intensity NR. Patients read the diary a median of 3 times (0-20)
Comparator	Waitlist
Intervention length (weeks)	8

BME, Black and minority ethnic; ICU, Intensive care unit; NR, not reported;

See appendix D for full evidence tables.

Quality assessment of clinical studies included in the evidence review

The clinical evidence profile for this review (practical support for the prevention of PTSD in adults) is presented in Table 65.

Table 65: Summary clinical evidence profile: Intensive care diary versus waitlist for the early treatment (1-3 months) of non-significant PTSD symptoms

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist	Corresponding risk Intensive care diary			
PTSD symptomatology self-rated PTSS-14 change score Follow-up: mean 8 weeks		The mean PTSD symptomatology self-rated in the intervention groups was 0.26 standard deviations lower (0.48 to 0.04 lower)		322 (1 study)	very low[1,2]
PTSD at endpoint Number meeting criteria for PTSD Follow-up: mean 8 weeks	171 per 1000	130 per 1000 (79 to 214)	RR 0.76 (0.46 to 1.25)	352 (1 study)	very low[1,3]
Discontinuation Number of participants lost to follow-up Follow-up: mean 8 weeks	86 per 1000	85 per 1000 (43 to 168)	RR 0.99 (0.5 to 1.96)	352 (1 study)	very low[1,3]

CI=confidence interval; PTSD=post-traumatic stress disorder; PTSS-14=posttraumatic stress symptoms-14; RR=risk ratio; SMD=standardised mean difference
[1] Risk of bias is high or unclear across multiple outcomes
[2] OIS not met (N<400)
[3] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm

See appendix F for full GRADE tables.

Psychoeducational interventions: clinical evidence

Included studies

Twenty-two studies of psychoeducational interventions for the prevention of PTSD in adults were identified for full-text review. Of these 22 studies, 4 RCTs (N=613) were included in a single comparison for the early prevention (intervention initiated within 1 month of trauma) of PTSD in adults: single psychoeducation session (alone or in addition to TAU) compared with TAU (Miller 2015; Rose 1999; Tuckey 2014; Wijesinghe 2015).

Excluded studies

Eighteen studies were reviewed at full text and excluded from this review. The most common reasons for exclusion were that the intervention was not targeted at PTSD symptoms, or the paper was a systematic review with no new useable data and any meta-analysis results not appropriate to extract.

Studies not included in this review with reasons for their exclusions are provided in Appendix K.

Summary of clinical studies included in the evidence review

Table 66 provides a brief summary of the included studies and evidence from these are summarised in the clinical GRADE evidence profile below (Table 67).

See also the study selection flow chart in Appendix C, forest plots in Appendix E and study evidence tables in Appendix D.

Table 66: Summary of included studies: Psychoeducational interventions for early prevention (<1 month)

Comparison	Single psychoeducation session (+/- TAU) versus TAU
Total no. of studies (N randomised)	4 (613)
Study ID	Miller 2015[1] Rose 1999[2] Tuckey 2014[3] Wijesinghe 2015[4]
Country	US[1] UK[2] Australia[3] Sri Lanka[4]
Diagnostic status	Clinically important PTSD symptoms (scoring above a threshold on validated scale) [1,2] Non-significant symptoms (below threshold and <50% maximum score on scale) [3] Unclear[4]
Mean age (range)	28.8 (18-70) [1] 35.9 (18-76) [2] NR[3] 42.1 (range NR) [4]
Sex (% female)	100[1] 25[2,4] 9[3]
Ethnicity (% BME)	38[1] NR[2,3,4]
Coexisting conditions	NR[1,2,3] 0.02% treated in intensive care[4]
Mean months since traumatic event	Mean NR (intervention delivered within 72 hours of assault) [1] 0.7[2] 0.1 (within 3 days) [3] Mean NR (intervention initiated 1-month post-discharge) [4]

Comparison	Single psychoeducation session (+/- TAU) versus TAU
Type of traumatic event	Exposure to sexual abuse or assault: Women who participated in a sexual assault examination. 35% reported the assailant threatened harm; 68% reported at least one injury sustained; 8% reported the assailant used a weapon during the assault. 57% reported a completed rape. 60% assailant was an acquaintance; 20% were strangers; 12%were romantic partners; 6% were unsure who assaulted them; 1% assault by a family member[1] Exposure to non-sexual violence: Actual physical assault (94%); Threatened physical assault (4%); Actual or threatened sexual assault (4%)[2] Being an emergency responder in a traumatic event: Firemen responding to a potentially traumatic event (PTE). All but one of these PTEs were motor vehicle accidents that resulted in fatalities or serious injuries to the vehicle occupants. The remaining PTE was a failed resuscitation attempt. All events involved secondary exposure (i.e., the fire-fighters provided fire and rescue services to primary victims) rather than primary exposure (where in fire-fighters' lives were directly threatened, by a burnover for example)[3] Unintentional injury: Snakebite[4]
Single or multiple incident index trauma	Unclear[1,3] Single[2,4]
Lifetime experience of trauma	72% prior sexual assault[1] 41% had a history of child abuse[2] NR[3,4]
Intervention details	Single psychoeducation session following standard care[1] Single psychoeducation session based on a specially prepared leaflet that included information on normal reactions to traumatic events and where and when to find help[2] Single psychoeducation session consisted of information about how to recognize and manage stress, including cognitive, behavioural, emotional and physical/physiological symptoms of stress, and general self-care strategies[3] Single psychoeducation session (psychological first-aid) prior to discharge[4]
Intervention format	Individual[1,2,4] Group[3]
Intervention intensity	9-minute video (0.15 hours)[1] 1 x 30-min session (0.5 hours)[2] 1 x 90-min session (1.5 hours)[3] 1 x 15-min session (0.25 hours)[4]
Comparator	TAU: Standard care involved meeting with a rape crisis advocate who provided information about what would happen during the examination and about services available in the community[1] No treatment[2,3,4]
Intervention length (weeks)	0.1[1,2,3] 1[4]

BME, Black and minority ethnic; NR, Not reported; PTE, Potentially traumatic event; PTSD, Post-traumatic stress disorder; TAU, Treatment as usual

See appendix D for full evidence tables.

Quality assessment of clinical studies included in the evidence review

The clinical evidence profile for this review (psychoeducation for the prevention of PTSD in adults) is presented in Table 67.

Table 67: Summary clinical evidence profile: Single psychoeducation session (+/- TAU) versus TAU or no treatment for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk TAU or no treatment	Corresponding risk Single psychoeducation session (+/- TAU)			
PTSD symptomatology self-rated at endpoint PSS-SR/IES-R change score Follow-up: mean 0.1 weeks		The mean PTSD symptomatology self-rated at endpoint in the intervention groups was 0.23 standard deviations higher (0.16 lower to 0.61 higher)		106 (2 studies)	very low[1,2]
PTSD symptomatology self-rated at 2-6 month follow-up PSS-SR change score Follow-up: 2-6 months		The mean PTSD symptomatology self-rated at 2-6 month follow-up in the intervention groups was 0.19 standard deviations lower (0.51 lower to 0.13 higher)		151 (2 studies)	very low[1,3]
PTSD at 6-month follow-up Number of people who met criteria for PTSD Follow-up: mean 6 months	246 per 1000	236 per 1000 (153 to 364)	RR 0.96 (0.62 to 1.48)	253 (2 studies)	very low[1,4]
Anxiety symptoms at endpoint STAI State change score Follow-up: mean 0.1 weeks		The mean anxiety symptoms at endpoint in the intervention		69 (1 study)	very low[1,5]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk TAU or no treatment	Corresponding risk Single psychoeducation session (+/- TAU)			
		groups was 0.77 standard deviations lower (1.26 to 0.28 lower)			
Anxiety symptoms at 2-month follow-up STAI State change score Follow-up: mean 2 months		The mean anxiety symptoms at 2-month follow-up in the intervention groups was 0.61 standard deviations lower (1.08 to 0.13 lower)		73 (1 study)	very low[1,5]
Depression symptoms BDI endpoint score Follow-up: mean 0.1 weeks		The mean depression symptoms in the intervention groups was 0.36 standard deviations lower (0.77 lower to 0.06 higher)		91 (1 study)	very low[1,3]
Discontinuation Number of participants lost to follow-up Follow-up: mean 0.1 weeks	313 per 1000	357 per 1000 (291 to 439)	RR 1.14 (0.93 to 1.4)	518 (4 studies)	low[1,2]

BDI=Beck Depression Inventory; CI=confidence interval; IES-R=Impact of event scale-revised; PSS-SR=PTSD symptom scale-self-report; PTSD=post-traumatic stress disorder; RR=risk ratio; SMD=standardised mean difference; STAI=State-Trait Anxiety Inventory

[1] Risk of bias is high or unclear across multiple outcomes

[2] 95% CI crosses both line of no effect and threshold for clinically important harm

[3] 95% CI crosses both line of no effect and threshold for clinically important benefit

[4] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm

[5] OIS not met (N<400)

See appendix F for full GRADE tables.

Peer support: clinical evidence

Included studies

Three studies of peer support for the prevention of PTSD in adults were identified for full-text review. None of these studies could be included.

Excluded studies

Three studies were reviewed at full text and excluded from this review because the intervention was not targeted at PTSD symptoms, efficacy or safety data could not be extracted, or the paper was a systematic review with no new useable data and any meta-analysis results not appropriate to extract.

Studies not included in this review with reasons for their exclusions are provided in Appendix K.

Relaxation: clinical evidence

Included studies

One study of relaxation for the prevention of PTSD in adults was identified for full-text review. This study could not be included.

Excluded studies

One study was reviewed at full text and excluded from this review because the paper was a systematic review with no new useable data and any meta-analysis results not appropriate to extract.

Studies not included in this review with reasons for their exclusions are provided in Appendix K.

Economic evidence

Included studies

No studies assessing the cost effectiveness of psychosocial interventions for the prevention of PTSD in adults were identified. The search strategy for economic studies is provided in Appendix B.

Excluded studies

No economic studies of psychosocial interventions for the prevention of PTSD in adults were reviewed at full text and excluded.

Economic model

No economic modelling was conducted for this question because other topics were agreed as higher priorities for economic evaluation.

Resource impact

As no recommendations were made in this area and psychosocial interventions for the prevention of PTSD in adults are not in widespread use in routine clinical practice, there is no impact on resources.

Clinical evidence statements

Meditation/Mindfulness-based stress reduction (MBSR) for delayed treatment (>3 months) of below threshold PTSD symptoms

- Very low quality evidence from 3 RCTs (N=105) suggests a moderate-to-large and statistically significant benefit of meditation or MBSR (alone or in addition to TAU) relative to no treatment, waitlist or TAU on improving PTSD symptomatology at endpoint for adults who have been exposed to a traumatic event more than 3 months ago and have below threshold PTSD symptoms at baseline. However, very low quality single-RCT (N=39) evidence suggests this benefit is short-term as non-significant at 3-month follow-up. Low quality single-RCT (N=39) evidence suggests a clinically important and statistically significant benefit on improving depression symptoms (no follow-up available). Conversely very low quality single-RCT (N=39-44) evidence suggests a non-significant effect on quality of life at endpoint or 3-month follow-up. Very low quality evidence from 3 RCTs (N=130) suggests a non-significant effect of meditation or MBSR on discontinuation.

Practical support for early prevention (≤1 month)

- Very low quality single-RCT (N=322) evidence suggests a small but statistically significant benefit of intensive care diaries relative to waitlist on improving PTSD symptomatology for adults who have been exposed to a traumatic event 1-3 months ago. Evidence from this same RCT suggests a clinically important but not statistically significant benefit on the number of people meeting criteria for PTSD at endpoint. Evidence from this RCT suggests non-significant effects of intensive care diaries on discontinuation.

Psychoeducational interventions for early prevention (≤1 month)

- Very low quality single-RCT (N=69-73) evidence suggests a clinically important and statistically significant benefit of a single psychoeducational session in addition to TAU relative to TAU-only on improving anxiety symptoms for adults who have been exposed to a traumatic event within the last month. However, very low quality evidence from 1-2 RCTs (N=91-253) suggests non-significant effects of a single psychoeducational session on PTSD symptomatology at endpoint or 2-6 month follow-up, the number of people meeting criteria for PTSD at 6-month follow-up, or depression symptoms at endpoint. Low quality evidence from 4 RCTs (N=518) also suggests a non-significant effect of psychoeducation on discontinuation.

Economic evidence statements

No economic evidence on psychosocial interventions for the prevention of PTSD in adults was identified and no economic modelling was undertaken.

The committee's discussion of the evidence

Interpreting the evidence

The outcomes that matter most

Critical outcomes were measures of PTSD symptom improvement on validated scales and prevention of PTSD (as measured by the number of adults with a diagnosis or scoring above clinical threshold on a validated scale at endpoint or follow-up). Attrition from treatment (for any reason) was also considered an important outcome, as a proxy for the acceptability and/or tolerability of treatment. The Committee considered dissociative symptoms, personal/social/occupational functioning (including global functioning/functional impairment, sleeping difficulties, and quality of life), and symptoms of a coexisting condition (including anxiety, depression and substance misuse problems) as important but not critical outcomes. This distinction was based on the primacy of preventing PTSD, whilst acknowledging that broader symptom measures may be indicators of a general pattern of effect. The Committee also acknowledged that these other measures are not routinely collected in trials. Generally change scores were favoured over final scores as although in theory randomisation should balance out any differences at baseline, this assumption can be violated by small sample sizes. The Committee also expressed a general preference for self-rated PTSD symptomatology over clinician-rated measures. However, in considering psychosocial interventions (relative to pharmacological interventions) a greater emphasis was placed on triangulating effects on self-rated PTSD symptomatology with clinician-rated outcome measures, given that the latter but not the former could be blinded.

The quality of the evidence

All the evidence reviewed was of low or very low quality, reflecting the high risk of bias associated with the studies (including for instance, high risk of bias associated with randomisation method as reflected by significant group differences at baseline, and lack of/unclear blinding of outcome assessment), the small numbers in trials and the imprecision of many of the results (in terms of both the width of the confidence intervals and the failure to meet the optimal information size). This uncertainty of the evidence is reflected in the Committee's decision to not make any recommendations for psychosocial interventions for the prevention of PTSD in adults.

Consideration of clinical benefits and harms

The Committee discussed the evidence for meditation and MBSR. These interventions were initially considered separately, however, the committee judged that given the considerable overlap in techniques and proposed mechanisms, meta-analysis that combined the two might be more informative. The Committee discussed that the clinically important and statistically significant benefits on improving self-rated PTSD symptomatology and depression symptoms was encouraging. However, evidence suggests these benefits are short-term. The Committee also discussed anecdotal evidence based on their experience that MBSR may be associated with potential harms, such as increasing the likelihood of intrusive thoughts. Furthermore, evidence for meditation or MBSR as a preventative intervention was only available for adults who have been exposed to a traumatic event more than 3 months ago and have below threshold PTSD symptoms at baseline and the Committee questioned the clinical need for an intervention for adults who had non-significant symptoms more than 3 months after trauma. Taken together, the Committee judged the uncertainty in the evidence to be too high to warrant a recommendation.

The Committee discussed limited evidence for intensive care diaries for adults who had been in an ICU and ventilated 1-3 months ago, that suggests a small but statistically

significant benefit of intensive care diaries on improving PTSD symptomatology. However, effects on PTSD caseness were not statistically significant. The Committee also questioned the generalisability of this very specific intervention for a very specific type of trauma. Based on these considerations the Committee agreed that a recommendation was not appropriate.

Limited evidence suggests that a single psychoeducational session may be effective at improving anxiety symptoms, however, the Committee agreed that non-significant effects on PTSD symptomatology, PTSD caseness, and depression symptoms did not warrant a recommendation for psychoeducation.

Cost effectiveness and resource use

No evidence on the cost effectiveness of psychosocial interventions for the prevention of PTSD in adults was identified and no economic modelling was undertaken in this area. As there was very limited clinical evidence, no recommendation was made. None of these interventions are in widespread use in routine clinical practice, therefore no impact on resources is expected.

References for included studies

Meditation/Mindfulness-based stress reduction (MBSR)

Kelly 2016

Kelly A and Garland EL (2016) Trauma-Informed Mindfulness-Based Stress Reduction for Female Survivors of Interpersonal Violence: Results From a Stage I RCT. Journal of clinical psychology 72(4), 311-28

Kim 2013

Kim SH, Schneider SM, Bevans M, et al. (2013) PTSD symptom reduction with mindfulness-based stretching and deep breathing exercise: randomized controlled clinical trial of efficacy. The Journal of Clinical Endocrinology & Metabolism 98(7), 2984-92

Schellenkens 2017

Schellekens MP, Hurk DG, Prins JB, et al. (2017) Mindfulness-based stress reduction added to care as usual for lung cancer patients and/or their partners: A multicentre randomized controlled trial. Psycho-oncology 26(12), 2118-26

Practical support

Jones 2010/2012

Jones C, Bäckman C, Capuzzo M, et al. (2010) Intensive care diaries reduce new onset post traumatic stress disorder following critical illness: a randomised, controlled trial. Critical care 14(5):R168

Jones C, Bäckman C and Griffiths RD (2012) Intensive care diaries and relatives' symptoms of posttraumatic stress disorder after critical illness: a pilot study, American journal of critical care: an official publication. American Association of Critical-Care Nurses 21, 172-176

Psychoeducational interventions

Miller 2015

Miller K, Cranston C, Davis J, et al. (2015) Psychological outcomes after a sexual assault vidoe intervention: a randomised trial. Journal of Forensic Nursing 11, 129-136

Rose 1999

Rose S, Brewin CR, Andrews B and Kirk M (1999) A randomized controlled trial of individual psychological debriefing for victims of violent crime. Psychological Medicine 29, 793-799

Tuckey 2014

Tuckey MR and Scott JE (2014) Group critical incident stress debriefing with emergency services personnel: A randomized controlled trial. Anxiety, Stress and Coping 27, 38-54

Wijesinghe 2015

Wijesinghe CA, Williams SS, Kasturiratne A, et al. (2015) A Randomized controlled trial of a brief intervention for delayed psychological effects in snakebite victims. PLoS Negl Trop Dis 9(8):e0003989

Other non-pharmacological interventions for the prevention of PTSD in adults

Introduction to clinical evidence

Other non-pharmacological interventions will be considered as classes of intervention (acupuncture; exercise; repetitive transcranial magnetic stimulation [rTMS]; yoga; massage; bio-/neuro-feedback) and form the subsections below.

Acupuncture: clinical evidence

Included studies

Two studies of acupuncture for the prevention of PTSD in adults were identified for full-text review. Of these 2 studies, 1 RCT (N=91) was included in a single comparison for the early prevention (intervention initiated within 1 month of trauma) of PTSD in adults: combined acupuncture and trauma-focused CBT intervention compared with trauma-focused CBT-only (Zhang 2011).

Excluded studies

One study could not be reviewed at full text as the paper was unavailable.

Studies not included in this review with reasons for their exclusions are provided in Appendix K.

Summary of clinical studies included in the evidence review

Table 68 provides a brief summary of the included study and evidence from this study is summarised in the clinical GRADE evidence profile below (Table 69).

See also the study selection flow chart in Appendix C, forest plots in Appendix E and study evidence tables in Appendix D.

Table 68: Summary of included studies: Acupuncture for early prevention (<1 month)

Comparison	Acupuncture + trauma-focused CBT versus trauma-focused CBT
Total no. of studies (N randomised)	1 (91)
Study ID	Zhang 2011
Country	China
Diagnostic status	Clinically important PTSD symptoms (scoring above a threshold on validated scale)
Mean age (range)	34.9 (4-89)
Sex (% female)	60
Ethnicity (% BME)	NR
Coexisting conditions	NR
Mean months since traumatic event	Mean NR (intervention delivered 8-19 days after trauma)

Comparison	Acupuncture + trauma-focused CBT versus trauma-focused CBT
Type of traumatic event	Natural disaster: Wenchuan earthquake. 67% direct relatives had been killed by the earthquake and 33% buried under debris during the earthquake
Single or multiple incident index trauma	Single
Lifetime experience of trauma	NR
Intervention details	Electroacupuncture + brief trauma-focused CBT
Intervention format	Individual
Intervention intensity	4x 30-min sessions of acupuncture + 4x 30-min sessions of TF-CBT (4 hours in total)
Comparator	Brief trauma-focused CBT
Intervention length (weeks)	1

BME, Black and minority ethnic; CBT, Cognitive behavioural therapy; NR, not reported; TF-CBT, Trauma-focused cognitive behavioural therapy

See appendix D for full evidence tables.

Quality assessment of clinical studies included in the evidence review

The clinical evidence profile for this review (acupuncture for the prevention of PTSD in adults) is presented in Table 69.

Table 69: Summary clinical evidence profile: Acupuncture + trauma-focused CBT versus trauma-focused CBT for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Trauma-focused CBT	Corresponding risk Acupuncture + trauma-focused CBT			
PTSD symptomatology self-rated OES-R change score Follow-up: mean 1 weeks		The mean PTSD symptomatology self-rated in the intervention groups was 1.56 standard deviations lower (2.08 to 1.04 lower)		90 (1 study)	low[1,2]
Discontinuation Number of participants lost to follow-up Follow-up: mean 1 weeks	0 per 1000	0 per 1000 (0 to 0)	RR 1.1 (0.05 to 26.2)	91 (1 study)	low[3]

CBT=cognitive behavioural therapy; CI=confidence interval; OES-R=; PTSD=post-traumatic stress disorder
[1] Risk of bias is high or unclear across multiple outcomes
[2] OIS not met (N<400)
[3] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm

See appendix F for full GRADE tables.

Exercise: clinical evidence

Included studies

Two studies of exercise for the prevention of PTSD in adults were identified for full-text review. Neither of these studies could be included.

Excluded studies

Two studies were reviewed at full text and excluded from this review because the intervention was not targeted at PTSD symptoms, or the paper was a systematic review with no new useable data and any meta-analysis results not appropriate to extract.

Studies not included in this review with reasons for their exclusions are provided in Appendix K.

Repetitive transcranial magnetic stimulation (rTMS): clinical evidence

Included studies

One study of repetitive transcranial magnetic stimulation (rTMS) for the prevention of PTSD in adults was identified for full-text review. This study could not be included.

Excluded studies

One study could not be reviewed at full text because the paper was unavailable.

Studies not included in this review with reasons for their exclusions are provided in Appendix K.

Yoga: clinical evidence

Included studies

Four studies of yoga for the prevention of PTSD in adults were identified for full-text review. Of these 2 studies, 2 RCTs (N=199) were included. One of these RCTs was a three-armed trial and included in more than one comparison. There were 3 comparisons for yoga.

For the early prevention (intervention initiated within 1 month of trauma) of PTSD in adults, there was evidence from 1 RCT (N=178) for 2 relevant comparisons: yoga compared with attention-placebo, and yoga compared with TAU (Ratcliff 2016).

For prevention of PTSD in adults with ongoing exposure to trauma (for instance, war zone), there were no included studies.

For the early treatment (1-3 months) of non-significant PTSD symptoms in adults, there were no included studies.

For the delayed treatment (>3 months) of non-significant PTSD symptoms in adults, there was evidence for 1 relevant comparison: 1 RCT (N=21) compared yoga with waitlist (Seppälä 2014).

Excluded studies

Two studies were reviewed at full text and excluded from this review and excluded from the review because the intervention was not targeted at PTSD symptoms.

Studies not included in this review with reasons for their exclusions are provided in Appendix K.

Summary of clinical studies included in the evidence review

Table 70 and Table 71 provide brief summaries of the included studies and evidence from these are summarised in the clinical GRADE evidence profiles below (Table 72, Table 73 and Table 74).

See also the study selection flow chart in Appendix C, forest plots in Appendix E and study evidence tables in Appendix D.

Table 70: Summary of included studies: Yoga for early prevention (<1 month)

Comparison	Yoga versus attention-placebo	Yoga versus TAU
Total no. of studies (N randomised)	1 (178)	1 (178)
Study ID	Ratcliff 2016	Ratcliff 2016
Country	US	US
Diagnostic status	Non-significant symptoms (below threshold and <50% maximum score on scale)	Non-significant symptoms (below threshold and <50% maximum score on scale)
Mean age (range)	51.9 (range NR)	51.9 (range NR)
Sex (% female)	100	100
Ethnicity (% BME)	40	40
Coexisting conditions	NR	NR
Mean months since traumatic event	NR (randomised immediately prior to radiotherapy)	NR (randomised immediately prior to radiotherapy)
Type of traumatic event	Diagnosis of life-threatening condition: Diagnosed with stage 0 to III breast cancer, and scheduled to undergo daily adjuvant radiotherapy. 11% stage 0; 31% stage I; 27% stage II; 31% stage III	Diagnosis of life-threatening condition: Diagnosed with stage 0 to III breast cancer, and scheduled to undergo daily adjuvant radiotherapy. 11% stage 0; 31% stage I; 27% stage II; 31% stage III
Single or multiple incident index trauma	Single	Single
Lifetime experience of trauma	NR	NR
Intervention details	Integrated yoga programme	Integrated yoga programme
Intervention format	Group	Group
Intervention intensity	Up to 18x thrice-weekly 1-hour sessions (18 hours). Mean attended 13.8 sessions	Up to 18x thrice-weekly 1-hour sessions (18 hours). Mean attended 13.8 sessions
Comparator	Attention-placebo: Stretching control	TAU (no further details reported)

Comparison	Yoga versus attention-placebo	Yoga versus TAU
Intervention length (weeks)	6	6

BME, Black and minority ethnic; NR, Not reported; TAU, Treatment as usual

Table 71: Summary of included studies: Yoga for delayed treatment (>3 months) of non-significant PTSD symptoms

Comparison	Yoga versus waitlist
Total no. of studies (N randomised)	1 (21)
Study ID	Seppala 2014
Country	US
Diagnostic status	Non-significant symptoms (below threshold and <50% maximum score on scale)
Mean age (range)	28.6 (range NR)
Sex (% female)	0
Ethnicity (% BME)	14
Coexisting conditions	NR
Mean months since traumatic event	NR
Type of traumatic event	Military combat: Veterans with service in Afghanistan or Iraq (no further detail reported)
Single or multiple incident index trauma	Multiple
Lifetime experience of trauma	NR
Intervention details	Sudarshan Kriya yoga
Intervention format	Group
Intervention intensity	7x daily 3-hour sessions (21 hours)
Comparator	Waitlist
Intervention length (weeks)	1

BME, Black and minority ethnic; NR, Not reported; TAU, Treatment as usual

See appendix D for full evidence tables.

Quality assessment of clinical studies included in the evidence review

The clinical evidence profiles for this review (yoga for the prevention of PTSD in adults) are presented in Table 72, Table 73 and Table 74.

Table 72: Summary clinical evidence profile: Yoga versus attention-placebo for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Attention-placebo	Corresponding risk Yoga			
PTSD symptomatology self-rated at		The mean PTSD symptomatology self-rated at		101 (1 study)	very low[1,2]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Attention -placebo	Corresponding risk Yoga			
endpoint IES change score Follow-up: mean 6 weeks		endpoint in the intervention groups was 0.23 standard deviations lower (0.62 lower to 0.16 higher)			
PTSD symptomatology self-rated at 1-month follow-up IES change score Follow-up: mean 1 months		The mean PTSD symptomatology self-rated at 1-month follow-up in the intervention groups was 0.17 standard deviations lower (0.6 lower to 0.26 higher)		83 (1 study)	very low[1,2]
PTSD symptomatology self-rated at 3-month follow-up IES change score Follow-up: mean 3 months		The mean PTSD symptomatology self-rated at 3-month follow-up in the intervention groups was 0.08 standard deviations lower (0.51 lower to 0.36 higher)		82 (1 study)	very low[1,2]
PTSD symptomatology self-rated at 6-month follow-up IES change score Follow-up: mean 6 months		The mean PTSD symptomatology self-rated at 6-month follow-up in the intervention groups was 0.04 standard deviations higher (0.38 lower to 0.46 higher)		86 (1 study)	very low[1,3]
Depression symptoms at endpoint CES-D change score Follow-up: mean 6 weeks		The mean depression symptoms at endpoint in the intervention groups was 0.27 standard deviations lower (0.67 lower to 0.12 higher)		101 (1 study)	very low[1,2]
Depression symptoms at 1-month follow-up CES-D change score		The mean depression symptoms at 1-month follow-up in the intervention		83 (1 study)	very low[1,2]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Attention -placebo	Corresponding risk Yoga			
Follow-up: mean 1 months		groups was 0.3 standard deviations lower (0.73 lower to 0.14 higher)			
Depression symptoms at 3-month follow-up CES-D change score Follow-up: mean 3 months		The mean depression symptoms at 3-month follow-up in the intervention groups was 0.1 standard deviations higher (0.33 lower to 0.54 higher)		82 (1 study)	very low[1,4]
Depression symptoms at 6-month follow-up CES-D change score Follow-up: mean 6 months		The mean depression symptoms at 6-month follow-up in the intervention groups was 0.01 standard deviations lower (0.44 lower to 0.41 higher)		86 (1 study)	very low[1,3]
Sleeping difficulties at endpoint PSQI change score Follow-up: mean 6 weeks		The mean sleeping difficulties at endpoint in the intervention groups was 0.51 standard deviations lower (0.91 to 0.12 lower)		101 (1 study)	very low[1,3]
Sleeping difficulties at 1-month follow-up PSQI change score Follow-up: mean 1 months		The mean sleeping difficulties at 1-month follow-up in the intervention groups was 0.11 standard deviations lower (0.54 lower to 0.33 higher)		83 (1 study)	very low[1,2]
Sleeping difficulties at 3-month follow-up PSQI change score Follow-up: mean 3 months		The mean sleeping difficulties at 3-month follow-up in the intervention groups was 0.19 standard deviations lower		82 (1 study)	very low[1,2]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Attention -placebo	Corresponding risk Yoga			
		(0.62 lower to 0.25 higher)			
Sleeping difficulties at 6-month follow-up PSQI change score Follow-up: mean 6 months		The mean sleeping difficulties at 6-month follow-up in the intervention groups was 0 standard deviations higher (0.42 lower to 0.42 higher)		86 (1 study)	very low[1,3]
Quality of life at endpoint SF-36 MCS change score Follow-up: mean 6 weeks Better indicated by higher values		The mean quality of life at endpoint in the intervention groups was 0.12 standard deviations higher (0.27 lower to 0.51 higher)		101 (1 study)	very low[1,2]
Quality of life at 1-month follow-up SF-36 MCS change score Follow-up: mean 1 months Better indicated by higher values		The mean quality of life at 1-month follow-up in the intervention groups was 0.31 standard deviations higher (0.12 lower to 0.74 higher)		83 (1 study)	very low[1,2]
Quality of life at 3-month follow-up SF-36 MCS change score Follow-up: mean 3 months Better indicated by higher values		The mean quality of life at 3-month follow-up in the intervention groups was 0.02 standard deviations higher (0.41 lower to 0.46 higher)		82 (1 study)	very low[1,3]
Quality of life at 6-month follow-up SF-36 MCS change score Follow-up: mean 6 months Better indicated by higher values		The mean quality of life at 6-month follow-up in the intervention groups was 0.06 standard deviations lower (0.48 lower to 0.36 higher)		86 (1 study)	very low[1,3]

CES-D=Centre for epidemiological studies-depression; CI=confidence interval; IES=Impact of event scale; PSQI=Pittsburgh Sleep Quality Index; PTSD=post-traumatic stress disorder; RR=risk ratio; SF-36 MCS=short form-36 (mental component summary); SMD=standardised mean difference

[1] Risk of bias is high or unclear across multiple outcomes

[2] 95% CI crosses both line of no effect and threshold for clinically important benefit

[3] OIS not met (N<400)
[4] 95% CI crosses both line of no effect and threshold for clinically important harm

Table 73: Summary clinical evidence profile: Yoga versus TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk TAU	Corresponding risk Yoga			
PTSD symptomatology self-rated at endpoint IES change score Follow-up: mean 6 weeks		The mean PTSD symptomatology self-rated at endpoint in the intervention groups was 0.01 standard deviations lower (0.41 lower to 0.39 higher)		97 (1 study)	very low[1,2]
PTSD symptomatology self-rated at 1-month follow-up IES change score Follow-up: mean 1 months		The mean PSTD symptomatology self-rated at 1-month follow-up in the intervention groups was 0.11 standard deviations higher (0.32 lower to 0.55 higher)		82 (1 study)	very low[1,3]
PTSD symptomatology self-rated at 3-month follow-up IES change score Follow-up: mean 3 months		The mean PTSD symptomatology self-rated at 3-month follow-up in the intervention groups was 0.09 standard deviations higher (0.34 lower to 0.52 higher)		83 (1 study)	very low[1,3]
PTSD symptomatology self-rated at 6-month follow-up IES change score Follow-up: mean 6 months		The mean PTSD symptomatology self-rated at 6-month follow-up in the intervention groups was 0.51 standard deviations higher (0.09 to 0.93 higher)		89 (1 study)	very low[1,3]
Depression symptoms at endpoint CES-D change score Follow-up: mean 6 weeks		The mean depression symptoms at endpoint in the intervention groups was 0.11 standard		97 (1 study)	very low[1,4]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk TAU	Corresponding risk Yoga			
		deviations lower (0.51 lower to 0.29 higher)			
Depression symptoms at 1-month follow-up CES-D change score Follow-up: mean 1 months		The mean depression symptoms at 1-month follow-up in the intervention groups was 0.03 standard deviations higher (0.41 lower to 0.46 higher)		82 (1 study)	very low[1,2]
Depression symptoms at 3-month follow-up CES-D change score Follow-up: mean 3 months		The mean depression symptoms at 3-month follow-up in the intervention groups was 0.05 standard deviations higher (0.38 lower to 0.48 higher)		83 (1 study)	very low[1,2]
Depression symptoms at 6-month follow-up CES-D change score Follow-up: mean 6 months		The mean depression symptoms at 6-month follow-up in the intervention groups was 0.24 standard deviations higher (0.18 lower to 0.66 higher)		89 (1 study)	very low[1,3]
Sleeping difficulties at endpoint PSQI change score Follow-up: mean 6 weeks		The mean sleeping difficulties at endpoint in the intervention groups was 0.27 standard deviations lower (0.67 lower to 0.13 higher)		97 (1 study)	very low[1,4]
Sleeping difficulties at 1-month follow-up PSQI change score Follow-up: mean 1 months		The mean sleeping difficulties at 1-month follow-up in the intervention groups was 0.37 standard deviations higher (0.06 lower to 0.81 higher)		82 (1 study)	very low[1,3]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk TAU	Corresponding risk Yoga			
Sleeping difficulties at 3-month follow-up PSQI change score Follow-up: mean 3 months		The mean sleeping difficulties at 3-month follow-up in the intervention groups was 0.04 standard deviations lower (0.47 lower to 0.39 higher)		83 (1 study)	very low[1,2]
Sleeping difficulties at 6-month follow-up PSQI change score Follow-up: mean 6 months		The mean sleeping difficulties at 6-month follow-up in the intervention groups was 0.18 standard deviations higher (0.23 lower to 0.6 higher)		89 (1 study)	very low[1,3]
Quality of life at endpoint SF-36 MCS change score Follow-up: mean 6 weeks Better indicated by higher values		The mean quality of life at endpoint in the intervention groups was 0.06 standard deviations higher (0.34 lower to 0.45 higher)		97 (1 study)	very low[1,2]
Quality of life at 1-month follow-up SF-36 MCS change score Follow-up: mean 1 months Better indicated by higher values		The mean quality of life at 1-month follow-up in the intervention groups was 0.3 standard deviations lower (0.74 lower to 0.13 higher)		82 (1 study)	very low[1,3]
Quality of life at 3-month follow-up SF-36 MCS change score Follow-up: mean 3 months Better indicated by higher values		The mean quality of life at 3-month follow-up in the intervention groups was 0.03 standard deviations lower (0.46 lower to 0.4 higher)		83 (1 study)	very low[1,2]
Quality of life at 6-month follow-up SF-36 MCS change score Follow-up: mean 6 months		The mean quality of life at 6-month follow-up in the intervention groups was 0.22 standard		89 (1 study)	very low[1,3]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk TAU	Corresponding risk Yoga			
Better indicated by higher values		deviations lower (0.63 lower to 0.2 higher)			

CES-D=Centre for epidemiological studies-depression; CI=confidence interval; IES=Impact of event scale; PSQI=Pittsburgh Sleep Quality Index; PTSD=post-traumatic stress disorder; RR=risk ratio; SMD=standardised mean difference; TAU=treatment as usual
[1] Risk of bias is high or unclear across multiple outcomes
[2] OIS not met (N<400)
[3] 95% CI crosses both line of no effect and threshold for clinically important harm
[4] 95% CI crosses both line of no effect and threshold for clinically important benefit

Table 74: Summary clinical evidence profile: Yoga versus waitlist for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist	Corresponding risk Yoga			
PTSD symptomatology self-rated PCL change score Follow-up: mean 1 weeks		The mean PTSD symptomatology self-rated in the intervention groups was 1.13 standard deviations lower (2.09 to 0.17 lower)		20 (1 study)	low[1,2]
Discontinuation Number of participants lost to follow-up Follow-up: mean 1 weeks	0 per 1000	0 per 1000 (0 to 0)	RR 2.75 (0.12 to 60.7)	21 (1 study)	low[3]

CI=confidence interval; PCL=PTSD Checklist; PTSD=post-traumatic stress disorder; RR=risk ratio; SMD=standardised mean difference
[1] Risk of bias is high or unclear across multiple outcomes
[2] OIS not met (N<400)
[3] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm

See appendix F for full GRADE tables.

Massage: clinical evidence

Included studies

Two studies of massage for the prevention of PTSD in adults were identified for full-text review. Of these 2 studies, 1 RCT (N=119) was included in a single comparison for the early prevention (intervention initiated within 1 month of trauma) of PTSD in adults: a combined massage and relaxation intervention for parent (and a massage and humour therapy targeted at child) compared with TAU (Phipps 2010/2012/ Lindwall 2014 [1 study reported across 3 papers]).

Excluded studies

One study was reviewed at full text and excluded from this review because outcome measures were not validated.

Studies not included in this review with reasons for their exclusions are provided in Appendix K.

Summary of clinical studies included in the evidence review

Table 75 provides a brief summary of the included study and evidence from this study is summarised in the clinical GRADE evidence profile below (Table 76).

See also the study selection flow chart in Appendix C, forest plots in Appendix E and study evidence tables in Appendix D.

Table 75: Summary of included studies: Massage for early prevention (<1 month)

Comparison	Massage + relaxation for parent (+ massage + humour therapy targeted at child) versus TAU
Total no. of studies (N randomised)	1 (119)
Study ID	Phipps 2010/2012/Lindwall 2014
Country	US and Canada
Diagnostic status	Non-significant symptoms (below threshold and <50% maximum score on scale)
Mean age (range)	NR
Sex (% female)	81
Ethnicity (% BME)	NR
Coexisting conditions	NR
Mean months since traumatic event	NR (≤1 month)
Type of traumatic event	Parent of children undergoing paediatric stem cell transplantation (SCT). Diagnostic group: ALL (27%); AML (25%); other leukaemia (14%); HD/NHL (11%); solid tumour (12%); nonmalignancy (11%)
Single or multiple incident index trauma	Single
Lifetime experience of trauma	NR
Intervention details	Massage + relaxation (for parent; + massage + humour therapy targeted at child)
Intervention format	Individual
Intervention intensity	3x massages for 4 weeks plus weekly relaxation sessions and 15-20mins daily relaxation exercises
Comparator	TAU: routine, comprehensive services that are provided for families during the SCT process at these major paediatric SCT centres
Intervention length (weeks)	4

AML, Acute myeloblastic leukaemia; ALL, Acute lymphoblastic leukaemia; BME, Black and minority ethnic; HD, Hodgkin disease; NHL, Non-Hodgkin lymphoma; NR, Not reported; SCT, Stem cell transplantation; TAU, Treatment as usual

See appendix D for full evidence tables.

Quality assessment of clinical studies included in the evidence review

The clinical evidence profile for this review (massage for the prevention of PTSD in adults) is presented in Table 76.

Table 76: Summary clinical evidence profile: Massage + relaxation for parent (+ massage + humour therapy targeted at child) versus TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk TAU	Corresponding risk Massage + relaxation for parent (+ massage + humour therapy targeted at child)			
PTSD symptomatology self-rated at 5-month follow-up IES-R change score Follow-up: mean 5 months		The mean PTSD symptomatology self-rated at 5-month follow-up in the intervention groups was 0.18 standard deviations lower (0.71 lower to 0.34 higher)		62 (1 study)	low[1,2]
Depression symptoms at 5-month follow-up CES-D change score Follow-up: mean 5 months		The mean depression symptoms at 5-month follow-up in the intervention groups was 0.33 standard deviations lower (0.87 lower to 0.2 higher)		59 (1 study)	low[1,2]
Discontinuation Number of participants lost to follow-up Follow-up: mean 4 weeks	633 per 1000	323 per 1000 (209 to 488)	RR 0.51 (0.33 to 0.77)	119 (1 study)	moderate[3]

CES-D=Centre for epidemiological studies-depression; CI=confidence interval; IES-R=Impact of event scale-revised; PTSD=post-traumatic stress disorder; RR=risk ratio; SMD=standardised mean difference; TAU=treatment as usual

[1] Risk of bias is high or unclear across multiple outcomes

[2] 95% CI crosses both line of no effect and threshold for clinically important benefit

[3] OIS not met (events<300)

See appendix F for full GRADE tables.

Bio-/Neuro-feedback: clinical evidence

Included studies

One study of neurofeedback for the prevention of PTSD in adults was identified for full-text review. This study could not be included.

Excluded studies

One study was reviewed at full text and excluded because efficacy or safety data could not be extracted.

Studies not included in this review with reasons for their exclusions are provided in Appendix K.

Economic evidence

Included studies

No studies assessing the cost effectiveness of other non-pharmacological interventions for the prevention of PTSD in adults were identified. The search strategy for economic studies is provided in Appendix B.

Excluded studies

No economic studies of other non-pharmacological interventions for the prevention of PTSD in adults were reviewed at full text and excluded.

Economic model

No economic modelling was conducted for this question because other topics were agreed as higher priorities for economic evaluation.

Resource impact

As no recommendations were made in this area and other non-pharmacological interventions for the prevention of PTSD in adults are not in widespread use in routine clinical practice, there is no impact on resources.

Clinical evidence statements

Acupuncture for early prevention (≤1 month)

- Low quality single-RCT (N=90) evidence suggests a large and statistically significant benefit of a combined acupuncture and trauma-focused CBT intervention relative to trauma-focused CBT-only on improving PTSD symptomatology for adults who have been exposed to a traumatic event within the last month. Evidence from this same RCT (N=91) suggests a non-significant effect of acupuncture on discontinuation.

Yoga for early prevention (≤1 month)

- Very low quality single-RCT (N=82-101) evidence suggests non-significant effects of yoga relative to attention-placebo on PTSD symptomatology, depression symptoms or quality of life at endpoint, 1-month, 3-month or 6-month follow-up for adults who have been exposed to a traumatic event within the last month. Evidence from this same RCT (N=101) suggests a clinically important and statistically significant benefit of yoga relative to attention-placebo on improving sleeping difficulties at endpoint, however, this benefit is

short-term with non-significant effects observed at 1-month, 3-month and 6-month follow-up. No evidence on discontinuation is available.

- Very low quality single-RCT (N=89) evidence suggests a delayed clinically important and statistically significant harm of yoga relative to TAU on PTSD symptomatology at 6-month follow-up with greater improvement observed in the TAU arm, for adults who have been exposed to a traumatic event within the last month. Evidence from this same RCT (N=82-97) suggests non-significant effects of yoga on PTSD symptomatology at endpoint, 1-month or 3-month follow-up, or on depression symptoms, sleeping difficulties or quality of life at endpoint, 1-month, 3-month or 6-month follow-up. No evidence on discontinuation is available.

Yoga for delayed treatment (>3 months) of below threshold PTSD symptoms

- Low quality single-RCT (N=20) evidence suggests a large and statistically significant benefit of yoga relative to waitlist on improving PTSD symptomatology for adults who have been exposed to a traumatic event more than 3 months ago and have non-significant PTSD symptoms at baseline. Evidence from this same RCT (N=21) suggests a higher rate of discontinuation may be associated with yoga, however absolute numbers are small and this effect is not statistically significant.

Massage for early prevention (≤1 month)

- Low quality single-RCT (N=62) evidence suggests non-significant effects of a combined massage and relaxation intervention for the parent (in addition to a combined massage and humour therapy targeted at the child) relative to TAU on PTSD symptomatology or depression symptoms at 5-month follow-up for adults who have been exposed to a traumatic event within the last month. Moderate quality evidence from this same RCT (N=119) suggests a significantly lower rate of discontinuation associated with massage and relaxation relative to TAU.

Economic evidence statements

No evidence on other non-pharmacological interventions for the prevention of PTSD in adults was identified and no economic modelling was undertaken.

The committee's discussion of the evidence

Interpreting the evidence

The outcomes that matter most

Critical outcomes were measures of PTSD symptom improvement on validated scales and prevention of PTSD (as measured by the number of adults with a diagnosis or scoring above clinical threshold on a validated scale at endpoint or follow-up). Attrition from treatment (for any reason) was also considered an important outcome, as a proxy for the acceptability and/or tolerability of treatment. The Committee considered dissociative symptoms, personal/social/occupational functioning (including global functioning/functional impairment, sleeping difficulties, and quality of life), and symptoms of a coexisting condition (including anxiety, depression and substance misuse problems) as important but not critical outcomes. This distinction was based on the primacy of preventing PTSD, whilst acknowledging that broader symptom measures may be indicators of a general pattern of effect. Generally change scores were favoured over final scores as although in theory randomisation should balance out any differences at baseline, this assumption can be violated by small sample sizes. The Committee also expressed a general preference for self-rated PTSD symptomatology over clinician-rated measures. However, in considering other non-pharmacological interventions (relative to pharmacological interventions) a greater emphasis

was placed on triangulating effects on self-rated PTSD symptomatology with clinician-rated outcome measures, given that the latter but not the former could be blinded.

The quality of the evidence

With the exception of a single moderate quality outcome, all the evidence reviewed was of low or very low quality, reflecting the high risk of bias associated with the studies (including for instance, high risk of bias associated with randomisation method as reflected by significant group differences at baseline, and lack of/unclear blinding of outcome assessment), the small numbers in trials and the imprecision of many of the results (in terms of both the width of the confidence intervals and the failure to meet the optimal information size). This uncertainty of the evidence is reflected in the Committee's decision to not make any recommendations for other non-pharmacological interventions for the prevention of PTSD in adults.

Consideration of clinical benefits and harms

The Committee discussed the evidence for a combined acupuncture and trauma-focused CBT intervention to improve PTSD symptomatology in adults exposed to a traumatic event within the last month. However, the lack of comparison against a non-active comparator made it difficult to quantify this benefit. Furthermore, the evidence base was considered too small for the Committee to be confident that the benefits observed are true effects and thus a recommendation could not be supported

Evidence showed non-significant effects of yoga on PTSD symptomatology, depression symptoms or quality of life for adults exposed to a traumatic event within the last month. In addition, there was some evidence of potential harm associated with yoga with greater improvement in PTSD symptomatology at 6-month follow-up observed for participants in the TAU arm. The Committee considered making a negative recommendation and judged this to be inappropriate based on the uncertainty of harm given the limited number of RCTs (single-RCT analyses) and the lack of non-active control (comparisons are against attention-placebo or TAU).

The Committee discussed the evidence suggesting non-significant effects on PTSD symptomatology and depression symptoms of a combined massage and relaxation intervention for the early prevention of PTSD in parents of children and young people undergoing stem cell or bone marrow transplantation. Given this limited evidence for neither significant benefit nor harm, the committee did not consider a recommendation to be warranted.

Cost effectiveness and resource use

No evidence on the cost effectiveness of other non-pharmacological interventions for the prevention of PTSD in adults was identified and no economic modelling was undertaken in this area. As there was very limited evidence on clinical benefits, no recommendation was made. None of these interventions are in widespread use in routine clinical practice, therefore no impact on resources is expected.

References for included studies

Acupuncture

Zhang 2011

Zhang Y, Bin FE, Xie JP, et al. (2011) Clinical study on treatment of the earthquake-caused post-traumatic stress disorder by cognitive-behavior therapy and acupoint stimulation. Journal of Traditional Chinese Medicine 31(1), 60-3

Yoga

Ratcliff 2016

Ratcliff CG, Milbury K, Chandwani KD, et al. (2016) Examining mediators and moderators of yoga for women with breast cancer undergoing radiotherapy. Integrative cancer therapies 15(3), 250-62

Seppala 2014

Seppälä EM, Nitschke JB, Tudorascu DL, et al. (2014) Breathing-based meditation decreases posttraumatic stress disorder symptoms in US Military veterans: A randomized controlled longitudinal study. Journal of traumatic stress 27(4), 397-405

Massage

Phipps 2010/2012/Lindwall 2014

Phipps S, Barrera M, Vannatta K, et al. (2010) Complementary therapies for children undergoing stem cell transplantation. Cancer 116(16), 3924-33

Phipps S, Peasant C, Barrera M, et al. (2012) Resilience in children undergoing stem cell transplantation: Results of a complementary intervention trial. Pediatrics 129(3), e762-70

Lindwall JJ, Russell K, Huang Q, et al. (2014) Adjustment in parents of children undergoing stem cell transplantation. Biology of Blood and Marrow Transplantation 20(4), 543-8

Appendices

Appendix A – Review protocols

Review protocol for "For adults at risk of PTSD, what are the relative benefits and harms of psychological, psychosocial or other non-pharmacological interventions targeted at PTSD symptoms?

Topic	Pharmacological interventions for the prevention of PTSD in adults
Review question(s)	RQ. 2.1 For adults at risk of PTSD, what are the relative benefits and harms of psychological, psychosocial or other non-pharmacological interventions targeted at PTSD symptoms?
Sub-question(s)	Where evidence exists, consideration will be given to the specific needs of:- women who have been exposed to sexual abuse or assault, or domestic violence lesbian, gay, bisexual, transsexual or transgender people people from black and minority ethnic groups people who are homeless or in insecure accommodation asylum seekers or refugees or other immigrants who are entitled to NHS treatment people who have been trafficked people who are socially isolated (and who are not captured by any other subgroup listed) people with complex PTSD people with neurodevelopmental disorders (including autism) people with coexisting conditions (drug and alcohol misuse, common mental health disorders, eating disorders, personality disorders, acquired brain injury, physical disabilities and sensory impairments) people who are critically ill or injured (for instance after a vehicle crash)
Objectives	To identify the most effective psychological, psychosocial or other non-pharmacological interventions for the prevention or treatment of PTSD in adults
Population	Adults at risk of PTSD At risk of PTSD is defined (in accordance with DSM) as: Exposure to actual or threatened death, serious injury or sexual violation. The exposure must result from one or more of the following scenarios, in which the individual: directly experiences the traumatic event;

Topic	Pharmacological interventions for the prevention of PTSD in adults
	witnesses the traumatic event in person; learns that the traumatic event occurred to a close family member or close friend (with the actual or threatened death being either violent or accidental); or experiences first-hand repeated or extreme exposure to aversive details of the traumatic event (not through media, pictures, television or movies unless work-related) This population includes people with a diagnosis of acute stress disorder/acute stress reaction (according to DSM, ICD or similar criteria), people with clinically important PTSD symptoms within a month of the traumatic event, and people with sub-threshold symptoms The at-risk population for this review will also include the following groups that may not be captured by the DSM criteria: family members of people with PTSD family members or carers of people with a life-threatening illness or injury Adults with clinically important post-traumatic stress symptoms more than one month after the traumatic event will be excluded from RQ 2.1 as this question addresses prevention, this group are included in RQ 2.2 For mixed adult and children populations, where possible disaggregated data will be obtained. If this is not possible then the study will be categorised according to the mean age of the population (<18 years as children and young people and ≥18 years as adult). If some, but not all, of a study's participants are eligible for the review, where possible disaggregated data will be obtained. If this is not possible then the study will be included if at least 80% of its participants are eligible for this review.
Exclude	Trials of people with adjustment disorders Trials of people with traumatic grief Trials of people with psychosis as a coexisting condition Trials of people with learning disabilities Trials of women with PTSD during pregnancy or in the first year following childbirth Trials of adults in contact with the criminal justice system (not solely as a result of being a witness or victim)

Topic	Pharmacological interventions for the prevention of PTSD in adults
Intervention	Psychological interventions (psychological interventions listed below are examples of interventions which may be included either alone or in combination in an individual or group format): Trauma-focused cognitive behavioural therapies (CBT), including cognitive therapy, cognitive processing therapy, compassion focused therapy, exposure therapy/prolonged exposure (PE), virtual reality exposure therapy (VRET), imagery rehearsal therapy, mindfulness-based cognitive therapy (MBCT) and narrative exposure therapy (NET) Non-trauma-focused CBT, including stress inoculation training (SIT) Psychologically-focused debriefing (including single session debriefing) Eye movement desensitisation and reprocessing (EMDR) Hypnotherapy Psychodynamic therapies, including traumatic incident reduction (TIR) Counselling, including non-directive/supportive/person-centred counselling Human givens therapy Combined somatic and cognitive therapies, including thought field therapy (TFT) and emotional freedom technique (EFT) Couple interventions, including cognitive-behavioural conjoint therapy Parent training/family interventions, including behavioural family therapy Psychosocial interventions (psychosocial interventions listed below are examples of interventions which may be included either alone or in combination): Meditation Mindfulness-based stress reduction (MBSR) Supported employment (including individual placement and support [IPS] supported employment and Veterans Health Administration Vocational Rehabilitation Programme [VRP]) Practical support (including financial and housing) Psychoeducational interventions Peer support (including (including self-help groups and support groups and Trauma Risk Management [TRiM]) Other non-pharmacological interventions (other non-pharmacological interventions listed below are examples of interventions which may be included either alone or in combination):

Topic	Pharmacological interventions for the prevention of PTSD in adults
	Acupuncture (including classical acupuncture, electroacupuncture, auricular acupuncture, laser acupuncture and acupoint stimulation [such as acupressure, moxibustion and tapping]) Exercise (including anaerobic [such as heavy weight training, sprinting, high-intensity interval training] and aerobic [such as running/jogging, swimming, cycling and walking] exercise, both supervised and unsupervised) Repetitive transcranial magnetic stimulation (rTMS) Yoga (including all types of yoga) Combination interventions, such as combined psychological plus pharmacological versus pharmacological alone, will also be considered here. A distinction will be made between early interventions (delivered within 3 months of the traumatic event) and delayed interventions (delivered more than 3 months after the traumatic event) Exclude: Inoculation interventions for people who may be at risk of experiencing but have not experienced, a traumatic event Interventions that are not targeted at PTSD symptoms
Comparison	Any other intervention Treatment as usual Waitlist Placebo
Critical outcomes	Efficacy PTSD symptomology (mean endpoint score or change in PTSD score from baseline) Diagnosis of PTSD (number of people meeting diagnostic criteria for PTSD according to DSM, ICD or similar criteria) The following PTSD scales will be included: Assessor-rated PTSD symptom scales: Clinician-Administered PTSD Scale for DSM–IV (CAPS) or DSM-V (CAPS-5) Anxiety Disorders Interview Schedule for DSM-IV: Lifetime version (ADIS-IV-L) or DSM-5 (ADIS-5) - Adult and Lifetime Version

Topic	Pharmacological interventions for the prevention of PTSD in adults
	PTSD Symptom Scale – Interview Version (PSS-I) Number of symptoms on the Structured Clinical Interview for DSM-IV (SCID) Symptoms of Trauma Scale (SOTS) Self-report instruments of PTSD symptoms: PTSD Checklist (PCL), including all versions (PCL-5, PCL-M, PCL-C and PCL-S) PTSD Symptom Scale – Self Report (PSS-SR) Life Events Checklist for DSM-5 (LEC-5) Trauma Screening Questionnaire (TSQ) Primary Care PTSD Screen (PC-PTSD) Davidson Trauma Scale (DTS) Post-Traumatic Diagnostic Scale (PDS) Impact of Event Scale (IES)/Impact of Event Scale Revised (IES-R) Acceptability/tolerability Acceptability of the intervention Discontinuation due to adverse effects Discontinuation due to any reason (including adverse effects)
Important, but not critical outcomes	Dissociative symptoms as assessed with a validated scale including: Assessor-rated scales: Dissociation symptom cluster score on CAPS Self-report scales: Dissociative Experiences Scale (DES) Multiscale Dissociation Inventory (MDI) Traumatic Dissociation Scale Personal, social, and occupational functioning Sleeping difficulties (as assessed with a validated scale, including the Pittsburgh Sleep Quality Index Addendum for PTSD [PSQI-A] and Insomnia Severity Index [ISI]) Employment (for instance, number in paid employment) Housing (for instance, number homeless or in insecure accommodation)

Topic	Pharmacological interventions for the prevention of PTSD in adults
	Functional impairment (as assessed with a validated scale including the Work and Social Adjustment Scale [WSAS]) Relationship difficulties (with spouse and/or children) Quality of life (as assessed with a validated scale including the 36-item Short-Form Survey [SF-36] and Warwick-Edinburgh Mental Well-being Scale [WEMWBS]) Coexisting conditions (note that target of intervention should be PTSD symptoms): Symptoms of and recovery from a coexisting condition Self-harm Suicide
Study design	Systematic reviews of RCTs RCTs
Include unpublished data?	Clinical trial registries (ISRCTN and ClinicalTrials.gov) will be searched to identify any relevant unpublished trials and authors will be contacted to request study reports (where these are not available online). Unpublished data will only be included where a full study report is available with sufficient detail to properly assess the risk of bias. Authors of unpublished evidence will be asked for permission to use such data, and will be informed that summary data from the study and the study's characteristics will be published in the full guideline Conference abstracts and dissertations will not be included.
Restriction by date?	All relevant studies from existing reviews from the 2005 guideline will be carried forward. No restriction on date for the updated search.
Minimum sample size	N = 10 in each arm
Study setting	Primary, secondary, tertiary, social care and community settings. Prevention provided to troops on operational deployment or exercise will not be covered.
The review strategy	Reviews If existing systematic reviews are found, the GC will assess their quality, completeness, and applicability to the NHS and to the scope of the guideline. If the GC agrees that a systematic review appropriately addresses a review question, a search for studies published since the review will be conducted.

Topic	Pharmacological interventions for the prevention of PTSD in adults
	Data Extraction (selection and coding) Citations from each search will be downloaded into EndNote and duplicates removed. Titles and abstracts of identified studies will be screened by two reviewers for inclusion against criteria, until a good inter-rater reliability has been observed (percentage agreement =>90% or Kappa statistics, K>0.60). Initially 10% of references will be double-screened. If inter-rater agreement is good then the remaining references will be screened by one reviewer. All primary-level studies included after the first scan of citations will be acquired in full and re-evaluated for eligibility at the time they are being entered into a study database (standardised template created in Microsoft Excel). At least 10% of data extraction will be double-coded. Discrepancies or difficulties with coding will be resolved through discussion between reviewers or the opinion of a third reviewer will be sought. Non-English-language papers will be excluded (unless data can be obtained from an existing review). Data Analysis Where data is available, meta-analysis using a fixed-effects model will be used to combine results from similar studies. Heterogeneity will be considered and if a random-effects model is considered more appropriate it will be conducted. For risk of bias, outcomes will be downgraded if the randomisation and/or allocation concealment methods are unclear or inadequate. Outcomes will also be downgraded if no attempts are made to blind the assessors or participants in some way, i.e. by either not knowing the aim of the study or the result from other tests. Outcomes will also be downgraded if there is considerable missing data (see below). Handling missing data: Where possible an intention to treat approach will be used. Outcomes will be downgraded if there is a dropout of more than 20%, or if there was a difference of >20% between the groups. For heterogeneity: outcomes will be downgraded once if I2>50%, twice if I2 >80% For imprecision: outcomes will be downgraded if: Step 1: If the 95% CI is imprecise i.e. crosses 0.8 or 1.25 (dichotomous) or -0.5 or 0.5 (for continuous). Outcomes will be downgraded one or two levels depending on how many lines it crosses. Step 2: If the clinical decision threshold is not crossed, we will consider whether the criterion for Optimal Information Size is met, if not we will downgrade one level for the following. for dichotomous outcomes: <300 events

Topic	Pharmacological interventions for the prevention of PTSD in adults
	for continuous outcomes: <400 participants For clinical effectiveness, if studies report outcomes using the same scale mean differences will be considered, if not standardized mean differences (SMDs) will be considered and the following criteria will be used: SMD <0.2 too small to likely show an effect SMD 0.2 small effect SMD 0.5 moderate effect SMD 0.8 large effect RR <0.8 or >1.25 clinical benefit Anything less (RR >0.8 and <1.25), the absolute numbers will be looked at to make a decision on whether there may be a clinical effect.
Heterogeneity (sensitivity analysis and subgroups)	Where substantial heterogeneity exists, sensitivity analyses will be considered, for instance: Studies with <50% completion data (drop out of >50%) will be excluded Where possible, the influence of subgroups will be considered, including subgroup analyses giving specific consideration to the groups outlined in the sub-question section and to the following groups: Trauma type (including single incident relative to chronic exposure) Duration of intervention (for instance, short-term [≤12 weeks] relative to long-term [>12 weeks]) Intensity of intervention (for instance, low intensity [≤15 sessions] relative to high intensity [>15 sessions]) Format of intervention (individual relative to group) Mode of intervention delivery (including digital relative to face-to-face) First-line prevention relative to second-line prevention and prevention-resistant PTSD (≥2 inadequate preventions) Acute PTSD symptoms (clinically important PTSD symptoms for less than 3 months) relative to chronic PTSD symptoms (clinically important PTSD symptoms for 3 months or more)
Notes	Practical and social support (area of scope) is covered quantitatively by interventions listed under psychosocial interventions: • Supported employment (including individual placement and support [IPS] supported employment and Veterans Health Administration Vocational Rehabilitation Programme [VRP]) • Practical support (including financial and housing) • Peer support (including self-help groups and support groups)

Appendix B – Literature search strategies

Literature search strategies for 2.1 For adults at risk of PTSD, what are the relative benefits and harms of psychological, psychosocial or other non-pharmacological interventions targeted at PTSD symptoms?

Clinical evidence

Database: Medline

Last searched on: **Epub Ahead of Print, In-Process & Other Non-Indexed Citations, Ovid MEDLINE(R) Daily and Ovid MEDLINE(R), Embase, PsycINFO**

Date of last search: 29 January 2018

#	Searches
1	*acute stress/ or *behavioural stress/ or *emotional stress/ or *critical incident stress/ or *mental stress/ or *posttraumatic stress disorder/ or *psychotrauma/
2	1 use emez
3	stress disorders, traumatic/ or combat disorders/ or psychological trauma/ or stress disorders, post-traumatic/ or stress disorders, traumatic, acute/ or stress, psychological/
4	3 use mesz, prem
5	exp posttraumatic stress disorder/ or acute stress disorder/ or combat experience/ or emotional trauma/ or post-traumatic stress/ or traumatic neurosis/ or trauma/ or psychological stress/ or chronic stress/
6	5 use psyh
7	(railway spine or (rape adj2 trauma*) or reexperienc* or re experienc* or torture syndrome or traumatic neuros* or traumatic stress).ti,ab.
8	(trauma* and (avoidance or grief or horror or death* or nightmare* or night mare* or emotion*)).ti,ab.
9	(posttraumatic* or post traumatic* or stress disorder* or acute stress or ptsd or asd or desnos or (combat neuros* or combat syndrome or concentration camp syndrome or extreme stress or flashback* or flash back* or hypervigilan* or hypervigilen* or psych* stress or psych* trauma* or psycho?trauma* or psychotrauma*) or (posttrauma* or traumagenic* or traumatic stress*)).ti,ab.
10	or/2,4,6-9
11	*psychotherapy/ use emez or psychotherapy/ use mesz, prem,psyh
12	(((psycholog* or psycho social* or psychosocial*) adj3 (intervention* or program* or therap* or treat*)) or psychotherap* or psycho therap* or talk* therap* or therapeutic technique* or therapist* or third wave or time limited).ti,ab,sh.
13	exp *behavior therapy/ or exp *cognitive therapy/
14	13 use emez
15	exp behavior therapy/ use mesz, prem
16	exp behavior therapy/ or exp cognitive behavior therapy/
17	16 use psyh
18	(((behaviour* or behavior*) adj2 cognitiv*) or cbt or ccbt or ((behav* or cognitive*) adj3 (intervention* or manag* or program* or restructure* or therap* or treat*)) or (stress inoculation adj2 (intervention* or program* or therap* or train* or treat*)) or (behav* adj2 activat*) or ((trauma adj (based or focused or led)) or exposure based or prolonged exposure)).ti,ab.
19	*emotion/ use emez or emotions/ use mesz, prem
20	emotion focused therapy/ or sympathy/

#	Searches
21	20 use psyh
22	(((compassion or emotion* or emotive*) adj (based or focused or led)) or emotional processing or ((compassion or emotion* or emotive*) adj3 (coach* or intervention* or program* or therap* or treat*))).ti,ab.
23	exposure therapy/ or narrative therapy/ or virtual reality exposure therapy/
24	23 use emez
25	implosive therapy/ or narrative therapy/ or virtual reality exposure therapy/
26	25 use mesz, prem
27	exposure therapy/ or narrative therapy/ or virtual reality/
28	27 use psyh
29	(((augmented or virtual) adj2 reality) or (virtual adj (environment or restorative)) or ((exposure or implosive or virtual reality) adj2 (intervention* or program* or therap* or train*))).ti,ab.
30	((imagery adj2 (rehears* or re hears*)) or (((lower* or reduc*) adj3 (bad dream* or nightmare*)) and (intervention* or program* or therap* or treat*)) or ((intervention* or program* or therap* or treat*) adj3 nightmare*)).mp. or ((presleep or presleep) adj2 imagery).ti,ab.
31	(mindfulness or ((exposure or narrative) adj therapy)).sh.
32	(kidnet or mindful* or narrative therap*).ti,ab.
33	exp "debriefing (psychological)"/ use psyh
34	debrief*.ti,ab.
35	eye movement desensitization reprocessing/ use mesz, prem or eye movement desensitization therapy/ use psyh or (emdr or (eye movement adj2 desensiti*)).ti,ab.
36	hypnosis/ use emez or exp hypnosis/ use mesz, prem or exp hypnotherapy/ use psyh or (hypnosis or hypnotherap*).ti,ab.
37	psychodynamic psychotherapy/ use emez or psychotherapy, psychodynamic/ use mesz, prem or psychodynamic psychotherapy/ use psyh or repetitive transcranial magnetic stimulation/ use emez or Transcranial Magnetic Stimulation/ use mesz, prem, psyh
38	((psychodynamic or (dynamic adj (psychotherapy* or therap*)) or incident reduction) or ((brain or transcranial) adj2 stimulat*) or rtms).ti,ab.
39	(psychoanal* or psychosomatic*).ti,ab.
40	exp counseling/ use emez,mesz,psyh or counsel*.ti,ab.
41	(hg therap* or human givens).ti,ab.
42	psychosomatic disorder/th use emez or exp somatoform disorders/th use mesz, prem
43	(exp somatoform disorders/ or somatization/) and (intervention* or program* or therap* or treat*).ti,ab,hw. use psyh
44	(psychosomatic* or somatherap* or somatic*).ti,ab.
45	(emotional freedom or holistic or thought field).ti,ab.
46	dance therap*.ti,ab,sh.
47	couple therapy/ or family therapy/ or marital therapy/ or exp parent/ed
48	47 use emez
49	couples therapy/ or family therapy/ or marital therapy/ or exp parents/ed
50	49 use mesz, prem
51	couples therapy/ or family intervention/ or exp family therapy/ or exp marriage counseling/ or parent training/
52	51 use psyh
53	(((con?joint or couple* or family or families or husband* or marriage* or marital* or partner* or relations* or spous* or wife or wives* or (child* adj5 parent*)) adj6 (counsel* or intervention* or program* or support* or therap* or treat*)) or ((couples* or family* or relations*) adj (based

#	Searches
	or focused or led)) or ecological therap* or expressed emotion or family dynamics or family relationships).tw.
54	((child* adj2 family traumatic stress intervention) or cftsi).ti,ab.
55	play therapy.sh.
56	(doll therap* or ((play or playful) adj3 (intervention* or program* or therap* or treat*)) or sandplay or sand play).ti,ab.
57	meditation.sh. or meditat*.ti,ab.
58	mindfulness.sh. or (mbsr or mindful*).ti,ab.
59	exp horticulture/ or occupational therapy/ or recreational therapy/
60	59 use emez
61	horticultural therapy/ or occupational therapy/ or recreation therapy/
62	61 use mesz, prem
63	exp "nature (environment)"/ or horticulture therapy/ or recreation therapy/ or occupational therapy/
64	63 use psyh
65	((nature adj (assisted or based)) or (nature adj3 (intervention* or program* or therap* or treat*)) or ecotherap* or e cotherap* or gardening or horticult* or leisure activit* or naturopath* or occupational therap*).ti,ab. or exp animal assisted therapy/ use emez, mesz or animal assisted therapy/ use psyh or (((animal* or dog* or equine* or horse* or pet or pets) adj2 (assist* or based or facilitat*)) or ((animal* or dog* or equine* or horse* or pet or pets) adj3 (intervention* or therap* or treat* or program*))).ti,ab.
66	psychoeducation.sh. or (psychoed* or psycho ed*).ti,ab.
67	exp acupuncture/ use emez or exp alternative medicine/ use emez or biofeedback/ or massage/ use emez or meditation/ use emez or acupressure/ use mesz, prem or massage/ use mesz, prem or acupuncture/ use mesz, prem or exp complementary therapies/ use mesz, prem or exp alternative medicine/ use psyh or biofeedback/ use psyh or massage/ use psyh or mind body therapy/ use psyh
68	(chinese medicine or medicine, chinese traditional or (moxibustion or electroacupuncture)).sh,id. or ((alternative or complementary) adj2 (medicine* or therap*)).ti,ab,sh. or (acu point* or acupoint* or acupressur* or acupunctur* or (ching adj2 lo) or cizhen or dianzhen or electroacupunctur* or (jing adj2 luo) or jingluo or massag* or needle therap* or tapping or zhenjiu or zhenci).tw.
69	exp *exercise/ use emez or exp *kinesiotherapy/ use emez or exp exercise/ use mesz, prem or exercise therapy/ use mesz, prem or exp exercise/ use psyh (physiotherap* or physio therap* or rehab*).ti,ab,hw.
70	(((balance or flexibility or resistance or sitting* or strenth*) adj2 (exercise* or train*)) or aerobic* or anaerobic* or bowls or dancing or dance or cycling or cycle* or elliptical train* or jogging or low impact activit* or running or swimming or sprinting or swim*1 or walking or yoga or tai chi or weight train* or (weight and brain* and (change* or increas* or volum*))).ti,ab.
71	friendship/ or peer counseling/ or peer group/ or self help/ or self care/ or social network/ or social support/ or support group/
72	71 use emez
73	community networks/ or friends/ or exp peer group/ or self care/ or self-help groups/ or social networking/ or social support/
74	73 use mesz, prem
75	friendship/ or network therapy/ or exp social networks/ or peer relations/ or peers/ or peer counseling/ or self care skills/ or exp self help techniques/ or social support/ or exp support groups/
76	75 use psyh

#	Searches
77	((self adj (administer* or assess* or attribut* or care or change or directed or efficacy or help* or guide* or instruct* or manag* or medicat* or monitor* or regulat* or reinforc* or re inforc* or support* or technique* or therap* or train* or treat*)) or selfadminister* or selfassess* or selfattribut* or selfcare or selfchange or selfdirected or selfefficacy or selfhelp* or selfguide* or selfinstruct* or selfmanag* or selfmedicat* or selfmonitor* or selfregulat* or selfreinforc* or self re inforc* or selfsupport* or selftechnique* or selftherap* or selftrain* or selftreat* or (wellness adj (therap* or train* or treat*))).ti,ab,sh.
78	(befriend* or be*1 friend* or buddy or buddies or ((community or lay or paid or support) adj (person or worker*))).ti,ab.
79	(((consumer* or famil* or friend* or lay or mutual* or peer* or social* or spous* or voluntary or volunteer*) adj3 (assist* or advice* or advis* or counsel* or educat* or forum* or help* or mentor* or network* or support* or visit*)) or ((consumer* or famil* or peer* or self help or social* or support* or voluntary or volunteer*) adj2 group*) or ((consumer* or famil* or friend* or lay or mutual* or peer* or self help or social* or spous* or support* or voluntary or volunteer*) adj3 (intervention* or program* or rehab* or therap* or service* or skill* or treat*)) or (((consumer* or famil* or friend* or lay* or peer* or spous* or user* or support* or voluntary or volunteer*) adj (based or counsel* or deliver* or interact* or led or mediat* or operated or provides or provider* or run*)) or ((consumer* or famil* or friend* or lay* or peer* or relation* or spous* or support*) adj3 trust*) or voluntary work*)).ti,ab.
80	(((lay or peer*) adj3 (advis* or consultant or educator* or expert* or facilitator* or instructor* or leader* or mentor* or person* or tutor* or worker*)) or expert patient* or mutual aid).ti,ab.
81	(peer* adj3 (assist* or counsel* or educat* or program* or rehab* or service* or supervis*)).ti,ab.
82	((psychoeducat* or psycho educat*) adj3 (group or network* or service*)).ti,ab.
83	((psychosocial or social) adj work*).ti,ab.
84	((ptsd or posttrauma* or post trauma* or trauma*) adj2 support*).ti,ab.
85	recovery support.ti,ab.
86	financial management/ use emez or financial support/ use mesz, prem or finance/ use psyh
87	((financ* or money) adj2 (assist* or educat* or guidance or intervention* or program* or support* or train*)).ti,ab.
88	assisted living facility/ or emergency shelter/ or halfway house/ or housing/ or independent living/ or residential home/ or residential home/
89	88 use emez
90	assisted living facilities/ or emergency shelter/ or group homes/ or halfway houses/ or housing/ or independent living/ or residential facilities/
91	90 use mesz, prem or (exp assisted living/ or exp shelters/ or exp group homes/ or exp halfway Houses/ or housing/ or exp residential care Institutions/) use psyh
92	assisted living / use psyh or shelters/ use psyh or group homes/ use psyh or halfway houses/ use psyh or housing/ use psyh or residential care institutions/ use psyh or ((resident* or hous* or accommod* or commun* or comu* or home*) adj5 (support* or support* or shelter* or outreach* or visit* or appointment*)).ti,ab.
93	(residential treatm* or residential facility* or supported hous* or public hous*).ti,ab.
94	(accomod* or assertive community treatment* or home* or housing* or outreach* or residential*).ti,ab.
95	absenteeism/ or daily life activity/ or employment/ or medical leave/ or mentoring/ or occupational health/ or occupational therapy/ or return to work/ or supported employment/ or unemployment/ or vocational guidance/ or vocational rehabilitation/ or work capacity/ or work/
96	95 use emez
97	absenteeism/ or "activities of daily living"/ or employment, supported/ or employment/ or mentoring/ or occupational health/ or occupational therapy/ or rehabilitation, vocational/ or return to work/ or sick leave/ or unemployment/ or vocational guidance/ or work/
98	97 use mesz, prem

#	Searches
99	"activities of daily living"/ or exp coaching/ or employee absenteeism/ or employment status/ or occupational guidance/ or occupational health/ or occupational therapy/ or reemployment/ or unemployment/ or vocational counselors/ or exp vocational rehabilitation/
100	99 use psyh
101	(((supp* or transitional*) adj5 (employ* or work*)) or individual placement or (placement* adj3 (employ* or work*))).ti,ab.
102	((employ* or placement* or psychosocial* or psycho-social* or occupation* or soc* or vocation* or work* or job* or counsel*) adj5 rehab*).ti,ab.
103	(sheltered work* or vocatio* or fountain house* or fountainhouse* or clubhouse* or club house* or work therap*).ti,ab.
104	(transitional employment or rehabilitation counsel* or (occupational adj (health or medicine)) or work* adjustment).ti,ab.
105	((performance adj (activit* or coach* or management or occupation*)) or coaching).ti,ab.
106	(((sheltered or permitted or voluntary or vocational or return* or rehabilitat*) adj3 work*) or work capacity or reemploy* or re employ* or job retention or work capacity).ti,ab.
107	((employ* or job or occupation* or vocation* or work*) adj5 (counsel* or educat* or guidance* or intervention* or program* or rehab* or reintegrat* or re integrat* or support* or therap* or train*)).ti,ab.
108	placement.ti,ab.
109	or/11-12,14-15,17-19,21-22,24,26,28-46,48,50,52-58,60,62,64-70,72,74,76-87,89,91-94,96,98,100-108
110	meta analysis/ or "meta analysis (topic)"/ or systematic review/
111	110 use emez
112	meta analysis.sh,pt. or "meta-analysis as topic"/ or "review literature as topic"/
113	112 use mesz, prem
114	(literature review or meta analysis).sh,id,md. or systematic review.id,md.
115	114 use psyh
116	(exp bibliographic database/ or (((electronic or computer* or online) adj database*) or bids or cochrane or embase or index medicus or isi citation or medline or psyclit or psychlit or scisearch or science citation or (web adj2 science)).ti,ab.) and (review*.ti,ab,sh,pt. or systematic*.ti,ab.)
117	116 use emez
118	(exp databases, bibliographic/ or (((electronic or computer* or online) adj database*) or bids or cochrane or embase or index medicus or isi citation or medline or psyclit or psychlit or scisearch or science citation or (web adj2 science)).ti,ab.) and (review*.ti,ab,sh,pt. or systematic*.ti,ab.)
119	118 use mesz, prem
120	(computer searching.sh,id. or (((electronic or computer* or online) adj database*) or bids or cochrane or embase or index medicus or isi citation or medline or psyclit or psychlit or scisearch or science citation or (web adj2 science)).ti,ab.) and (review*.ti,ab,pt. or systematic*.ti,ab.)
121	120 use psyh
122	((analy* or assessment* or evidence* or methodol* or quantativ* or systematic*) adj2 (overview* or review*)).tw. or ((analy* or assessment* or evidence* or methodol* or quantativ* or systematic*).ti. and review*.ti,pt.) or (systematic* adj2 search*).ti,ab.
123	(metaanal* or meta anal*).ti,ab.
124	(research adj (review* or integration)).ti,ab.
125	reference list*.ab.
126	bibliograph*.ab.

#	Searches
127	published studies.ab.
128	relevant journals.ab.
129	selection criteria.ab.
130	(data adj (extraction or synthesis)).ab.
131	(handsearch* or ((hand or manual) adj search*)).ti,ab.
132	(mantel haenszel or peto or dersimonian or der simonian).ti,ab.
133	(fixed effect* or random effect*).ti,ab.
134	((pool* or combined or combining) adj2 (data or trials or studies or results)).ti,ab.
135	or/111,113,115,117,119,121-134
136	exp "clinical trial (topic)"/ or exp clinical trial/ or crossover procedure/ or double blind procedure/ or placebo/ or randomization/ or random sample/ or single blind procedure/
137	136 use emez
138	exp clinical trial/ or exp "clinical trials as topic"/ or cross-over studies/ or double-blind method/ or placebos/ or random allocation/ or single-blind method/
139	138 use mesz, prem
140	(clinical trials or placebo or random sampling).sh,id.
141	140 use psyh
142	(clinical adj2 trial*).ti,ab.
143	(crossover or cross over).ti,ab.
144	(((single* or doubl* or trebl* or tripl*) adj2 blind*) or mask* or dummy or doubleblind* or singleblind* or trebleblind* or tripleblind*).ti,ab.
145	(placebo* or random*).ti,ab.
146	treatment outcome*.md. use psyh
147	animals/ not human*.mp. use emez
148	animal*/ not human*/ use mesz, prem
149	(animal not human).po. use psyh
150	or/137,139,141-146
151	150 not (or/147-149)
152	or/135,151
153	10 and 109 and 152

Database: CDSR, DARE, HTA, CENTRAL

Date of last search: 29 January 2018

#	Searches
#1	MeSH descriptor: Stress Disorders, Traumatic this term only
#2	MeSH descriptor: Combat Disorders this term only
#3	MeSH descriptor: Psychological Trauma this term only
#4	MeSH descriptor: Stress Disorders, Post-Traumatic this term only
#5	MeSH descriptor: Stress Disorders, Traumatic, Acute this term only
#6	MeSH descriptor: Stress, Psychological this term only
#7	("railway spine" or (rape near/2 trauma*) or reexperienc* or "re experienc*" or "torture syndrome" or "traumatic neuros*" or "traumatic stress"):ti (Word variations have been searched)
#8	("railway spine" or (rape near/2 trauma*) or reexperienc* or "re experienc*" or "torture syndrome" or "traumatic neuros*" or "traumatic stress"):ab (Word variations have been searched)

#	Searches
#9	(trauma* and (avoidance or grief or horror or death* or nightmare* or "night mare*" or emotion*)):ti (Word variations have been searched)
#10	(trauma* and (avoidance or grief or horror or death* or nightmare* or "night mare*" or emotion*)):ab (Word variations have been searched)
#11	(posttraumatic* or "post traumatic*" or "stress disorder*" or "acute stress" or ptsd or asd or desnos or ("combat neuros*" or "combat syndrome" or "concentration camp syndrome" or "extreme stress" or flashback* or "flash back*" or hypervigilan* or hypervigilen* or "psych* stress" or "psych* trauma*" or psychotrauma* or psychotrauma*) or (posttrauma* or traumagenic* or "traumatic stress*")):ti (Word variations have been searched)
#12	(posttraumatic* or "post traumatic*" or "stress disorder*" or "acute stress" or ptsd or asd or desnos or ("combat neuros*" or "combat syndrome" or "concentration camp syndrome" or "extreme stress" or flashback* or "flash back*" or hypervigilan* or hypervigilen* or "psych* stress" or "psych* trauma*" or psychotrauma* or psychotrauma*) or (posttrauma* or traumagenic* or "traumatic stress*")):ab (Word variations have been searched)
#13	#1 or #2 or #3 or #4 or #5 or #6 or #7 or #8 or #9 or #10 or #11 or #12

Database: CINAHL PLUS

Date of last search: 29 January 2018

#	Searches
s52	s6 and s51
s51	s40 or s50
s50	s48 not s49
s49	(mh "animals") not (mh "human")
s48	s41 or s42 or s43 or s44 or s45 or s46 or s47
s47	ti (placebo* or random*) or ab (placebo* or random*)
s46	ti (single blind* or double blind* or treble blind* or mask* or dummy* or singleblind* or doubleblind* or trebleblind* or tripleblind*) or ab (single blind* or double blind* or treble blind* or mask* or dummy* or singleblind* or doubleblind* or trebleblind* or tripleblind*)
s45	ti (crossover or cross over) or ab (crossover or cross over)
s44	ti clinical n2 trial* or ab clinical n2 trial*
s43	(mh "crossover design") or (mh "placebos") or (mh "random assignment") or (mh "random sample")
s42	mw double blind* or single blind* or triple blind*
s41	(mh "clinical trials+")
s40	s7 or s8 or s9 or s10 or s11 or s12 or s13 or s14 or s15 or s16 or s17 or s18 or s19 or s20 or s21 or s22 or s23 or s29 or s30 or s31 or s34 or s35 or s36 or s37 or s38 or s39
s39	ti (analy* n5 review* or evidence* n5 review* or methodol* n5 review* or quantativ* n5 review* or systematic* n5 review*) or ab (analy* n5 review* or assessment* n5 review* or evidence* n5 review* or methodol* n5 review* or qualitativ* n5 review* or quantativ* n5 review* or systematic* n5 review*)
s38	ti (pool* n2 results or combined n2 results or combining n2 results) or ab (pool* n2 results or combined n2 results or combining n2 results)
s37	ti (pool* n2 studies or combined n2 studies or combining n2 studies) or ab (pool* n2 studies or combined n2 studies or combining n2 studies)
s36	ti (pool* n2 trials or combined n2 trials or combining n2 trials) or ab (pool* n2 trials or combined n2 trials or combining n2 trials)
s35	ti (pool* n2 data or combined n2 data or combining n2 data) or ab (pool* n2 data or combined n2 data or combining n2 data)
s34	s32 and s33

#	Searches
s33	ti review* or pt review*
s32	ti analy* or assessment* or evidence* or methodol* or quantativ* or qualitativ* or systematic*
s31	ti “systematic* n5 search*” or ab “systematic* n5 search*”
s30	ti “systematic* n5 review*” or ab “systematic* n5 review*”
s29	(s24 or s25 or s26) and (s27 or s28)
s28	ti systematic* or ab systematic*
s27	tx review* or mw review* or pt review*
s26	(mh "cochrane library")
s25	ti (bids or cochrane or embase or “index medicus” or “isi citation” or medline or psyclit or psychlit or scisearch or “science citation” or web n2 science) or ab (bids or cochrane or “index medicus” or “isi citation” or psyclit or psychlit or scisearch or “science citation” or web n2 science)
s24	ti (“electronic database*” or “bibliographic database*” or “computeri?ed database*” or “online database*”) or ab (“electronic database*” or “bibliographic database*” or “computeri?ed database*” or “online database*”)
s23	(mh "literature review")
s22	pt systematic* or pt meta*
s21	ti (“fixed effect*” or “random effect*”) or ab (“fixed effect*” or “random effect*”)
s20	ti (“mantel haenszel” or peto or dersimonian or “der simonian”) or ab (“mantel haenszel” or peto or dersimonian or “der simonian”)
s19	ti (handsearch* or "hand search*" or "manual search*") or ab (handsearch* or "hand search*" or "manual search*")
s18	ab "data extraction" or "data synthesis"
s17	ab "selection criteria"
s16	ab "relevant journals"
s15	ab "published studies"
s14	ab bibliograph*
s13	ti "reference list*"
s12	ab "reference list*"
s11	ti (“research review*” or “research integration”) or ab (“research review*” or “research integration”)
s10	ti (metaanal* or “meta anal*” or metasynthes* or “meta synethes*”) or ab (metaanal* or “meta anal*” or metasynthes* or “meta synethes*”)
s9	(mh "meta analysis")
s8	(mh "systematic review")
s7	(mh "literature searching+")
s6	s1 or s2 or s3 or s4 or s5
s5	ti ((posttraumatic* or "post traumatic*" or "stress disorder*" or "acute stress" or ptsd or asd or desnos or ("combat neuros*" or "combat syndrome" or "concentration camp syndrome" or "extreme stress" or flashback* or "flash back*" or hypervigilan* or hypervigilen* or "psych* stress" or "psych* trauma*" or psychotrauma* or psychotrauma*) or (posttrauma* or traumagenic* or "traumatic stress*"))) or ab ((posttraumatic* or "post traumatic*" or "stress disorder*" or "acute stress" or ptsd or asd or desnos or ("combat neuros*" or "combat syndrome" or "concentration camp syndrome" or "extreme stress" or flashback* or "flash back*" or hypervigilan* or hypervigilen* or "psych* stress" or "psych* trauma*" or psychotrauma* or psychotrauma*) or (posttrauma* or traumagenic* or "traumatic stress*")))
s4	ti ((trauma* and (avoidance or grief or horror or death* or nightmare* or "night mare*" or emotion*))) or ab ((trauma* and (avoidance or grief or horror or death* or nightmare* or "night mare*" or emotion*)))

#	Searches
s3	ti (("railway spine" or (rape near/2 trauma*) or reexperienc* or "re experienc*" or "torture syndrome" or "traumatic neuros*" or "traumatic stress")) or ab (("railway spine" or (rape near/2 trauma*) or reexperienc* or "re experienc*" or "torture syndrome" or "traumatic neuros*" or "traumatic stress"))
s2	(mh "stress, psychological")
s1	(mh "stress disorders, post-traumatic")

Health economic evidence

Note: evidence resulting from the health economic search update was screened to reflect the final dates of the searches that were undertaken for the clinical reviews (see review protocols).

Database: Medline

Last search on: **Epub Ahead of Print, In-Process & Other Non-Indexed Citations, Ovid MEDLINE(R) Daily and Ovid MEDLINE(R), Embase, PsycINFO**

Date of last search: 1 March 2018

#	Searches
1	*acute stress/ or *behavioural stress/ or *emotional stress/ or *critical incident stress/ or *mental stress/ or *posttraumatic stress disorder/ or *psychotrauma/
1	*acute stress/ or *behavioural stress/ or *emotional stress/ or *critical incident stress/ or *mental stress/ or *posttraumatic stress disorder/ or *psychotrauma/
2	1 use emez
3	stress disorders, traumatic/ or combat disorders/ or psychological trauma/ or stress disorders, post-traumatic/ or stress disorders, traumatic, acute/ or stress, psychological/
4	3 use mesz, prem
5	exp posttraumatic stress disorder/ or acute stress disorder/ or combat experience/ or "debriefing (psychological)"/ or emotional trauma/ or post-traumatic stress/ or traumatic neurosis/ or "trauma"/ or stress reactions/ or psychological stress/ or chronic stress/
6	5 use psyh
7	(railway spine or (rape adj2 trauma*) or reexperienc* or re experienc* or torture syndrome or traumatic neuros* or traumatic stress).ti,ab.
8	(trauma* and (avoidance or grief or horror or death* or nightmare* or night mare* or emotion*)).ti,ab.
9	(posttraumatic* or post traumatic* or stress disorder* or acute stress or ptsd or asd or desnos or (combat neuros* or combat syndrome or concentration camp syndrome or extreme stress or flashback* or flash back* or hypervigilan* or hypervigilen* or psych* stress or psych* trauma* or psycho?trauma* or psychotrauma*)).ti,ab.
10	or/2,4,6-9
11	budget/ or exp economic evaluation/ or exp fee/ or funding/ or exp health care cost/ or health economics/ or exp pharmacoeconomics/ or resource allocation/
12	151 use emez
13	exp budgets/ or exp "costs and cost analysis"/ or economics/ or exp economics, hospital/ or exp economics, medical/ or economics, nursing/ or economics, pharmaceutical/ or exp "fees and charges"/ or value of life/
14	153 use mesz, prem
15	exp "costs and cost analysis"/ or cost containment/ or economics/ or finance/ or funding/ or "health care economics"/ or pharmacoeconomics/ or exp professional fees/ or resource allocation/
16	155 use psyh

#	Searches
17	(cost* or economic* or pharmacoeconomic* or pharmaco economic*).ti. or (cost* adj2 (effective* or utilit* or benefit* or minimi*)).ab. or (budget* or fee or fees or financ* or price or prices or pricing or resource* allocat* or (value adj2 (monetary or money))).ti,ab.
18	or/12,14,16-17
19	decision theory/ or decision tree/ or monte carlo method/ or nonbiological model/ or (statistical model/ and exp economic aspect/) or stochastic model/ or theoretical model/
20	159 use emez
21	exp decision theory/ or markov chains/ or exp models, economic/ or models, organizational/ or models, theoretical/ or monte carlo method/
22	161 use mesz, prem
23	exp decision theory/ or exp stochastic modeling/
24	163 use psyh
25	((decision adj (analy* or model* or tree*)) or economic model* or markov).ti,ab.
26	or/20,22,24-25
27	quality adjusted life year/ or "quality of life index"/ or short form 12/ or short form 20/ or short form 36/ or short form 8/ or sickness impact profile/
28	167 use emez
29	quality-adjusted life years/ or sickness impact profile/
30	169 use mesz, prem
31	(((disability or quality) adj adjusted) or (adjusted adj2 life)).ti,ab.
32	(disutili* or dis utili* or (utilit* adj1 (health or score* or value* or weigh*))).ti,ab.
33	(health year equivalent* or hye or hyes).ti,ab.
34	(daly or qal or qald or qale or qaly or qtime* or qwb*).ti,ab.
35	discrete choice.ti,ab.
36	(euroqol* or euro qol* or eq5d* or eq 5d*).ti,ab.
37	(hui or hui1 or hui2 or hui3).ti,ab.
38	(((general or quality) adj2 (wellbeing or well being)) or quality adjusted life or qwb or (value adj2 (money or monetary))).ti,ab.
39	(qol or hql* or hqol* or hrqol or hr ql or hrql).ti,ab.
40	rosser.ti,ab.
41	sickness impact profile.ti,ab.
42	(standard gamble or time trade* or tto or willingness to pay or wtp).ti,ab.
43	(sf36 or sf 36 or short form 36 or shortform 36 or shortform36).ti,ab.
44	(sf6 or sf 6 or short form 6 or shortform 6 or shortform6).ti,ab.
45	(sf12 or sf 12 or short form 12 or shortform 12 or shortform12).ti,ab.
46	(sf16 or sf 16 or short form 16 or shortform 16 or shortform16).ti,ab.
47	(sf20 or sf 20 or short form 20 or shortform 20 or shortform20).ti,ab.
48	(sf8 or sf 8 or short form 8 or shortform 8 or shortform8).ti,ab.
49	or/28,30-48
50	or/18,26,49

Database: HTA, NHS EED

Date of last search: 1 March 2018

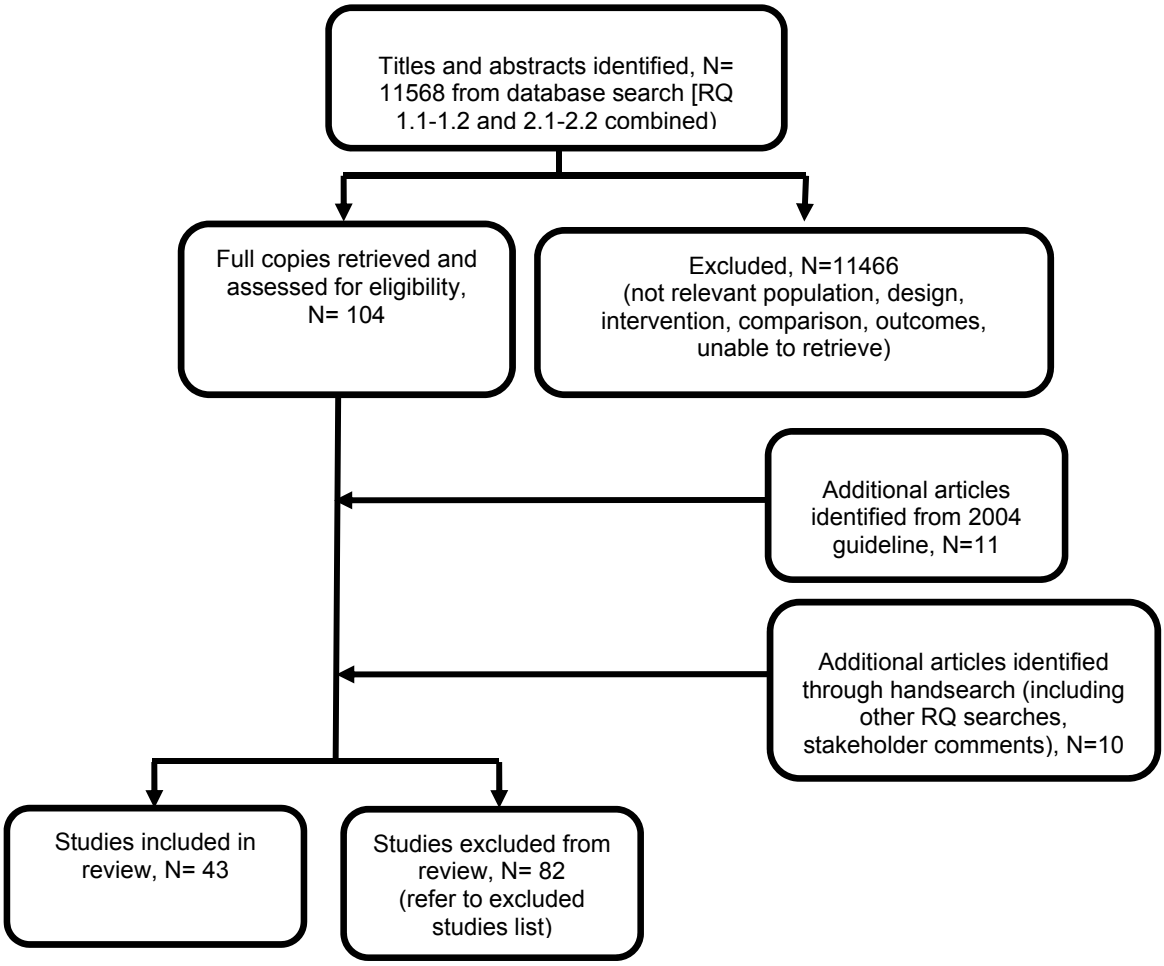
#	Searches
#1	MeSH descriptor: Stress Disorders, Traumatic this term only
#2	MeSH descriptor: Combat Disorders this term only

#	Searches
#3	MeSH descriptor: Psychological Trauma this term only
#4	MeSH descriptor: Stress Disorders, Post-Traumatic this term only
#5	MeSH descriptor: Stress Disorders, Traumatic, Acute this term only
#6	MeSH descriptor: Stress, Psychological this term only
#7	("railway spine" or (rape near/2 trauma*) or reexperienc* or "re experienc*" or "torture syndrome" or "traumatic neuros*" or "traumatic stress"):ti (Word variations have been searched)
#8	("railway spine" or (rape near/2 trauma*) or reexperienc* or "re experienc*" or "torture syndrome" or "traumatic neuros*" or "traumatic stress"):ab (Word variations have been searched)
#9	(trauma* and (avoidance or grief or horror or death* or nightmare* or "night mare*" or emotion*)):ti (Word variations have been searched)
#10	(trauma* and (avoidance or grief or horror or death* or nightmare* or "night mare*" or emotion*)):ab (Word variations have been searched)
#11	(posttraumatic* or "post traumatic*" or "stress disorder*" or "acute stress" or ptsd or asd or desnos or ("combat neuros*" or "combat syndrome" or "concentration camp syndrome" or "extreme stress" or flashback* or "flash back*" or hypervigilan* or hypervigilen* or "psych* stress" or "psych* trauma*" or psychotrauma* or psychotrauma*) or (posttrauma* or traumagenic* or "traumatic stress*")):ti (Word variations have been searched)
#12	(posttraumatic* or "post traumatic*" or "stress disorder*" or "acute stress" or ptsd or asd or desnos or ("combat neuros*" or "combat syndrome" or "concentration camp syndrome" or "extreme stress" or flashback* or "flash back*" or hypervigilan* or hypervigilen* or "psych* stress" or "psych* trauma*" or psychotrauma* or psychotrauma*) or (posttrauma* or traumagenic* or "traumatic stress*")):ab (Word variations have been searched)
#13	#1 or #2 or #3 or #4 or #5 or #6 or #7 or #8 or #9 or #10 or #11 or #12

Appendix C – Clinical evidence study selection

Clinical evidence study selection for "For adults at risk of PTSD, what are the relative benefits and harms of psychological, psychosocial or other non-pharmacological interventions targeted at PTSD symptoms?"

Figure 1: Flow diagram of clinical article selection for review



Appendix D – Clinical evidence tables

Clinical evidence tables for "For adults at risk of PTSD, what are the relative benefits and harms of psychological, psychosocial or other non-pharmacological interventions targeted at PTSD symptoms?"

Psychological: Trauma-focused CBT

Trauma-focused CBT (± psycho-education) versus waitlist or no treatment for the early prevention (intervention initiated ≤ 1 month) of PTSD in adults

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
Bryant 2008a	Trauma-focused CBT: CBT individual	Acute stress disorder/acute stress reaction diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Exposure to non-sexual violence - Nonsexual assault (63%); motor vehicle accident (37%)	90	Age range (mean): NR (35.4) Gender (% female): 58 BME (% non-white): 13 Country: Australia Coexisting conditions: 47% MDD; 4% anxiety disorder; 2% substance use disorder Lifetime experience of trauma (mean number of prior traumas/%	Inclusion criteria: aged 17-70 years; had been involved in a motor vehicle crash or nonsexual assault in the previous month; had a primary diagnosis of Acute Stress Disorder (diagnosed using the using the Acute Stress Disorder Interview). Exclusion criteria: had a history of psychosis, organic brain syndrome, current substance dependence or borderline personality disorder; presented a suicidal risk; were unable to converse in English

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					with previous trauma): NR Single or multiple incident index trauma: single	
Rothbaum 2012	Trauma-focused CBT: Brief exposure therapy/prolonged exposure (PE)	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	Mixed - Rape (34%); Nonsexual assault (27%); Motor vehicle accident (34%); Other (5%)	137	Age range (mean): 18-65 (31.5) Gender (% female): 65 BME (% non-white): 87 Country: US Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): 46% had previous trauma. Prior trauma exposure: Rape (12%); Nonsexual assault (13%); Motor vehicle accident (16%); Other (4%)	Inclusion criteria: aged 18- 65 years; presented to the emergency department within 72 hours of experiencing a trauma and met criterion A of the DSM-IV; spoke English; had a memory of the event; alert and oriented. Exclusion criteria: loss of consciousness longer than 5 minutes; current intoxication

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					Single or multiple incident index trauma: Single	
Wijesinghe 2015	Trauma-focused CBT + psychoeducation: Trauma-focused CBT session following psychoeducation session	Unclear	Unintentional injury/illness/medical emergency (Snakebite)	225	Age range (mean): NR (42.1) Gender (% female): 25 BME (% non-white): NR Country: Sri Lanka Coexisting conditions: 0.02% treated in intensive care Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Single	All snakebite victims admitted to hospital identified as being envenomed and requiring treatment with antivenom were eligible for inclusion. Exclusion criteria were those under 18 years of age, those with known mental illness, and those without basic fluency in the Sinhala language

BME=Black and Minority Ethnic; CBT=cognitive behavioural therapy; DSM=Diagnostic and Statistical Manual of mental disorders; ICD=International Classification of Diseases; MDD=major depressive disorders; N=number being randomised; NR=not reported;

Trauma-focused CBT (+/- TAU/psycho-education) versus TAU, attention-placebo or psychoeducational session for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
Foa 2006	Trauma-focused CBT: Brief individual CBT	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	Exposure to sexual abuse or assault - Sexual assault (63%) or non-sexual assault (37%)	90	Age range (mean): NR (33.7) Gender (% female): 100 BME (% non-white): 69 Country: US Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: single	Inclusion criteria: had recently experienced sexual or non-sexual assault; met DSM-IV symptom (not duration) criteria for PTSD (assessed using the PTSD Symptom Scale-Interview Version). Exclusion criteria: were assaulted by an intimate partner with whom they had an ongoing relationship; had primary diagnoses of organic mental disorder, schizophrenia, bipolar disorder, or current alcohol/drug dependence
Nixon 2016	Trauma-focused CBT: Cognitive processing therapy	Acute stress disorder/acute stress reaction diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Exposure to sexual abuse or assault - Rape or sexual assault. Relationship to perpetrator: stranger (46%); acquaintance or friend (43%); ex-intimate or relative (11%)	47	Age range (mean): NR (31) Gender (% female): 98 BME (% non-white): 13 Country: Coexisting conditions: 86% had at	Inclusion criteria: aged at least 18 years; had experienced rape or sexual assault in the past month; able to attend face-to-face counselling; had to meet criteria for Acute Stress Disorder; for those taking psychotropic medication this had to be stable for the 4-week period prior to beginning therapy. Exclusion criteria: uncontrolled psychosis; current substance dependence requiring immediate attention; insufficient English; significant cognitive

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					least one other comorbid diagnosis: Mood disorder (61%), Anxiety disorder (52%), Substance (28%) Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): 91% prior trauma: sexual (74%); physical (54%); other (89%) Single or multiple incident index trauma: Single	impairment or disability; significant suicide risk; ongoing traumatisation (e.g., being stalked)
O'Donnell 2012	Trauma-focused CBT: CBT individual	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	Motor Vehicle Collisions - Motor vehicle accident (67%); Assault (22%) - data not reported for mechanism of injury for all participants (N=41 rather than 46)	46	Age range (mean): 18-70 (35.9) Gender (% female): 39 BME (% non-white): NR Country: Australia	Inclusion criteria: aged 18-70 years; sustained an injury severe enough to warrant a hospital admission of greater than 24 hours; proficient in English; classified as high-risk (identified as high-risk using the Posttraumatic Adjustment Screen [PAS] and had persistently high depression or anxiety symptoms [scored≥ 30 on the PCL and/or ≥11 on either subscale of the HADS] at 4 weeks post-trauma and were then assessed by a clinical psychologist as

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					Coexisting conditions: 48% mild traumatic brain injury; 67% major depressive episode; 39% other (not PTSD) anxiety disorder Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): Single or multiple incident index trauma: Single	having clinically significant mental health symptoms using the CAPS and the MINI). Exclusion criteria: moderate or severe traumatic brain injury; currently psychotic or suicidal.
Price 2014	Trauma-focused CBT: Brief exposure therapy/prolonged exposure (PE)	Non-significant symptoms (below threshold and <50% maximum score on scale)	Mixed (35% sexual assault)	137	Age range (mean): NR (31.5) Gender (% female): 65 BME (% non-white): 78 Country: Coexisting conditions: NR Lifetime experience of	Inclusion criteria: individuals who presented at the emergency department (ED) after experiencing a Criterion A trauma according to the DSM-IV. Exclusion criteria: Not reported

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Unclear	
Wijesinghe 2015	Trauma-focused CBT + psychoeducation: Trauma-focused CBT session following psychoeducation session	Unclear	Unintentional injury/illness/medical emergency (Snakebite)	225	Age range (mean): NR (42.1) Gender (% female): 25 BME (% non-white): NR Country: Sri Lanka Coexisting conditions: 0.02% treated in intensive care Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple	All snakebite victims admitted to hospital identified as being envenomed and requiring treatment with antivenom were eligible for inclusion. Exclusion criteria were those under 18 years of age, those with known mental illness, and those without basic fluency in the Sinhala language

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					incident index trauma: Single	

BME=Black and Minority Ethnic; CAPS=clinician-administered PTSD symptom scale; CBT=cognitive behavioural therapy; DSM=Diagnostic and Statistical Manual of mental disorders; HADS=Hospital Anxiety and Depression scale; ICD=International Classification of Diseases; MINI=Mini-International Neuropsychiatric Interview; N=number being randomised; NR=not reported; PCL=PTSD Checklist; PTSD=post-traumatic stress disorder

Trauma-focused CBT versus supportive counselling for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
Bryant (unpublished)	Trauma-focused CBT: CBT individual	Acute stress disorder/acute stress reaction diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Mixed (Nonsexual assault or motor vehicle accident)	24	Age range (mean): 18-60 (31) Gender (% female): 67 BME (% non-white): NR Country: Australia Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Single	Participants were included if they: (1)had experienced non-sexual assault or a motor vehicle accident within the last 2 weeks; (2) had a diagnosis of Acute stress disorder (diagnosed by Acute Stress Disorder Interview). Reasons for exclusion NR

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
Bryant 1998/2003b	Trauma-focused CBT: Cognitive therapy	Acute stress disorder/acute stress reaction diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Motor Vehicle Collisions (58% motor vehicle accidents; 42% industrial accident)	24	Age range (mean): NR (32.6) Gender (% female): 58 BME (% non-white): NR Country: Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: single	Inclusion criteria: having been involved in either a motor vehicle accident or an industrial accident within the past 2 weeks, satisfying criteria for acute stress disorder (ASD); proficiency in English; aged 18-60 years. Exclusion criteria: current suicidal ideation; diagnosis of psychosis, organic mental disorder, or substance abuse; evidence of brain injury sustained in the trauma.
Bryant 1999/2003b	Trauma-focused CBT: Exposure therapy/prolonged exposure (PE)	Acute stress disorder/acute stress reaction diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Exposure to non-sexual violence - Nonsexual assault (53%); motor vehicle accidents (47%)	66	Age range (mean): NR (34) Gender (% female): 51 BME (% non-white): NR Country: Australia Coexisting conditions: NR Lifetime experience of trauma (mean	Inclusion criteria: having been involved in either a motor vehicle accident or a nonsexual assault within the past 2 weeks; satisfying the criteria for acute stress disorder; proficiency in English; aged 18–60 years. Exclusion criteria: current suicidal ideation; a diagnosis of psychosis, organic mental disorder, or substance abuse; evidence of brain injury sustained in the trauma

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: single	
Bryant 2005/2006	Trauma-focused CBT: CBT individual	Acute stress disorder/acute stress reaction diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Exposure to non-sexual violence - Non-sexual assault (55%); motor vehicle accident (45%)	87	Age range (mean): NR (33.6) Gender (% female): 61 BME (% non-white): NR Country: Australia Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: single	Inclusion criteria: aged 17-60 years; having been involved in either a motor vehicle accident or non-sexual assault; meeting DSM-IV criteria for acute stress disorder (ASD). Exclusion criteria: history of psychosis; organic brain syndrome; substance dependence disorder; current suicidal ideation; history of childhood sexual abuse
Foa 2006	Trauma-focused CBT: Brief individual CBT	Clinically important PTSD symptoms (scoring above a	Exposure to sexual abuse or assault - Sexual assault (63%) or non-sexual assault (37%)	90	Age range (mean): NR (33.7) Gender (% female): 100	Inclusion criteria: had recently experienced sexual or non-sexual assault; met DSM-IV symptom (not duration) criteria for PTSD (assessed using the PTSD Symptom Scale-Interview Version). Exclusion criteria: were

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
		threshold on validated scale)			BME (% non-white): 69 Country: US Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: single	assaulted by an intimate partner with whom they had an ongoing relationship; had primary diagnoses of organic mental disorder, schizophrenia, bipolar disorder, or current alcohol/drug dependence
Kangas 2013	Trauma-focused CBT: CBT individual	Non-significant symptoms (below threshold and <50% maximum score on scale)	Diagnosis of life-threatening condition (Patients diagnosed with a primary, first-onset head and neck cancer)	35	Age range (mean): NR (54.8) Gender (% female): 20 BME (% non-white): NR Country: Australia Coexisting conditions: 17% met criteria for MDD; 9% social anxiety; 26% adjustment disorder	Inclusion criteria: aged 18-70 years; diagnosed with a primary, first-onset head and neck cancer; recommended to receive primary or adjuvant radiotherapy; expected prognosis more than 12 months; English fluency; significant psychological distress at referral as indicated by at least one of the following criteria: full or subthreshold (meeting two of three symptom clusters of) cancer-related PTSD as assessed by CAPS, and/or sub-clinical or clinical levels of MDD symptoms (as indicated by score ≥14 on the BDI-II and/or meeting full criteria for MDD as assessed by the SCID-DSM-IV, Depression module, or sub-clinical or clinical levels of general anxiety (as indicated by scoring a minimum T-score of 60 on the State Trait Anxiety Inventory—State subscale and/or meeting full criteria for a current anxiety disorder as assessed by the SCID-DSM-IV, Anxiety module. Exclusion

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Single	criteria: history of psychosis; organic brain syndrome; degenerative conditions; suicidal risk; severe substance dependence
Nixon 2012b	Trauma-focused CBT: Cognitive processing therapy	Acute stress disorder/acute stress reaction diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Exposure to non-sexual violence (93% physical assault; 7% sexual assault)	30	Age range (mean): NR (40.6) Gender (% female): 47 BME (% non-white): 3 Country: Coexisting conditions: 63% mood disorder; 27% anxiety disorder; 3% substance disorder Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): 83%	Inclusion criteria: a diagnosis of Acute Stress Disorder; ability to attend weekly therapy sessions. Exclusion criteria: the trauma not occurring in the previous 4 weeks; non-assault-related trauma; significant current suicidal ideation; still in a traumatic situation; already receiving treatment for the trauma; change of anxiolytic or antidepressant medication/ dosage since the trauma; substance dependence; current PTSD to a prior trauma.

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					previous trauma Single or multiple incident index trauma: Single	

BDI=Beck Depression Inventory; BME=Black and Minority Ethnic; CAPS=Clinician-administered PTSD scale; CBT=cognitive behavioural therapy; DSM=Diagnostic and Statistical Manual of mental disorders; ICD=International Classification of Diseases; MDD=major depressive disorders; N=number being randomised; NR=not reported; SCID=Structured Clinical Interview for DSM-IV Axis I Disorders

Trauma-focused CBT versus self-help (without support) for the early treatment (1-3 months) of below threshold PTSD symptoms in adults

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
Wu 2014	Trauma-focused CBT: Brief individual CBT	Subthreshold symptoms (below threshold but ≥50% maximum score on scale)	Motor Vehicle Collisions (Attended A&E after a motor vehicle collision)	60	Age range (mean): NR (39.6) Gender (% female): 32 BME (% non-white): NR Country: China Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR	Inclusion criteria: attended A&E after a motor vehicle collision (MVC); had a local home address; aged at least 18 years; able to fill in the questionnaire by themselves; evidence of persisting psychological distress on the Impact of Event Scale-Revised (IES-R), with a score ≥ 2 (i.e. a moderate level of distress) in ≥1 of the 3 IES-R subscales (i.e. Intrusion, Avoidance, and Hyperarousal) 1-month after the MVC. Exclusion criteria: existing major psychiatric disorders; evidence of cognitive deficit

Study ID	Interventio n	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					Single or multiple incident index trauma: Single	

BME=Black and Minority Ethnic; CBT=cognitive behavioural therapy; MVC=motor vehicle collision; N=number being randomised; NR=not reported;

Trauma-focused CBT versus waitlist/no treatment for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Study ID	Interventio n	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
Bolton 2014b	Trauma-focused CBT: CBT individual	Non-significant symptoms (below threshold and <50% maximum score on scale)	Witnessing war as a civilian (Burmese survivors of imprisonment, torture, and related traumas)	34 7	Age range (mean): 18-85 (I35.6) Gender (% female): 63 BME (% non-white): NR Country: Thailand Coexisting conditions: 10% harmful alcohol use (score ≥8 on AUDIT) Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): Mean number of traumatic	Inclusion criteria: Burmese refugees aged at least 18 years; witnessed or experienced a traumatic event; moderate to severe depression and/or post-traumatic stress symptoms (PTSS) based on DSM IV–based algorithms applied to baseline interviews with the Hopkins Symptom Checklist 25 (HSCL-25) and the Harvard Trauma Questionnaire (HTQ). Exclusion criteria: active psychosis

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					events either witnessed or experienced: 12.0 (range 1-24) Single or multiple incident index trauma: Multiple	
Classen 2011	Trauma-focused CBT: CBT group	Subthreshold symptoms (below threshold but ≥50% maximum score on scale)	Childhood sexual abuse - Participants experienced childhood sexual abuse between age 4 and 17 years and the perpetrator was at least 5 years older. Mean age of first abuse experience 6.7 (SD=3.1); mean duration of abuse 7.7 years (SD=6.6)	166	Age range (mean): NR (36.2) Gender (% female): 100 BME (% non-white): 27 Country: US and Canada Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): 52% met DSM–IV criteria for abuse or dependence (any substance) Single or multiple	Inclusion criteria: female; aged at least 18 years; English-speaking; at least one explicit memory of childhood sexual abuse (CSA) involving genital or anal contact; at least one CSA event between ages 4 and 17; perpetrator at least 5 years older; ability to talk about the abuse in group therapy; had to meet at least one of the following criteria within the previous year: (a) been sexually victimized (defined as meeting behavioural definitions for having experienced sexual coercion, attempted rape or rape, or having otherwise engaged in unwanted sex), (b) engaged in risky sex (defined as having unprotected sex with an unsafe partner, which is a partner of less than 12 months whose HIV status is unknown or who is known to have other sexual partners or to use intravenous drugs), or (c) met DSM–IV criteria for substance abuse or dependence as determined by the SCID. Exclusion criteria: psychotic or cognitive disorder; reported ritual abuse; were currently receiving psychotherapy; were actively suicidal within the previous month (indicating that they had thoughts of killing themselves in the past month and were at high risk for doing so); were judged inappropriate for group therapy (e.g., behaviourally or verbally

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					incident index trauma: multiple	threatening, hostile, or intoxicated at the screening or baseline assessment)
DuHamel 2010	Trauma-focused CBT: CBT individual	Non-significant symptoms (below threshold and <50% maximum score on scale)	Diagnosis of life-threatening condition - Survivors of hematopoietic stem-cell transplantation (HSCT) who had undergone HSCT 1-3 years earlier. Disease type: Non-Hodgkin's lymphoma (17%); Hodgkin's lymphoma (10%); Acute and chronic myeloid leukaemia (19%); Acute and chronic lymphoid leukaemia (5%); Myelodysplastic syndrome or myeloproliferative disease (11%); Multiple myeloma or amyloidosis (26%); other (1%); missing (11%). Current disease status: 54% free of disease; 25% alive with disease; 21% missing	89	Age range (mean): 19-74 (51) Gender (% female): 51 BME (% non-white): 19 Country: US Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: single	Inclusion criteria: survivors of hematopoietic stem-cell transplantation (HSCT) who had undergone HSCT 1-3 years earlier; English fluency; aged at least 18 years; significant distress as indicated by at least one of the following three criteria: probable illness-related PTSD on the PTSD Checklist-Civilian Version (PCL-C) by using the three- or four-symptom cluster criteria, subclinical PTSD symptoms as indicated by scores one or more standard deviations greater than the PCL-C mean, or general distress with some PTSD symptoms as indicated by scores exceeding the clinical cut-off on any two subscales of the Brief Symptom Inventory (BSI) or the BSI Global Severity Index and, according to either PCL-C scoring method, scores exceeding the cut-off for at least one PTSD symptom cluster. Exclusion criteria: currently awaiting another transplantation or receiving treatment for disease relapse; had severe cognitive impairment assessed with the six-item Mini-Mental State Exam; experienced active psychosis assessed with six items from the Psychotic Symptoms module of the SCID; reported suicidal ideation assessed with one item from the Beck Depression Inventory and one from the BSI; had substance dependence assessed with the four-item Rapid Alcohol Problems Screen-4 and the two-item Conjoint Screen for alcohol and other drug problems
Maercker 2006	Trauma-focused CBT: CBT individual	Subthreshold symptoms (below threshold but	Motor Vehicle Collisions - Continuing medical treatment after MVA in	65	Age range (mean): NR (40.4)	Inclusion criteria: met DSM-IV criteria for PTSD or had severely symptomatic subsyndromal PTSD (meets criterion A, E and F for PTSD and two of criteria B, C, or D) with a CAPS score ≥

Study ID	Interventio n	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
		≥50% maximum score on scale)	days: 21.5 as inpatient; 245.1 as outpatient		Gender (% female): 76 BME (% non-white): NR Country: Germany Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Single	30; aged 18-65 years; German language competency. Exclusion criteria: Co-morbid diagnoses (e.g. bipolar disorder, current alcohol or drug abuse and cognitive impairment)

BME=Black and Minority Ethnic; BSI=Brief Symptom Inventory; CAPS=Clinician-administered PTSD scale; CBT=cognitive behavioural therapy; CSA=Childhood Sexual Abuse; DSM=Diagnostic and Statistical Manual of Mental Disorders; HSCT=hematopoietic stem cell implantation; N=number being randomised; NR=not reported; PCL-C=PTSD Checklist-Civilian version; PTSD=post-traumatic stress disorder; SCID=Structured Clinical Interview for DSM-IV Axis I Disorders

Trauma-focused CBT versus attention-placebo/psycho-education for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
Berger 2016	Trauma-focused CBT: CBT group	Non-significant symptoms (below threshold and <50% maximum score on scale)	Natural disasters (such as severe floods, earthquakes or tsunamis) - Christchurch Earthquake, February 2011. 97% present during the earthquake; 40% lost friends or acquaintances; 59% had a family member or a friend injured; 52% witnessed building falling	69	Age range (mean): 22-69 (44.6) Gender (% female): 77 BME (% non-white): 25 Country: New Zealand Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Single	Inclusion criteria: members of the Linwood College's educational staff
Chambers 2014	Trauma-focused CBT: Cognitive therapy	Subthreshold symptoms (below threshold but ≥50% maximum score on scale)	Diagnosis of life-threatening condition - Patients with cancer who had called cancer helplines seeking support. The most frequent cancer types were breast (31%), colorectal (9%), prostate (9%), hematologic (8%), lung (8%), and gynaecologic (7%)	354	Age range (mean): NR (58.3) Gender (% female): 83 BME (% non-white): NR Country: Australia Coexisting conditions: NR Lifetime experience of	Inclusion criteria: having a score ≥ 4 on the distress thermometer (DT); being able to read and speak English. Exclusion criteria: previous history of head injury and/or dementia; people under current psychiatric care; those who presented with grief or bereavement

Study ID	Interventio n	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: single	

BME=Black and Minority Ethnic; CBT=cognitive behavioural therapy; N=number being randomised; NR=not reported; PTSD=Post-traumatic stress disorders

Trauma-focused CBT versus present-centred therapy for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Study ID	Interventio n	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
Classen 2011	Trauma-focused CBT: CBT group	Subthreshold symptoms (below threshold but ≥50% maximum score on scale)	Childhood sexual abuse - Participants experienced childhood sexual abuse between age 4 and 17 years and the perpetrator was at least 5 years older. Mean age of first abuse experience 6.7 (SD=3.1); mean duration of abuse 7.7 years (SD=6.6)	16 6	Age range (mean): NR (36.2) Gender (% female): 100 BME (% non-white): 27 Country: US and Canada Coexisting conditions: 52% met DSM–IV criteria for abuse or	Inclusion criteria: female; aged at least 18 years; English-speaking; at least one explicit memory of childhood sexual abuse (CSA) involving genital or anal contact; at least one CSA event between ages 4 and 17; perpetrator at least 5 years older; ability to talk about the abuse in group therapy; had to meet at least one of the following criteria within the previous year: (a) been sexually victimized (defined as meeting behavioural definitions for having experienced sexual coercion, attempted rape or rape, or having otherwise engaged in unwanted sex), (b) engaged in risky sex (defined as having unprotected sex with an unsafe partner, which is a partner of less than 12 months whose HIV

Study ID	Interventio n	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					dependence (any substance) Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Multiple	status is unknown or who is known to have other sexual partners or to use intravenous drugs), or (c) met DSM–IV criteria for substance abuse or dependence as determined by the SCID. Exclusion criteria: psychotic or cognitive disorder; reported ritual abuse; were currently receiving psychotherapy; were actively suicidal within the previous month (indicating that they had thoughts of killing themselves in the past month and were at high risk for doing so); were judged inappropriate for group therapy (e.g., behaviourally or verbally threatening, hostile, or intoxicated at the screening or baseline assessment)

BME=Black and Minority Ethnic; CBT=cognitive behavioural therapy; CSA=Childhood sexual abuse; DSM=Diagnostic and Statistical Manual of Mental Disorders; N=number being randomised; NR=not reported; SCID=Structured Clinical Interview for DSM IV Axis I disorder; SD=standard deviation

Trauma-focused CBT group versus peer support group for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Study ID	Interventio n	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
Deblinger 2001	Trauma-focused CBT: CBT group	Non-significant symptoms (below threshold and <50% maximum score on scale)	Non-offending mothers of children who had made a credible disclosure of contact sexual abuse	63	Age range (mean): NR (33.1) Gender (% female): 100 BME (% non-white): NR Country: US Coexisting conditions: NR Lifetime experience of	Inclusion criteria: non-offending mothers of children aged 2-8 years who were referred to the Regional Child Abuse Diagnostic and Treatment Centre for a forensic medical examination as part of a child sexual abuse investigation; had made a credible disclosure of contact sexual abuse to a professional (for child participants). Exclusion criteria: psychotic disorders; severe developmental delays; presented with behaviours that were dangerous to themselves or others

Study ID	Interventio n	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					trauma (mean number of prior traumas/% with previous trauma): 27% of the mothers reported sexual abuse as an adult and 45% mothers reported sexual abuse as child Single or multiple incident index trauma: Multiple	

Psychological: Non-trauma-focused CBT

Non-trauma-focused CBT (+ TAU) versus TAU for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
Nakamura 2011	Non-trauma-focused CBT: Mind-Body Bridging (MBB)	Subthreshold symptoms (below threshold but ≥50% maximum score on scale)	Military combat - Veterans' (no further detail reported)	63	Age range (mean): NR (52.1) Gender (% female): 5 BME (% non-white): NR Country: US Coexisting conditions: All	Inclusion criteria: male and female US veterans; aged 18–70 years; exhibited self-reported sleep disturbance, as defined by score≥35 on Medical Outcomes Study Sleep Survey (MOS-SS). Exclusion criteria: severe mental health issues, such as severe psychosis or major depression; were under intensive mental health case management, as determined by an attending physician in VA Primary Care; on antipsychotic medication

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					participants had sleep disturbance Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Multiple	
Potter 2016	Non-trauma-focused CBT: CBT for postconcussional symptoms	Non-significant symptoms (below threshold and <50% maximum score on scale)	Unintentional injury/illness/medical emergency: Traumatic brain injury. Injury type: road traffic accident (59%); assault (11%); other (30%)	46	Age range (mean): NR (41.4) Gender (% female): 46 BME (% non-white): NR Country: UK Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple	Inclusion criteria: aged 18-65 years; evidence for (at minimum) a mild traumatic brain injury at least 6 months before; symptoms consistent with the ICD-10 criteria for Postconcussional Disorder (F07.2), as laid out in the Diagnostic Criteria for Research (DCR-10). Exclusion criteria: non-fluent English; Mini-Mental State Exam scores of <20 and/or Frontal Assessment Battery scores of <10; moderate–severe physical disability (Barthel Index score <15); previous receipt of ≥4 sessions of CBT after their TBI; other neurological disorder independent of the TBI (e.g., non-post-traumatic epilepsy); drug/alcohol misuse meeting ICD-10 criteria for a dependence syndrome (F1x.2); clinically assessed risk of self-harm or severe psychiatric illness necessitating involvement of a Community Mental Health Team.

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					incident index trauma: Single	

BME=Black and Minority Ethnic; CBT=cognitive behavioural therapy; DSM=Diagnostic and Statistical Manual of Mental Disorders; ICD=International Classification of Diseases; N=number being randomised; NR=not reported; SCID=Structured Clinical Interview for DSM IV Axis I disorder; TBI=traumatic brain injury; VA=Veterans affairs

Present-centred therapy versus waitlist for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
Classen 2011	Trauma-focused CBT: CBT group	Subthreshold symptoms (below threshold but ≥50% maximum score on scale)	Childhood sexual abuse - Participants experienced childhood sexual abuse between age 4 and 17 years and the perpetrator was at least 5 years older. Mean age of first abuse experience 6.7 (SD=3.1); mean duration of abuse 7.7 years (SD=6.6)	166	Age range (mean): NR (36.2) Gender (% female): 100 BME (% non-white): 27 Country: US and Canada Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): 52% met DSM–IV criteria for abuse or dependence (any substance)	Inclusion criteria: female; aged at least 18 years; English-speaking; at least one explicit memory of childhood sexual abuse (CSA) involving genital or anal contact; at least one CSA event between ages 4 and 17; perpetrator at least 5 years older; ability to talk about the abuse in group therapy; had to meet at least one of the following criteria within the previous year: (a) been sexually victimized (defined as meeting behavioural definitions for having experienced sexual coercion, attempted rape or rape, or having otherwise engaged in unwanted sex), (b) engaged in risky sex (defined as having unprotected sex with an unsafe partner, which is a partner of less than 12 months whose HIV status is unknown or who is known to have other sexual partners or to use intravenous drugs), or (c) met DSM–IV criteria for substance abuse or dependence as determined by the SCID. Exclusion criteria: psychotic or cognitive disorder; reported ritual abuse; were currently receiving psychotherapy; were actively suicidal within the previous month (indicating that they had thoughts of killing

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					Single or multiple incident index trauma: multiple	themselves in the past month and were at high risk for doing so); were judged inappropriate for group therapy (e.g., behaviourally or verbally threatening, hostile, or intoxicated at the screening or baseline assessment)

BME=Black and Minority Ethnic; CBT=cognitive behavioural therapy; CSA=Childhood sexual abuse; DSM=Diagnostic and Statistical Manual of Mental Disorders; N=number being randomised; NR=not reported; SCID=Structured Clinical Interview for DSM IV Axis I disorder; SD=standard deviation

Psychological: Behavioural therapies

Brief behavioural intervention versus enhanced TAU for the prevention of PTSD in adults exposed to ongoing trauma (e.g. in a war zone)

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
Rahman 2016	Behavioural therapies: Brief behavioural intervention	Non-significant symptoms (below threshold and <50% maximum score on scale)	Witnessing war as a civilian - Adults living in conflict-affected areas of Pakistan. Witnessed or experienced in past year: Armed conflict or war (61%); Natural disaster (20%); Serious road accident (52%); Physical assault (26%); Unnatural death of family or friend (11%); Serious injury to self (8%); Ill health with no access to medical care (6%)	346	Age range (mean): NR (33) Gender (% female): 79 BME (% non-white): NR Country: Pakistan Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with	Inclusion criteria: routine patients from 3 primary care centres in Peshawar, Pakistan; aged 18-60 years; experiencing emotional distress (defined as both score ≥3 on 12-item General Health Questionnaire [GHQ-12] and score ≥17 on WHO Disability Assessment Schedule 2.0 [WHODAS 2.0]). Exclusion criteria: imminent risk of suicide; severe mental disorder (e.g., psychotic disorders, substance dependence); severe cognitive impairment (e.g., severe intellectual disability, dementia)

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					previous trauma): NR Single or multiple incident index trauma: Multiple	

BME=Black and Minority Ethnic; N=number being randomised; NR=not reported

Brief behavioural intervention versus enhanced TAU for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
Bryant 2017	Behavioural therapies: Brief behavioural intervention	Non-significant symptoms (below threshold and <50% maximum score on scale)	Domestic violence (Prior or current experience of interpersonal violence)	421	Age range (mean): NR (35.6) Gender (% female): 100 BME (% non-white): NR Country: Kenya Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): Mean lifetime traumas 6.9 (3.3). Lifetime trauma experienced:	Inclusion criteria: a history of gender-based violence (endorsement of any [prior or current] experience of interpersonal violence); score ≥ 3 on the GHQ-12 (using the dichotomous scoring method; range 0±12); score ≥ 17 on WHO Disability Assessment Schedule (WHODAS). Exclusion criteria: suicide risk; psychosis; cognitive impairment

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					Disaster (52%); Fire (57%); Road accident (55%); Serious accident (48%); Chemical exposure (33%); Physical assault (73%); Assault with weapon (47%); Sexual assault (31%); Unwanted sexual contact (29%); War exposure (28%); Kidnapped (19%); Life-threatening illness (50%); Witness violent death (48%); Unexpected death of loved one (75%); Intimate partner violence (72%) Single or multiple incident index trauma: multiple	

BME=Black and Minority Ethnic; GHQ=General Health Questionnaire; N=number being randomised; NR=not reported;

Behavioural sleep intervention versus pill placebo or attention-placebo for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
Germain 2012	Behavioural therapies: Behavioural sleep intervention (BSI)	Non-significant symptoms (below threshold and <50% maximum score on scale)	Military combat (Combat Theatre: 48% Operations Iraqi/Enduring Freedom; 18% Persian Gulf War; 12% Vietnam; 6% Other theatre of operations; 15% No conflict)	57	Age range (mean): NR (40.9) Gender (% female): 10 BME (% non-white): 18 Country: Coexisting conditions: All participants had sleep complaints. SCID primary diagnosis: GAD 4%; Major depressive disorder, recurrent episode, unspecified 2%; Primary Insomnia or Insomnia related to another disorder 30% Lifetime experience of trauma (mean number of prior traumas/% with	Inclusion criteria: had served or were serving in the US military; had current sleep complaints (defined by a score≥3 of the nightmare item of the Clinician-Administered PTSD Scale and a score>5 on the Pittsburgh Sleep Quality Index and at least one daytime functional impairment or sleep disruption, and persistence for more than 1 month). Exclusion criteria: unstable medical conditions; resting blood pressure of less than 90/60 during the physical examination; history of bipolar or psychotic disorder; current (within the last 3 months) substance/alcohol abuse or dependence; positive drug screen; diagnosis of obstructive sleep apnea; using a beta-blocker or another alpha-1 antagonist

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					previous trauma): NR Single or multiple incident index trauma: Multiple	
Germain 2014	Behavioural therapies: Behavioural sleep intervention (BSI)	Non-significant symptoms (below threshold and <50% maximum score on scale)	Military combat - Operations Enduring/Iraqi Freedom or Operation NewDawn (OEF/OIF/OND)	40	Age range (mean): NR (38.4) Gender (% female): 15 BME (% non-white): 22 Country: US Coexisting conditions: All participants had primary or comorbid insomnia. 25% met diagnostic criteria for current PTSD; 13% for current mood/anxiety disorder Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple	Inclusion criteria: Combat-exposed Veterans who served in combat theatres; having been deployed to or in support of Operations Enduring/Iraqi Freedom or Operation NewDawn (OEF/OIF/OND); aged 18-60 years; onset of insomnia occurred during or after deployment; meeting criteria for primary or comorbid insomnia as defined by the International Classification of Sleep Disorders; endorsing a baseline score ≥ 14 on the Insomnia Severity Index (ISI) which indicates moderate insomnia. Exclusion criteria: presence of diagnosed or suspected sleep breathing disorder; presence of another sleep disorder requiring treatments other than behavioural insomnia treatments (e.g., restless leg syndrome); severe and/or untreated psychiatric disorder with markedly impaired functioning and requiring immediate clinical attention; lifetime history of bipolar or psychotic disorder; unstable or untreated major medical condition; current alcohol/substance abuse or dependence (past three months)

Study ID	Interventio n	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					incident index trauma: Multiple	

BME=Black and Minority Ethnic; GAD=Generalised Anxiety Disorders; N=number being randomised; NR=not reported; SCID=Structured Clinical Interview for DSM IV Axis I disorder

Behavioural sleep intervention versus prazosin for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Study ID	Interventio n	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
Germain 2012	Behavioural therapies: Behavioural sleep intervention (BSI)	Non-significant symptoms (below threshold and <50% maximum score on scale)	Military combat (Combat Theatre: 48% Operations Iraqi/Enduring Freedom; 18% Persian Gulf War; 12% Vietnam; 6% Other theatre of operations; 15% No conflict)	57	Age range (mean): NR (40.9) Gender (% female): 10 BME (% non-white): 18 Country: Coexisting conditions: All participants had sleep complaints. SCID primary diagnosis: GAD 4%; Major depressive disorder, recurrent episode, unspecified 2%; Primary Insomnia or Insomnia related to	Inclusion criteria: had served or were serving in the US military; had current sleep complaints (defined by a score≥3 of the nightmare item of the Clinician-Administered PTSD Scale and a score>5 on the Pittsburgh Sleep Quality Index and at least one daytime functional impairment or sleep disruption, and persistence for more than 1 month). Exclusion criteria: unstable medical conditions; resting blood pressure of less than 90/60 during the physical examination; history of bipolar or psychotic disorder; current (within the last 3 months) substance/alcohol abuse or dependence; positive drug screen; diagnosis of obstructive sleep apnea; using a beta-blocker or another alpha-1 antagonist

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					another disorder 30% Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Multiple	

BME=Black and Minority Ethnic; GAD=Generalised Anxiety Disorders; N=number being randomised; NR=not reported; SCID=Structured Clinical Interview for DSM IV Axis I disorder

Psychological: Psychologically-focused debriefing

Single/two session debriefing (+/- psychoeducation) versus no treatment for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
Bisson 1997	Psychologically-focused debriefing: Single session debriefing	Non-significant symptoms (below threshold and <50% maximum score on scale)	Unintentional injury/illness/medical emergency - Burn trauma (length of hospital admission 16.1 [16.5] days)	133	Age range (mean): 16-65 (37.4) Gender (% female): 25 BME (% non-white): NR Country: UK	Inclusion criteria: adults aged 16-65 years consecutively recruited to the Welsh regional burns unit. Exclusion criteria: major psychiatric or physical disorder; residence outside South Wales; failure to complete the initial questionnaire.

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): 19% had past significant trauma Single or multiple incident index trauma: Single	
Conlon 1999	Psychologically -focused debriefing: Single session debriefing	Subthreshold symptoms (below threshold but ≥50% maximum score on scale)	Motor Vehicle Collisions - Ambulant trauma clinic attenders with minor road traffic accident (RTA) injuries	40	Age range (mean): 16-65 (33.9) Gender (% female): 53 BME (% non-white): NR Country: Ireland Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/%	Inclusion criteria: adults attending a trauma clinic who had been involved in separate road traffic accidents and sustained minor injuries (excluding head injury) not requiring hospital admission

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					with previous trauma): NR Single or multiple incident index trauma: single	
Dolan (unpublished)	Psychologically-focused debriefing: Single session debriefing	Non-significant symptoms (below threshold and <50% maximum score on scale)	Mixed (Motor vehicle accident, assault, house fire or industrial accident)	100	Age range (mean): 18-65 (35) Gender (% female): 54 BME (% non-white): NR Country: UK Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: single	Inclusion criteria: those presenting with life-threatening or near life-threatening experiences e.g. RTA, assault, house fire or industrial accident. Exclusion criteria: serious head injury; those too unwell to co-operate; those with no memory of the trauma
Hobbs 1996	Psychologically-focused debriefing: Single session debriefing	Non-significant symptoms (below threshold and <50% maximum score on scale)	Motor Vehicle Collisions (Victims of road accidents admitted consecutively to the John Radcliffe Hospital. 87% driver; 13% passengers. 67% car; 25%	106	Age range (median): 17-69 (26-29) Gender (% female): 38 BME (% non-white): NR	Inclusion criteria: adult consecutive victims of road traffic accidents admitted to the John Radcliffe Hospital in Oxford; aged 16-65 years; residents of Oxfordshire or adjacent areas. Exclusion criteria: those who could not remember the accident; intoxicated at the time of accident; those with no psychological

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
			motorcycle; 8% lorry or van)		Country: UK Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Single	symptoms; those who were discharged or were not available when the researcher visited them; refusal to participate.
Marchand 2006	Psychologically-focused debriefing: Two-session debriefing	Non-significant symptoms (below threshold and <50% maximum score on scale)	Exposure to mugging or robbery (Armed robbery)	75	Age range (mean): 16-53 (21.8) Gender (% female): 52 BME (% non-white): NR Country: Canada Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): Mean 2.5 prior	Inclusion criteria: victim of an armed robbery that included acts of violence ranging from threat of death or injury to physical assault and threat with a weapon; experienced intense fear, helplessness, or horror during or after the robbery such as described in Criterion A2 of the DSM-IV PTSD diagnosis. Exclusion criteria: not reported

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					traumatic events Single or multiple incident index trauma: Single	

BME=Black and Minority Ethnic; N=number being randomised; NR=not reported; RTA=Road Traffic Accidents: SCID=Structured Clinical Interview for DSM IV Axis I disorder

Group debriefing versus no treatment for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
Tuckey 2014	Psychologically -focused debriefing: Single session debriefing	Non-significant symptoms (below threshold and <50% maximum score on scale)	Being an emergency responder in a traumatic event - Firemen responding to a potentially traumatic event (PTE). All but one of these PTEs were motor vehicle accidents that resulted in fatalities or serious injuries to the vehicle occupants. The remaining PTE was a failed resuscitation attempt. All events involved secondary exposure (i.e., the fire-fighters provided fire and rescue services to primary victims) rather than primary exposure	67	Age range (mean): NR (NR) Gender (% female): 9 BME (% non-white): NR Country: Australia Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR	Participants were included if they had requested a post-PTE (potentially traumatic event) intervention through the employee assistance program (EAP)

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
			(where in fire-fighters' lives were directly threatened, by a burnover for example)		Single or multiple incident index trauma: Unclear	

BME=Black and Minority Ethnic; N=number being randomised; NR=not reported

Group debriefing versus attention-placebo or psychoeducational session for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
Grundlingh 2017	Psychologically-focused debriefing: Critical Incident Stress Management (CISM) group	Non-significant symptoms (below threshold and <50% maximum score on scale)	Indirect exposure through profession (Ugandan researchers employed by the Good Schools Study to interview children who experienced violence)	53	Age range (mean): NR (29.8) Gender (% female): 65 BME (% non-white): NR Country: Uganda Coexisting conditions: Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): Personal experience of violence (lifetime): Intimate partner	Inclusion criteria: Ugandan research assistants employed by the Good Schools Study (GSS). Research assistants engaged with research participants as violence researchers

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					violence (emotional, sexual or physical; 23%); sexual violence from others (6%) Single or multiple incident index trauma: Unclear	
Tuckey 2014	Psychologically-focused debriefing: Single session debriefing	Non-significant symptoms (below threshold and <50% maximum score on scale)	Being an emergency responder in a traumatic event - Firemen responding to a potentially traumatic event (PTE). All but one of these PTEs were motor vehicle accidents that resulted in fatalities or serious injuries to the vehicle occupants. The remaining PTE was a failed resuscitation attempt. All events involved secondary exposure (i.e., the fire-fighters provided fire and rescue services to primary victims) rather than primary exposure (where in fire-fighters' lives were directly threatened, by a burnover for example)	67	Age range (mean): NR (NR) Gender (% female): 9 BME (% non-white): NR Country: Australia Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Unclear	Participants were included if they had requested a post-PTE (potentially traumatic event) intervention through the employee assistance program (EAP)

BME=Black and Minority Ethnic; N=number being randomised; NR=not reported

Single session debriefing + psycho-education versus single psycho-education session for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
Rose 1999	Psychologically-focused debriefing: Single session debriefing	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	Exposure to non-sexual violence - Actual physical assault (94%); Threatened physical assault (4%); Actual or threatened sexual assault (4%)	157	Age range (mean): 18-76 (35.9) Gender (% female): 25 BME (% non-white): NR Country: UK Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): 41% had a history of child abuse Single or multiple incident index trauma: Single	Inclusion criteria: victims of a violent crime (actual or attempted physical or sexual assault, or bag snatch); aged over 18 years; assaulted by someone who was not a member of their household. Exclusion criteria: participants too ill; too long time lapse since trauma; lived outside study area

BME=Black and Minority Ethnic; N=number being randomised; NR=not reported

Psychological: Eye movement desensitisation and reprocessing

Eye movement desensitisation and reprocessing (EMDR) versus TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
Gil-Jardine 2018	EMDR: EMDR	Unclear	Unintentional injury/illness/medical emergency: Emergency room admissions: 63% medical emergency (35% neurology; 11% abdominal; 17% other); 37% injury (10% road traffic crash; 18% fall; 7% other accidents; 1% assault)	83	Age range (mean): NR (mean NR, medians 46 & 49) Gender (% female): 85 BME (% non-white): NR Country: France Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Single	Inclusion criteria: adults aged at least 18 years; admitted to the emergency room for an injury that had occurred within the last 24 hours; identified as at high risk of post concussion-like symptoms (PCLS; assessed using a scale developed for the study). Exclusion criteria: altered consciousness (defined as Glasgow coma scale score < 14); cognitive impairment; confusion according to the attending ER physician; not speaking French; unable to be contacted by phone; requiring admission to the operating room or critical care unit; if ER admission was for a medical disorder that had already been assessed or discovered during a previous ER visit

BME=Black and Minority Ethnic; EMDR=Eye movement desensitisation and reprocessing; N=number being randomised; NR=not reported

Eye movement desensitisation and reprocessing (EMDR) versus supportive counselling versus Eye Fixation desensitisation (EFD) for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
Lytle 2002	EMDR: EMDR	Subthreshold symptoms (below threshold but ≥50% maximum score on scale)	Mixed - The most commonly reported trauma types were automobile accidents (24%), witnessing or suffering serious physical injury (20%) and rape (13%)	48	Age range (mean): NR (18.9) Gender (% female): 80 BME (% non-white): 7 Country: US Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Single	Inclusion criteria: undergraduate students who identified a past stressful life experience; IES total score of >0; GAD and PTSD symptoms corresponding to DSM III R. Exclusion criteria: those who experienced traumatic event <2 months prior to testing; met the full DSM III R diagnostic criteria for PTSD on basis of self-report.

BME=Black and Minority Ethnic; DSM=Diagnostic and Statistical Manual of Mental Disorders; EMDR=Eye movement desensitisation and reprocessing; GAD=Generalised Anxiety Disorders; IES=Impact of Event Scale; N=number being randomised; NR=not reported;

Psychological: Hypnotherapy

Hypnotherapy + trauma-focused CBT versus trauma-focused CBT/supportive counselling for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
Bryant 2005/2006	Trauma-focused CBT: CBT individual	Acute stress disorder/acute stress reaction diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Exposure to non-sexual violence - Non-sexual assault (55%); motor vehicle accident (45%)	87	Age range (mean): NR (33.6) Gender (% female): 61 BME (% non-white): NR Country: Australia Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: single	Inclusion criteria: aged 17-60 years; having been involved in either a motor vehicle accident or non-sexual assault; meeting DSM-IV criteria for acute stress disorder (ASD). Exclusion criteria: history of psychosis; organic brain syndrome; substance dependence disorder; current suicidal ideation; history of childhood sexual abuse

BME=Black and Minority Ethnic; CBT=cognitive behavioural therapy; DSM=Diagnostic and Statistical Manual of Mental disorders; ICD=International Classification of Diseases; N=number being randomised; NR=not reported;

Psychological: Interpersonal psychotherapy

Interpersonal psychotherapy (IPT) versus TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
Holmes 2007	IPT: IPT	Non-significant symptoms (below threshold and <50% maximum score on scale)	Motor Vehicle Collisions (62.5% road traffic accidents, 17.5% falls or collisions and 13.8% non-accidental injury)	90	Age range (mean): NR (38.4) Gender (% female): 30 BME (% non-white): NR Country: Australia Coexisting conditions: 10% any DSM-IV psychiatric disorder: 3% MDD; 3% alcohol abuse/dependence; 5% substance abuse/dependence Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Single	Inclusion criteria: aged at least 18 years; experienced major physical trauma, defined as one or more of: Injury Severity Score (ISS)>15, serious injury to two or more body systems, urgent surgery for non-limb injuries, or injuries requiring mechanical ventilation for >24 h. Exclusion criteria: sustained a major head injury (post-traumatic amnesia lasted >24 h, there were lesions on computed tomography and patients scored <27 at assessment on the Mini-Mental State Examination); injury due to self-harm; had a psychotic illness

BME=Black and Minority Ethnic; DSM=Diagnostic and Statistical Manual of Mental disorders; IPT=interpersonal psychotherapy; MDD=Major Depressive disorders; N=Number being randomised; NR=not reported;

Psychological: Counselling

Supportive counselling versus attention-placebo for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
Foa 2006	Trauma-focused CBT: Brief individual CBT	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	Exposure to sexual abuse or assault - Sexual assault (63%) or non-sexual assault (37%)	90	Age range (mean): NR (33.7) Gender (% female): 100 BME (% non-white): 69 Country: US Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: single	Inclusion criteria: had recently experienced sexual or non-sexual assault; met DSM-IV symptom (not duration) criteria for PTSD (assessed using the PTSD Symptom Scale-Interview Version). Exclusion criteria: were assaulted by an intimate partner with whom they had an ongoing relationship; had primary diagnoses of organic mental disorder, schizophrenia, bipolar disorder, or current alcohol/drug dependence

BME=Black and Minority Ethnic; CBT=cognitive behavioural therapy; DSM=Diagnostic and Statistical Manual of Mental disorders; N=Number being randomised; NR=not reported;

Counselling versus no treatment for the early treatment (1-3 months) of below threshold PTSD symptoms in adults

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
Brom 1993	Counselling: Supportive counselling	Non-significant symptoms (below threshold and <50% maximum score on scale)	Motor Vehicle Collisions (Road accidents judged moderately serious to serious)	151	Age range (mean): NR (37.7) Gender (% female): 41 BME (% non-white): NR Country: Netherlands Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Single	Inclusion criteria: Individuals who had experienced motor vehicle collisions judged as moderately serious to serious.

BME=Black and Minority Ethnic; N=Number being randomised; NR=not reported;

Psychological: Combined somatic and cognitive therapy

Brief cognitive-behavioural conjoint therapy versus waitlist for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
Brunet 2013/Des Groseilliers 2013	Couple interventions : Cognitive-behavioural conjoint therapy	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	Motor Vehicle Collisions - Motor vehicle accident (55%), work accident (16%), leisure accident (14%), or physical assault (15%).	83	Age range (mean): 19-63 (36.3) Gender (% female): 46 BME (% non-white): NR Country: Canada Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Unclear	Inclusion criteria: experienced in the last 10 days a life-threatening event that elicited a peritraumatic reaction of fear, helplessness, or horror. This corresponds to the A1 and A2 criteria. Exclusion criteria: Non-English or French speaking; suspected of having a traumatic brain injury; had a lifetime diagnosis of psychosis; substance or alcohol dependence, bipolar disorder, or mental retardation; had been clinically depressed in the last 2 years; were taking psychotropic medication at the onset of the study; were injured to the extent that they could not participate in the study; lived outside the Montreal metropolitan area; did not have a significant other (a friend, a spouse or another family member) to bring to the therapy session, or did not succeed in making an appointment with the therapist within 30 days after trauma exposure

BME=Black and Minority Ethnic; N=Number being randomised; NR=not reported

Psychological: Parent training/family intervention

Self-help (without support; +/- TAU) versus TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
Stehl 2009	Family therapy: Family therapy	Subthreshold symptoms (below threshold but	Family member or carer of person with life-threatening illness or injury - Parent/caregiver	152 caregivers (76 families)	Age range (median): NR (35-40)	Inclusion criteria: families were English-speaking and had a child aged 0-17 years who was receiving chemotherapy and/or radiation treatment at selected hospital; two

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
		≥50% maximum score on scale)	of child (aged 0-17 years) with cancer who was receiving chemotherapy and/or radiation treatment		Gender (% female): 69 BME (% non-white): 23 Country: US Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Single	parents/caregivers to participate; the child had been diagnosed within 2 months prior to recruitment. Exclusion criteria: medical comorbidities; developmental delay; referred to palliative care

BME=Black and Minority Ethnic; N=Number being randomised; NR=not reported; TAU=treatment as usual

Psychological: Self-help (without support)

Self-help (without support) versus waitlist for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
Cox 2009/Kenardy 2015	Self-help (without support): Psychoeducational materials	Non-significant symptoms (below threshold and <50% maximum score on scale)	Family member or carer of child with unintentional injury caused by: falls (48%); sport injuries (15%); motor vehicle accidents as a passenger or pedestrian (7%); burns	85	Age range (mean): NR (40.7) Gender (% female): NR BME (% non-white): NR Country:	Child participants were included if they: (1) were aged 7-16 years; (2) consented (if aged ≥ 11 years) and their parent/s consented (for all ages); (3) were hospitalized overnight; (4) had acquired an accidental or unintentional injury including mild traumatic brain injury (as defined by the American Congress of Rehabilitation Medicine, 1993); (5) had

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
			(7%); knock or blow (1%); other types of unintentional injury (14%)		Australia Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Single	internet access. Participants were excluded if they: (a) had, or their parent had, insufficient English for completion of the questionnaires; (2) had acquired a moderate to severe head injury; (5) had an injury that was a result of suspected intentional trauma (e.g., child abuse, assault, self-harm).

Self-help (without support; +/- TAU) versus TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
Jones 2003	Self-help (without support): Cognitive bibliotherapy	Unclear	Unintentional injury/illness/medical emergency (Patients who had been in ICU and ventilated. Mean ICU stay 13.6 days (range 2-114))	126	Age range (mean): 17-84 (57.9) Gender (% female): 52 BME (% non-white): NR Country: UK Coexisting conditions: NR Lifetime experience of trauma (mean number of	Inclusion criteria: patients who had been in ICU and ventilated. Exclusion criteria: stayed in the ICU <48 hours; were suffering burn injury (due to prolonged recovery); were unable to follow the manual or had language difficulties; neurosurgical patients; pre-existing psychotic illness; discharged for terminal care and unlikely to survive the 6-month follow-up period

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Single	
Kenardy 2008	Self-help (without support): Psychoeducational materials	Non-significant symptoms (below threshold and <50% maximum score on scale)	Family member of child with unintentional injury/illness/medical emergency. Cause of accident: 35% falls; 30% sporting injuries; 28% motor vehicle accidents; 7% other types of accidents. Type of injury: 53% Fractures and dislocations; 28% Lacerations or abrasions; 18% Other	104	Age range (mean): NR (39.9) Gender (% female): 86 BME (% non-white): NR Country: US Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Single	One caregiver of each child participant who were included if they: had been admitted to a paediatric unit following accidental traumatic injury; spoke fluent English (equivalent to Grade 6 or above; both child and parent). Participants were excluded if: physical or sexual abuse was suspected; they had sustained head injuries
Marsac 2013	Self-help (without support): Computerised	Non-significant symptoms (below threshold and	Family member of child with unintentional injury/illness/medical emergency (Parent of	100	Age range (mean): 23-59 (41)	One parent of child participants who were included if they: (1) were aged 6-17 years; (2) had incurred an injury within the past 60 days and received medical treatment at a large

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
	psychoeducational intervention	<50% maximum score on scale)	children who incurred an injury and received medical treatment at a large urban Level I paediatric trauma centre. Children's injuries resulted primarily from recreation (31%), falls (31%), and motor vehicle crashes (16%). The majority of injuries were extremity fractures (51%), followed by lacerations (9%), other fractures (8%), multiple traumas (5%), organ injuries (5%), sprains or strains (4%), mild head injuries (4%), and other injuries (14%). Most children in this sample were recruited during an inpatient hospitalization (79%), whereas 21% participated during an emergency department visit)		Gender (% female): 82 BME (% non-white): 51 Country: US Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Single	urban Level I paediatric trauma centre. Participants were excluded if: (1) the parent or child was unable to read or understand English; (2) the child had sustained a traumatic brain injury preventing comprehension of surveys (i.e., Glasgow Coma Score<13); (3) the child's injury resulted from suspected abuse or family violence; (4) the child had sustained injuries as a result of an organized sport
Mouthaan 2013	Self-help (without support): Computerised psychoeducational intervention	Non-significant symptoms (below threshold and <50% maximum score on scale)	Motor Vehicle Collisions - Traffic accident (68%); Work-related accident (9%); Fall (14%); Interpersonal violence/physical abuse (2%); Other (7%)	300	Age range (mean): NR (43.8) Gender (% female): 40 BME (% non-white): NR Country:	Inclusion criteria: injury patients transported by ambulance or helicopter to the level 1 trauma centres of the Academic Medical Centre (AMC) and VU University Medical Centre (VUmc) in Amsterdam; aged at least 18 years; proficient in Dutch; experienced a potential traumatic event (Criterion A1 DSM-IV PTSD diagnosis), i.e., experienced, witnessed, or

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					Netherlands Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): Mean 2.9 prior traumatic events Single or multiple incident index trauma: Single	been confronted with an event or events that involve actual or threatened death or serious injury, or a threat to the physical integrity of oneself or others. Exclusion criteria: injury resulting from deliberate self-harm; organic brain condition; psychotic disorder, bipolar disorder, or depression with psychotic features; moderate to severe traumatic brain injury (TBI) (according to a Glasgow Coma Score<13); permanent residency outside the Netherlands.
Scholes 2007	Self-help (without support): Psychoeducational materials	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	Motor Vehicle Collisions - Road traffic accident (65%): Assault (27%); Occupational injury (7%)	227	Age range (mean): NR (36.6) Gender (% female): 36.6 BME (% non-white): NR Country: UK Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/%	Inclusion criteria: aged 16-65 years; injuries sustained as a result of a road traffic accident, an occupational injury or an assault; scored ≥50 on the ASDS. Exclusion criteria: non-English speaking

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					with previous trauma): NR Single or multiple incident index trauma: Single	

ASDS=Acute stress disorder scale; BME=Black and Minority Ethnic; ICU=intensive care unit; N=Number being randomised; NR=not reported; TAU=treatment as usual

Self-help (without support) versus waitlist for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
Beatty 2010a	Self-help (without support): Cognitive bibliotherapy	Subthreshold symptoms (below threshold but ≥50% maximum score on scale)	Diagnosis of life-threatening condition (Breast cancer)	42	Age range (mean): 29-79 (53.1) Gender (% female): 100 BME (% non-white): NR Country: Australia Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Unclear	Inclusion criteria: women with stage I or II breast cancer; completed treatment within the past 3 months; English speaking; aged at least 18 years. Exclusion criteria: Not reported

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
Hobfoll 2016	Self-help (without support): Computerised non-trauma-focused CBT	Non-significant symptoms (below threshold and <50% maximum score on scale)	Military combat (Non–active-duty veterans who served since September 11, 2001)	303	Age range (mean): NR (34.4) Gender (% female): 18 BME (% non-white): 28 Country: US Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Multiple	Inclusion criteria: aged at least 18 years; spoke and read English; were able to use computers without assistance; had regular access to a cell phone and broadband Internet; met criteria for at least mild-to-moderate distress based on scores on screening assessments (PCL-M score=24–61; CES-D-10 score=8–25). Exclusion criteria: risk for suicide, as evidenced by a past suicide attempt(s), psychiatric hospitalization during the past 5 years, and/or started or altered the dose of their psychiatric medication within 10 days prior to enrolling in study; those reporting higher than moderate distress

BME=Black and Minority Ethnic; CBT=cognitive behavioural therapy; CES-D=Centre for epidemiological studies-Depression; N=Number being randomised; NR=not reported; PCL-M=PTSD Checklist-Military

Self-help (without support; +/- TAU) versus attention-placebo or TAU for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
Ironson 2013	Self-help (without support): Expressive writing	Non-significant symptoms (below threshold and <50% maximum score on scale)	Diagnosis of life-threatening condition (HIV-affected men and women)	244	Age range (mean): NR (42.8) Gender (% female): 39 BME (% non-white): 83	Inclusion criteria: HIV-affected men and women in south Florida

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					Country: US Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Single	
Koopman 2005	Self-help (without support): Expressive writing	Subthreshold symptoms (below threshold but ≥50% maximum score on scale)	Domestic violence - 83% had been slapped, hit or punched; 79% had been pushed or shoved; 50% had been choked; 46% had been kicked; 46% had been raped; 16% had been threatened with a weapon. Women had left the abusive partner on average 5 years earlier (SD = 5.9) and had been in the relationship on average for 6.3 years (SD = 6.9)	59	Age range (mean): 21-56 (36.5) Gender (% female): 100 BME (% non-white): 32 Country: US Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Multiple	Inclusion criteria: having been a victim of intimate partner violence; aged over 18 years; the ability to converse and write in English. Exclusion criteria: had been romantically involved with their abusive partners within the previous 30 days or if they had lived with them within the previous 6 months

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
Short 2017	Self-help (without support): Computerised cognitive training	Sub-threshold symptoms (below threshold but ≥50% maximum score on scale)	Unclear	63	Age range (mean): 19-66 (40.1) Gender (% female): 51 BME (% non-white): 51 Country: Coexisting conditions: 49% met criteria for a mood disorder, 75% for at least one anxiety disorder Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Unclear	Inclusion criteria: had participated in a larger randomized clinical trial examining the efficacy of a computerized intervention for anxiety sensitivity and had complete data for all measures of interest; had experienced a trauma according to the Structured Clinical Interview for DSM-5; aged at least 18 years; English-speaking; demonstrated elevated levels of at least one suicide risk factor (i.e., anxiety sensitivity cognitive concerns, perceived burdensomeness, or thwarted belongingness). Exclusion criteria: evidence of a current psychotic or bipolar spectrum disorder; serious suicidal intent; unstable psychiatric medication usage (i.e., participants were required to maintain the same prescription for at least 6 weeks before starting the trial)

BME=Black and Minority Ethnic; DSM=Diagnostic and Statistical Manual of Mental disorders; N=Number being randomised; NR=not reported; SD=standard deviation

Psychological: Self-help with support

Self-help with support versus attention-placebo for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
Iyadurai 2017	Self-help with support: Tetris computer game + memory reminder cue	Unclear	Motor Vehicle Collisions (All participants experienced motor vehicle accident (rather than witnessed). 76% were brought in by ambulance. Type of motor vehicle accident: Car/van/bus driver (45%); Car/van passenger (6%); Motorcyclist (15%); Cyclist (28%); Pedestrian (6%). 28% admitted as inpatient)	71	Age range (mean): NR (39.7) Gender (% female): 52 BME (% non-white): 21 Country: UK Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): 73% prior trauma Single or multiple incident index trauma: Single	Inclusion criteria: aged at least 18 years; experienced/witnessed a motor vehicle accident (as a driver, passenger, motorcyclist or pedestrian); met DSM-IV PTSD criterion A1 for a traumatic event ('experienced, witnessed or was confronted with an event or events that involved actual or threatened death or serious injury'); seen in emergency department within 6 hours of leaving scene of the accident; reported memory of the accident; fluent in written and spoken English; alert and orientated, Glasgow Coma Scale score = 15; sufficient physical mobility to play a computer game on the intervention platform (Nintendo DS) at the point of taking informed consent. Exclusion criteria: loss of consciousness for >5 min; reported history of severe mental illness; current intoxication; substance abuse; neurological condition; currently suicidal

BME=Black and Minority Ethnic; DSM=Diagnostic and Statistical Manual of Mental disorders; N=Number being randomised; NR=not reported;

Self-help with support (+ TAU) versus TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
Bugg 2009	Self-help with support: Expressive	Clinically important PTSD symptoms (scoring above a	Motor Vehicle Collisions - Motor vehicle accident (79%), occupational	148	Age range (mean): 18-65 (37.5)	Inclusion criteria: aged 18-65 years; scored ≥ 50 on the Acute Stress Disorder Scale (ASDS); had sustained an injury through a road traffic accident (RTA), occupational injury or assault.

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
	writing with support	threshold on validated scale)	injury (3%) or assault (18%)		Gender (% female): 72 BME (% non-white): NR Country: UK Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: single	Exclusion criteria: not English speaking due to potential difficulties with writing

BME=Black and Minority Ethnic; N=Number being randomised; NR=not reported; SD=standard deviation

Self-help with support versus waitlist for the early treatment (1-3 months) of below threshold PTSD symptoms in adults

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
Cernvall 2015	Self-help with support: Computerised CBT with support	Subthreshold symptoms (below threshold but ≥50% maximum score on scale)	Family member or carer of person with life-threatening illness or injury - Parents of children on cancer treatment (52% Leukaemia; 17% Sarcoma; 7% Lymphoma; 15% CNS tumour; 9% Other malignant disease)	58	Age range (mean): NR (38) Gender (% female): 67 BME (% non-white): Country: NR Coexisting conditions: NR	Inclusion criteria: Swedish-speaking parents of children receiving treatment for cancer disease; had access to a computer with an Internet connection; fulfilled the modified symptom criteria (scored ≥3 on at least one out of five symptoms of re-experiencing, one out of seven symptoms of avoidance, and one out of five symptoms of hyperarousal, corresponding to partial PTSD) on the PTSD Checklist Civilian Version (PCL-C). Exclusion criteria: had any

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): 45% had experience of previous traumatic events Single or multiple incident index trauma: single	psychiatric disorder in immediate need of treatment

BME=Black and Minority Ethnic; CBT=cognitive behavioural therapy; CNS=central nervous system; N=Number being randomised; NR=not reported; SD=standard deviation

Self-help with support versus waitlist for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
Sveen 2017	Self-help with support: Computerised trauma-focused CBT with support	Non-significant symptoms (below threshold and <50% maximum score on scale)	Parent of a child with severe burns admitted to a burn centre. Mean age of child at time of injury 3.0 years, mean length of stay in hospital 7.2 days. Cause of injury: scalds (76%); fire (4%); contact burns (14%); other, e.g. electrical or chemical (6%)	104	Age range (mean): NR (37.4) Gender (% female): 68 BME (% non-white): NR Country: Sweden Coexisting conditions: NR Lifetime experience of trauma (mean number of prior	Inclusion criteria: parents of children (aged under 18 years) with severe burns admitted to one of two study burn centres; the burn of the child was not intentional and there was no indication of abuse or neglect of the child as a cause of burn. Exclusion criteria: the parent was being treated for burns at the same time as the child; inability to understand and respond in Swedish.

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					traumas/% with previous trauma): NR Single or multiple incident index trauma: Single	

Self-help with support versus attention-placebo for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
Carrico 2015	Self-help with support: Expressive writing with support	Non-significant symptoms (below threshold and <50% maximum score on scale)	Diagnosis of life-threatening condition (Men who are HIV-positive)	23	Age range (mean): NR (45.5) Gender (% female): 0 BME (% non-white): 64 Country: US Coexisting conditions: All participants had used methamphetamine in the past 30 days Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: single	Inclusion criteria: identify as male; report having anal sex with a man in the past year; diagnosed with HIV for at least 3 months (and provided evidence of HIV-positive sero status, i.e. a letter of diagnosis or antiretroviral medication bottles bearing their name, that was verified using photo identification); report using methamphetamine in the past 30 days

BME=Black and Minority Ethnic; N=Number being randomised; NR=not reported;

Psychosocial: Meditation/Mindfulness-based stress reduction

Meditation/MBSR (+/- TAU) versus no treatment, waitlist or TAU for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
Kelly 2016	MBSR: MBSR	Subthreshold symptoms (below threshold but ≥50% maximum score on scale)	Domestic violence (Female survivors of IPV)	45	Age range (mean): 19-69 (41.5) Gender (% female): 100 BME (% non-white): 27 Country: US Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): Mean number of lifetime types of IPV-related traumatic experience was 2.1 (SD = 1.7, range 1–6) Single or multiple incident index trauma: Multiple	Inclusion criteria: females aged at least 18 years; a history of IPV (defined as physical or sexual abuse by a family member or intimate partner during the life course); comprehension of spoken and written English; having their own transportation to and from study activities. Exclusion criteria: currently experiencing IPV; screened positive for current suicidality or substance dependence as determined via the Mini-International Neuropsychiatric Interview

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
Kim 2013	Meditation: Mindfulness-based stretching and deep breathing exercise	Subthreshold symptoms (below threshold but ≥50% maximum score on scale)	Unclear - Nurses with subthreshold PTSD symptoms	22	Age range (mean): NR (46.3) Gender (% female): 95 BME (% non-white): 41 Country: US Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Unclear	Inclusion criteria: aged over 18 years; employed as a nurse at the University of New Mexico Hospital; PCL-C score ≥28 and a score ≥ 3 on ≥1 individual items. Exclusion criteria: inability to participate in the exercise program; a positive answer to any of the 7 screening questions on the Physical Activity Readiness Questionnaire; current use of systemic glucocorticoid
Schellekens 2017	MBSR: MBSR	Non-significant symptoms (below threshold and <50% maximum score on scale)	Diagnosis of life-threatening condition - Adults with nonsmall cell (86%) or small cell (11%) lung cancer (curative [51%] or palliative stage [49%])	63	Age range (mean): NR (58.8) Gender (% female): 52 BME (% non-white): NR Country: Netherlands Coexisting conditions: NR Lifetime experience of trauma (mean	Inclusion criteria: patients presenting with cytologically or histologically proven nonsmall cell or small cell lung cancer (curative or palliative stage). Exclusion criteria: aged under 18 years; insufficient understanding of Dutch language; former mindfulness based intervention participation; current participation in other psychosocial programme; current weekly treatment by psychologist/psychiatrist; physical impairments (i.e., hospitalization, life expectancy shorter than study period); cognitive impairments (i.e., Mini-Mental State Examination <26)

Study ID	Interventio n	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Single	

BME=Black and Minority Ethnic; IPV=Intensive partner violence; MBSR=Mindful-Based Stress Reduction; N=Number being randomised; NR=not reported; PCL-C=PTSD Checklist-Civilian version; SD=standard deviation

Psychosocial: Intensive care diary

Intensive care diary versus waitlist for the early treatment (1-3 months) of non-significant PTSD symptoms in adults

Study ID	Interventio n	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
Jones 2010/2012	Diary: Intensive care diaries	Non-significant symptoms (below threshold and <50% maximum score on scale)	Unintentional injury/illness/medical emergency - Respiratory failure (22%); Sepsis (15%); Circulatory failure (13%); Multi-organ failure (14%); Multiple trauma without head injury (9%); Multiple trauma with head injury (3%); Isolated head injury (2%); Combined (pulmonary/circulatory) (11%); Gastrointestinal failure (6%); Neurological failure (3%); Other (2%).	35 2	Age range (median): 18-82 (59-60) Gender (% female): 36 BME (% non-white): NR Country: Denmark, Italy, Norway, Portugal, Sweden, UK Coexisting conditions: NR Lifetime experience of	The inclusion criteria were that the patients had been in the ICU and ventilated. Patients were excluded if they: stayed in the ICU for less than 72 hours; were ventilated for less than 24 hours; were too confused to give informed consent (including severe traumatic brain injury); and had pre-existing psychotic illness such as schizophrenic and manic depression (a confounding factor for psychological recovery) or diagnosed PTSD

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
			Median ICU stay 13 days (range 3-79)		trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Single	

BME=Black and Minority Ethnic; ICU=intensive care unit; N=Number being randomised; NR=not reported;

Psychosocial: Psycho-education

Single psycho-education session (+/- TAU) versus TAU or no treatment for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
Miller 2015	Psychoeducation: Single psychoeducation session	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	Exposure to sexual abuse or assault (Women who participated in a sexual assault examination. 35% reported the assailant threatened harm; 68% reported at least one injury sustained; 8% reported the assailant used a weapon during the assault. 57% reported a completed rape. 60% assailant was an acquaintance; 20% were strangers; 12%were	164	Age range (mean): 18-70 (28.8) Gender (% female): 100 BME (% non-white): 38 Country: US Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous	Inclusion criteria: women who participated in a sexual assault examination within 72 hours of their victimization; English speaking; aged at least 18 years; female. Exclusion criteria: unable to provide consent because of intoxication, loss of consciousness, apparent psychosis, or other reasons preventing them from providing consent (e.g., ventilator dependent, developmental delays)

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
			romantic partners; 6% were unsure who assaulted them; 1% assault by a family member)		trauma): 72% prior sexual assault Single or multiple incident index trauma: Unclear	
Tuckey 2014	Psychologically-focused debriefing: Single session debriefing	Non-significant symptoms (below threshold and <50% maximum score on scale)	Being an emergency responder in a traumatic event - Firemen responding to a potentially traumatic event (PTE). All but one of these PTEs were motor vehicle accidents that resulted in fatalities or serious injuries to the vehicle occupants. The remaining PTE was a failed resuscitation attempt. All events involved secondary exposure (i.e., the fire-fighters provided fire and rescue services to primary victims) rather than primary exposure (where in fire-fighters' lives were directly threatened, by a burnover for example)	67	Age range (mean): NR (NR) Gender (% female): 9 BME (% non-white): NR Country: Australia Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Unclear	Participants were included if they had requested a post-PTE (potentially traumatic event) intervention through the employee assistance program (EAP)

BME=Black and Minority Ethnic; N=Number being randomised; NR=not reported; PTE=potentially traumatic event

Other non-pharmacological: Acupuncture

Acupuncture + trauma-focused CBT versus trauma-focused CBT for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
Zhang 2011	Acupuncture: Electro-acupuncture	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	Natural disasters (such as severe floods, earthquakes or tsunamis) - Wenchuan earthquake. 67% direct relatives had been killed by the earthquake and 33% buried under debris during the earthquake	91	Age range (mean): 4-89 (34.9) Gender (% female): 60 BME (% non-white): NR Country: China Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Single	Inclusion criteria: those with psychological distress after being buried under debris during the earthquake and/or whose direct relatives had been killed by the earthquake; often suffered from repeated dreams, constant recalls, painful experience and horror under aftershocks; evaded or inclined to evade topics on the earthquake and on loss of their relatives; difficulty in recalling some important details of the earthquake; had 2 of the following items: difficulty in falling asleep, irritability, episodic rage, distraction and excessive alert. Exclusion criteria: at risk of suicide; had injured others; reactive psychosis; organic psychosis; severe personality disturbance; cerebral trauma; severe and unstable illness; hypophrenosis

BME=Black and Minority Ethnic; N=Number being randomised; NR=not reported;

Other non-pharmacological: Yoga

Yoga versus attention-placebo/TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
Ratcliff 2016	Yoga: Yoga	Non-significant symptoms (below threshold and <50% maximum score on scale)	Diagnosis of life-threatening condition (Diagnosed with stage 0 to III breast cancer, and scheduled to undergo daily adjuvant radiotherapy. 11% stage 0; 31% stage I; 27% stage II; 31% stage III.)	178	Age range (mean): NR (51.9) Gender (% female): 100 BME (% non-white): 40 Country: US Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Single	Inclusion criteria: women aged at least 18 years; ability to read, write, and speak English; diagnosed with stage 0 to III breast cancer; scheduled to undergo daily adjuvant radiotherapy for 6 weeks at MD Anderson Cancer Centre. Exclusion criteria: lymphedema; metastatic bone disease; deep-vein thrombosis; documented diagnosis of a formal thought disorder; extreme mobility problems; those who had practiced yoga in the year before diagnosis

BME=Black and Minority Ethnic; N=Number being randomised; NR=not reported; TAU=treatment as usual

Yoga versus waitlist for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
Seppala 2014	Yoga: Yoga	Non-significant symptoms (below threshold and <50% maximum score on scale)	Military combat - Veterans with service in Afghanistan or Iraq (no further detail reported)	21	Age range (mean): NR (28.6) Gender (% female): 0 BME (% non-white): 14 Country: US Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Multiple	Inclusion criteria: male veterans with service in Afghanistan or Iraq; aged at least 18 years; English fluency. Exclusion criteria: reported substance dependence; psychosis; use of alpha or beta-blocking medications

BME=Black and Minority Ethnic; N=Number being randomised; NR=not reported;

Other non-pharmacological: Massage

Massage + relaxation for parent (+ massage + humour therapy targeted at child) versus TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
Phipps 2010/2012/Lindwall 2014	Massage + self-help (with	Non-significant symptoms (below	Family member or carer of person with life-threatening illness or	119	Age range (mean): NR (81)	Inclusion criteria: parent of a child undergoing stem cell or bone marrow transplantation (allogeneic or autologous); expected hospital

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
	support): Massage + relaxation (for parent; + massage + humour therapy targeted at child)	threshold and <50% maximum score on scale)	injury: Parent of children undergoing paediatric stem cell transplantation (SCT). Diagnostic group: ALL (27%); AML (25%); other leukaemia (14%); HD/NHL (11%); solid tumour (12%); nonmalignancy (11%)		Gender (% female): 81 BME (% non-white): NR Country: US and Canada Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Single	stay for child of 3 weeks; child aged 6-18 years; able to speak and read English fluently; primarily responsible for caring for the child during his/her hospital stay; available to participate throughout the duration of the child's hospitalization for transplantation

AML=Acute Myeloblastic leukaemia; ALL=Acute Lymphoblastic leukaemia; BME=Black and Minority Ethnic; HD=Hodgkin disease; N=Number being randomised; NHL=Non-Hodgkin lymphoma; NR=not reported;

Appendix E – Forest plots

Forest plots for "For adults at risk of PTSD, what are the relative benefits and harms of psychological, psychosocial or other non-pharmacological interventions targeted at PTSD symptoms?"

Psychological: Trauma-focused CBT

Trauma-focused CBT (±psycho-education) versus waitlist or no treatment for the early prevention (intervention initiated ≤ 1 month) of PTSD in adults

Figure 2: Trauma-focused CBT (±psycho-education) versus waitlist or no treatment for the early prevention (intervention initiated ≤ 1 month) of PTSD in adults: PTSD symptomatology self-rated (PDS change score)

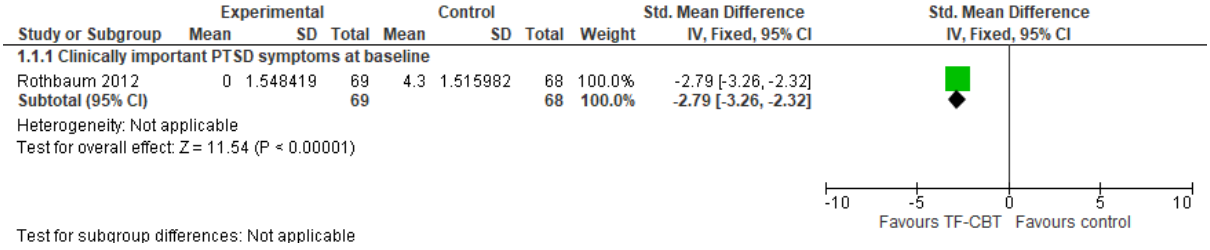


Figure 3: Trauma-focused CBT (±psycho-education) versus waitlist or no treatment for the early prevention (intervention initiated ≤ 1 month) of PTSD in adults: PTSD symptomatology clinician-rated at endpoint (CAPS change score/PSS-I endpoint score)

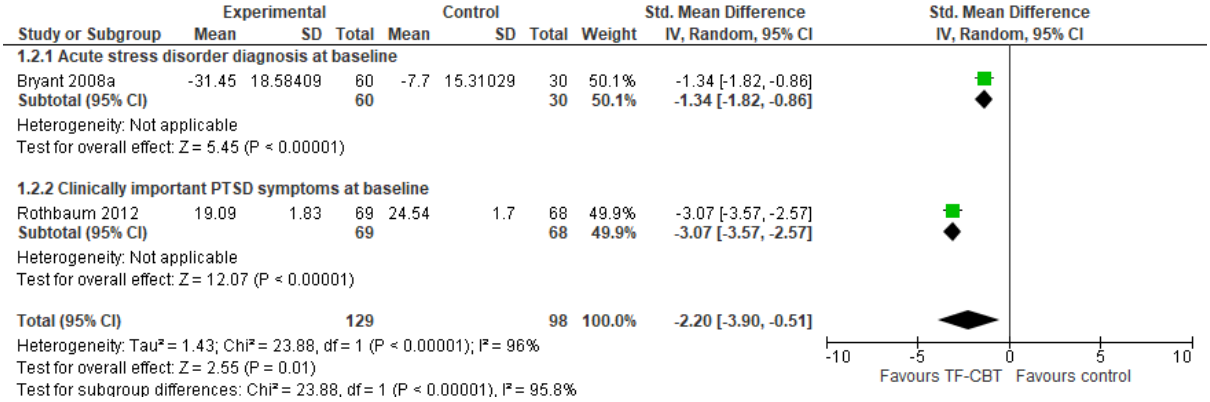


Figure 4: Trauma-focused CBT (±psycho-education) versus waitlist or no treatment for the early prevention (intervention initiated ≤ 1 month) of PTSD in adults:

PTSD symptomatology clinician-rated at 2-month follow-up (PSS-I endpoint score)

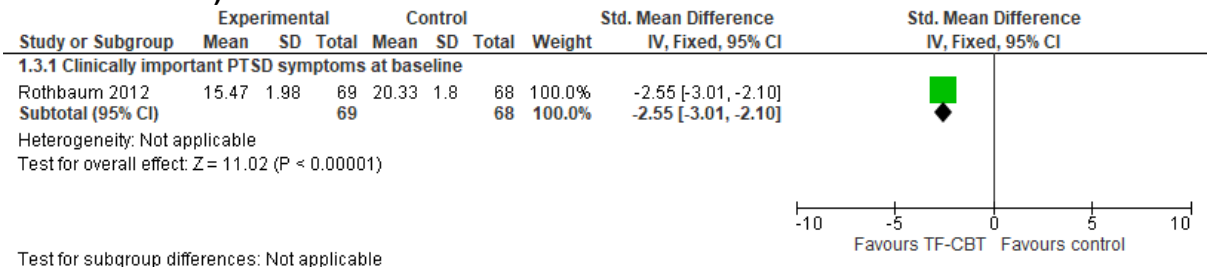


Figure 5: Trauma-focused CBT (±psycho-education) versus waitlist or no treatment for the early prevention (intervention initiated ≤ 1 month) of PTSD in adults: PTSD at endpoint

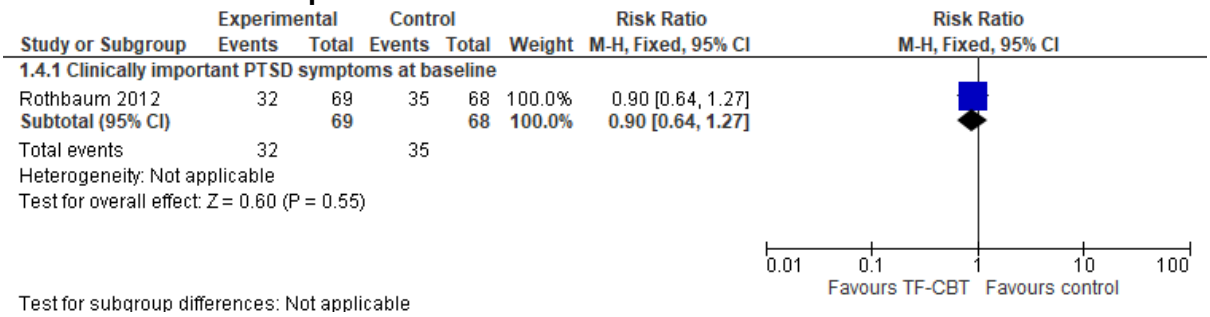


Figure 6: Trauma-focused CBT (±psycho-education) versus waitlist or no treatment for the early prevention (intervention initiated ≤ 1 month) of PTSD in adults: PTSD at 2-month follow-up

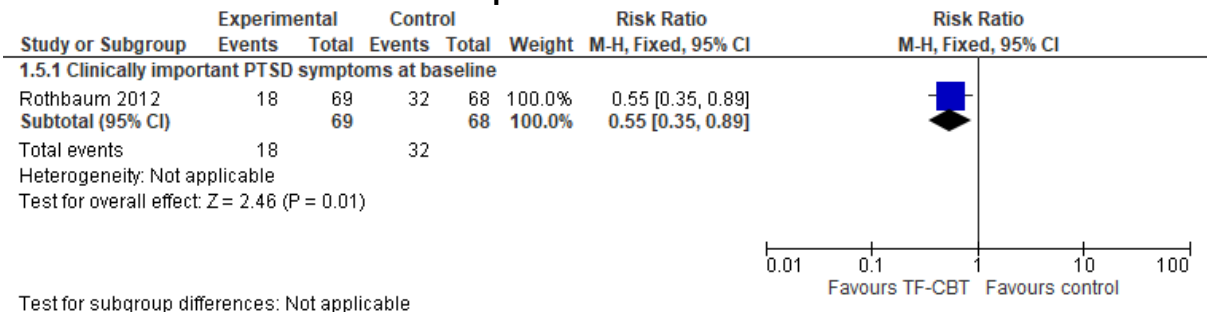


Figure 7: Trauma-focused CBT (±psycho-education) versus waitlist or no treatment for the early prevention (intervention initiated ≤ 1 month) of PTSD in adults: PTSD at 6-month follow-up

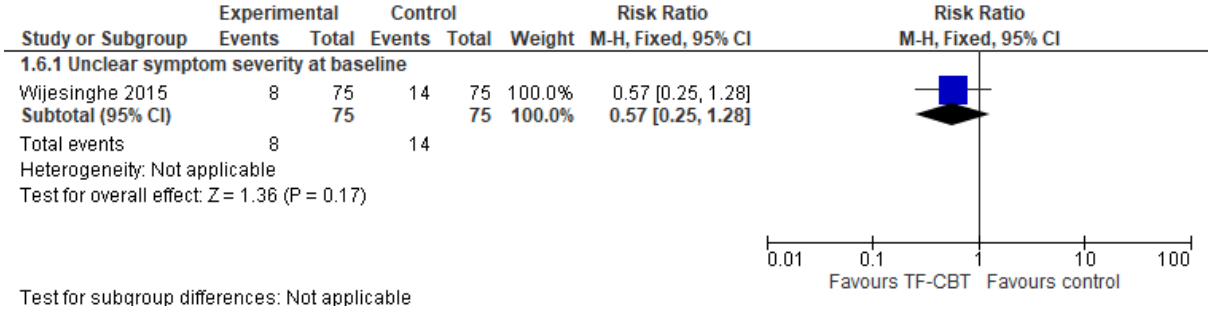


Figure 8: Trauma-focused CBT (±psycho-education) versus waitlist or no treatment for the early prevention (intervention initiated ≤ 1 month) of PTSD in adults: Anxiety symptoms (BAI change score)

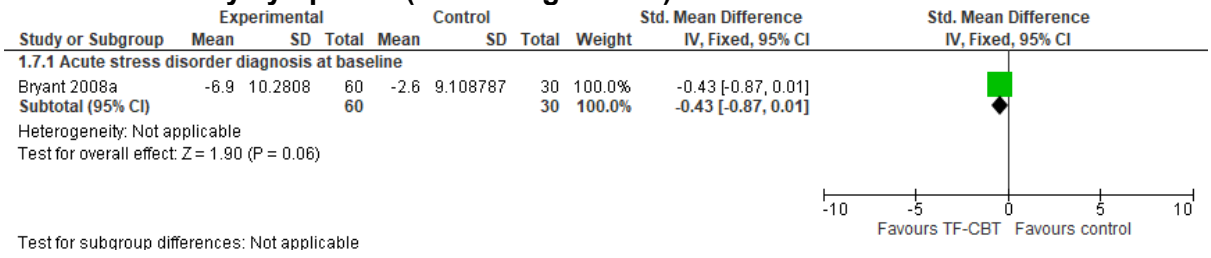


Figure 9: Trauma-focused CBT (±psycho-education) versus waitlist or no treatment for the early prevention (intervention initiated ≤ 1 month) of PTSD in adults: Depression symptoms (BDI-II change score)

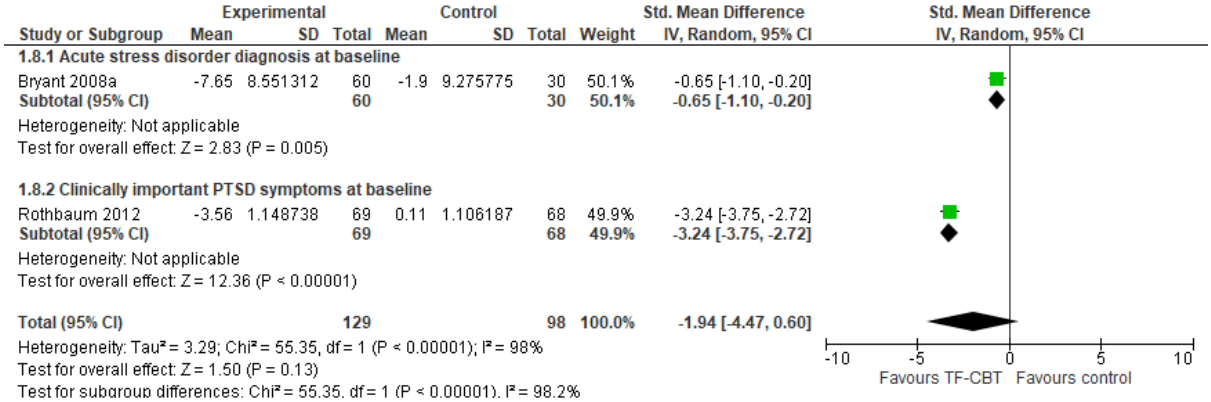
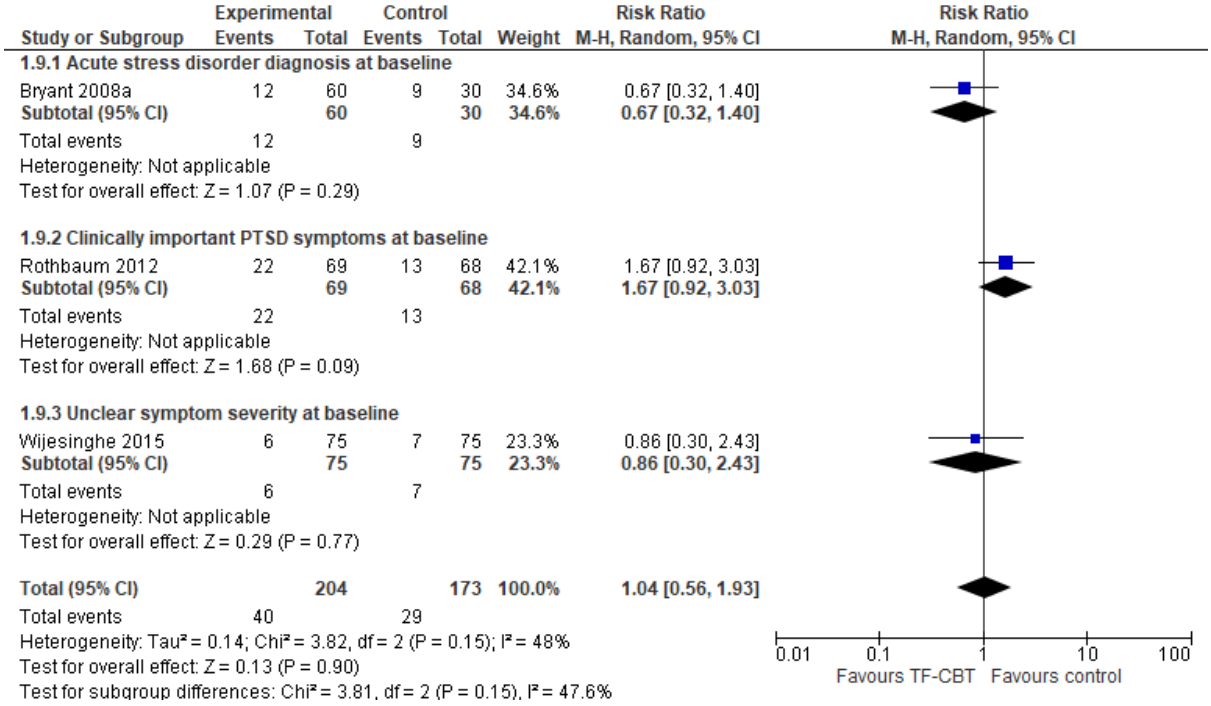


Figure 10: Trauma-focused CBT (±psycho-education) versus waitlist or no treatment for the early prevention (intervention initiated ≤ 1 month) of PTSD in adults: Discontinuation (loss to follow-up



Trauma-focused CBT (+/- TAU/psycho-education) versus TAU, attention-placebo or psycho-educational session for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Figure 11: Trauma-focused CBT (+/- TAU/psycho-education) versus TAU, attention-placebo or psycho-educational session for the early prevention (intervention initiated ≤1 month) of PTSD in adults: PTSD symptomatology self-rated at endpoint (PCL/PSS-SR change score)

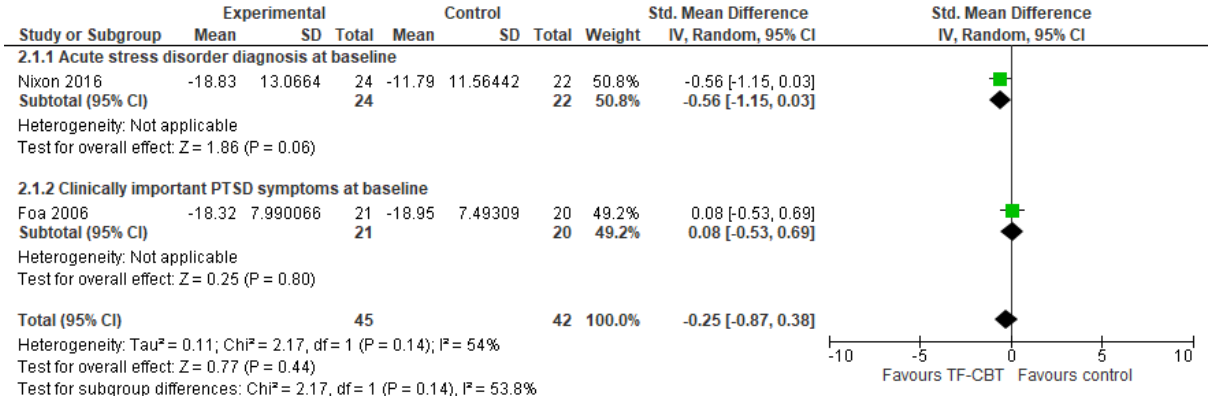


Figure 12: Trauma-focused CBT (+/- TAU/psycho-education) versus TAU, attention-placebo or psycho-educational session for the early prevention (intervention

initiated ≤1 month) of PTSD in adults: PTSD symptomatology self-rated at 3-month follow-up (PCL/PSS-SR change score)

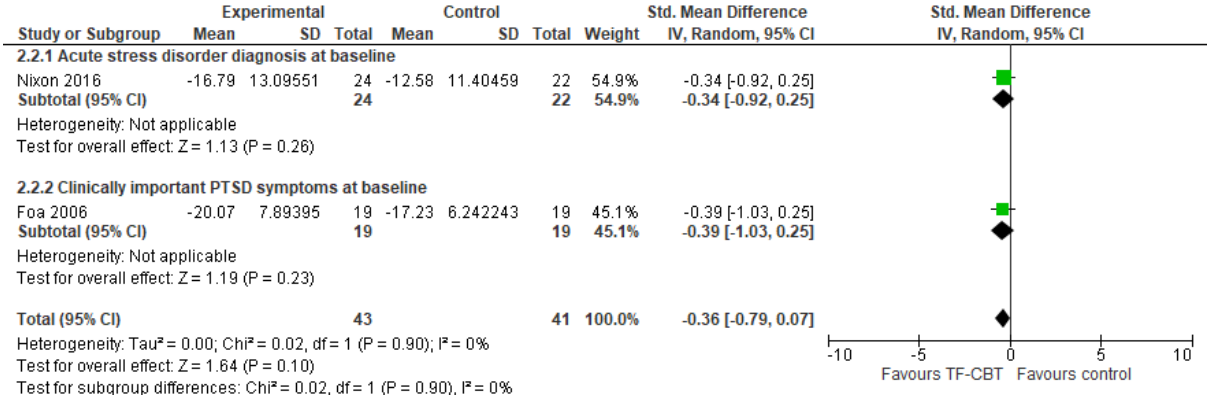


Figure 13: Trauma-focused CBT (+/- TAU/psycho-education) versus TAU, attention-placebo or psycho-educational session for the early prevention (intervention initiated ≤1 month) of PTSD in adults: PTSD symptomatology self-rated at 6-month follow-up (PCL change score)

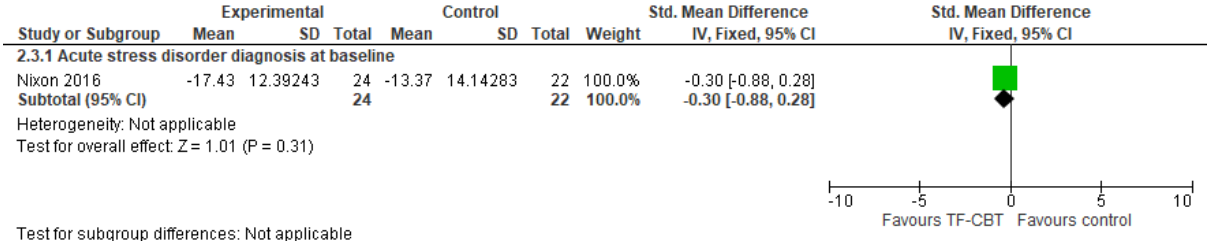


Figure 14: Trauma-focused CBT (+/- TAU/psycho-education) versus TAU, attention-placebo or psycho-educational session for the early prevention (intervention initiated ≤1 month) of PTSD in adults: PTSD symptomatology self-rated at 1-year follow-up (PCL/PSS-SR change score)

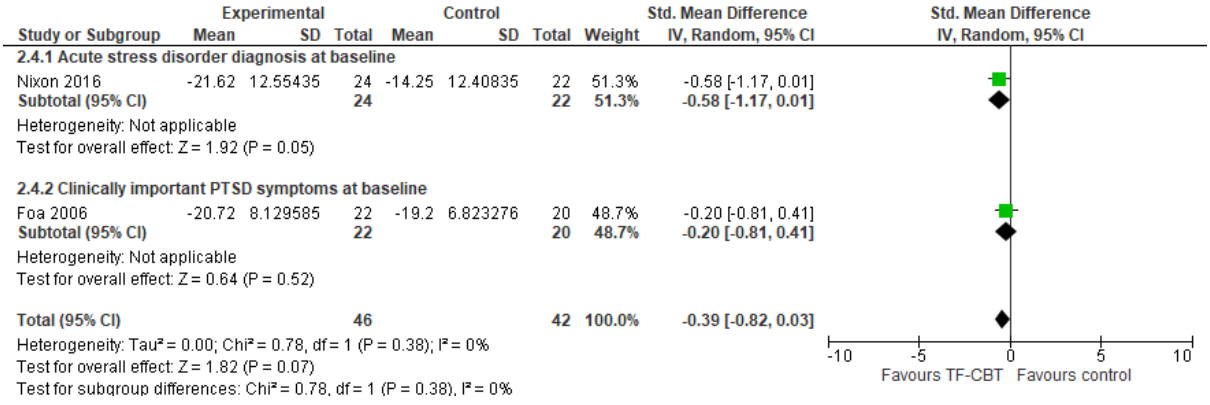


Figure 15: Trauma-focused CBT (+/- TAU/psycho-education) versus TAU, attention-placebo or psycho-educational session for the early prevention (intervention

initiated ≤1 month) of PTSD in adults: PTSD symptomatology clinician-rated at endpoint (CAPS/PSS-I change score)

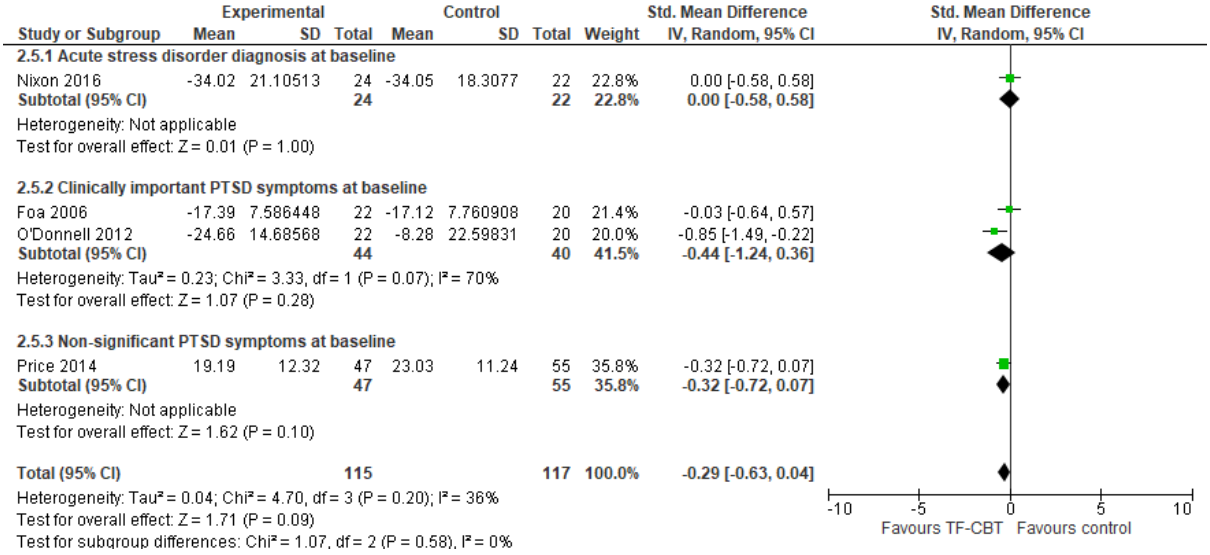


Figure 16: Trauma-focused CBT (+/- TAU/psycho-education) versus TAU, attention-placebo or psycho-educational session for the early prevention (intervention initiated ≤1 month) of PTSD in adults: PTSD symptomatology clinician-rated at 2-3 month follow-up (CAPS/PSS-I change score)

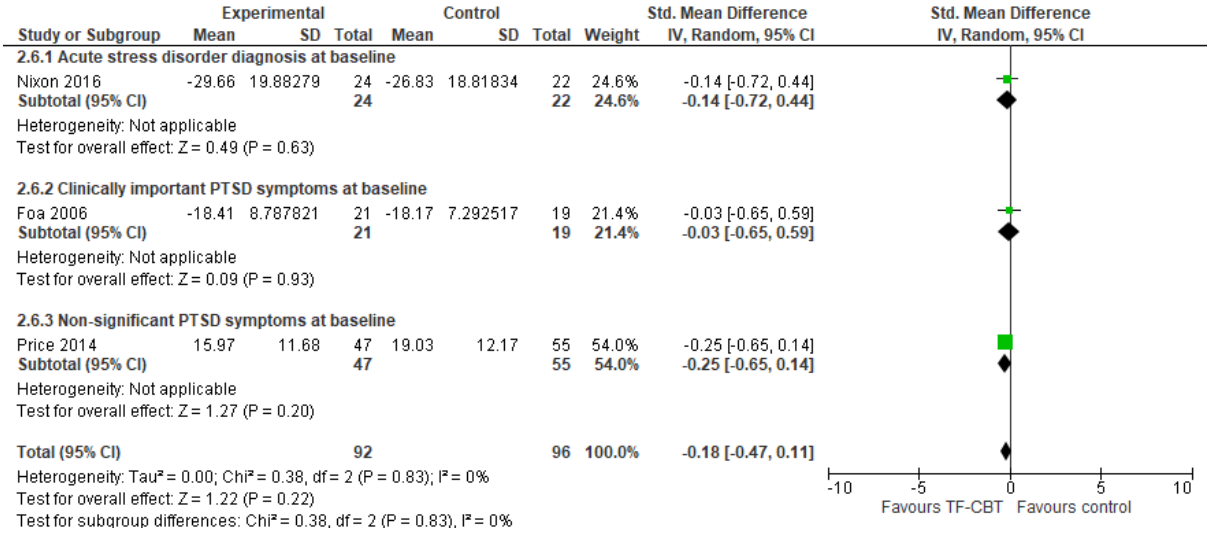


Figure 17: Trauma-focused CBT (+/- TAU/psycho-education) versus TAU, attention-placebo or psycho-educational session for the early prevention (intervention

initiated ≤1 month) of PTSD in adults: PTSD symptomatology clinician-rated at 6-month follow-up (CAPS change score)

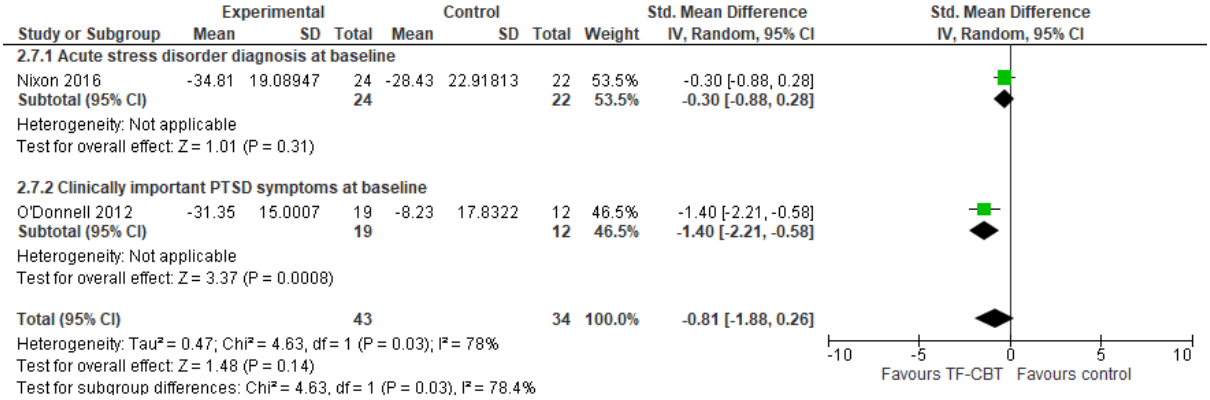


Figure 18: Trauma-focused CBT (+/- TAU/psycho-education) versus TAU, attention-placebo or psycho-educational session for the early prevention (intervention initiated ≤1 month) of PTSD in adults: PTSD symptomatology clinician-rated at 1-year follow-up (CAPS/PSS-I change score)

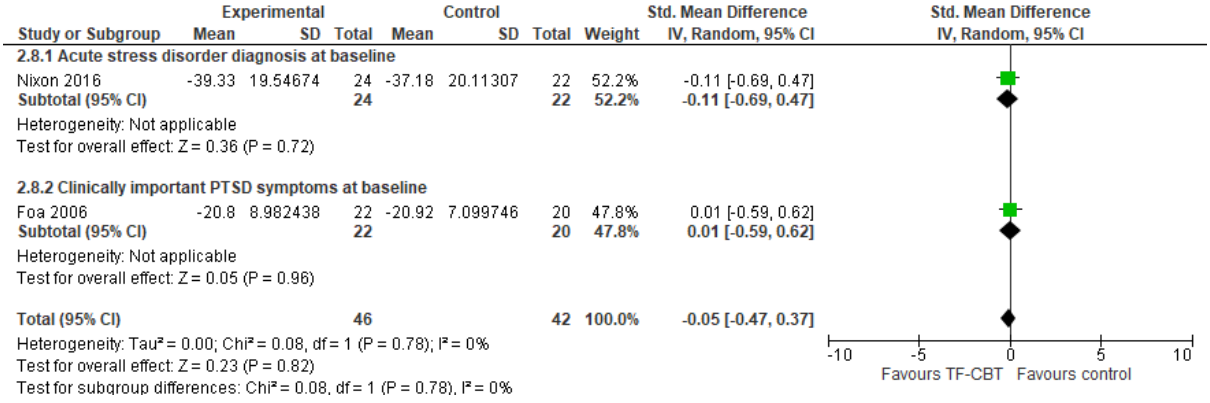


Figure 19: Trauma-focused CBT (+/- TAU/psycho-education) versus TAU, attention-placebo or psycho-educational session for the early prevention (intervention

initiated ≤1 month) of PTSD in adults: PTSD at endpoint (number meeting criteria for PTSD)

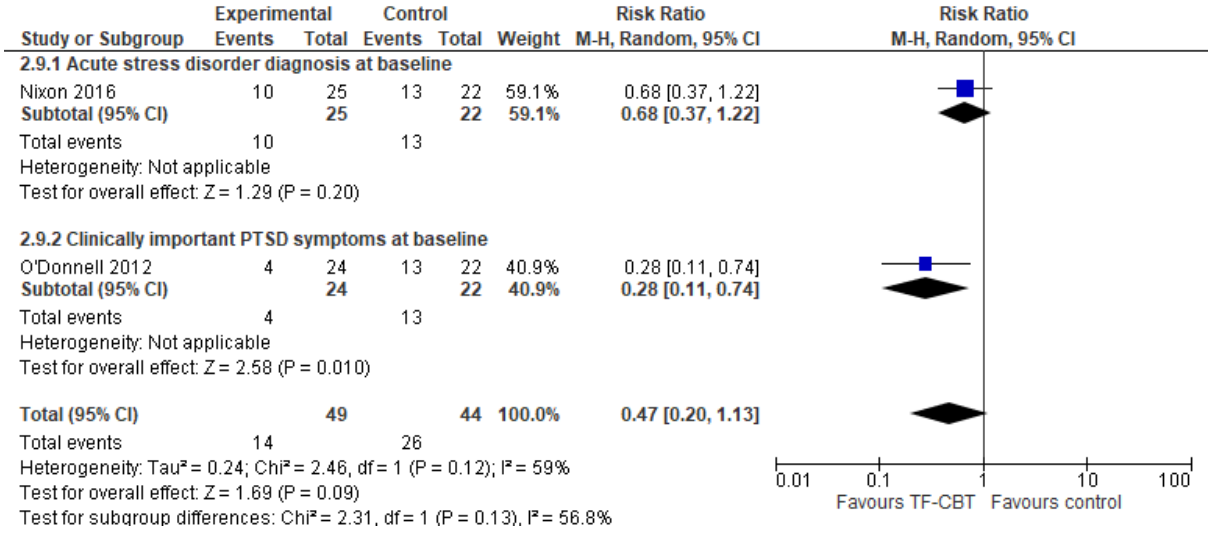


Figure 20: Trauma-focused CBT (+/- TAU/psycho-education) versus TAU, attention-placebo or psycho-educational session for the early prevention (intervention initiated ≤1 month) of PTSD in adults: PTSD at 2-3 month follow-up (number meeting criteria for PTSD)

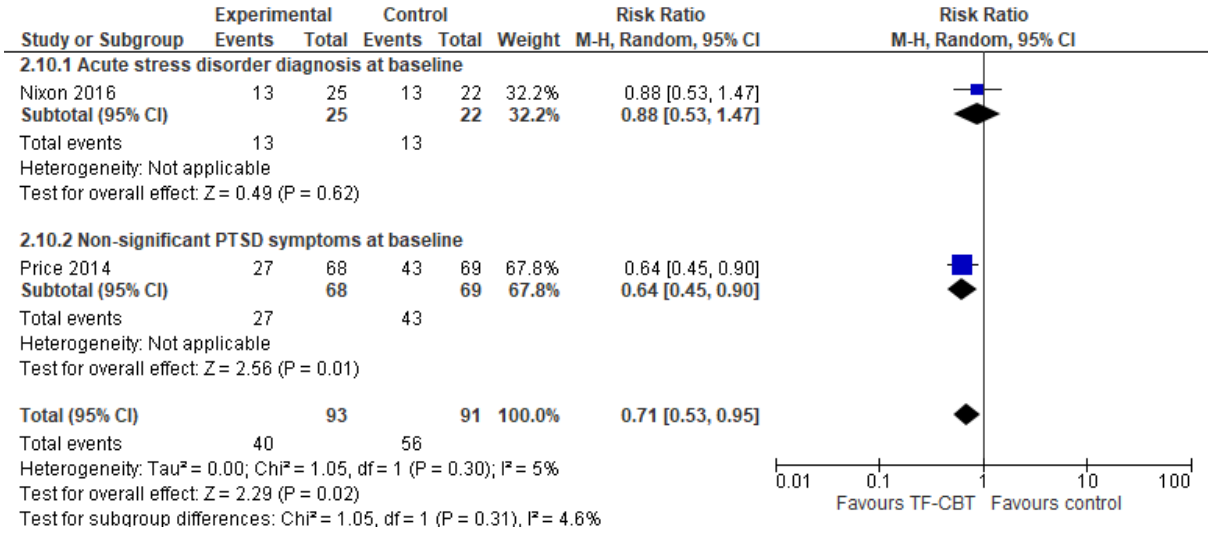


Figure 21: Trauma-focused CBT (+/- TAU/psycho-education) versus TAU, attention-placebo or psycho-educational session for the early prevention (intervention

initiated ≤1 month) of PTSD in adults: PTSD at 6-month follow-up (number meeting criteria for PTSD)

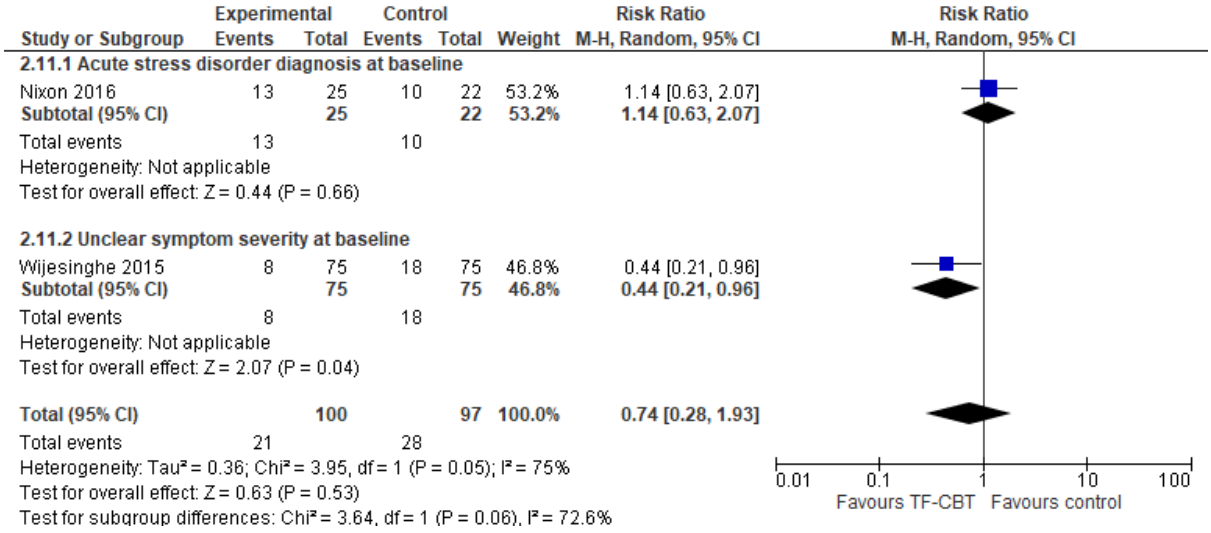


Figure 22: Trauma-focused CBT (+/- TAU/psycho-education) versus TAU, attention-placebo or psycho-educational session for the early prevention (intervention initiated ≤1 month) of PTSD in adults: PTSD at 1-year follow-up (number meeting criteria for PTSD)

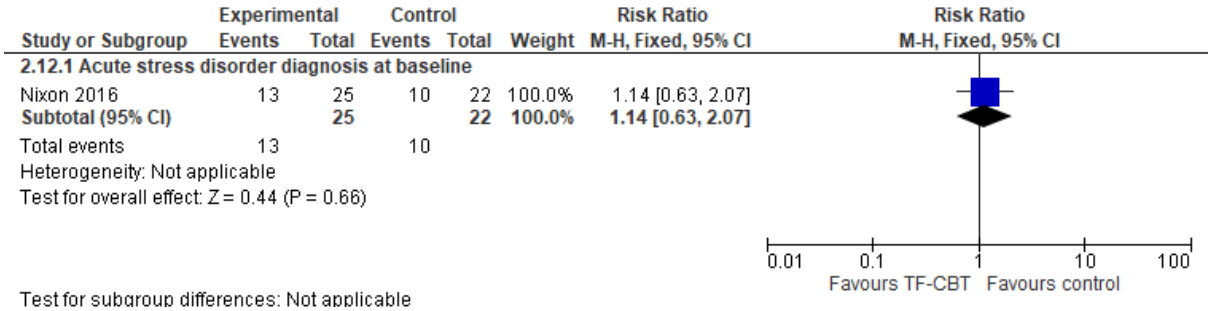


Figure 23: Trauma-focused CBT (+/- TAU/psycho-education) versus TAU, attention-placebo or psycho-educational session for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Response (number of people showing

improvement of at least 12 points on CAPS); Acute stress disorder diagnosis at baseline

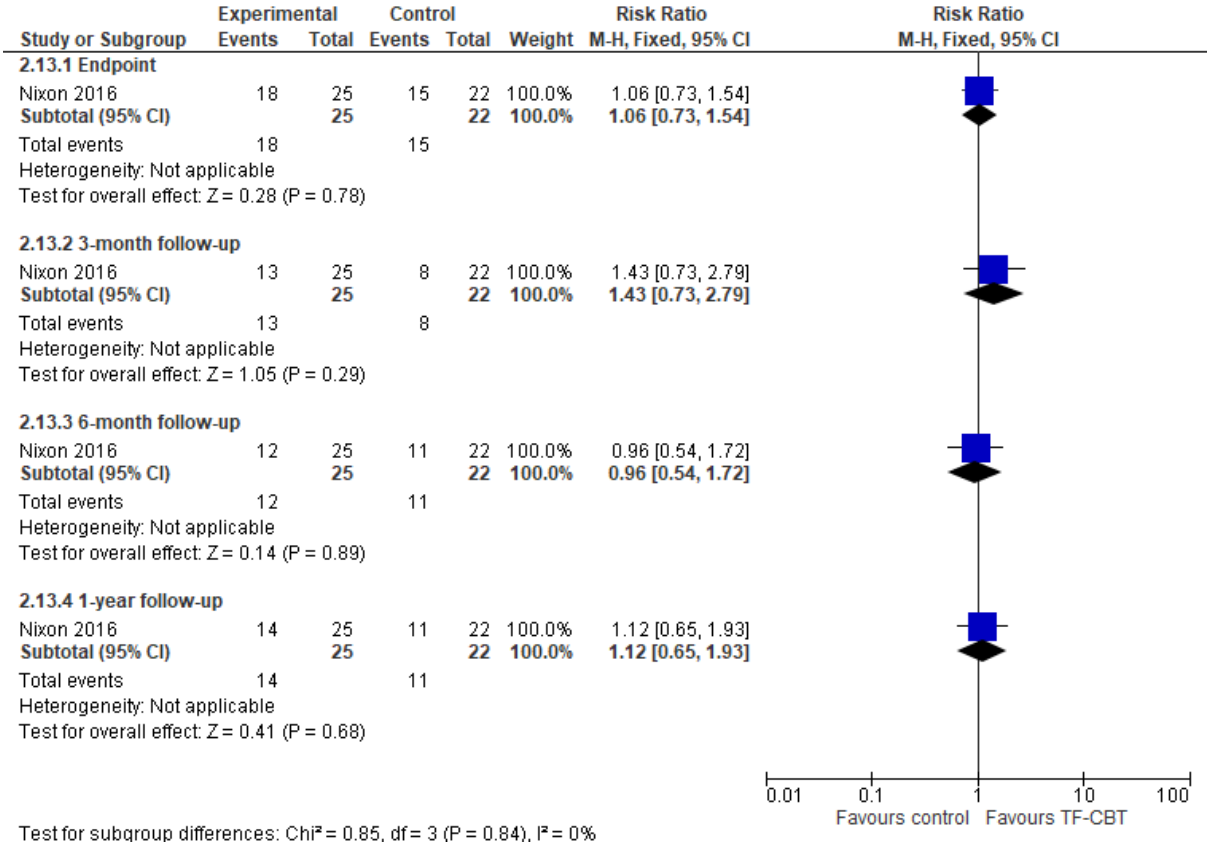


Figure 24: Trauma-focused CBT (+/- TAU/psycho-education) versus TAU, attention-placebo or psycho-educational session for the early prevention (intervention

initiated ≤1 month) of PTSD in adults: Anxiety symptoms (BAI/HADS-A change score); Clinically important PTSD symptoms at baseline

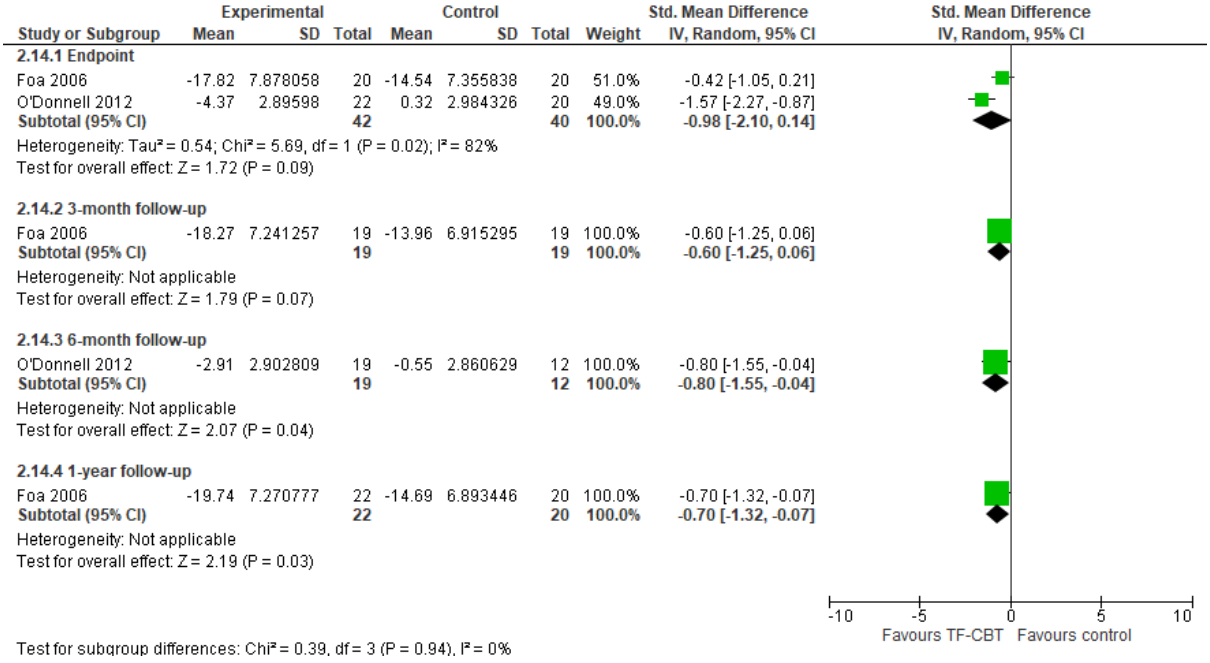


Figure 25: Trauma-focused CBT (+/- TAU/psycho-education) versus TAU, attention-placebo or psycho-educational session for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Depression symptoms at endpoint (BDI/BDI-II change score)

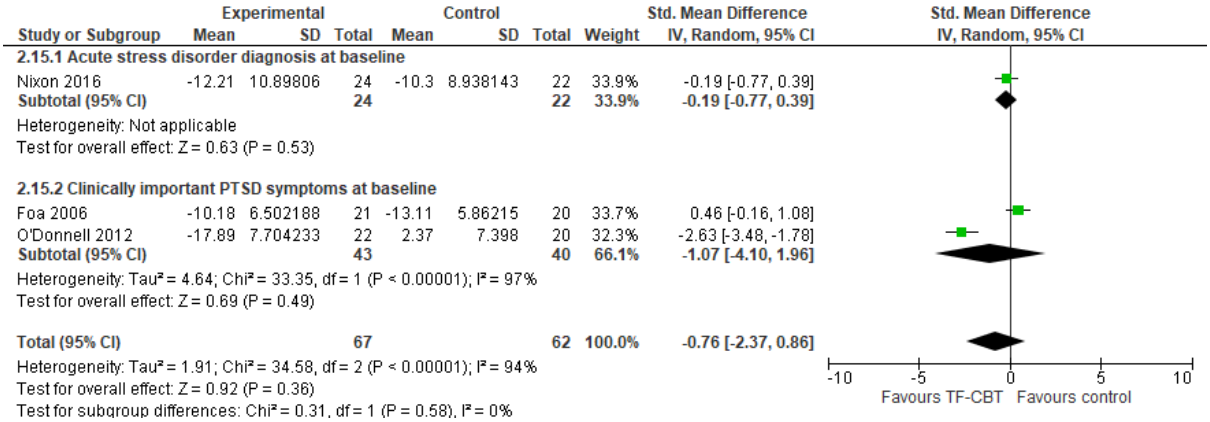


Figure 26: Trauma-focused CBT (+/- TAU/psycho-education) versus TAU, attention-placebo or psycho-educational session for the early prevention (intervention

initiated ≤1 month) of PTSD in adults: Depression symptoms at 3-month follow-up (BDI/BDI-II change score)

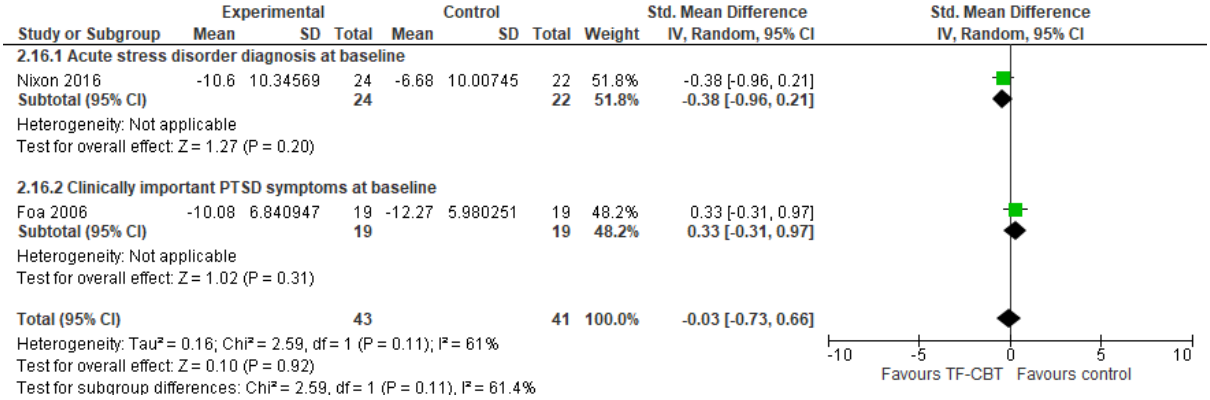


Figure 27: Trauma-focused CBT (+/- TAU/psycho-education) versus TAU, attention-placebo or psycho-educational session for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Depression symptoms at 6-month follow-up (BDI/BDI-II change score)

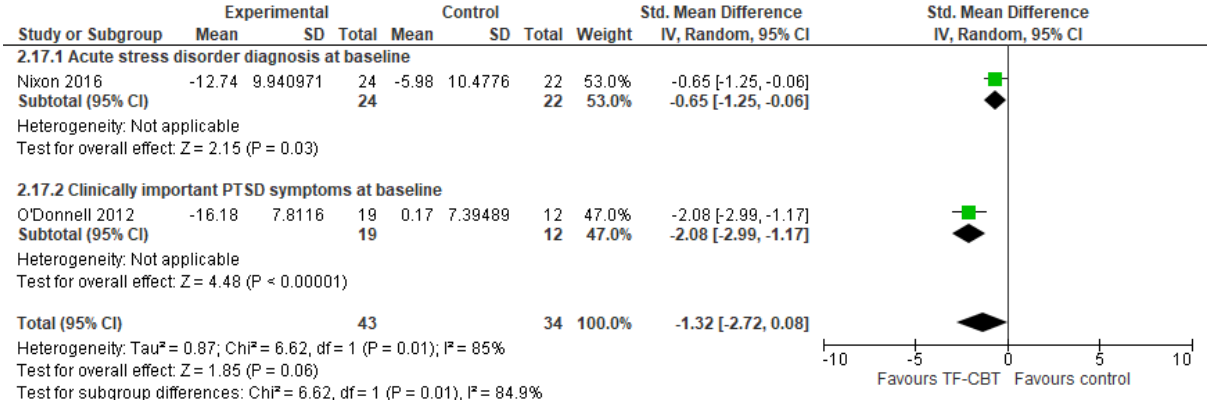


Figure 28: Trauma-focused CBT (+/- TAU/psycho-education) versus TAU, attention-placebo or psycho-educational session for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Depression symptoms at 1-year follow-up (BDI/BDI-II change score)

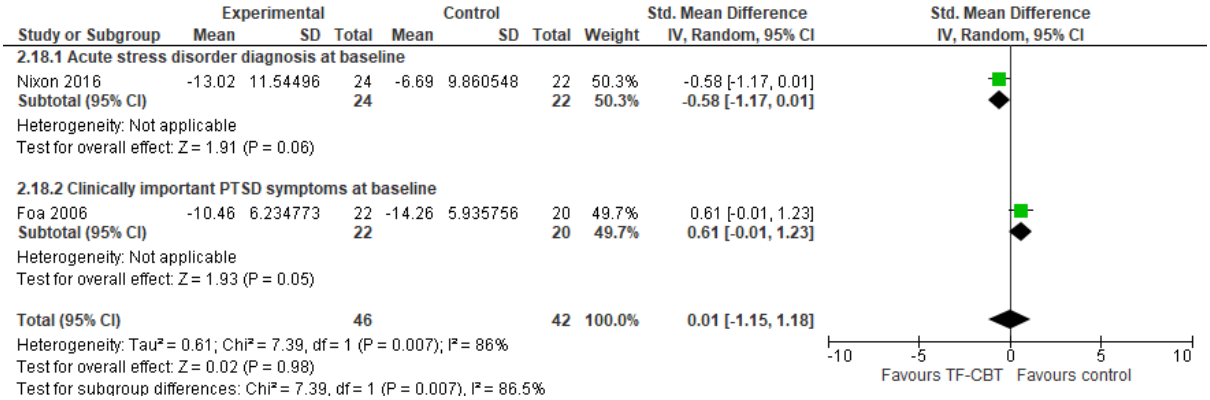
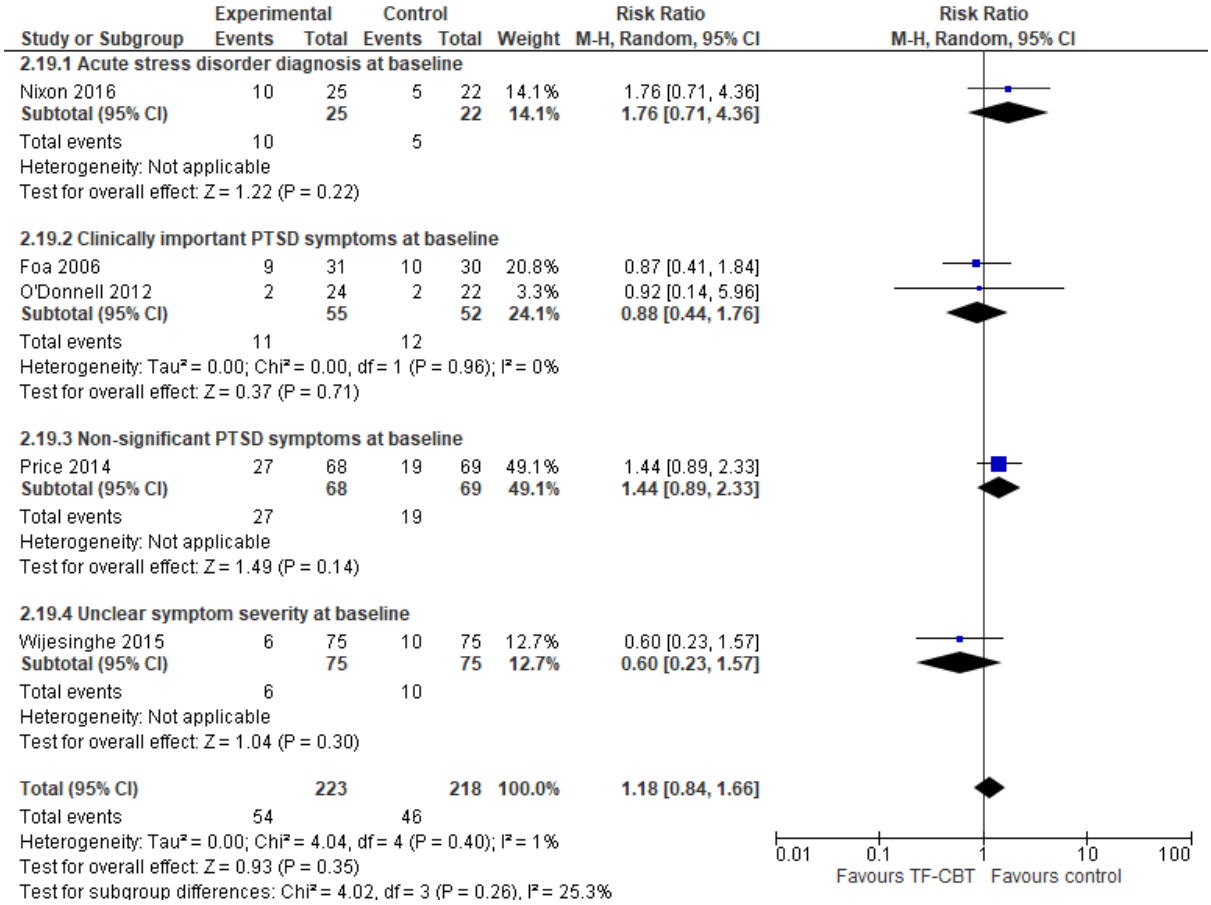


Figure 29: Trauma-focused CBT (+/- TAU/psycho-education) versus TAU, attention-placebo or psycho-educational session for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Discontinuation (loss to follow-up)



Trauma-focused CBT versus supportive counselling for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Figure 30: Trauma-focused CBT versus supportive counselling for the early prevention (intervention initiated ≤1 month) of PTSD in adults: PTSD

symptomatology self-rated at endpoint (IES-R endpoint/PCL/PDS/PSS-SR change score)

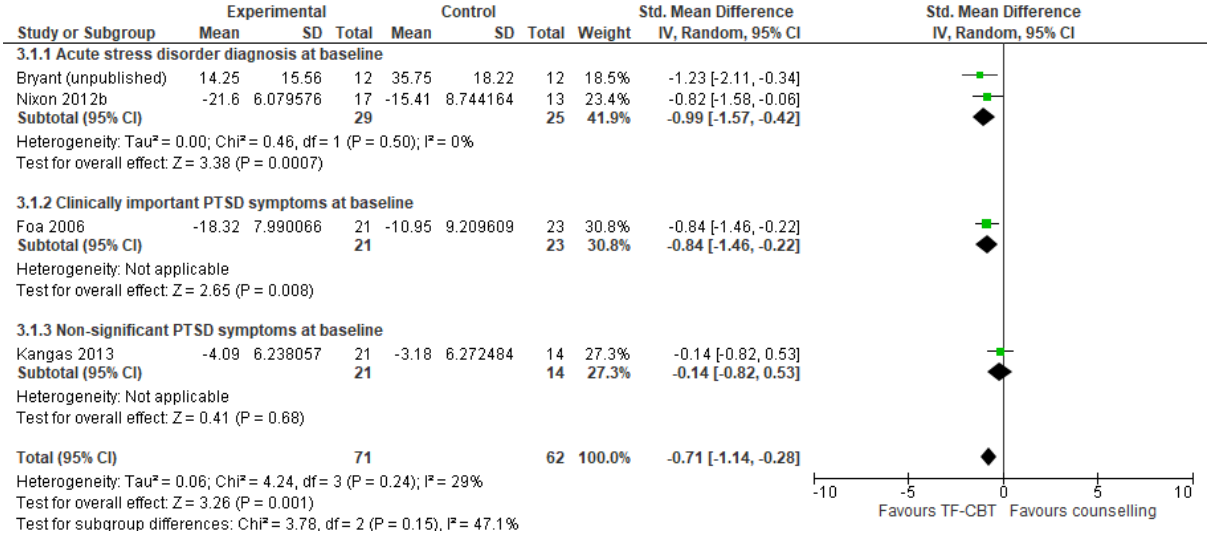


Figure 31: Trauma-focused CBT versus supportive counselling for the early prevention (intervention initiated ≤1 month) of PTSD in adults: PTSD symptomatology self-rated at 3-month follow-up (PSS-SR change score)

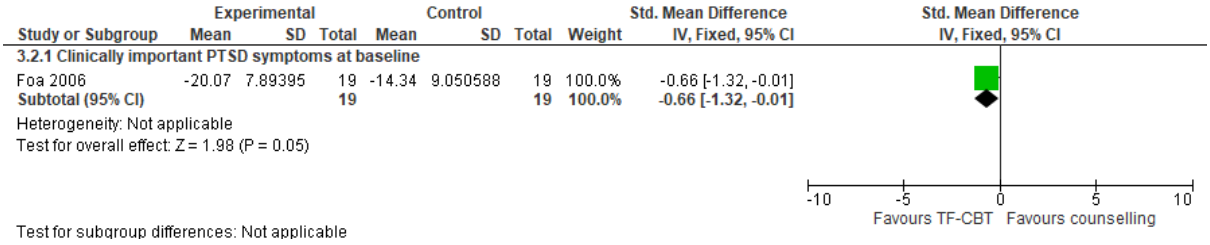


Figure 32: Trauma-focused CBT versus supportive counselling for the early prevention (intervention initiated ≤1 month) of PTSD in adults: PTSD symptomatology self-rated at 5-6 month follow-up (IES-R endpoint/PCL change score)

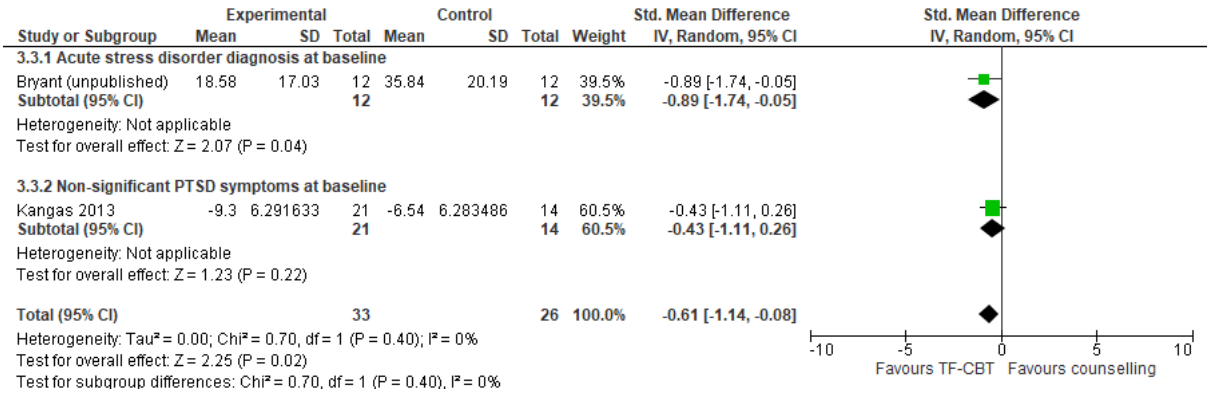


Figure 33: Trauma-focused CBT versus supportive counselling for the early prevention (intervention initiated ≤1 month) of PTSD in adults: PTSD

symptomatology self-rated at 11-12 month follow-up (PCL/PSS-SR change score)

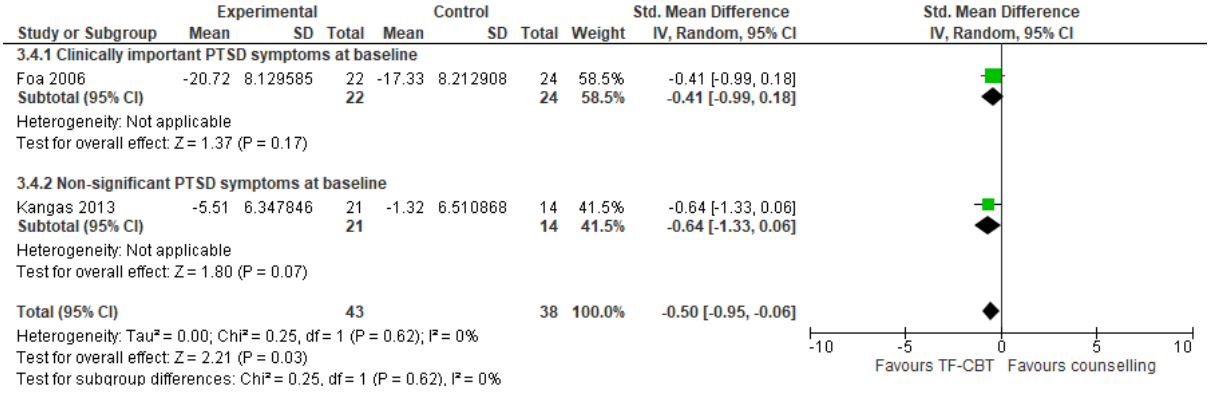


Figure 34: Trauma-focused CBT versus supportive counselling for the early prevention (intervention initiated ≤1 month) of PTSD in adults: PTSD symptomatology clinician-rated at endpoint (CAPS/PSS-I endpoint/change score)

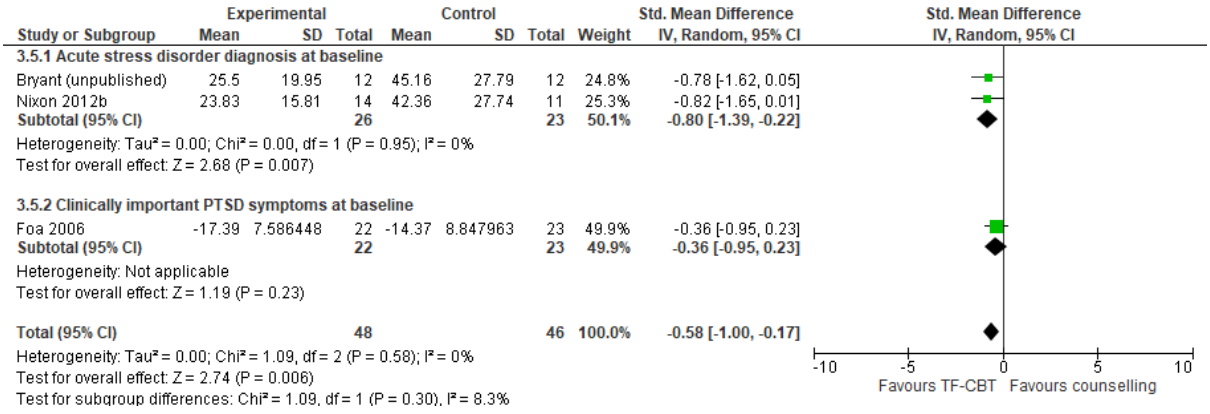


Figure 35: Trauma-focused CBT versus supportive counselling for the early prevention (intervention initiated ≤1 month) of PTSD in adults: PTSD symptomatology clinician-rated at 3-6 month follow-up (PSS-I/CAPS change score)

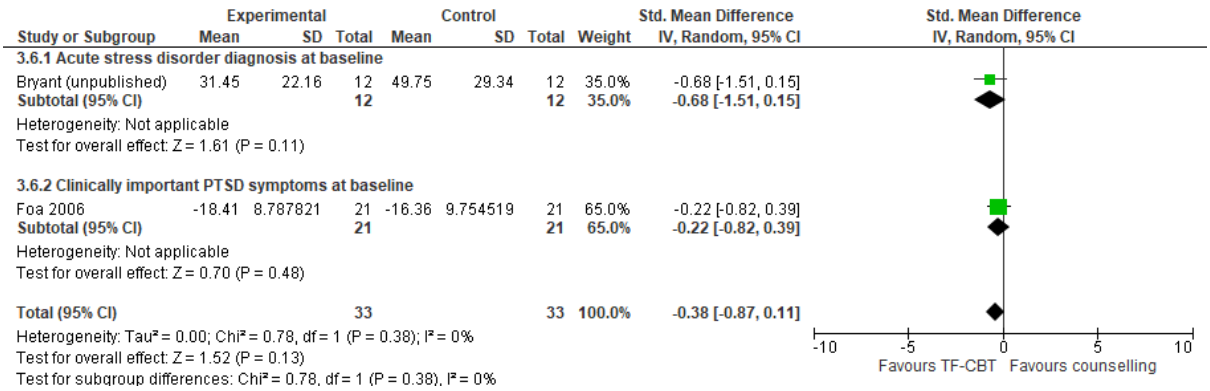


Figure 36: Trauma-focused CBT versus supportive counselling for the early prevention (intervention initiated ≤1 month) of PTSD in adults: PTSD symptomatology clinician-rated at 1-3 year follow-up (PSS-I/CAPS change score)

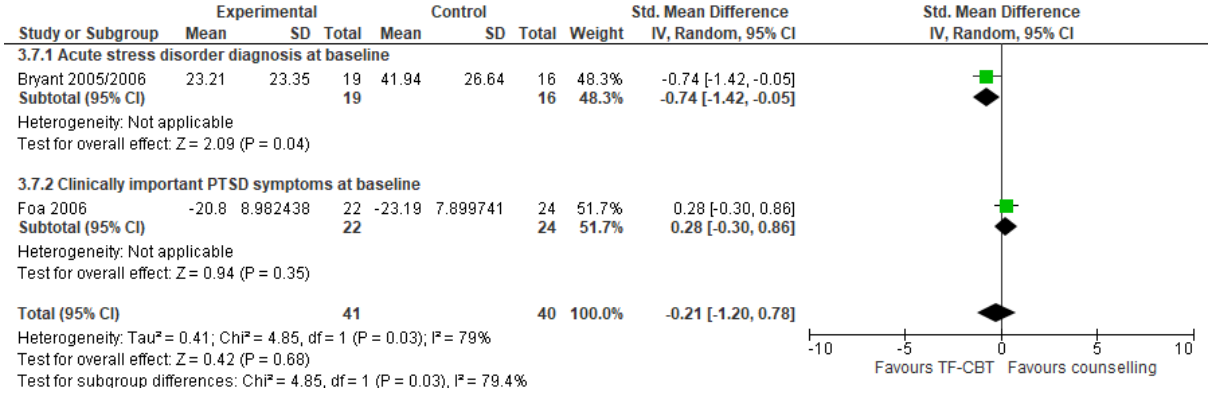


Figure 37: Trauma-focused CBT versus supportive counselling for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Diagnosis of PTSD; Acute stress disorder diagnosis at baseline

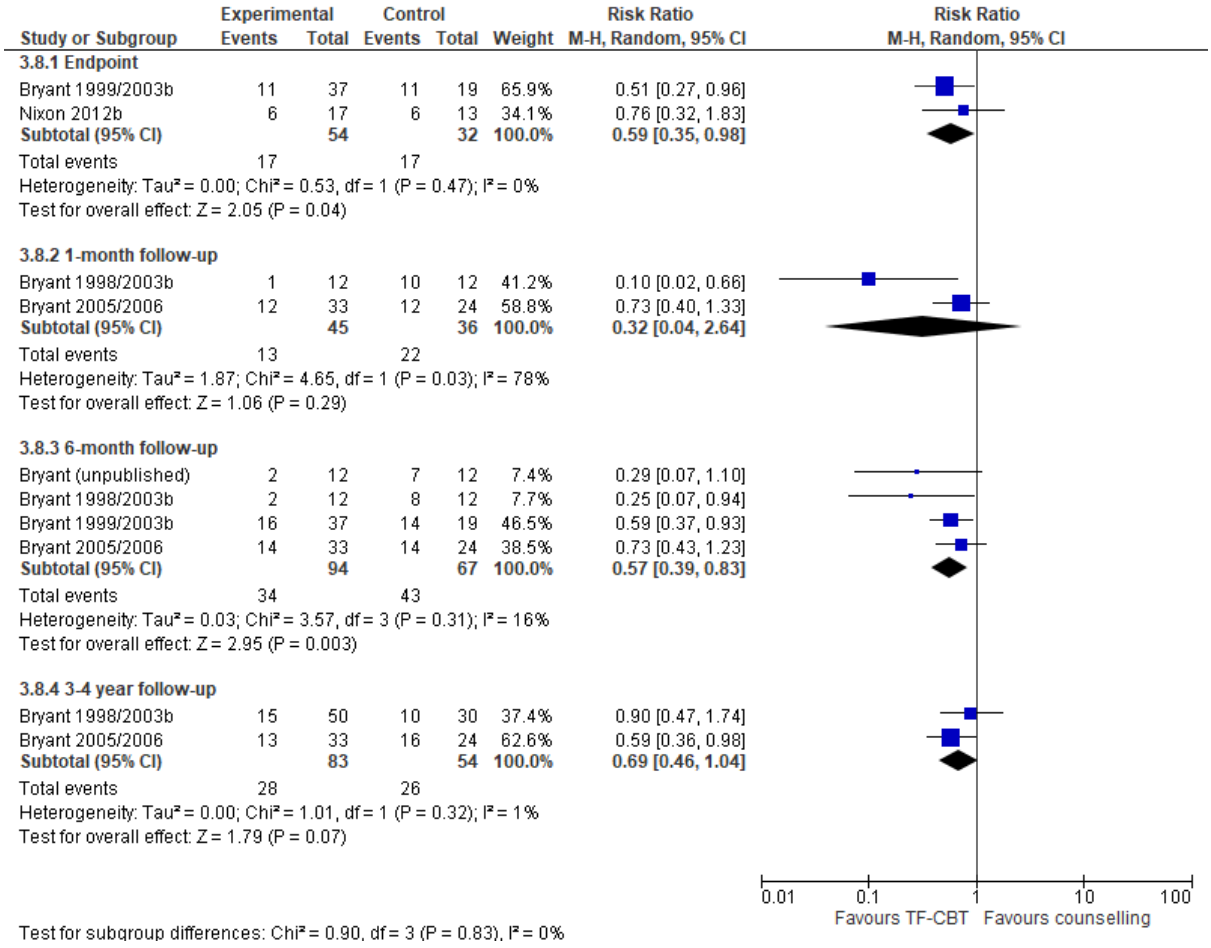


Figure 38: Trauma-focused CBT versus supportive counselling for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Anxiety symptoms at endpoint (BAI endpoint or change score/STAI State change score)

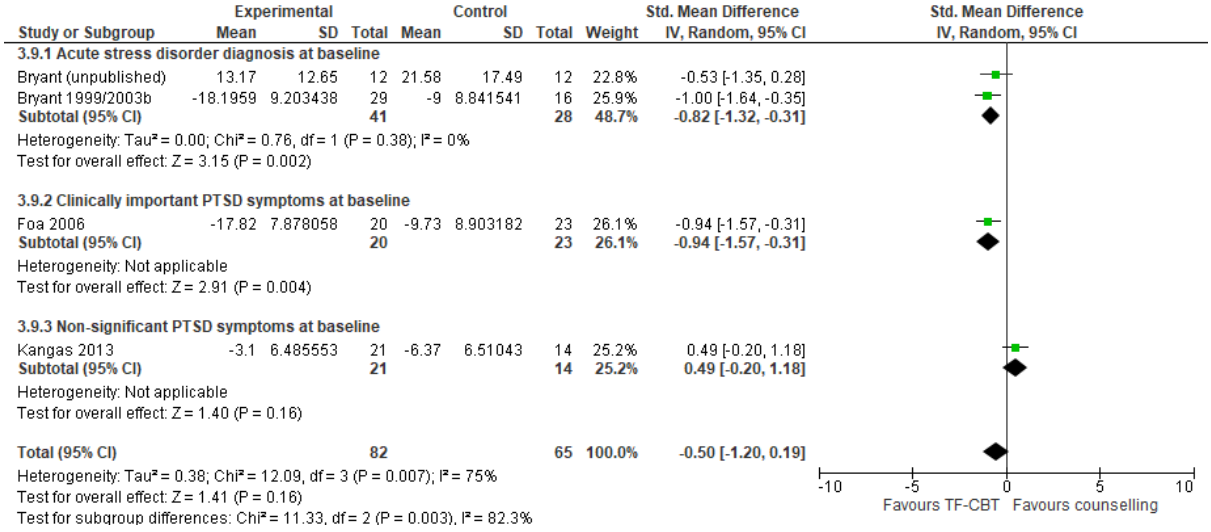


Figure 39: Trauma-focused CBT versus supportive counselling for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Anxiety symptoms at 1-3 month follow-up (BAI/STAI State change score)

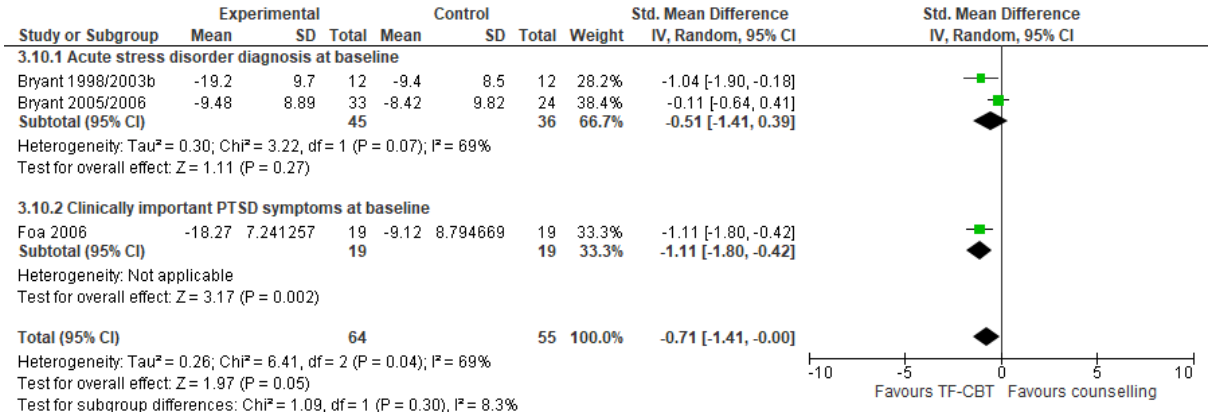


Figure 40: Trauma-focused CBT versus supportive counselling for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Anxiety

symptoms at 5-6 month follow-up (STAI State change score/BAI endpoint/change score)

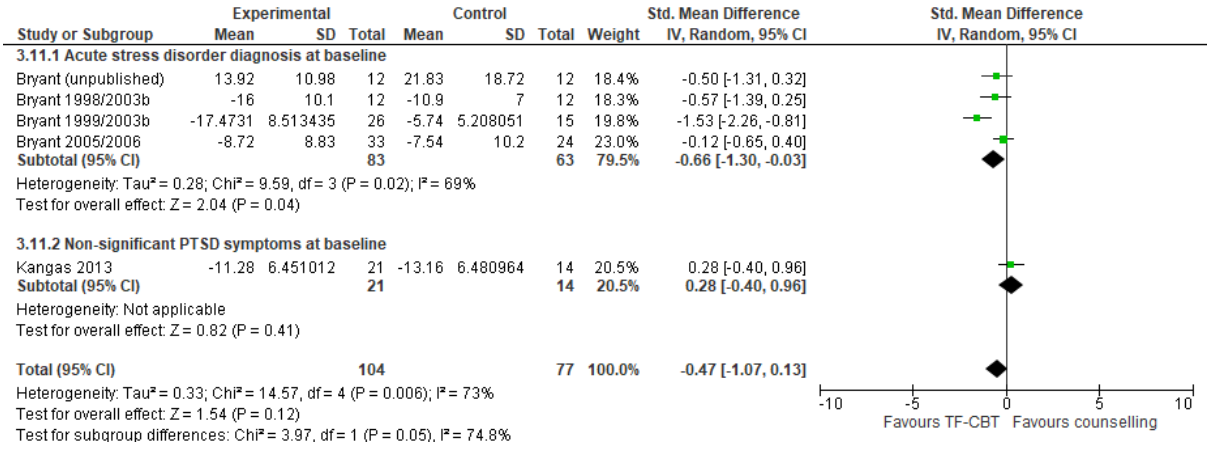


Figure 41: Trauma-focused CBT versus supportive counselling for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Anxiety symptoms at 11-12 month follow-up (BAI/STAI State change score)

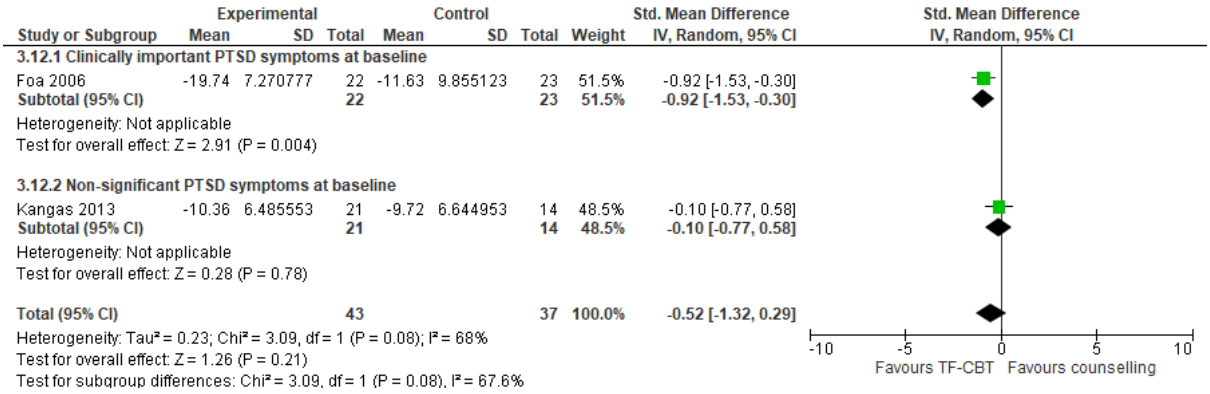


Figure 42: Trauma-focused CBT versus supportive counselling for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Depression symptoms at endpoint (BDI/BDI-II endpoint/change score)

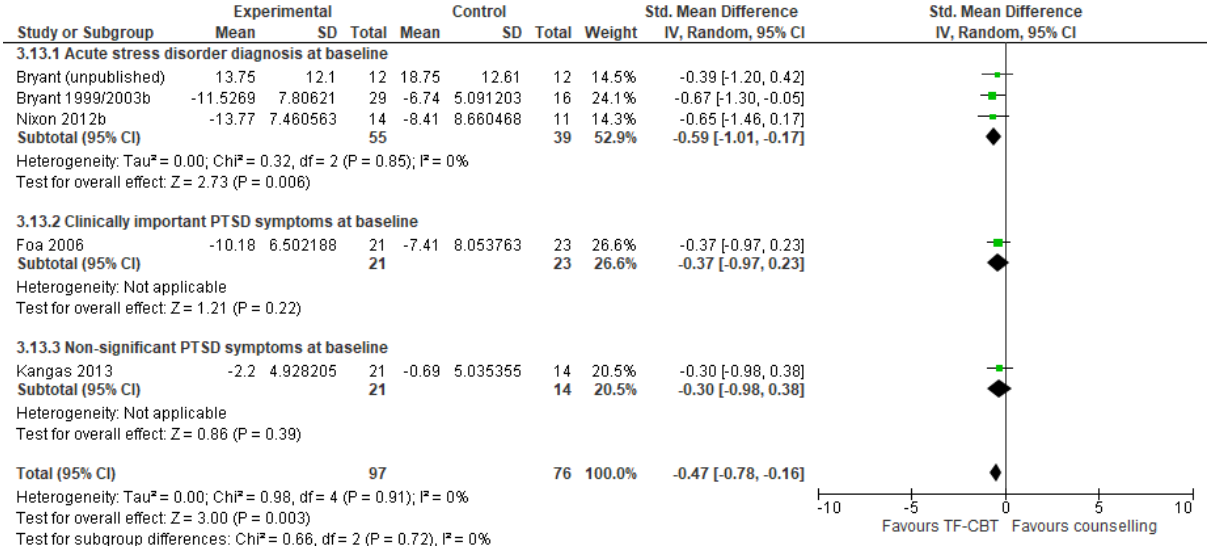


Figure 43: Trauma-focused CBT versus supportive counselling for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Depression symptoms at 1-3 month follow-up (BDI/BDI-II change score)

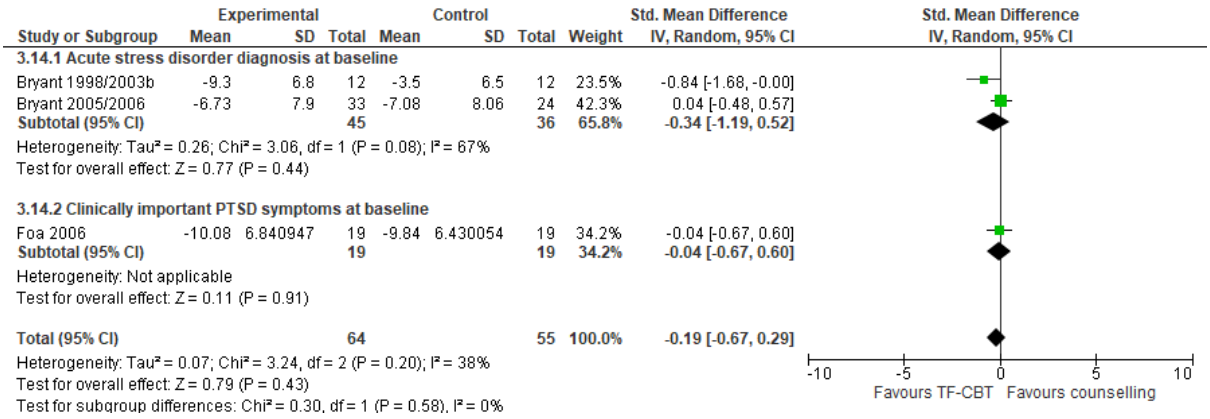


Figure 44: Trauma-focused CBT versus supportive counselling for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Depression symptoms at 5-6 month follow-up (BDI/BDI-II endpoint/change score)

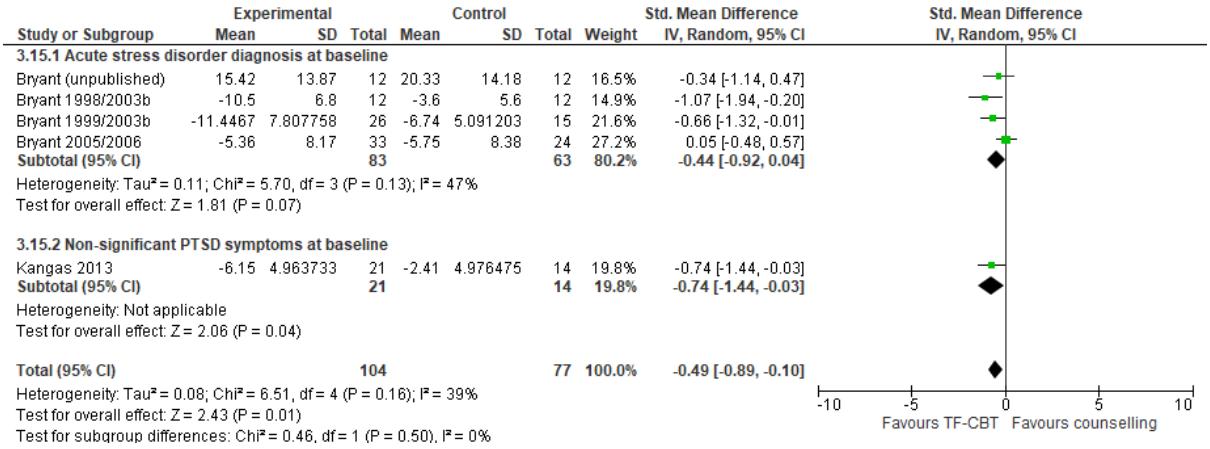


Figure 45: Trauma-focused CBT versus supportive counselling for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Depression symptoms at 11-12 month follow-up (BDI/BDI-II change score)

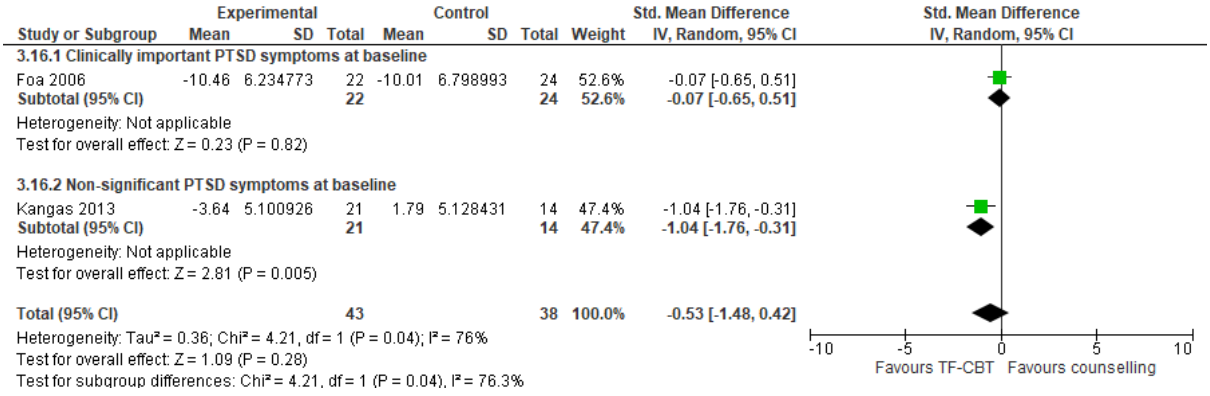


Figure 46: Trauma-focused CBT versus supportive counselling for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Depression symptoms at 3-year follow-up (BDI-II change score)

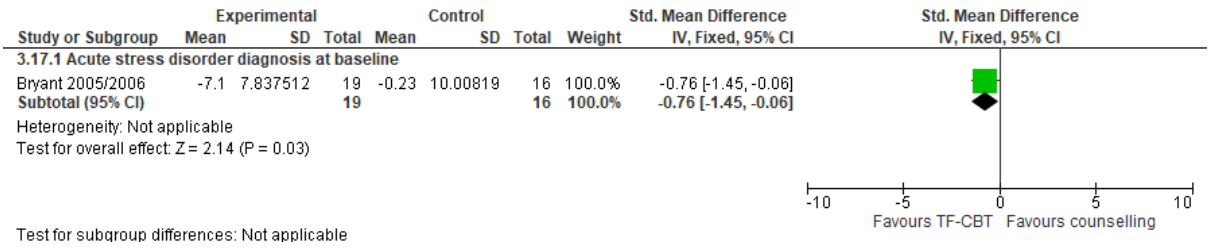


Figure 47: Trauma-focused CBT versus supportive counselling for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Quality of life (FACT-G change score); Non-significant PTSD symptoms at baseline

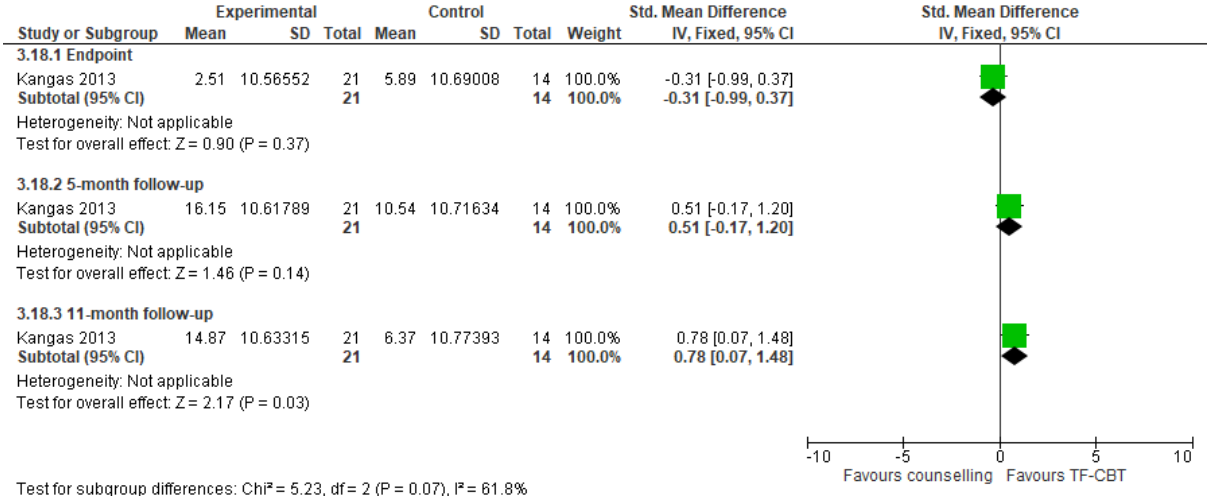
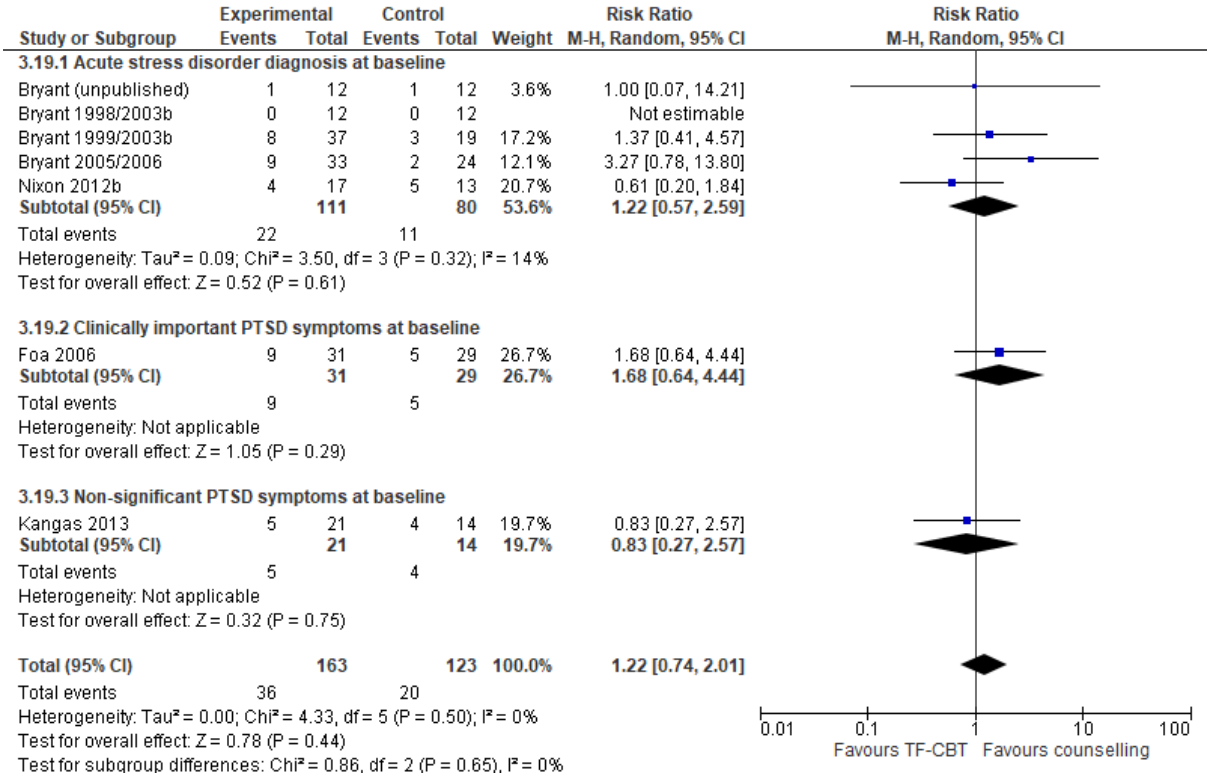


Figure 48: Trauma-focused CBT versus supportive counselling for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Discontinuation (loss to follow-up)



Trauma-focused CBT versus self-help (without support) for the early treatment (1-3 months) of below threshold PTSD symptoms in adults

Figure 49: Trauma-focused CBT versus self-help (without support) for the early treatment (1-3 months) of below threshold PTSD symptoms in adults: PTSD symptomatology self-rated (IES-R change score); Sub-threshold PTSD symptoms (just below threshold) at baseline

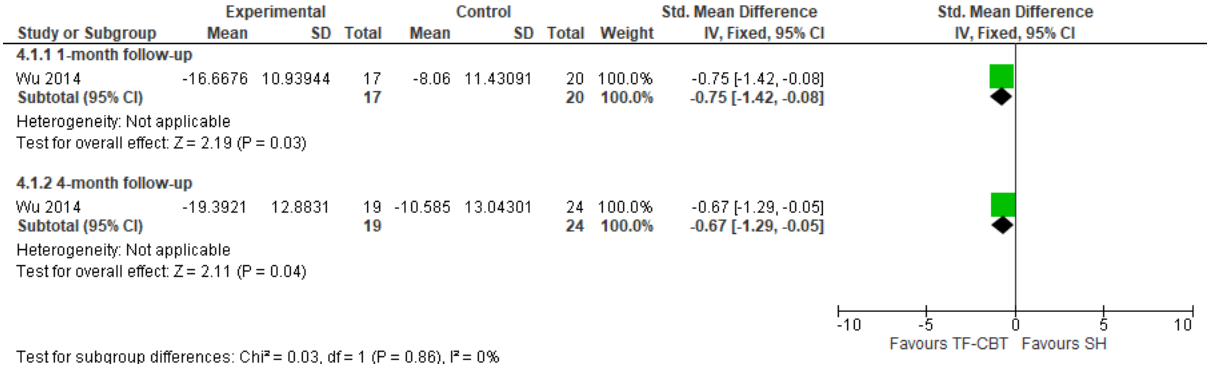


Figure 50: Trauma-focused CBT versus self-help (without support) for the early treatment (1-3 months) of below threshold PTSD symptoms in adults: Anxiety symptoms (HADS-A change score); Subthreshold PTSD symptoms (just below threshold) at baseline

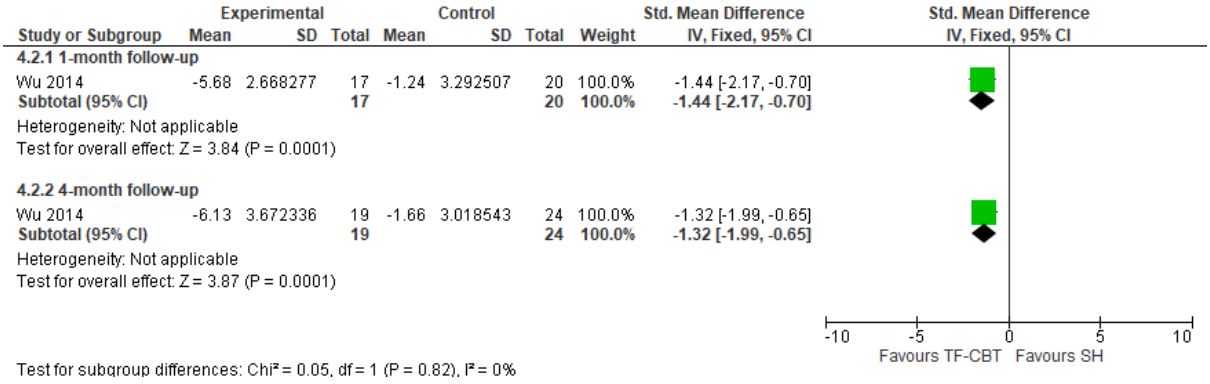


Figure 51: Trauma-focused CBT versus self-help (without support) for the early treatment (1-3 months) of below threshold PTSD symptoms in adults:

Depression symptoms (HADS-D change score); Subthreshold PTSD symptoms (just below threshold) at baseline

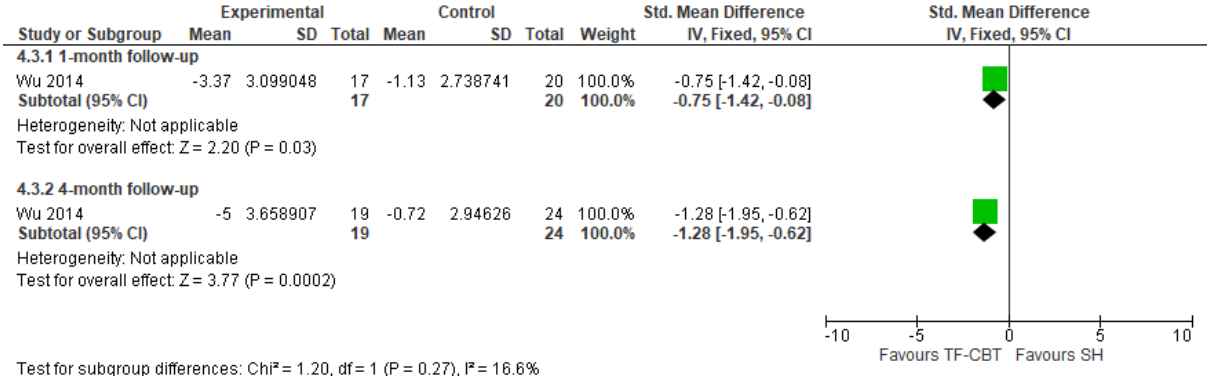
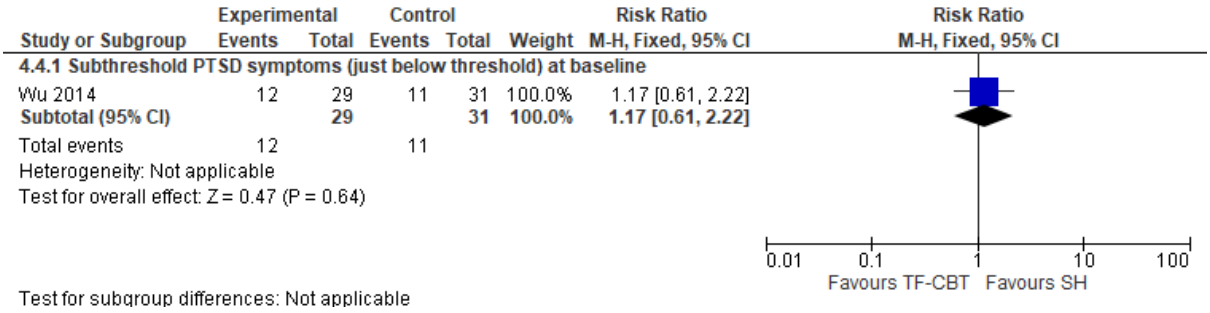


Figure 52: Trauma-focused CBT versus self-help (without support) for the early treatment (1-3 months) of below threshold PTSD symptoms in adults: Discontinuation (loss to follow-up)



Trauma-focused CBT versus waitlist/no treatment for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Figure 53: Trauma-focused CBT versus waitlist/no treatment for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: PTSD symptomatology self-rated at endpoint (PCL change score)

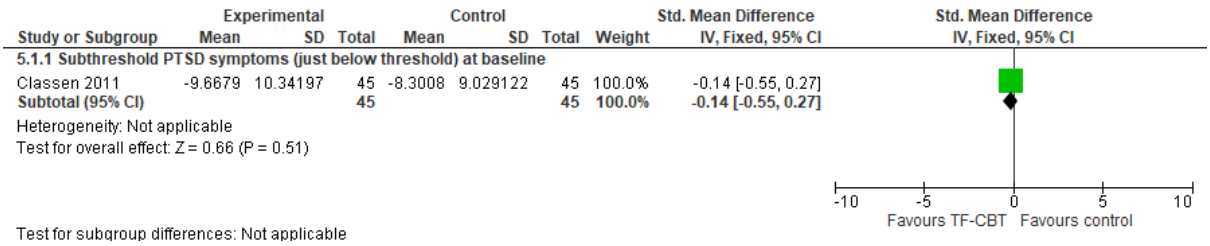


Figure 54: Trauma-focused CBT versus waitlist/no treatment for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: PTSD symptomatology self-rated at 1-2 month follow-up (PCL/HTQ change score)

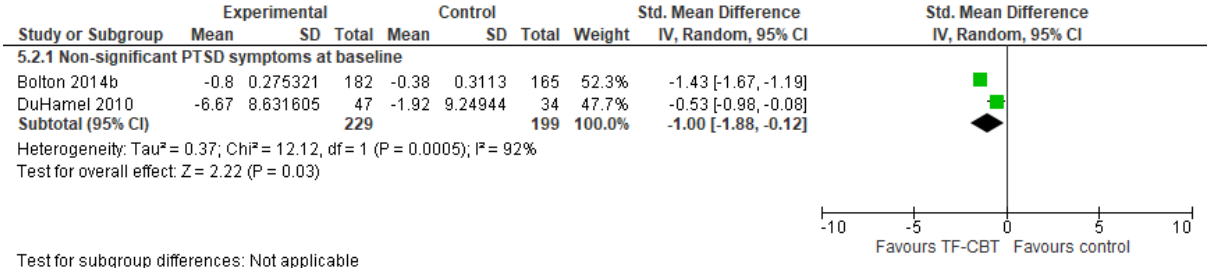


Figure 55: Trauma-focused CBT versus waitlist/no treatment for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: PTSD symptomatology self-rated at 5-6 month follow-up (PCL change score)

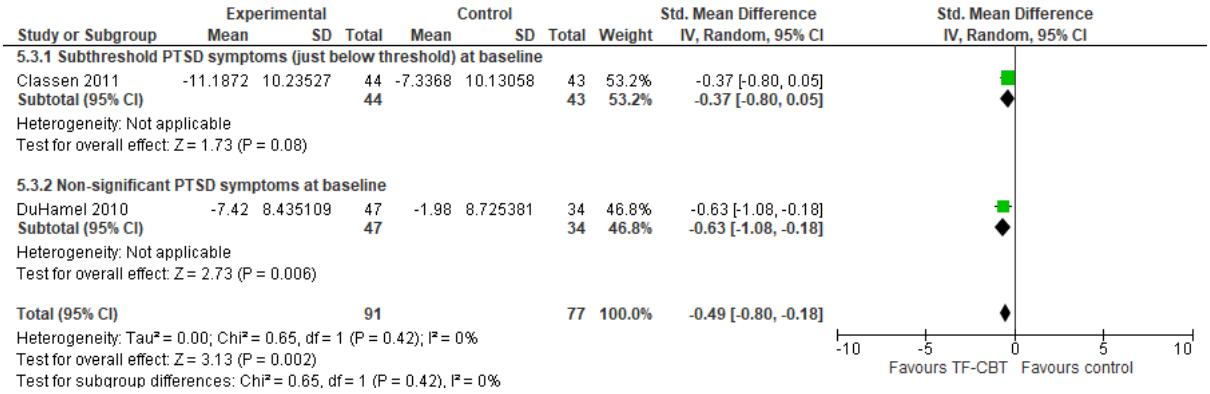


Figure 56: Trauma-focused CBT versus waitlist/no treatment for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: PTSD symptomatology self-rated at 8-month follow-up (PCL change score)

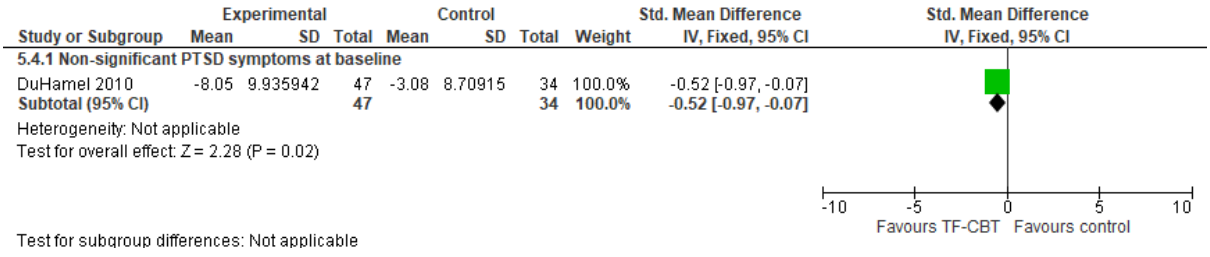


Figure 57: Trauma-focused CBT versus waitlist/no treatment for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: PTSD symptomatology clinician-rated (CAPS change score)

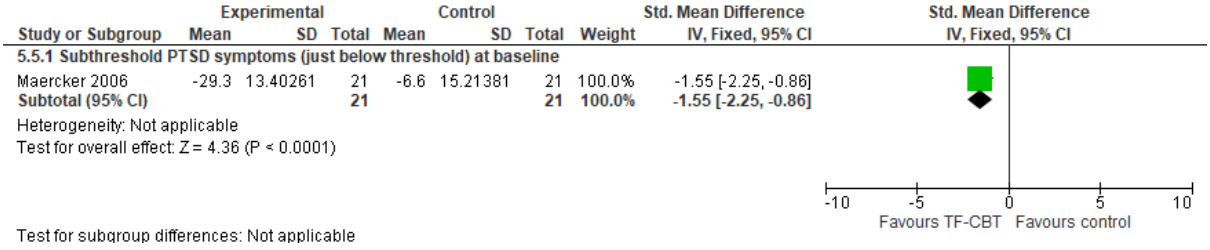


Figure 58: Trauma-focused CBT versus waitlist/no treatment for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: PTSD at endpoint (number who met criteria for PTSD)

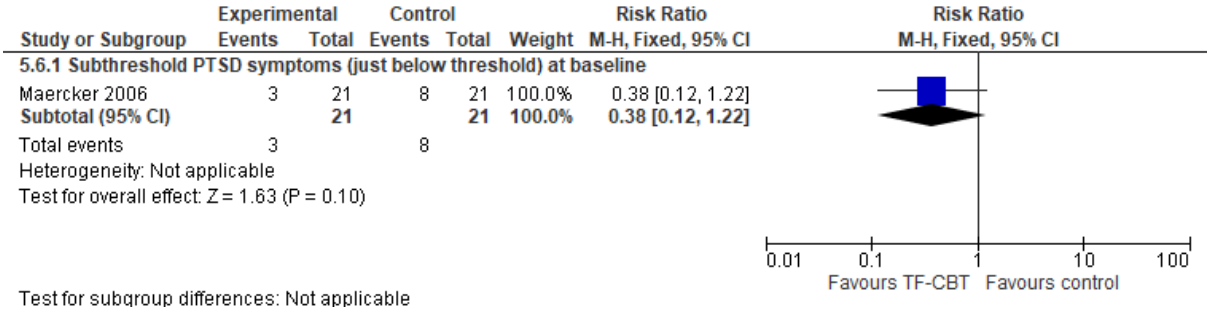


Figure 59: Trauma-focused CBT versus waitlist/no treatment for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: Anxiety symptoms at 1-month follow-up (HSCL-25 Anxiety change score)

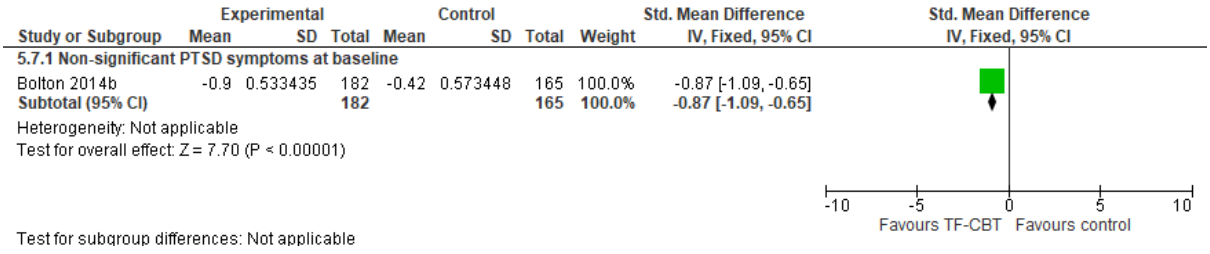


Figure 60: Trauma-focused CBT versus waitlist/no treatment for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: Depression

symptoms (HSCL-25/BSI Depression change score); Non-significant PTSD symptoms at baseline

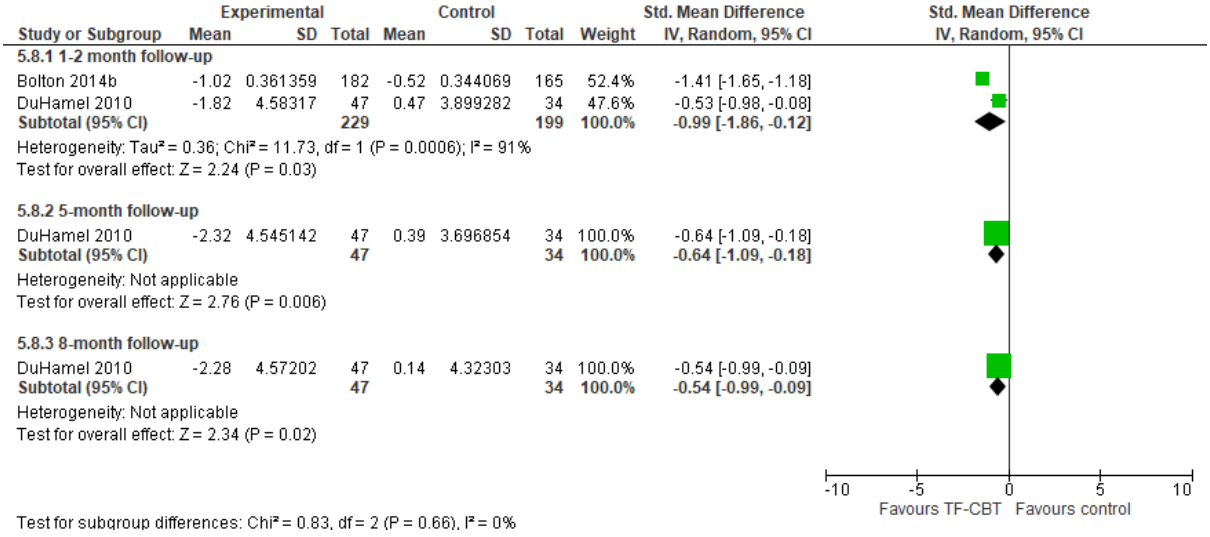


Figure 61: Trauma-focused CBT versus waitlist/no treatment for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: Alcohol use disorder symptoms at 1-month follow-up (AUDIT change score)

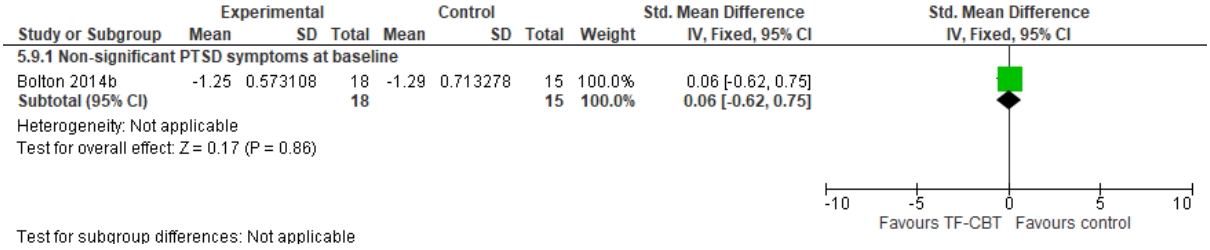


Figure 62: Trauma-focused CBT versus waitlist/no treatment for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: Alcohol use (Drug and Alcohol Use Interview: Total drinks in last 3 months change score); Subthreshold PTSD symptoms (just below threshold) at baseline

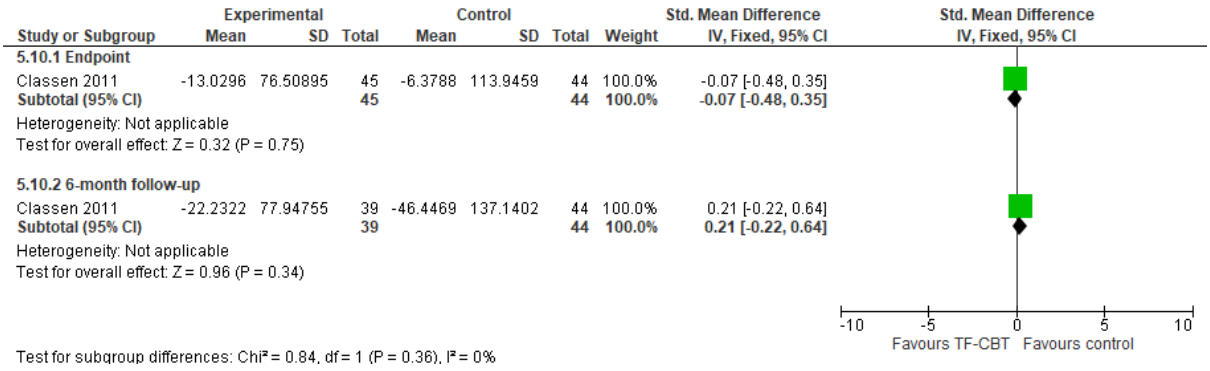


Figure 63: Trauma-focused CBT versus waitlist/no treatment for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: Drug use (Drug

and Alcohol Use Interview: Total joints in last 3 months change score); Subthreshold PTSD symptoms (just below threshold) at baseline

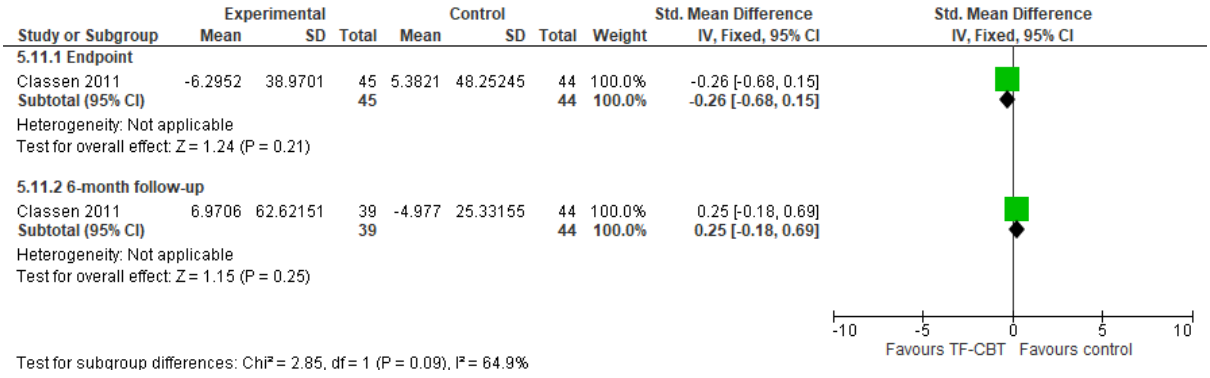


Figure 64: Trauma-focused CBT versus waitlist/no treatment for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: Relationship difficulties (IIP change score); Subthreshold PTSD symptoms (just below threshold) at baseline

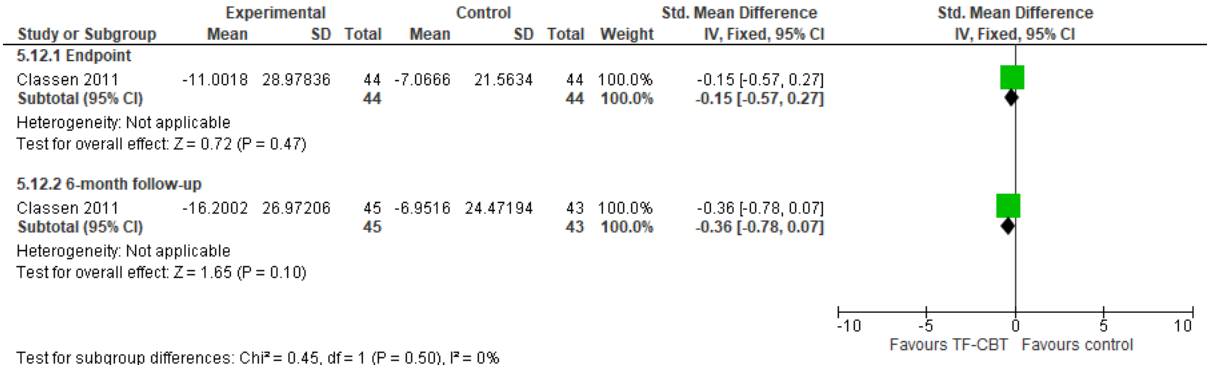
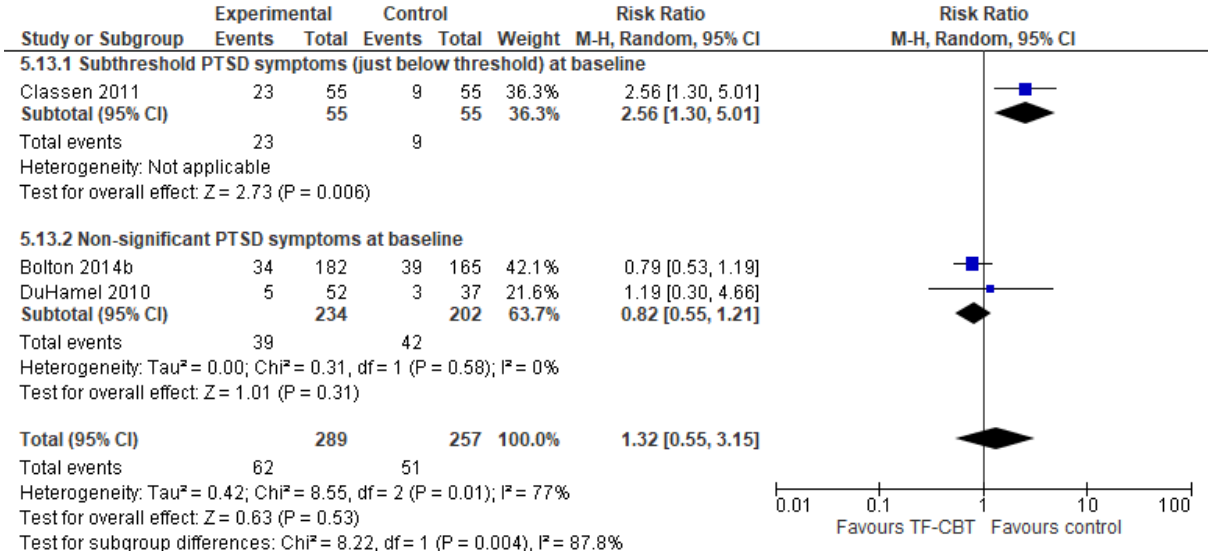


Figure 65: Trauma-focused CBT versus waitlist/no treatment for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: Discontinuation (loss to follow-up)



Trauma-focused CBT versus attention-placebo/psycho-education for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Figure 66: Trauma-focused CBT versus attention-placebo/psycho-education for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: PTSD symptomatology self-rated at endpoint (PCL/IES change score)

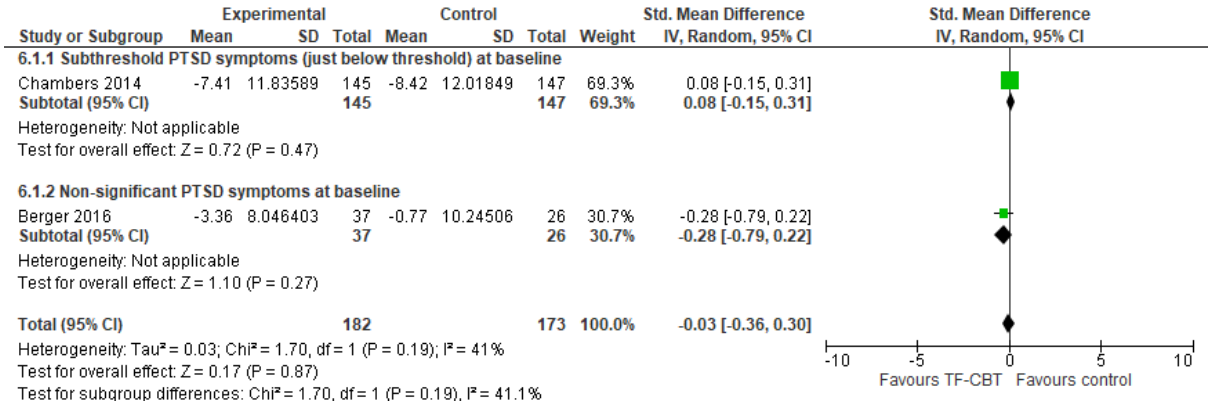


Figure 67: Trauma-focused CBT versus attention-placebo/psycho-education for the delayed treatment (>3 months) of below threshold PTSD symptoms in

adults: PTSD symptomatology self-rated at 3-month follow-up (IES change score)

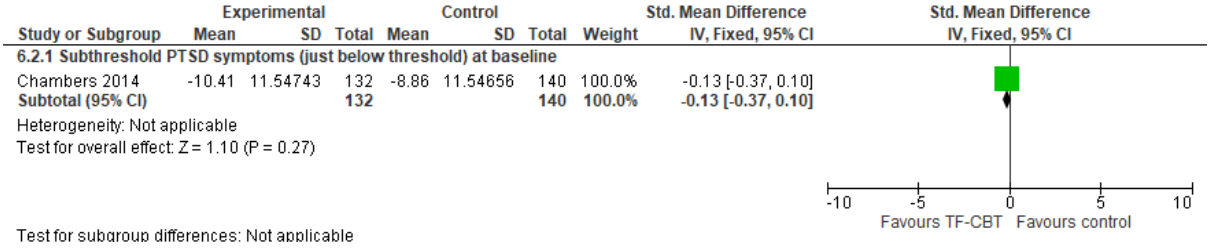


Figure 68: Trauma-focused CBT versus attention-placebo/psycho-education for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: PTSD symptomatology self-rated at 6-8 month follow-up (PCL/IES change score)

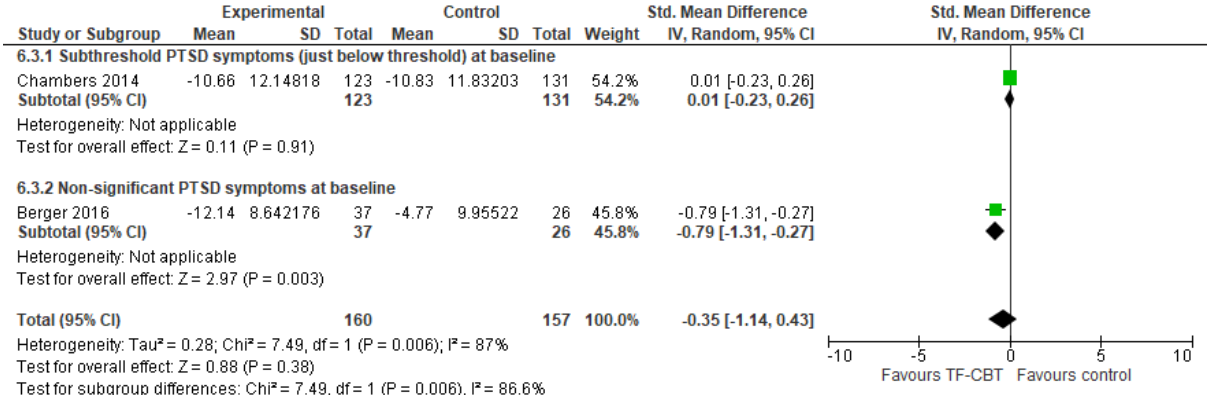
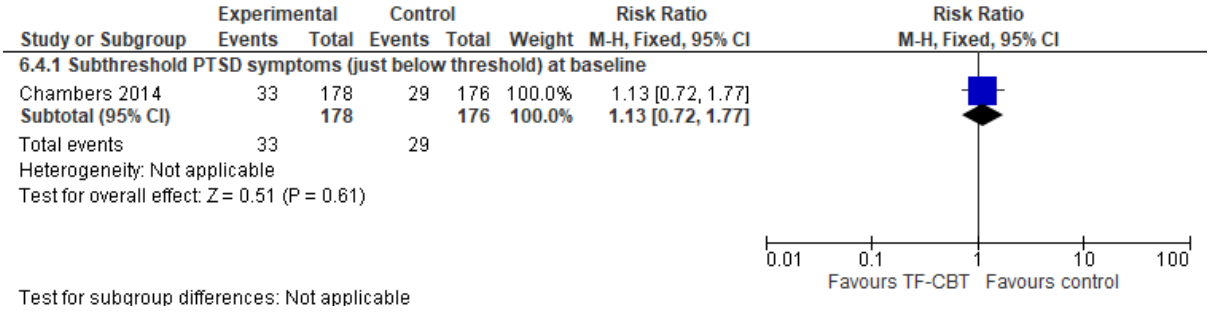


Figure 69: Trauma-focused CBT versus attention-placebo/psycho-education for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: Discontinuation (loss to follow-up)



Trauma-focused CBT versus present-centred therapy for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Figure 70: Trauma-focused CBT versus present-centred therapy for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: PTSD

symptomatology self-rated (PCL change score); Subthreshold PTSD symptoms (just below threshold) at baseline

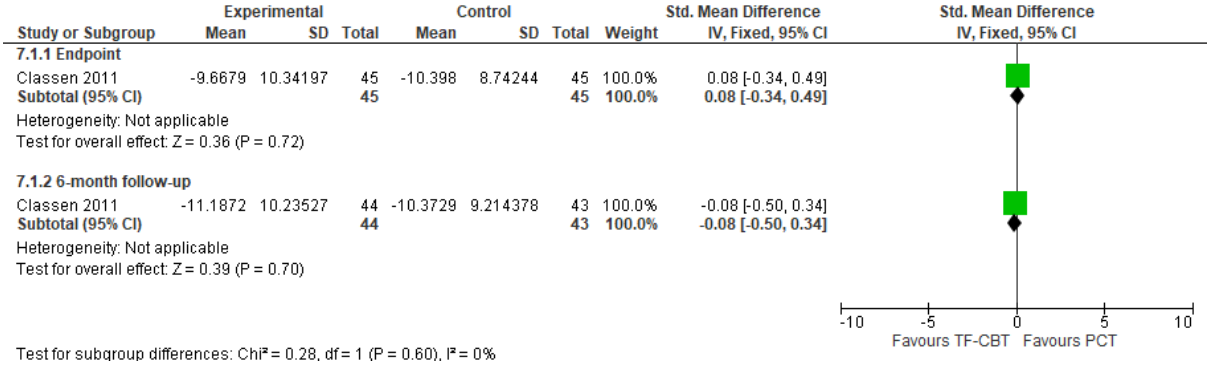


Figure 71: Trauma-focused CBT versus present-centred therapy for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: Alcohol use (Drug and Alcohol Use Interview: Total drinks in last 3 months change score); Sub-threshold PTSD symptoms (just below threshold) at baseline

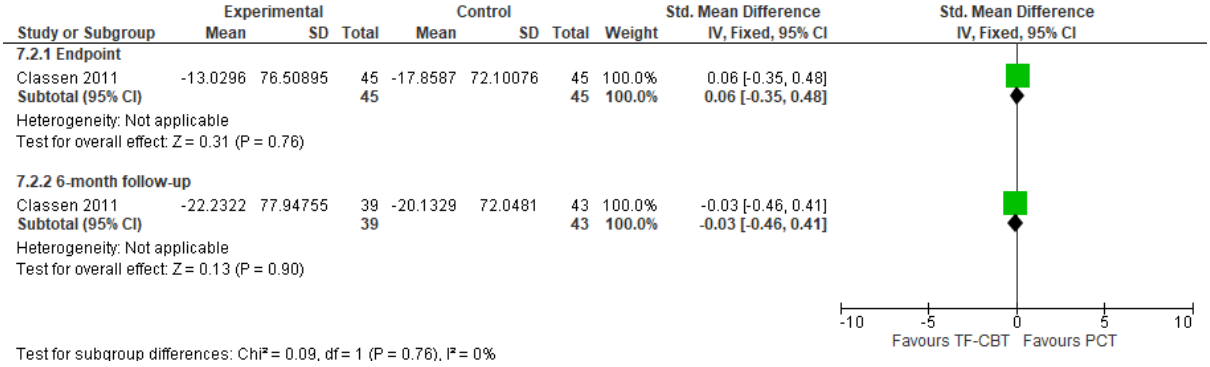


Figure 72: Trauma-focused CBT versus present-centred therapy for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: Drug use (Drug and Alcohol Use Interview: Total joints in last 3 months change score); Sub-threshold PTSD symptoms (just below threshold) at baseline

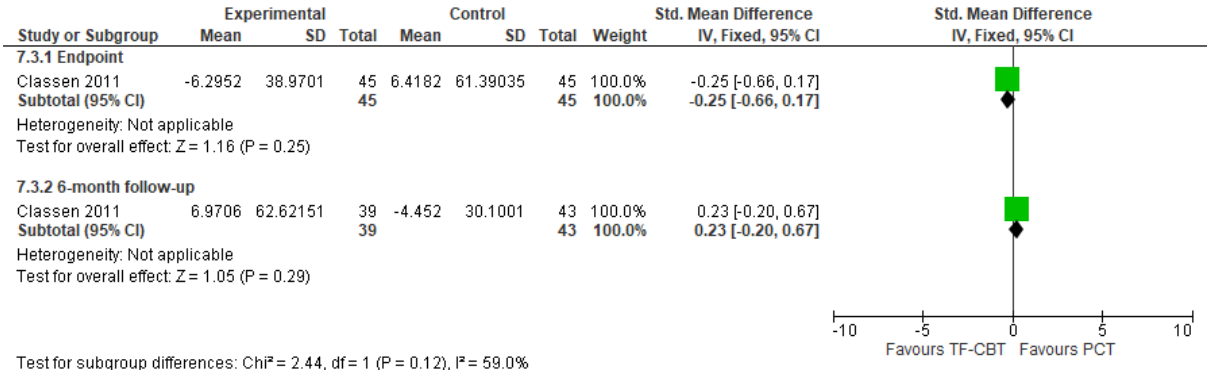


Figure 73: Trauma-focused CBT versus present-centred therapy for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults:

Relationship difficulties (IIP change score); Sub-threshold PTSD symptoms (just below threshold) at baseline

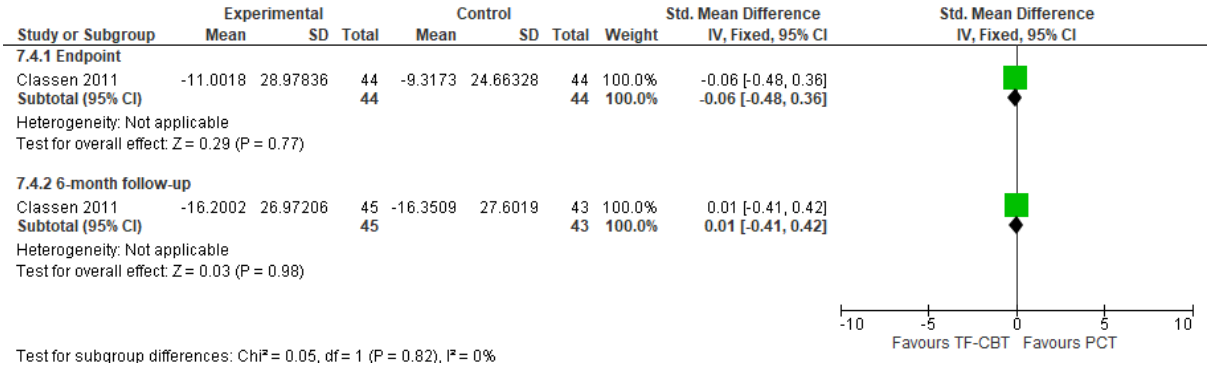
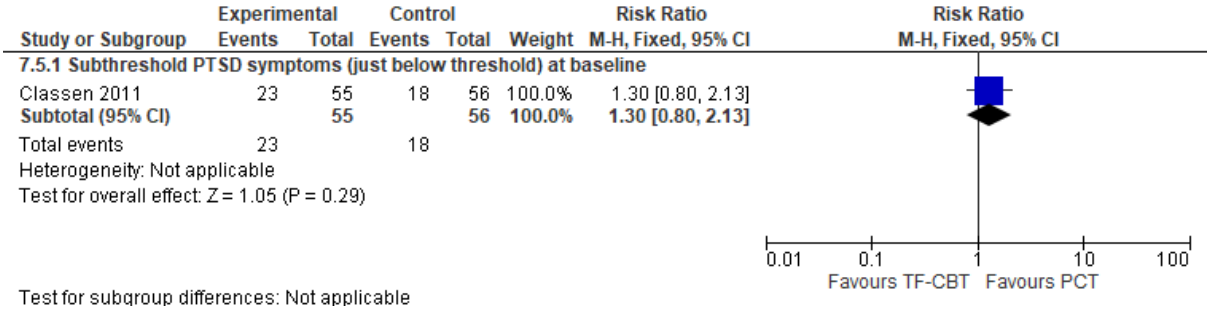
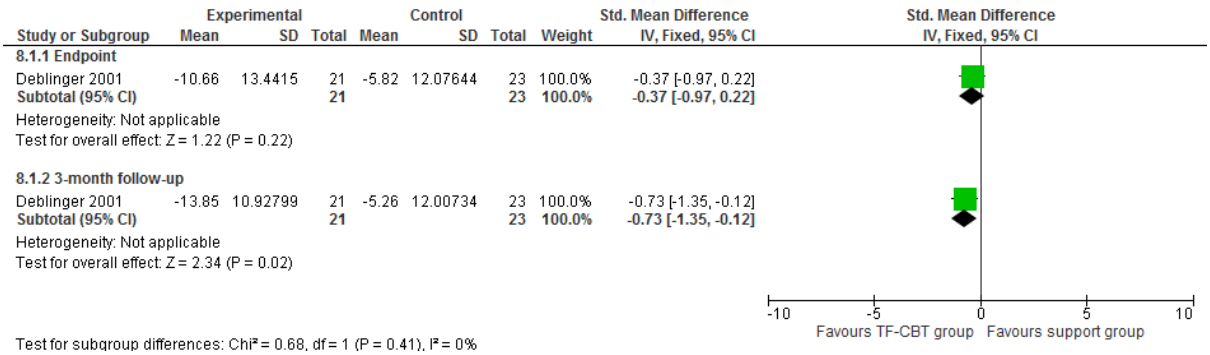


Figure 74: Trauma-focused CBT versus present-centred therapy for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: Discontinuation (loss to follow-up)



Trauma-focused CBT group versus peer support group for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Figure 75: Trauma-focused CBT group versus peer support group for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: PTSD symptomatology self-rated (SCL-90-R Posttraumatic Symptom Scale change score); Non-significant PTSD symptoms at baseline



Psychological: Non-trauma focused CBT

Non-trauma-focused CBT (+ TAU) versus TAU for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Figure 76: Non-trauma-focused CBT (+ TAU) versus TAU for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: Non-trauma-focused CBT (+ TAU) versus TAU for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: PTSD symptomatology self-rated (PCL/IES-R change score)

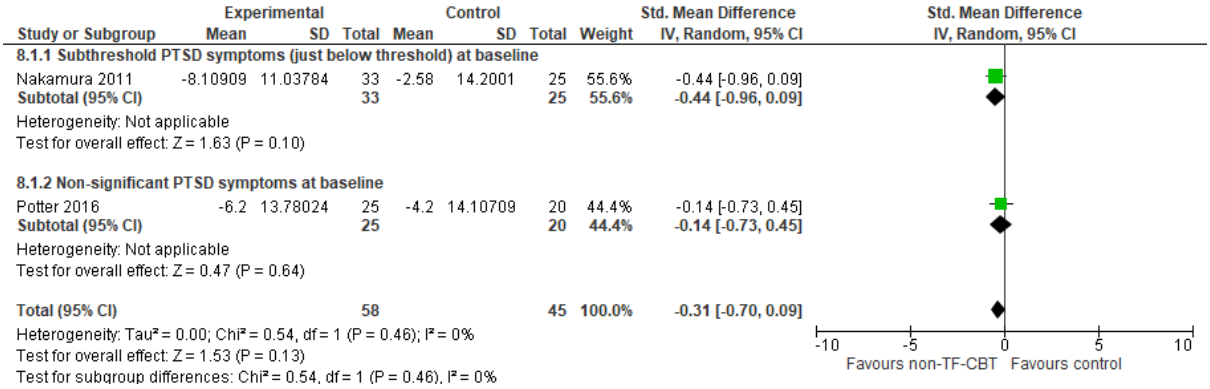


Figure 77: Non-trauma-focused CBT (+ TAU) versus TAU for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: PTSD (number who met criteria for PTSD at endpoint)

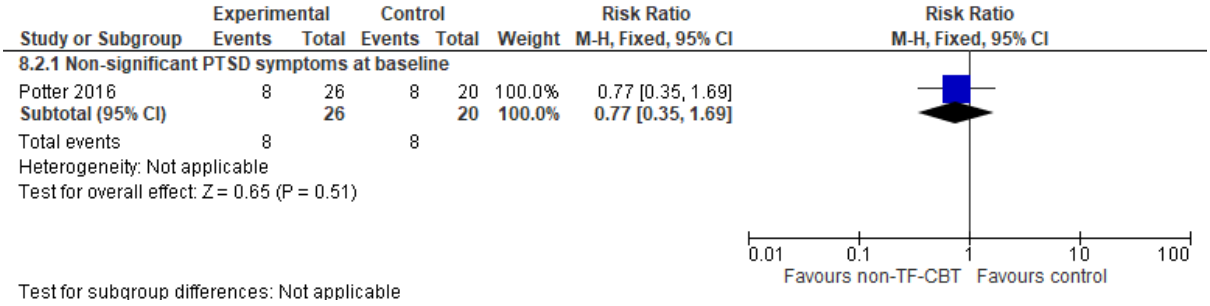


Figure 78: Non-trauma-focused CBT (+ TAU) versus TAU for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: Anxiety symptoms (HADS-A change score)

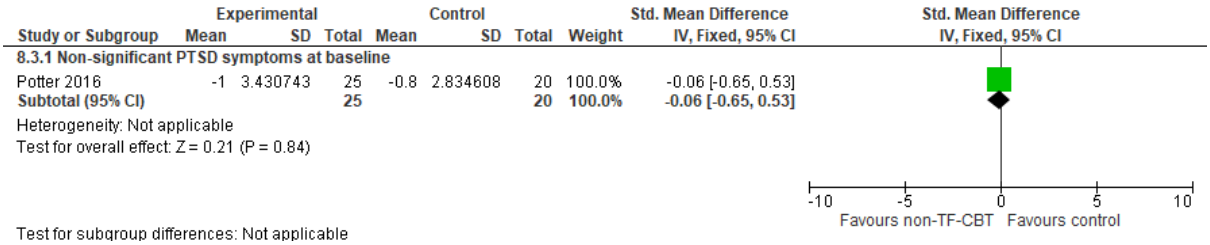


Figure 79: Non-trauma-focused CBT (+ TAU) versus TAU for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: Depression symptoms (CES-D/HADS-D change score)

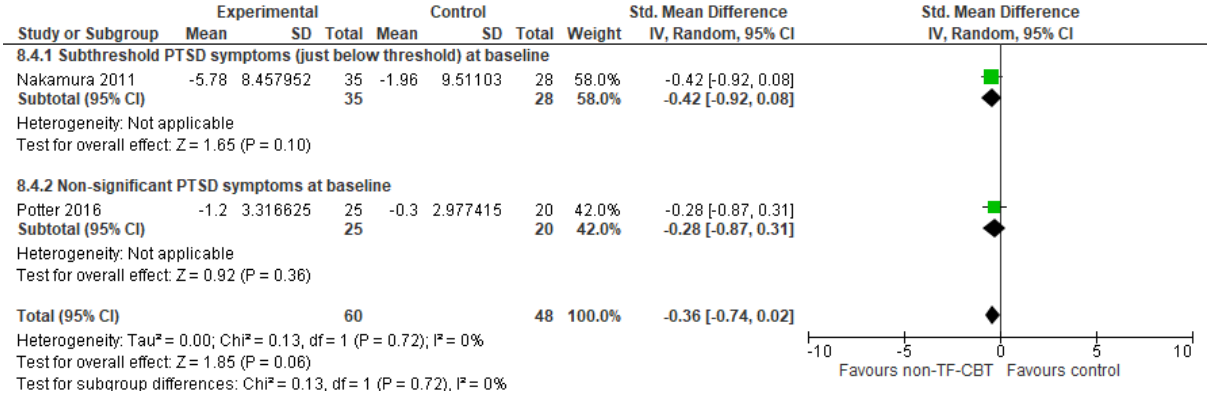


Figure 80: Non-trauma-focused CBT (+ TAU) versus TAU for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: Anger (STAXI-2 change score)

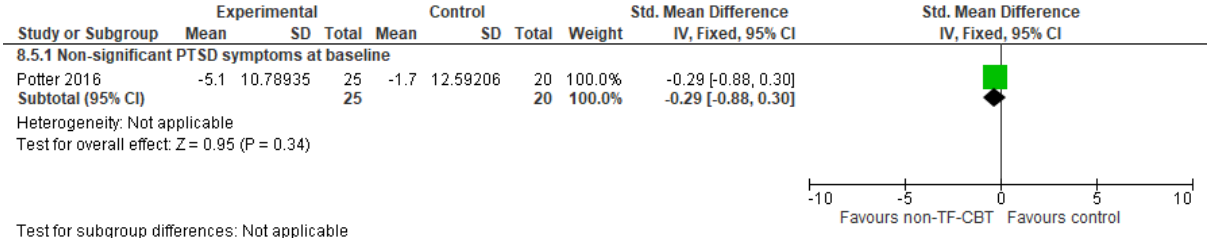


Figure 81: Non-trauma-focused CBT (+ TAU) versus TAU for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: Sleeping difficulties (MOS-SS: Sleep Problems Index II change score)

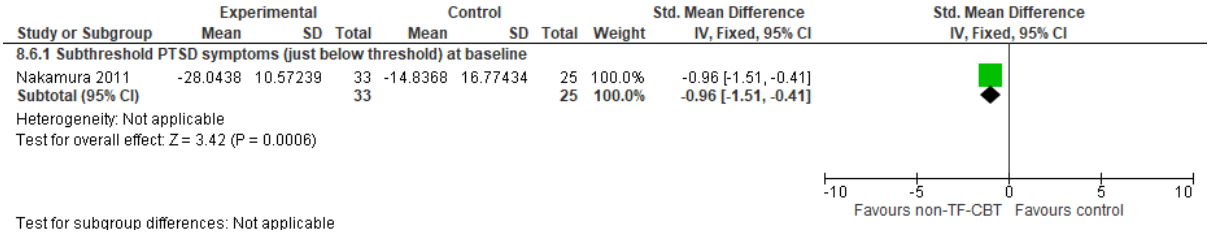


Figure 82: Non-trauma-focused CBT (+ TAU) versus TAU for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: Quality of life (SF-36 total/Euro QoI change score)

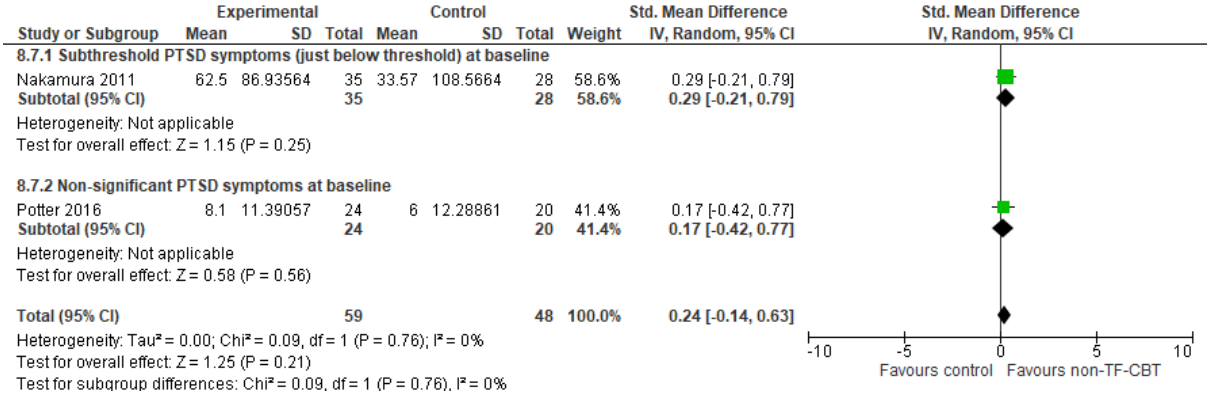
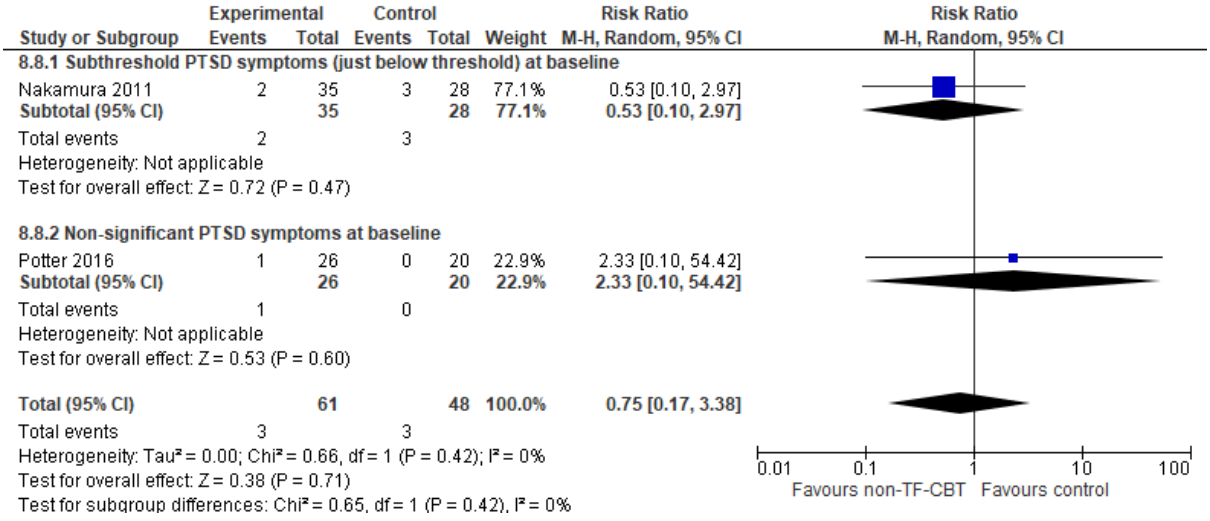


Figure 83: Non-trauma-focused CBT (+ TAU) versus TAU for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: Discontinuation (loss to follow-up)



Present-centred therapy versus waitlist for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Figure 84: Present-centred therapy versus waitlist for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: PTSD

symptomatology self-rated (PCL change score); Sub-threshold PTSD symptoms (just below threshold) at baseline

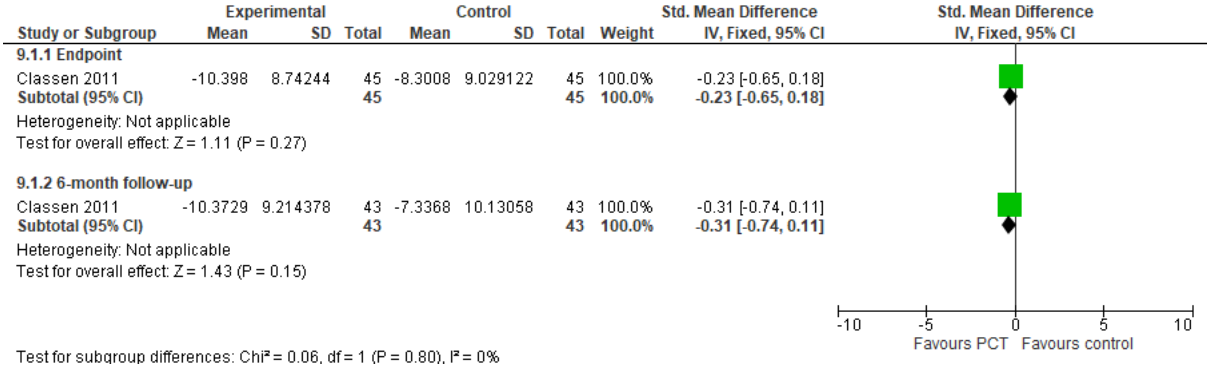


Figure 85: Present-centred therapy versus waitlist for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: Alcohol use (Drug and Alcohol Use Interview: Total drinks in last 3 months change score); Sub-threshold PTSD symptoms (just below threshold) at baseline

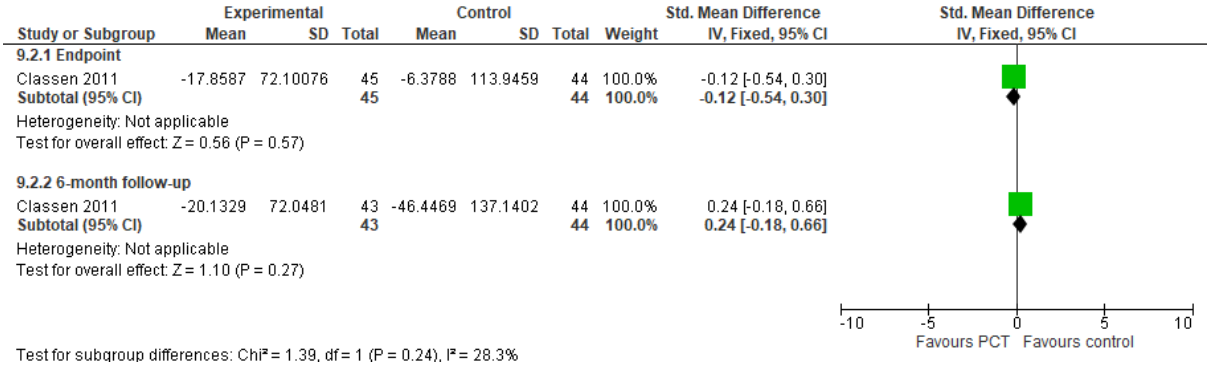


Figure 86: Present-centred therapy versus waitlist for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: Drug use (Drug and Alcohol Use Interview: Total joints in last 3 months change score); Sub-threshold PTSD symptoms (just below threshold) at baseline

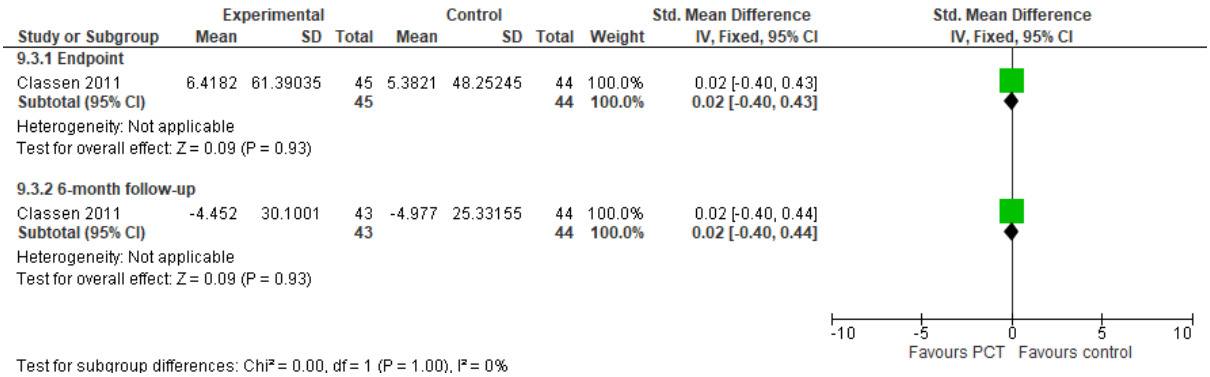


Figure 87: Present-centred therapy versus waitlist for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: Relationship

difficulties (IIP change score); Sub-threshold PTSD symptoms (just below threshold) at baseline

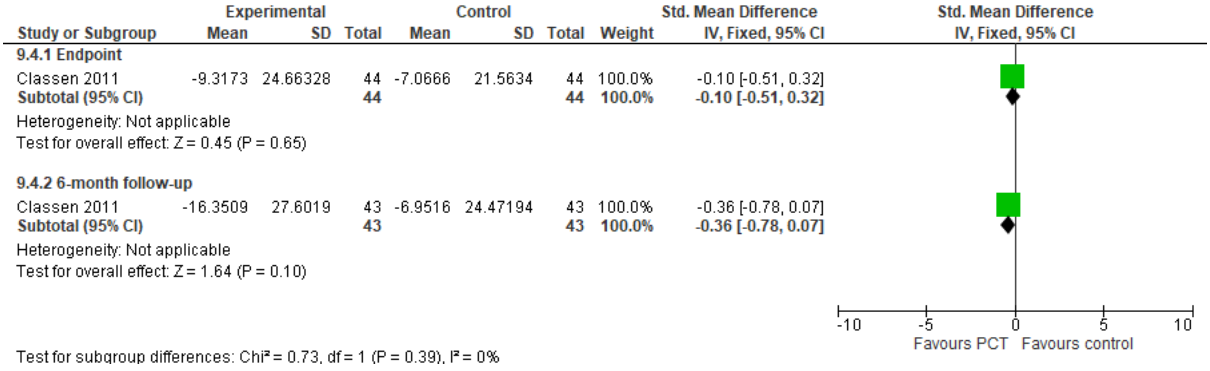
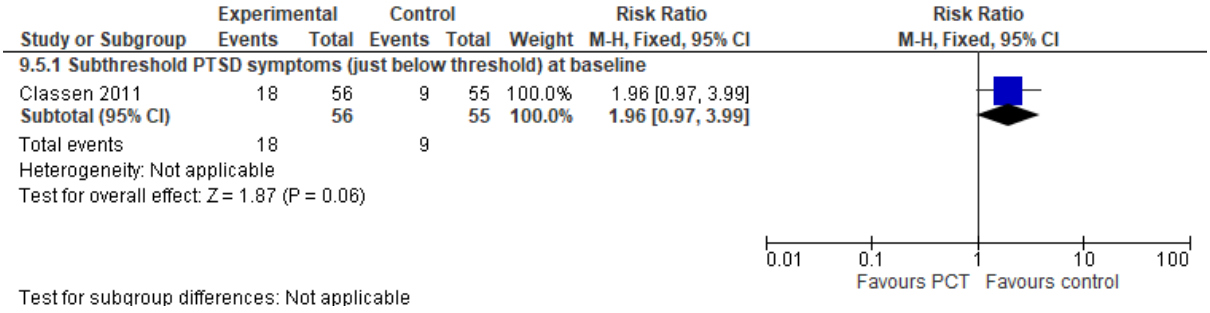


Figure 88: Present-centred therapy versus waitlist for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: Discontinuation (loss to follow-up)



Psychological: Behavioural therapies

Brief behavioural intervention versus enhanced TAU for the prevention of PTSD in adults exposed to ongoing trauma (e.g. in a war zone)

Figure 89: Brief behavioural intervention versus enhanced TAU for the prevention of PTSD in adults exposed to ongoing trauma (e.g. in a war zone): PTSD symptomatology self-rated (PCL change score); Non-significant PTSD symptoms at baseline

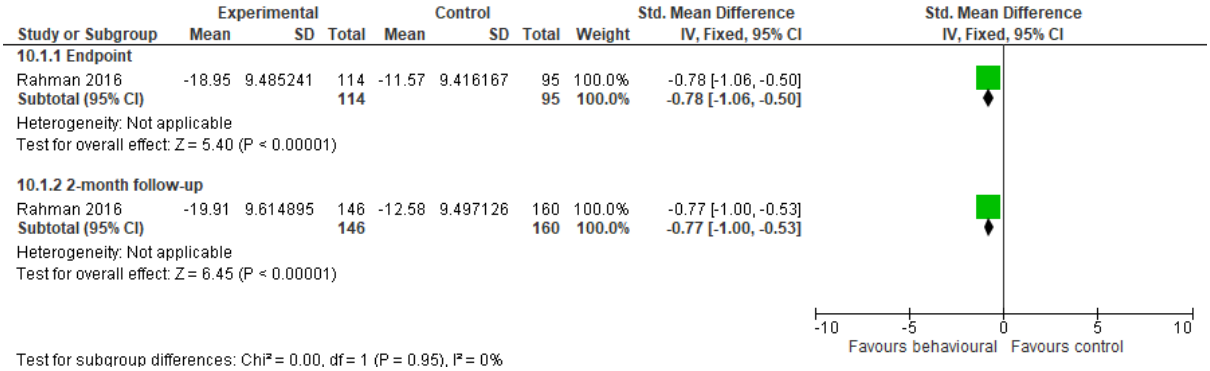


Figure 90: Brief behavioural intervention versus enhanced TAU for the prevention of PTSD in adults exposed to ongoing trauma (e.g. in a war zone): Anxiety symptoms (HADS-A change score); Non-significant PTSD symptoms at baseline

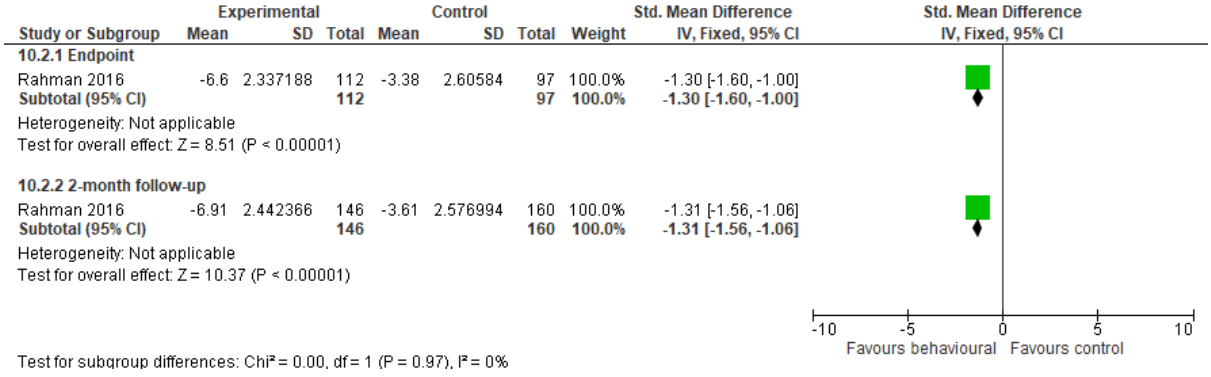


Figure 91: Brief behavioural intervention versus enhanced TAU for the prevention of PTSD in adults exposed to ongoing trauma (e.g. in a war zone): Depression symptoms (PHQ-9 change score); Non-significant PTSD symptoms at baseline

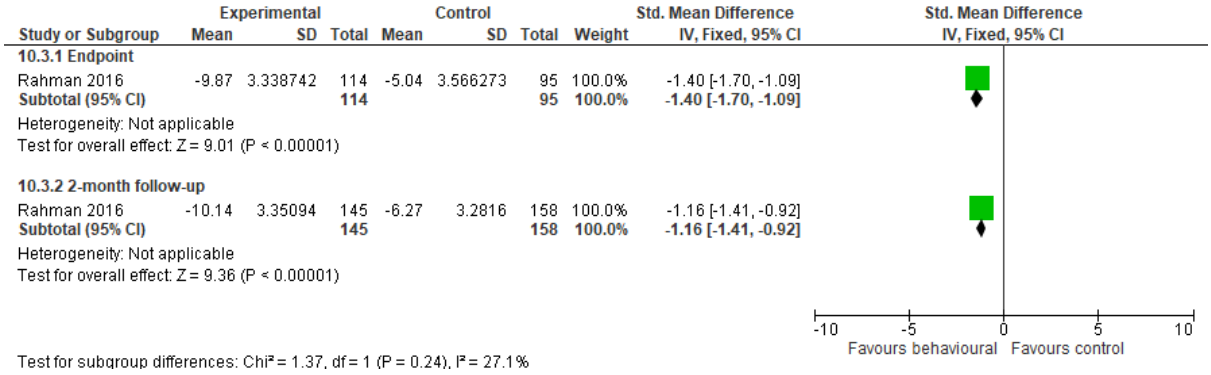


Figure 92: Brief behavioural intervention versus enhanced TAU for the prevention of PTSD in adults exposed to ongoing trauma (e.g. in a war zone): Functional impairment (WHODAS change score); Non-significant PTSD symptoms at baseline

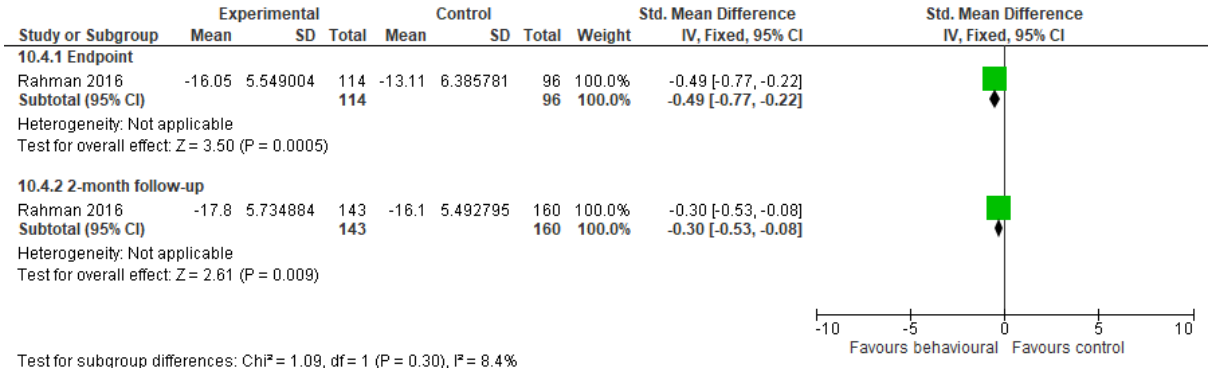
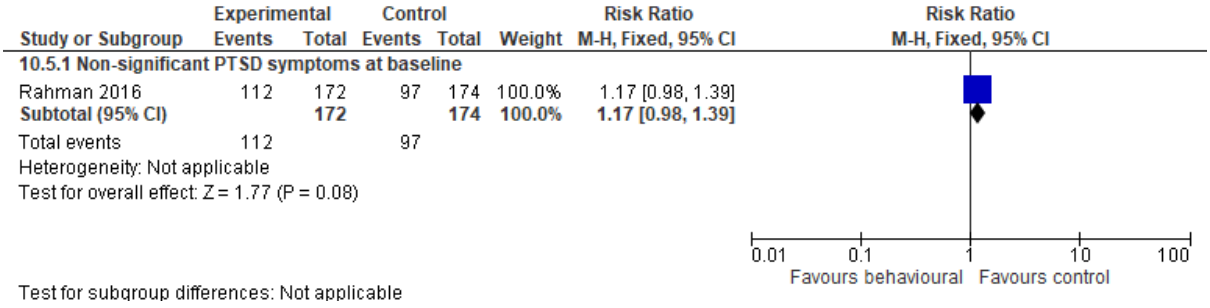


Figure 93: Brief behavioural intervention versus enhanced TAU for the prevention of PTSD in adults exposed to ongoing trauma (e.g. in a war zone): Discontinuation (loss to follow-up)



Brief behavioural intervention versus enhanced TAU for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Figure 94: Brief behavioural intervention versus enhanced TAU for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: PTSD symptomatology self-rated (PCL change score); Non-significant PTSD symptoms at baseline

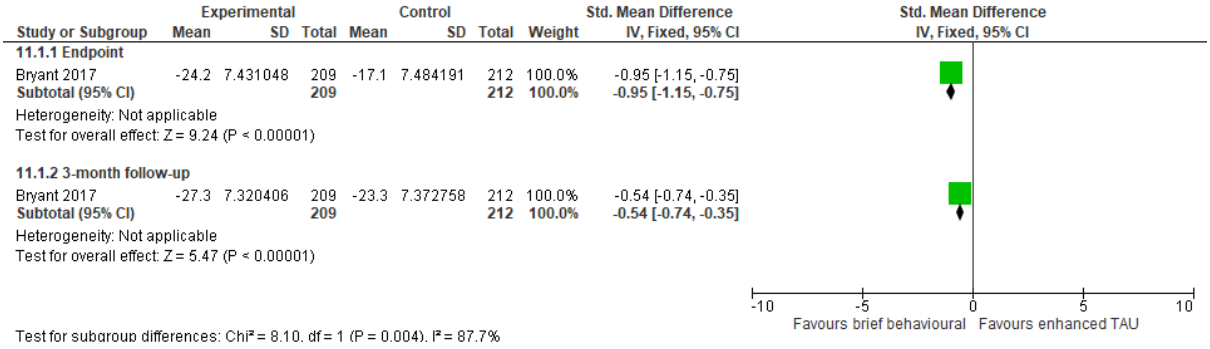


Figure 95: Brief behavioural intervention versus enhanced TAU for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: Functional impairment (WHODAS change score); Non-significant PTSD symptoms at baseline

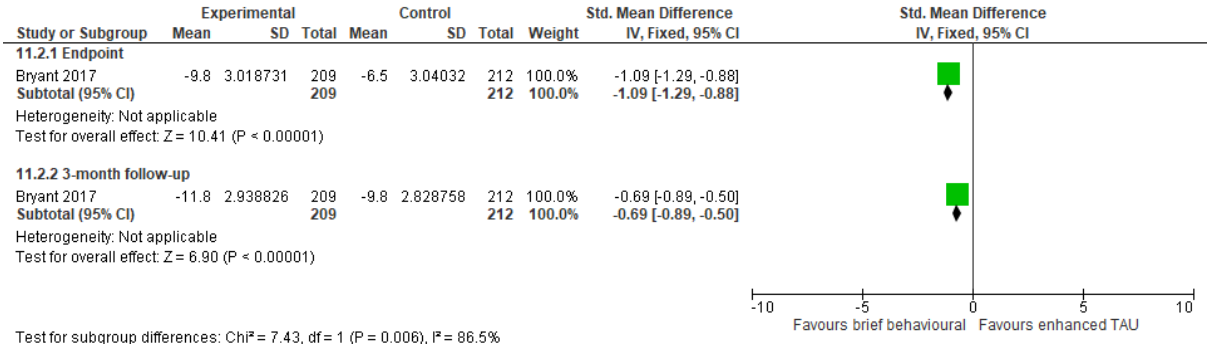
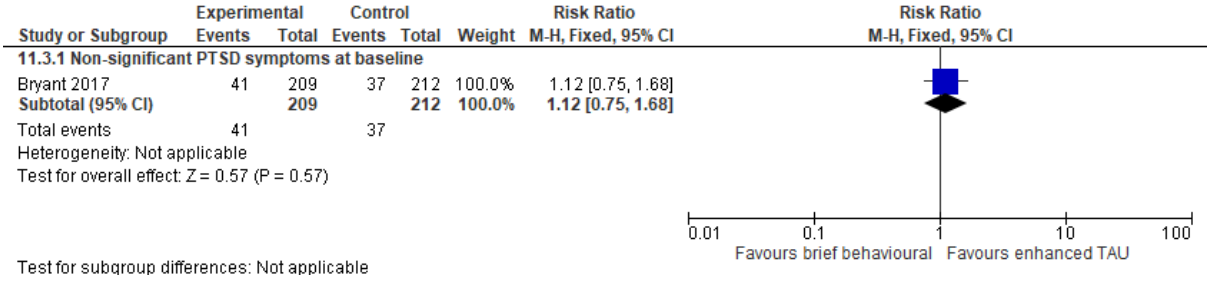


Figure 96: Brief behavioural intervention versus enhanced TAU for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: Discontinuation (loss to follow-up)



Behavioural sleep intervention versus pill placebo or attention-placebo for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Figure 97: Behavioural sleep intervention versus pill placebo or attention-placebo for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: PTSD symptomatology self-rated (PCL change score); Non-significant PTSD symptoms at baseline

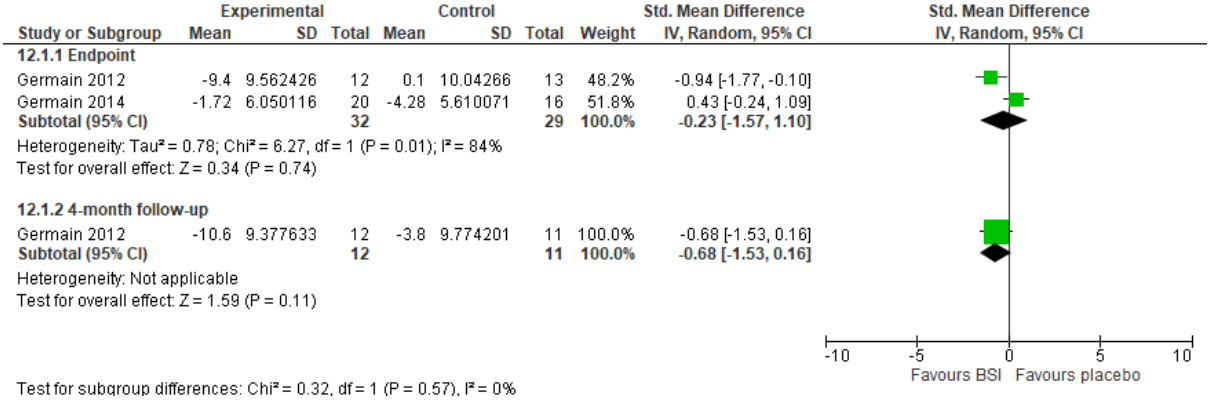


Figure 98: Behavioural sleep intervention versus pill placebo or attention-placebo for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: Anxiety symptoms (BAI change score); Non-significant PTSD symptoms at baseline

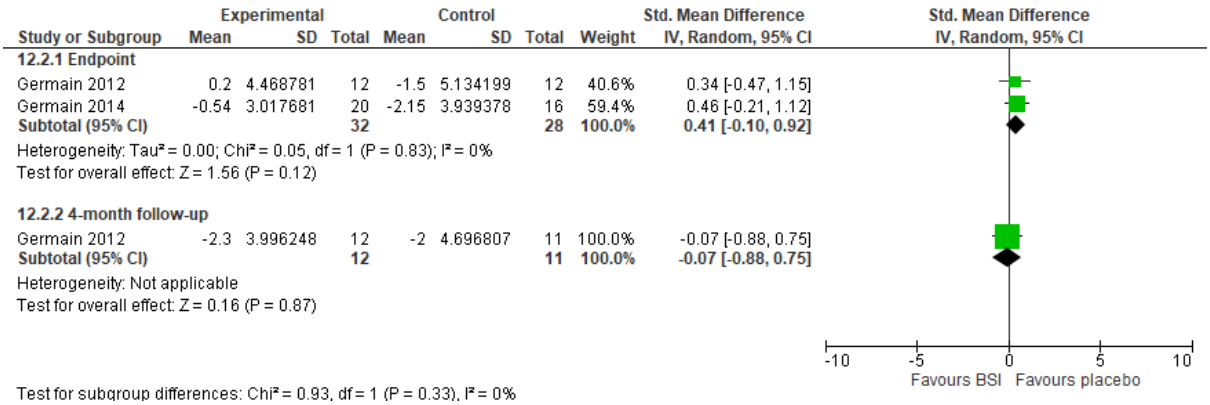


Figure 99: Behavioural sleep intervention versus pill placebo or attention-placebo for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: Depression symptoms (BDI change score); Non-significant PTSD symptoms at baseline

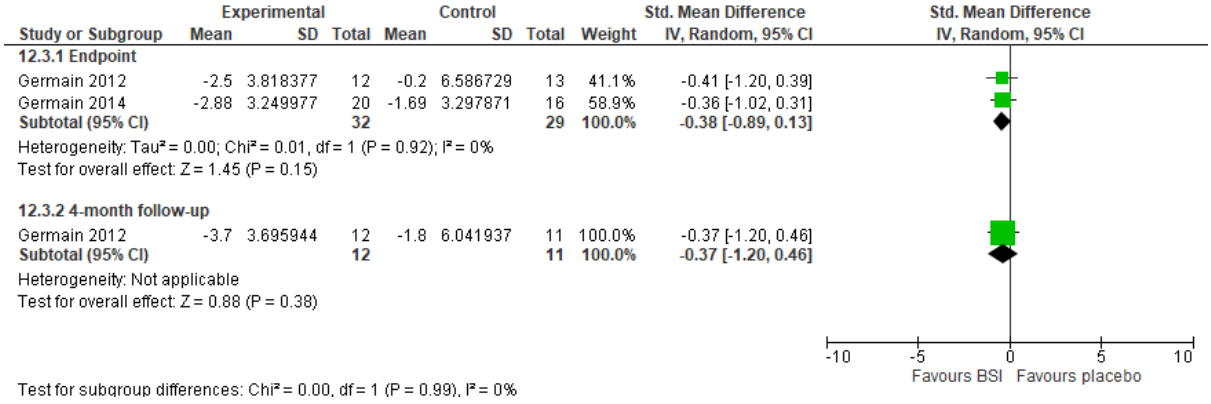


Figure 100: Behavioural sleep intervention versus pill placebo or attention-placebo for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: Functional impairment (SDS change score); Non-significant PTSD symptoms at baseline

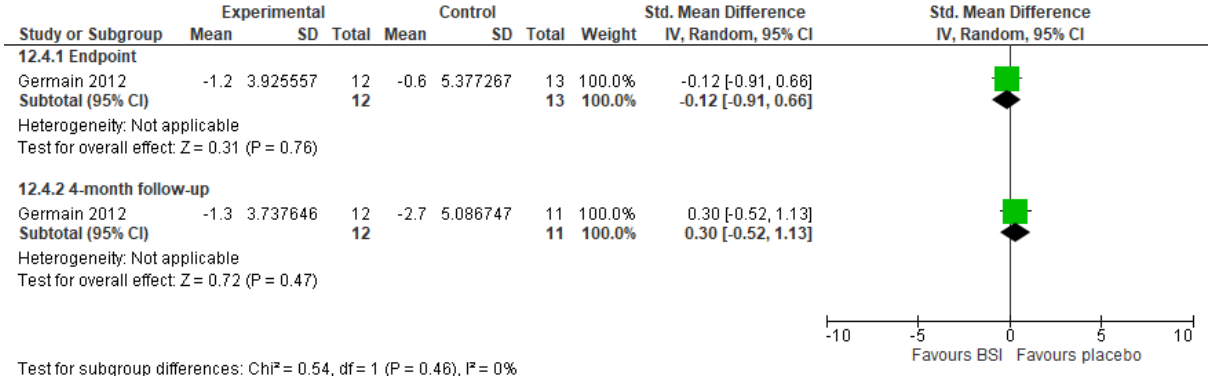


Figure 101: Behavioural sleep intervention versus pill placebo or attention-placebo for the delayed treatment (>3 months) of below threshold PTSD symptoms in

adults: Sleeping difficulties (PSQI change score); Non-significant PTSD symptoms at baseline

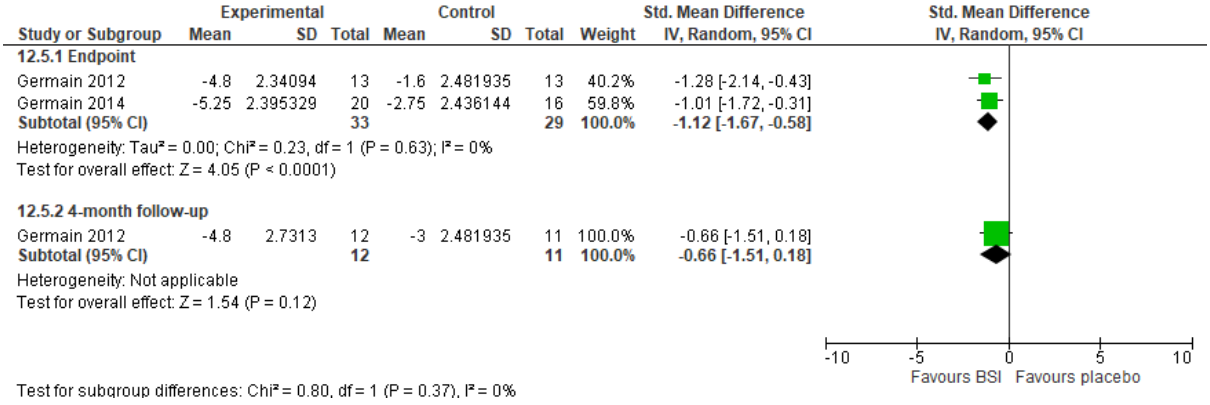
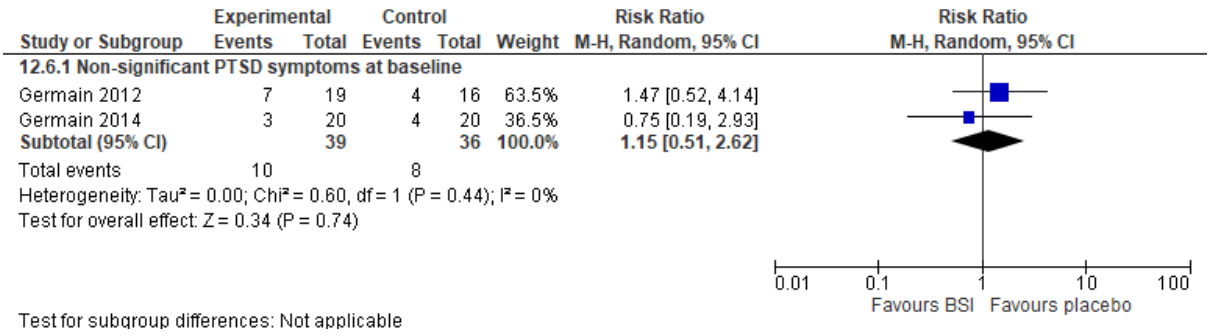


Figure 102: Behavioural sleep intervention versus pill placebo or attention-placebo for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: Discontinuation (loss to follow-up)



Behavioural sleep intervention versus prazosin for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Figure 103: Behavioural sleep intervention versus prazosin for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: PTSD symptomatology self-rated (PCL change score); Non-significant PTSD symptoms at baseline

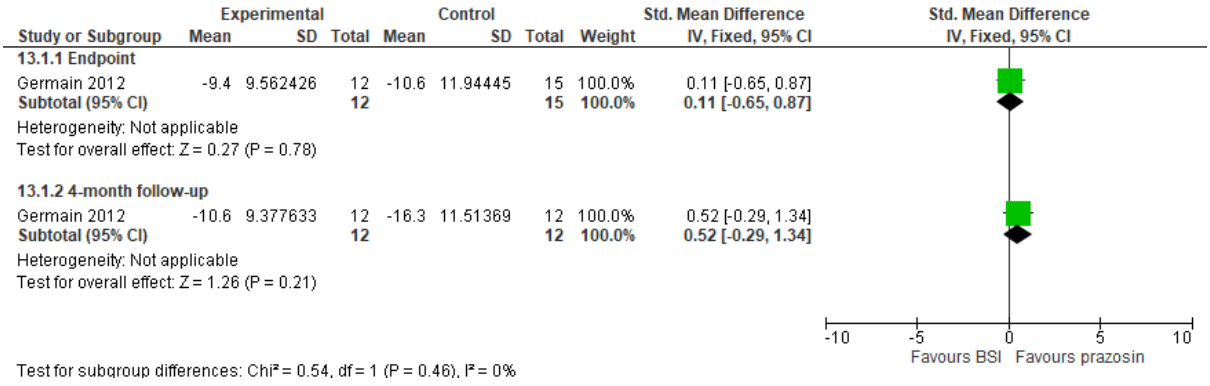


Figure 104: Behavioural sleep intervention versus prazosin for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: Anxiety symptoms (BAI change score); Non-significant PTSD symptoms at baseline

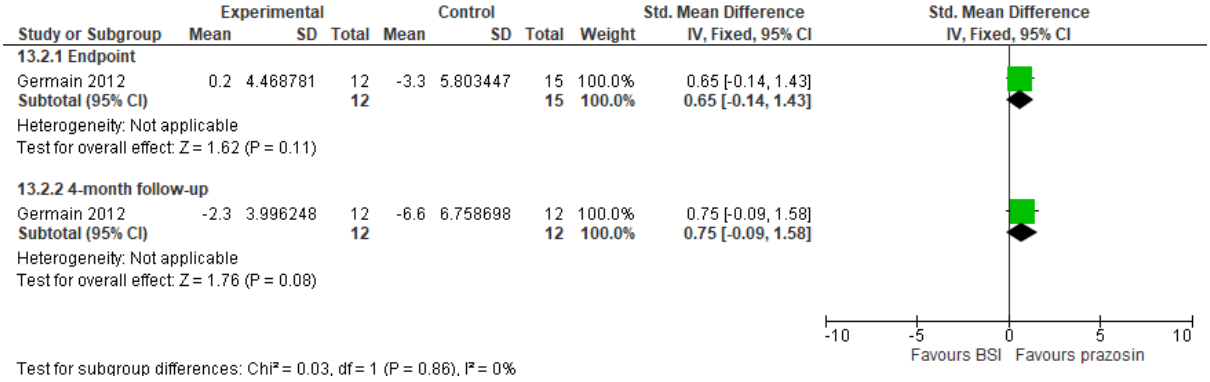


Figure 105: Behavioural sleep intervention versus prazosin for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: Depression symptoms (BDI change score); Non-significant PTSD symptoms at baseline

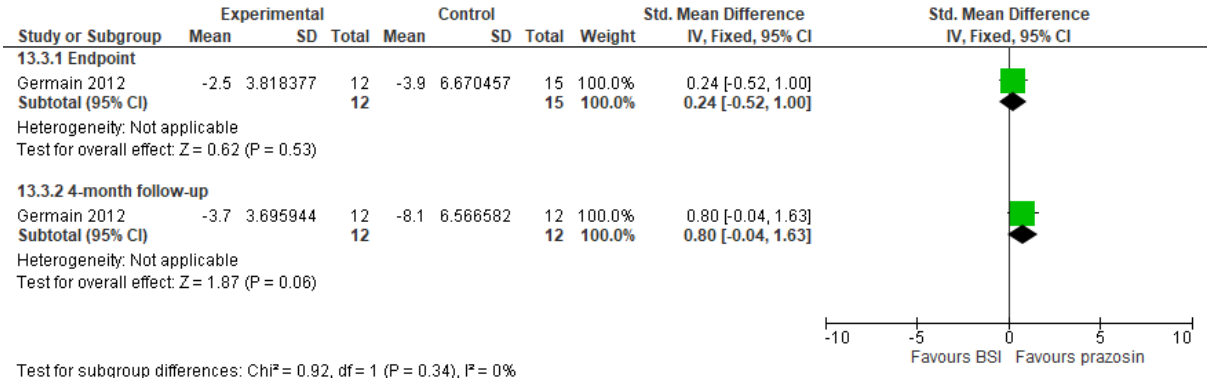


Figure 106: Behavioural sleep intervention versus prazosin for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: Functional impairment (SDS change score); Non-significant PTSD symptoms at baseline

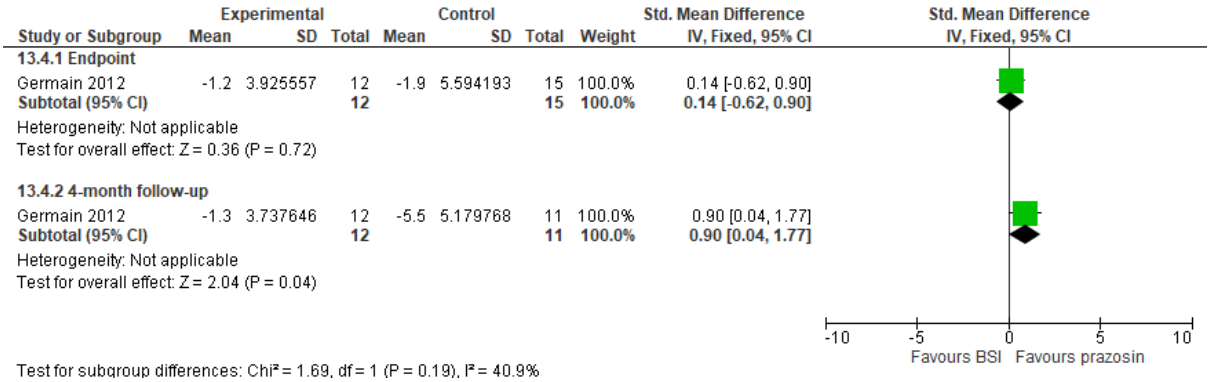


Figure 107: Behavioural sleep intervention versus prazosin for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: Sleeping difficulties (PSQI change score); Non-significant PTSD symptoms at baseline

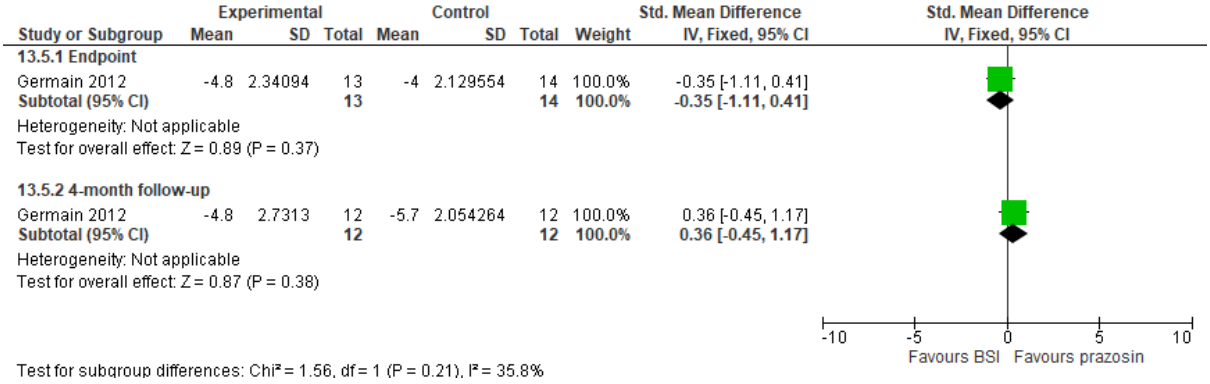
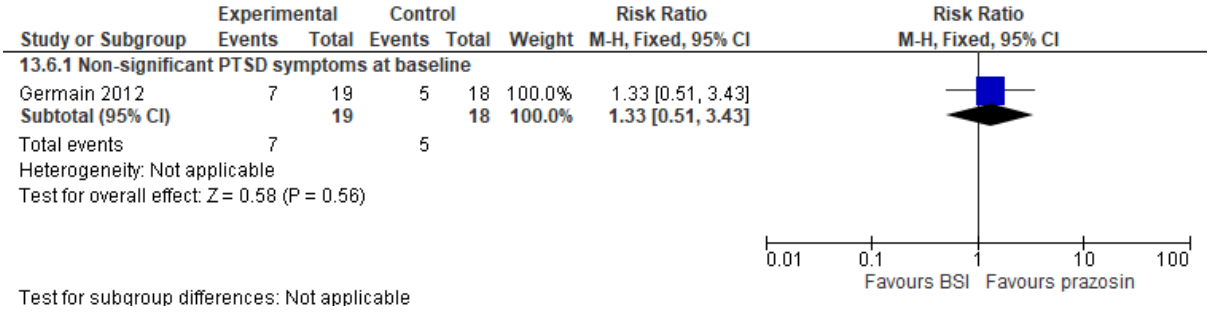


Figure 108: Behavioural sleep intervention versus prazosin for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: Discontinuation (loss to follow-up)



Psychological: Psychologically-focused debriefing

Single/two session debriefing (+/- psycho-education) versus no treatment for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Figure 109: Single/two session debriefing (+/- psycho-education) versus no treatment for the early prevention (intervention initiated ≤1 month) of PTSD in adults:

PTSD symptomatology self-rated at 1-4 month follow-up (IES endpoint/change score)

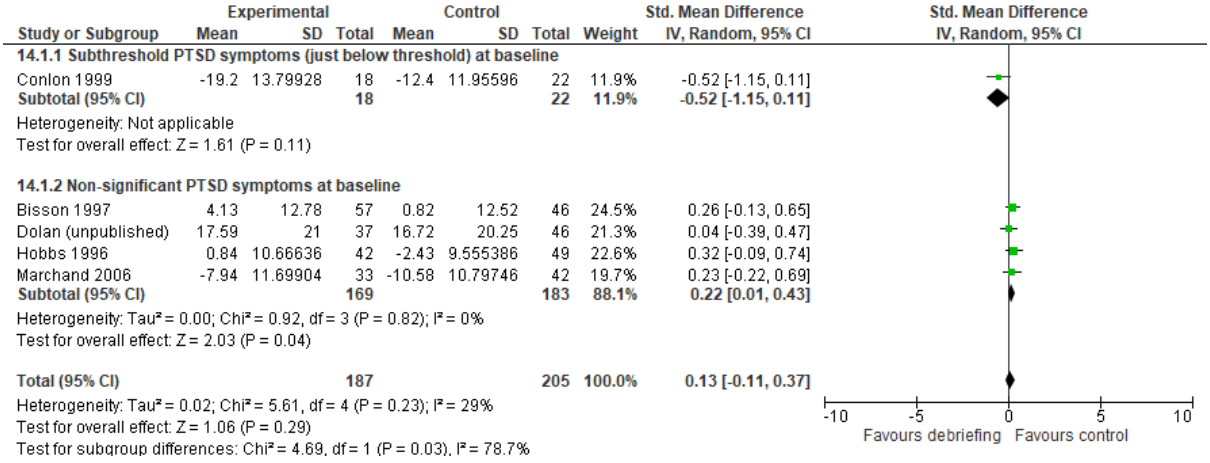


Figure 110: Single/two session debriefing (+/- psycho-education) versus no treatment for the early prevention (intervention initiated ≤1 month) of PTSD in adults: PTSD symptomatology self-rated at 6-month follow-up (IES endpoint score/PSS-SR change score)

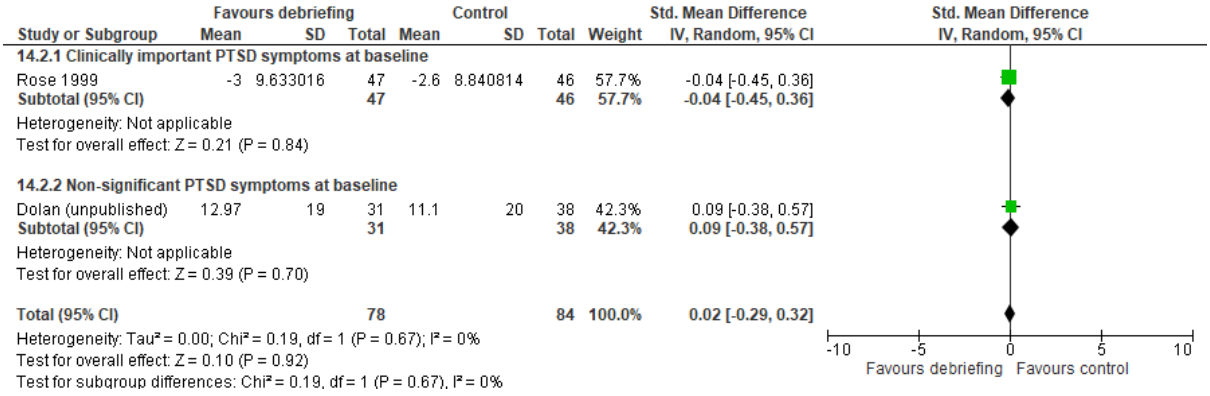


Figure 111: Single/two session debriefing (+/- psycho-education) versus no treatment for the early prevention (intervention initiated ≤1 month) of PTSD in adults: PTSD symptomatology self-rated at 1-year follow-up (IES change score)

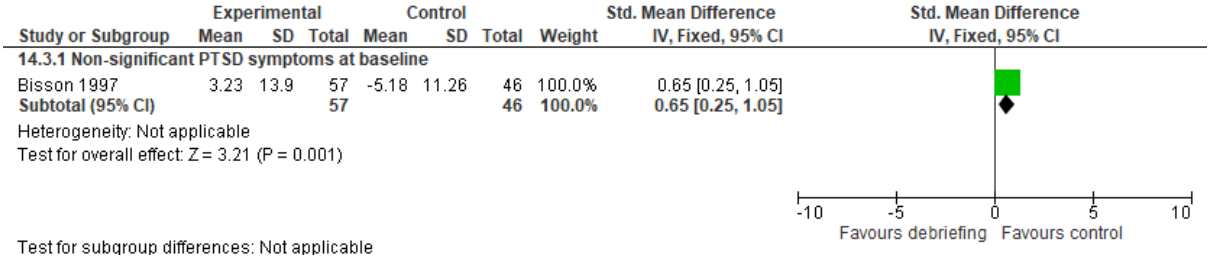


Figure 112: Single/two session debriefing (+/- psycho-education) versus no treatment for the early prevention (intervention initiated ≤1 month) of PTSD in adults: PTSD symptomatology clinician-rated at endpoint (SI–PTSD change score)

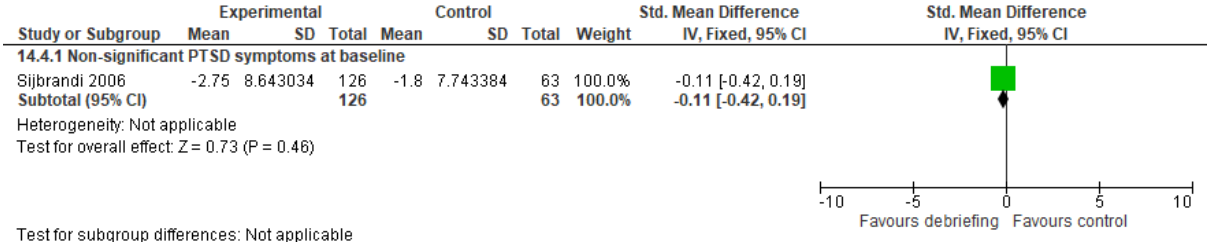


Figure 113: Single/two session debriefing (+/- psycho-education) versus no treatment for the early prevention (intervention initiated ≤1 month) of PTSD in adults: PTSD symptomatology clinician-rated at 1-3 month follow-up (SI–PTSD/CAPS change score)

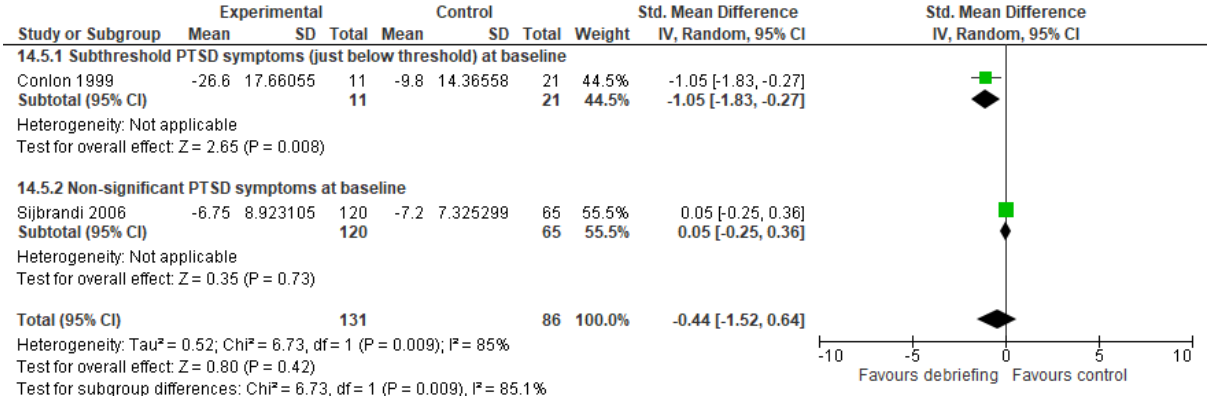


Figure 114: Single/two session debriefing (+/- psycho-education) versus no treatment for the early prevention (intervention initiated ≤1 month) of PTSD in adults: PTSD symptomatology clinician-rated at 6-month follow-up (SI–PTSD change score)

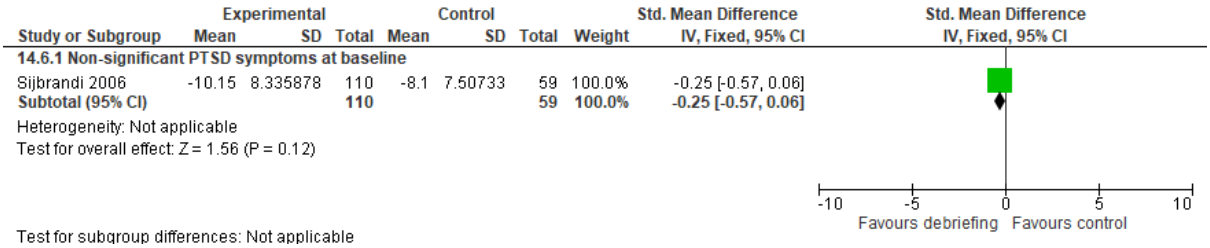


Figure 115: Single/two session debriefing (+/- psycho-education) versus no treatment for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Diagnosis of PTSD at 1-month follow-up

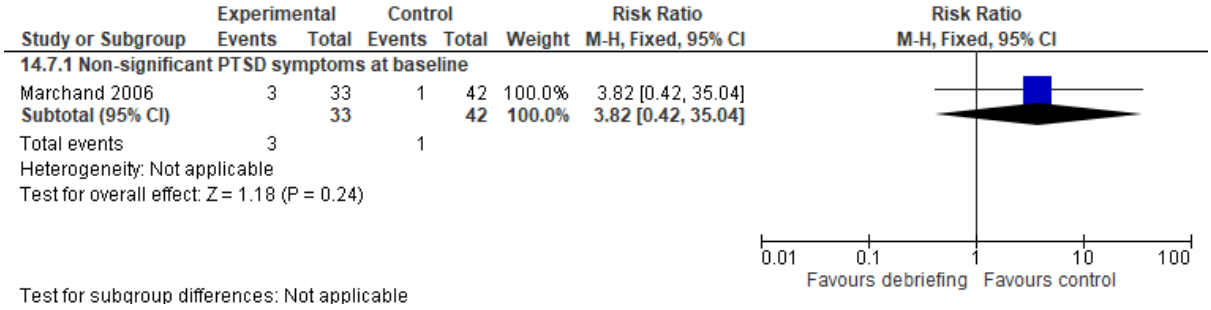


Figure 116: Single/two session debriefing (+/- psycho-education) versus no treatment for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Diagnosis of PTSD at 3-6 month follow-up

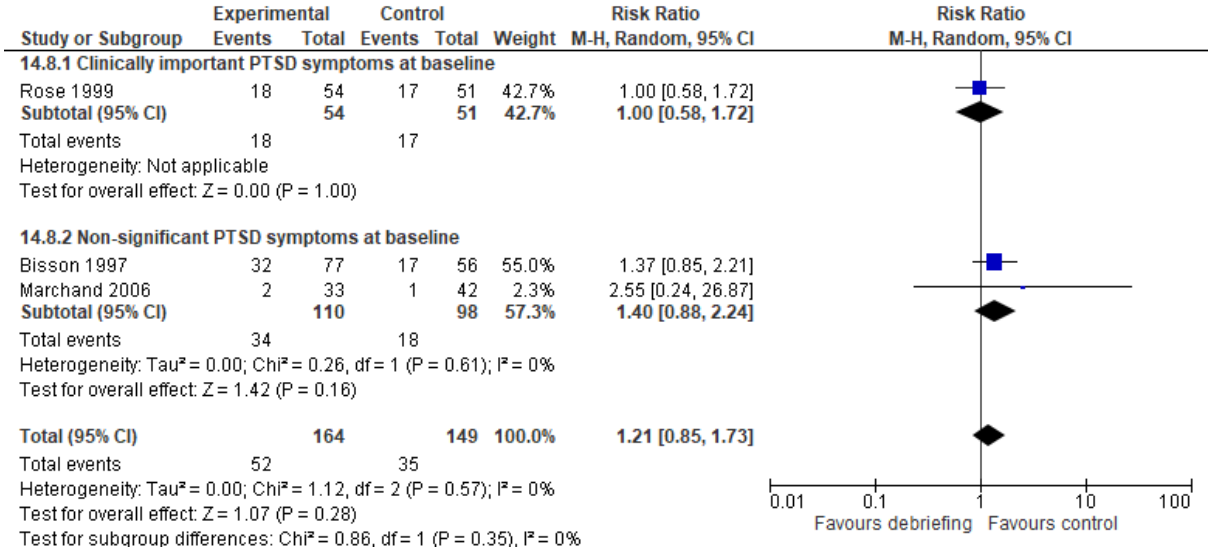


Figure 117: Single/two session debriefing (+/- psycho-education) versus no treatment for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Diagnosis of PTSD at 1-year follow-up

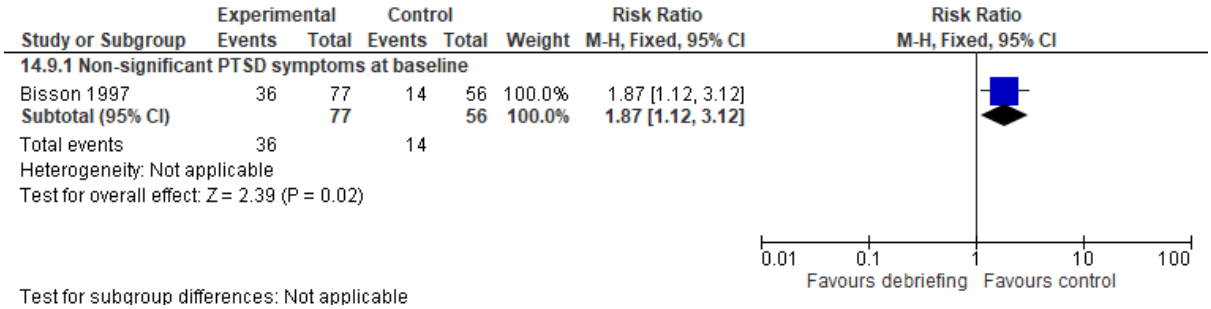


Figure 118: Single/two session debriefing (+/- psycho-education) versus no treatment for the early prevention (intervention initiated ≤1 month) of PTSD in adults:

Anxiety symptoms (HADS-A endpoint/change score; HAM-A change score); Non-significant PTSD symptoms at baseline

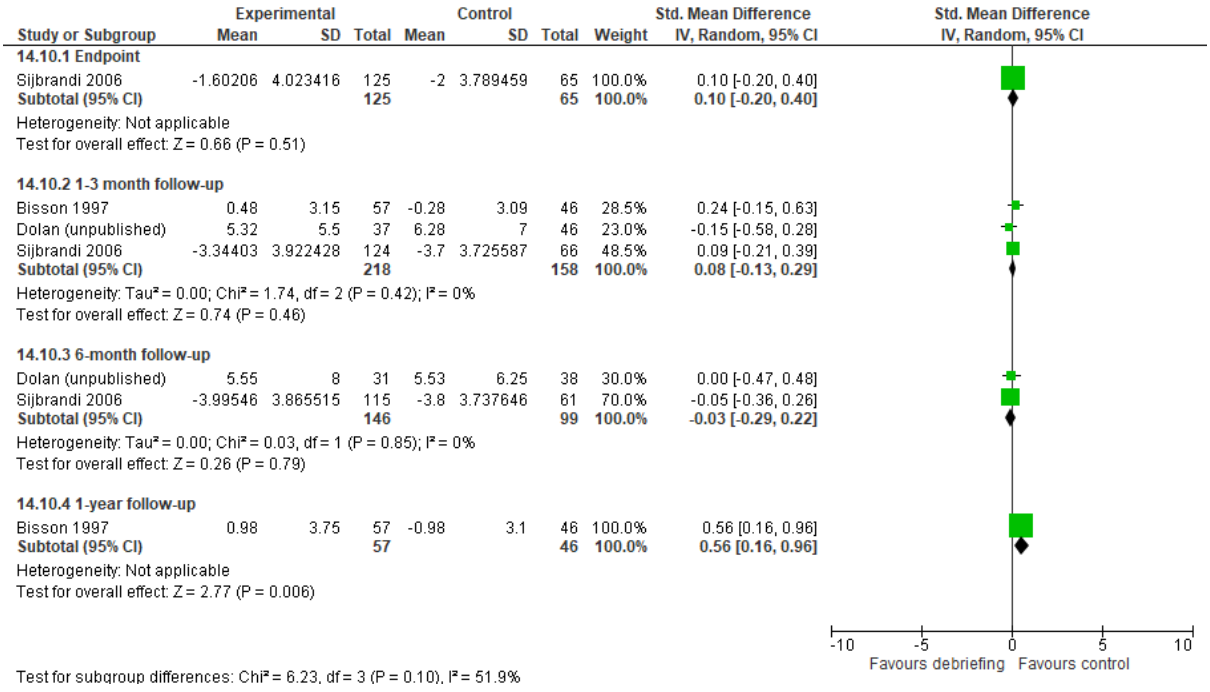


Figure 119: Single/two session debriefing (+/- psycho-education) versus no treatment for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Depression symptoms at endpoint (HAM-D change score)

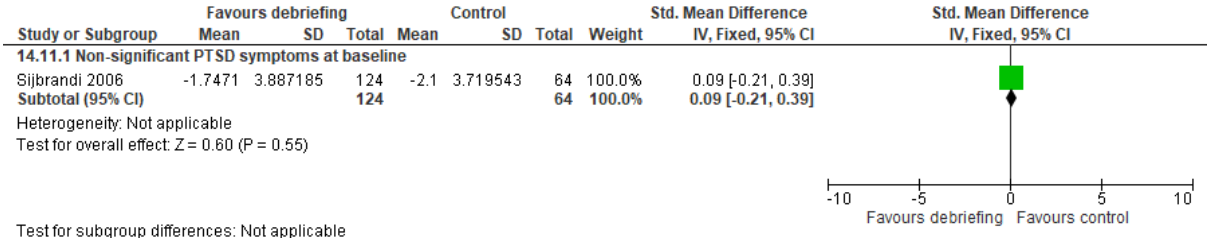


Figure 120: Single/two session debriefing (+/- psycho-education) versus no treatment for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Depression symptoms at 1-3 month follow-up (HADS-D endpoint/change score; HAM-D change score)

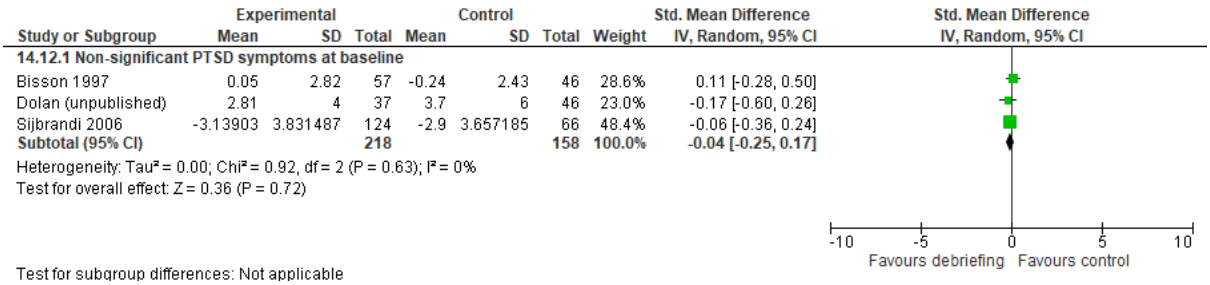


Figure 121: Single/two session debriefing (+/- psycho-education) versus no treatment for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Depression symptoms at 6-month follow-up (HADS-D/BDI endpoint score/HAM-D change score)

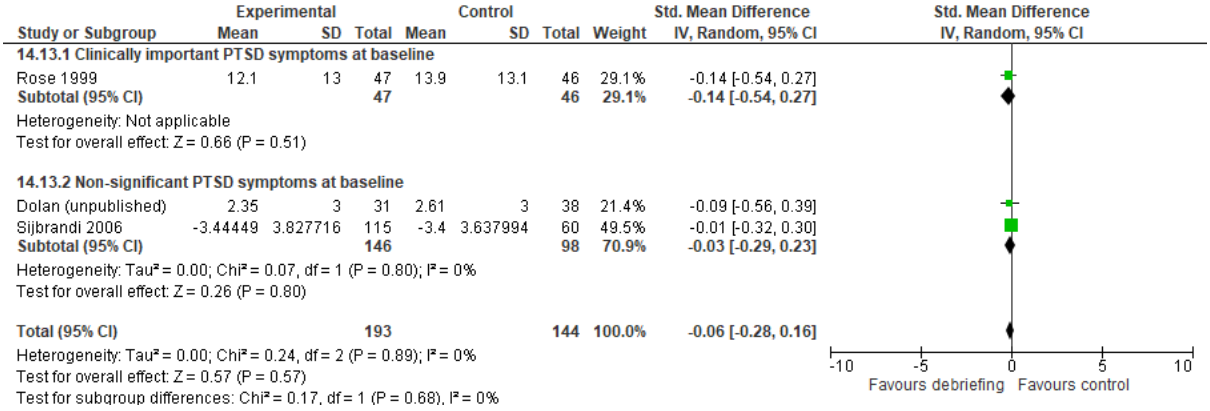


Figure 122: Single/two session debriefing (+/- psycho-education) versus no treatment for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Depression symptoms at 1-year follow-up (HADS-D change score)

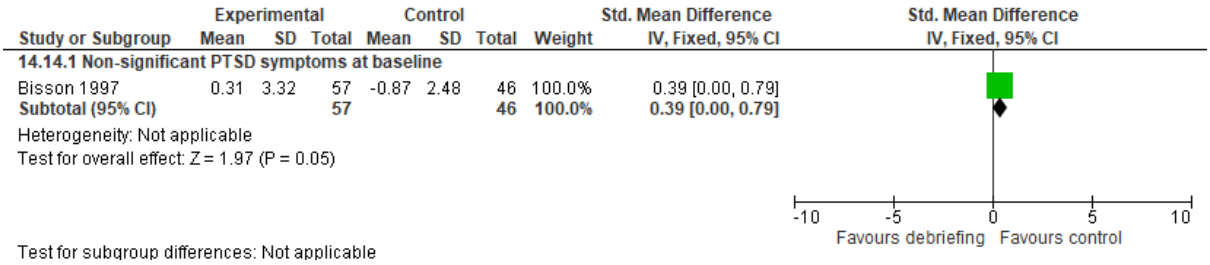
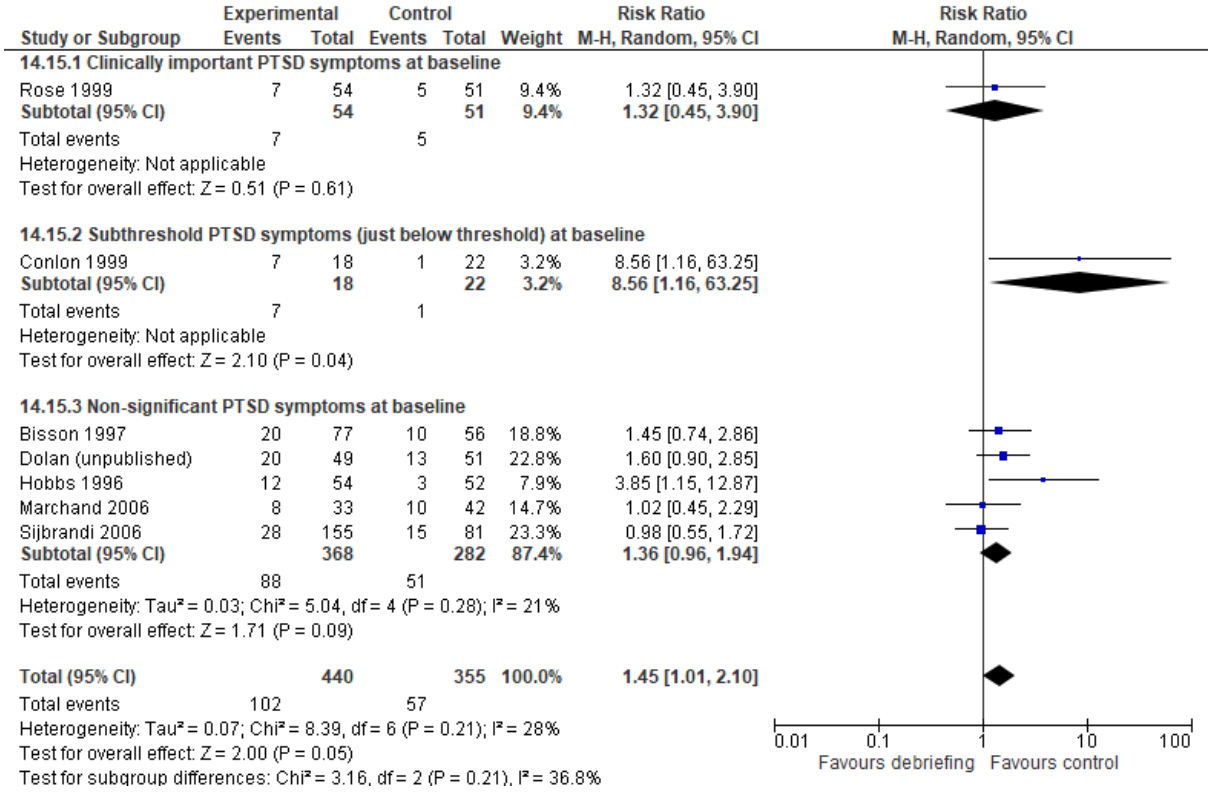


Figure 123: Single/two session debriefing (+/- psycho-education) versus no treatment for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Discontinuation (loss to follow-up)



Group debriefing versus no treatment for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Figure 124: Group debriefing versus no treatment for the early prevention (intervention initiated ≤1 month) of PTSD in adults: PTSD symptomatology self-rated (IES-R change score)

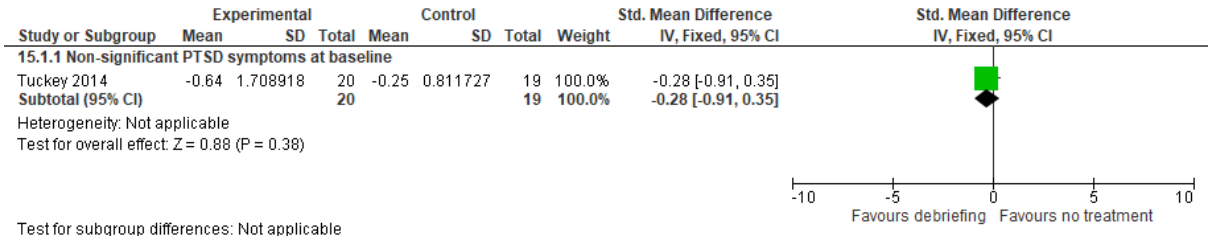
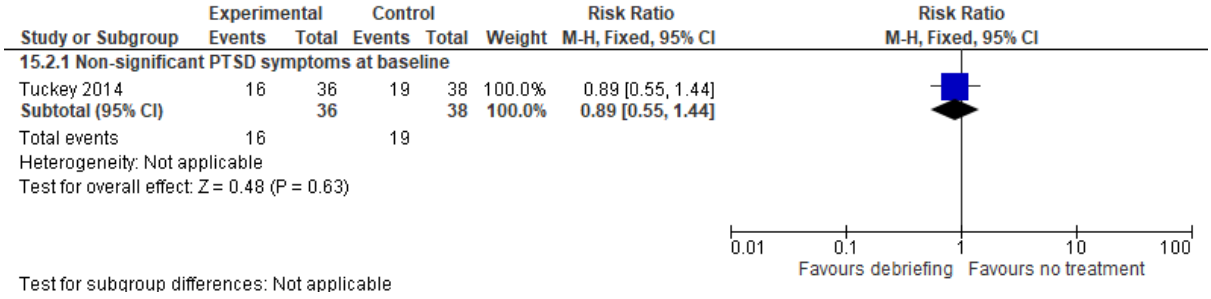


Figure 125: Group debriefing versus no treatment for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Discontinuation (loss to follow-up)



Group debriefing versus attention-placebo or psycho-educational session for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Figure 126: Group debriefing versus attention-placebo or psycho-educational session for the early prevention (intervention initiated ≤1 month) of PTSD in adults: PTSD symptomatology self-rated (IES-R endpoint/change score)

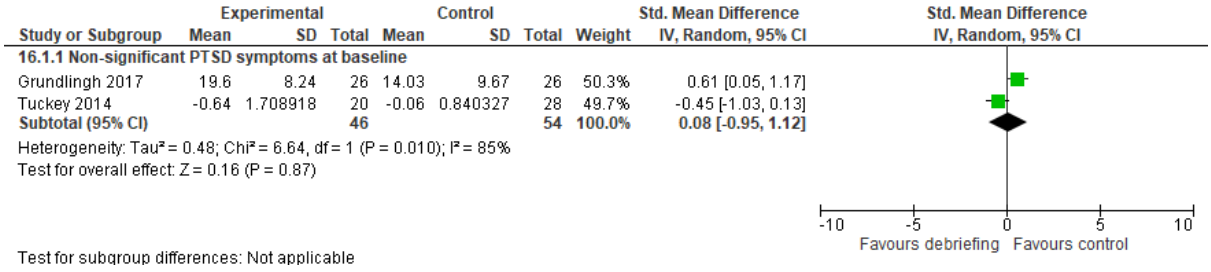
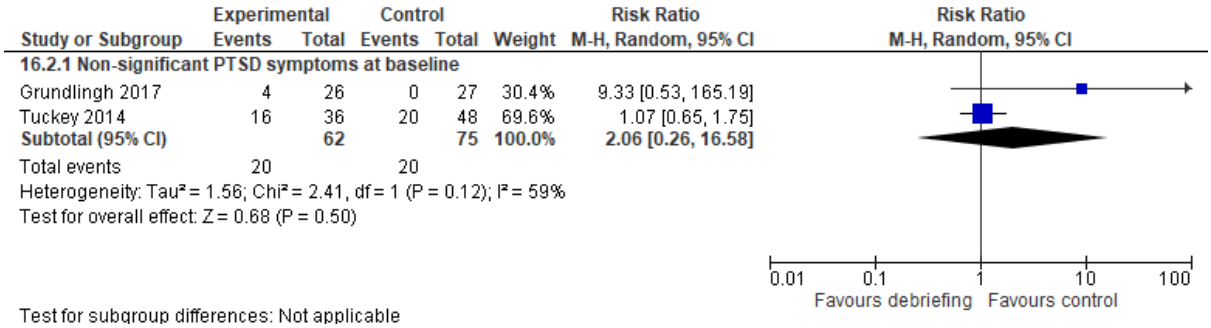


Figure 127: Group debriefing versus attention-placebo or psycho-educational session for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Discontinuation (loss to follow-up)



Single session debriefing + psycho-education versus single psycho-education session for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Figure 128: Single session debriefing + psycho-education versus single psycho-education session for the early prevention (intervention initiated ≤1 month)

of PTSD in adults: PTSD symptomatology self-rated at 6-month follow-up (PSS-SR change score)

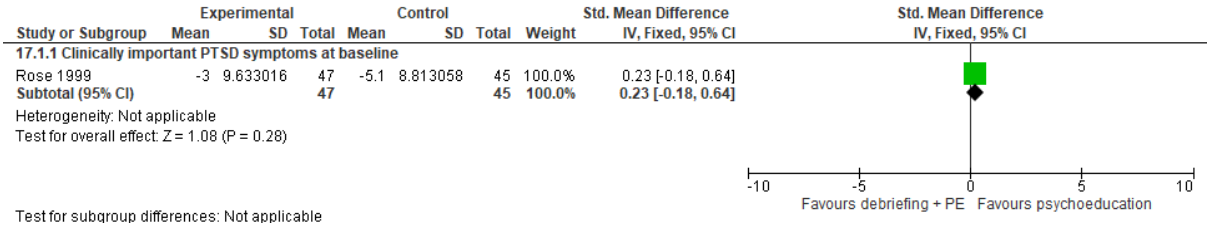


Figure 129: Single session debriefing + psycho-education versus single psycho-education session for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Diagnosis of PTSD at 6-month follow-up

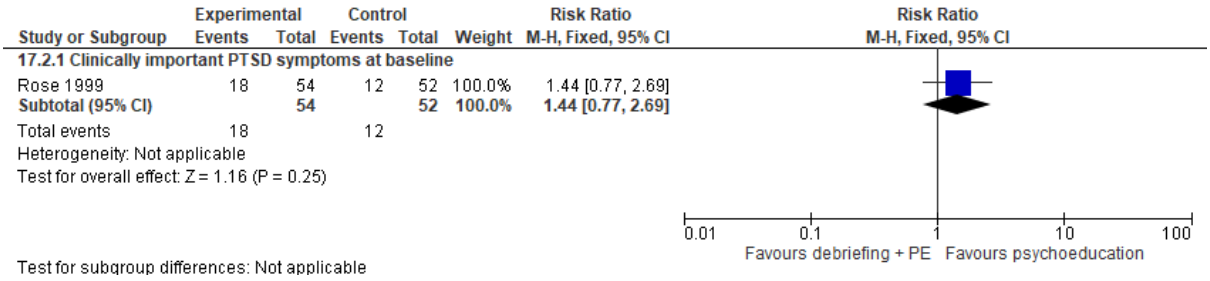


Figure 130: Single session debriefing + psycho-education versus single psycho-education session for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Depression symptoms at 6-month follow-up (BDI endpoint score)

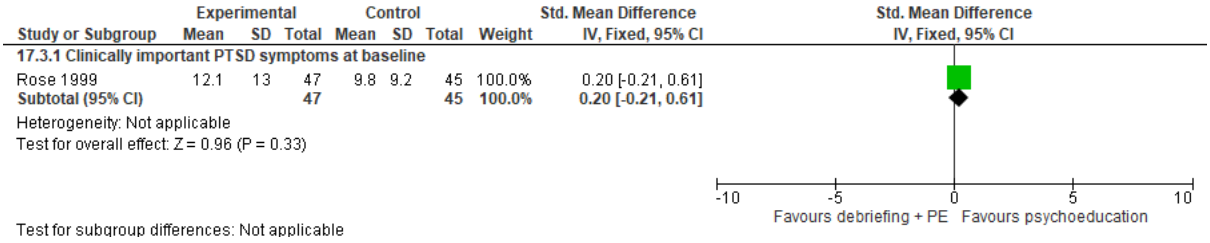
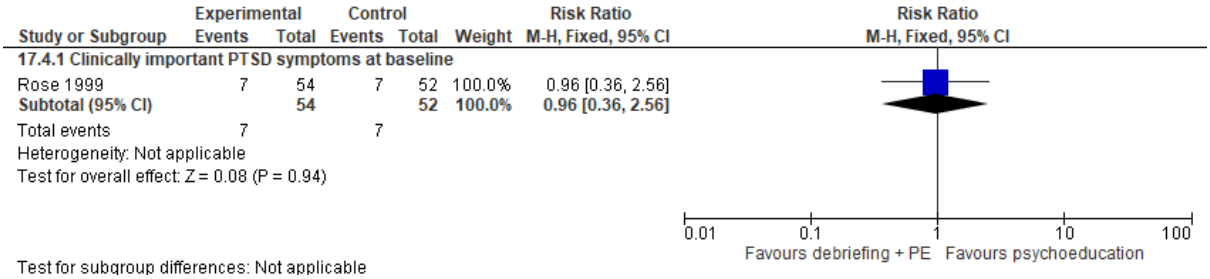


Figure 131: Single session debriefing + psycho-education versus single psycho-education session for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Discontinuation (loss to follow-up)



Psychological: Eye movement desensitisation and reprocessing

Eye movement desensitisation and reprocessing (EMDR) versus TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Figure 132: Eye movement desensitisation and reprocessing (EMDR) versus TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults: PTSD at 3-month follow-up

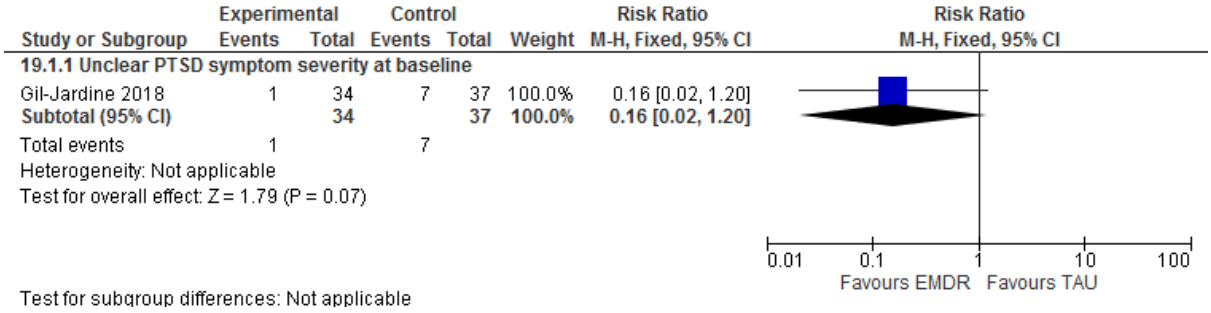
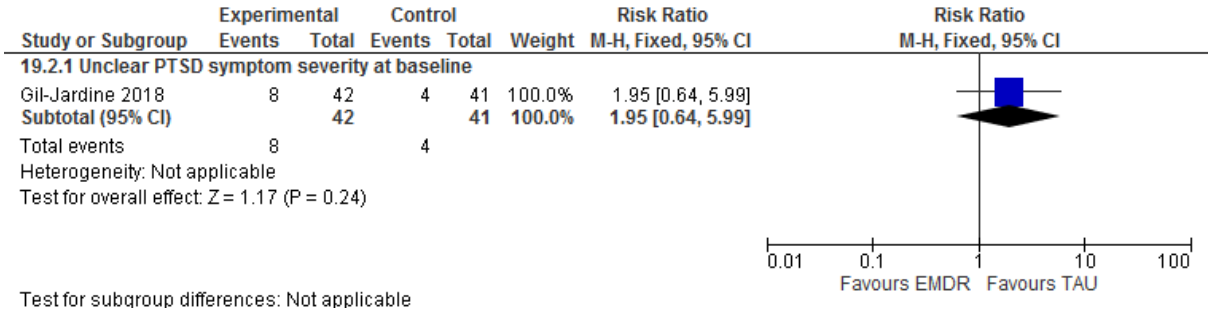


Figure 133: Eye movement desensitisation and reprocessing (EMDR) versus TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Discontinuation (loss to follow-up)



Eye movement desensitisation and reprocessing (EMDR) versus supportive counselling for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Figure 134: Eye movement desensitisation and reprocessing (EMDR) versus supportive counselling for the delayed treatment (>3 months) of below

threshold PTSD symptoms in adults: PTSD symptomatology self-rated (IES change score)

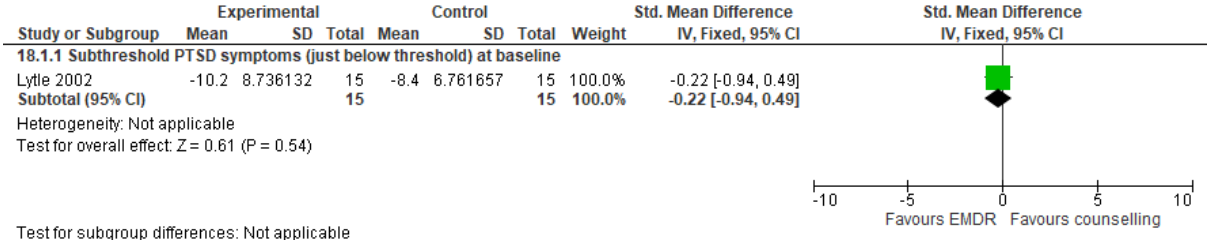
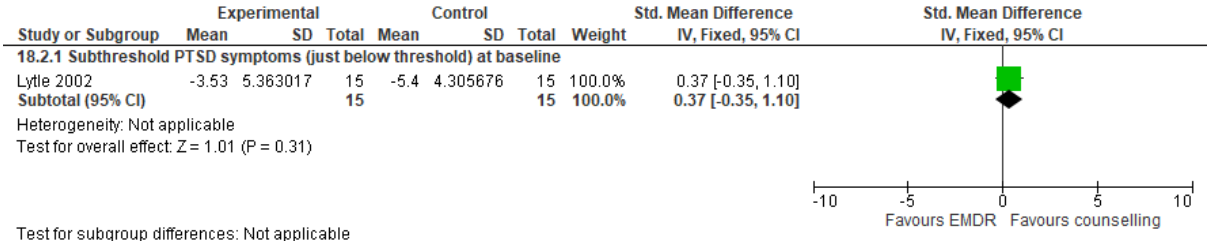


Figure 135: Eye movement desensitisation and reprocessing (EMDR) versus supportive counselling for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: Depression symptoms (BDI change score)



Eye movement desensitisation and reprocessing (EMDR) versus eye fixation desensitisation (EFD) for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Figure 136: Eye movement desensitisation and reprocessing (EMDR) versus eye fixation desensitisation (EFD) for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: PTSD symptomatology self-rated (IES change score)

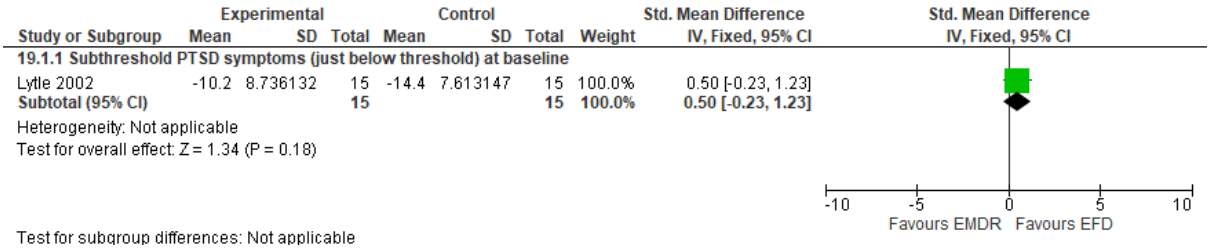
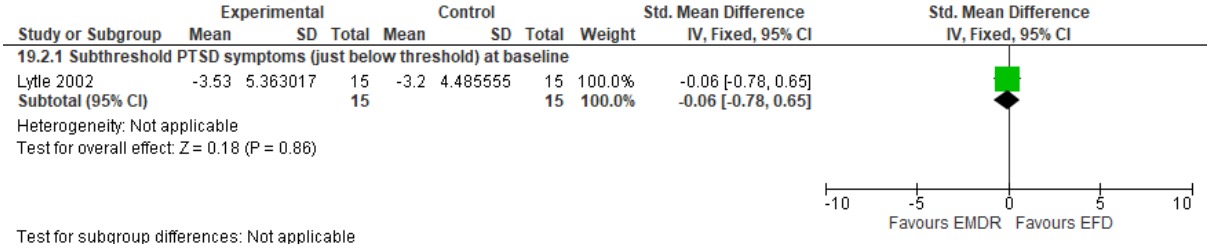


Figure 137: Eye movement desensitisation and reprocessing (EMDR) versus eye fixation desensitisation (EFD) for the delayed treatment (>3 months) of

below threshold PTSD symptoms in adults: Depression symptoms (BDI change score)



Eye fixation desensitisation (EFD) versus supportive counselling for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Figure 138: Eye fixation desensitisation (EFD) versus supportive counselling for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: PTSD symptomatology self-rated (IES change score)

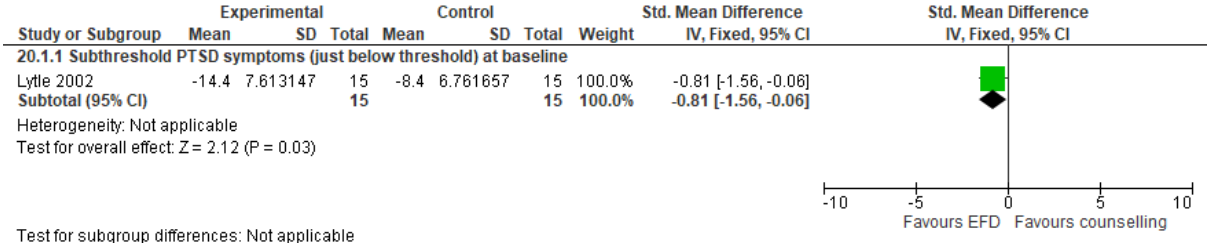
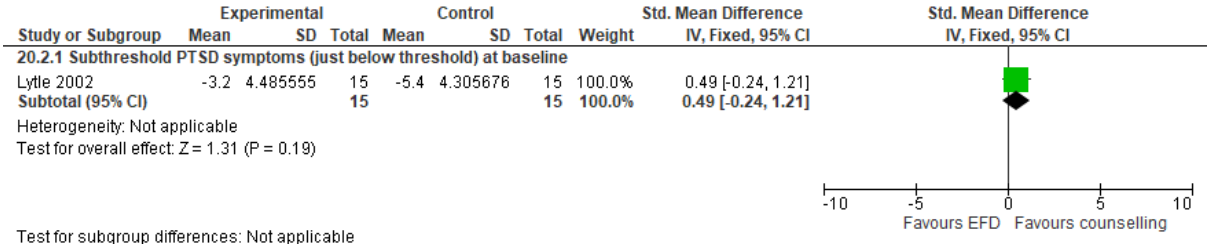


Figure 139: Eye fixation desensitisation (EFD) versus supportive counselling for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: Depression symptoms (BDI change score)



Psychological: Hypnotherapy

Hypnotherapy + trauma-focused CBT versus trauma-focused CBT for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Figure 140: Hypnotherapy + trauma-focused CBT versus trauma-focused CBT for the early prevention (intervention initiated ≤1 month) of PTSD in adults: PTSD symptomatology clinician-rated at 3-year follow-up (CAPS endpoint score)

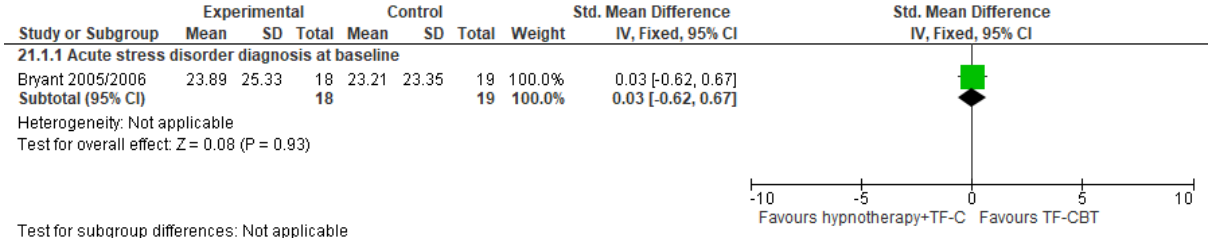


Figure 141: Hypnotherapy + trauma-focused CBT versus trauma-focused CBT for the early prevention (intervention initiated ≤1 month) of PTSD in adults: PTSD (number who met criteria for PTSD); Acute stress disorder diagnosis at baseline

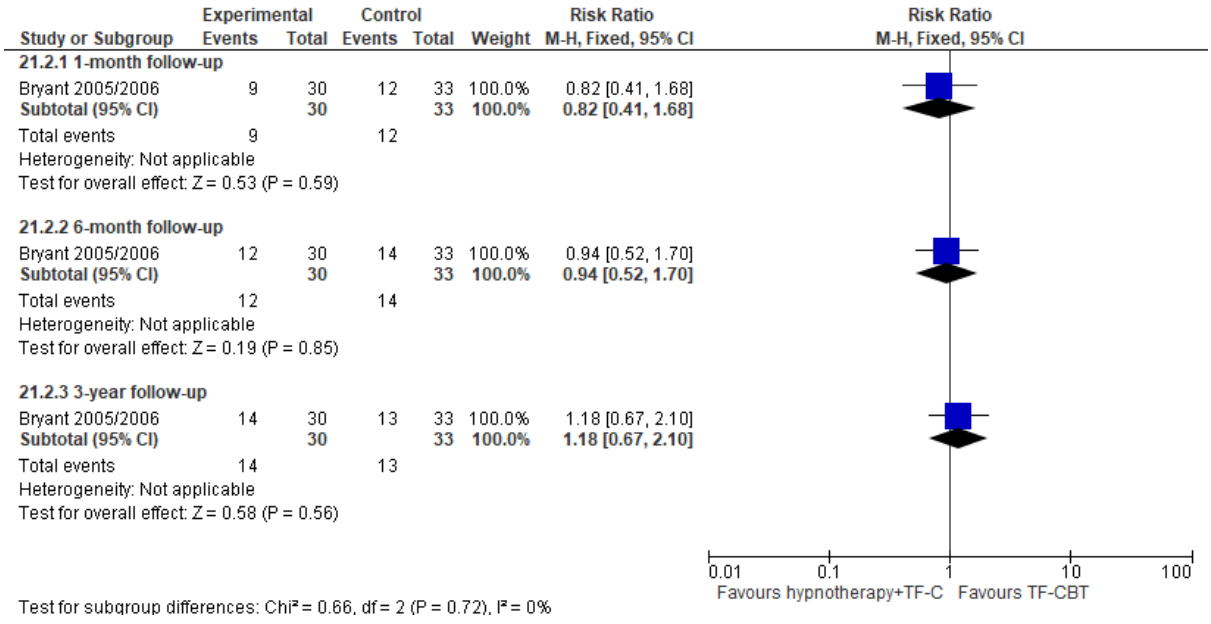


Figure 142: Hypnotherapy + trauma-focused CBT versus trauma-focused CBT for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Anxiety symptoms (BAI change score); Acute stress disorder diagnosis at baseline

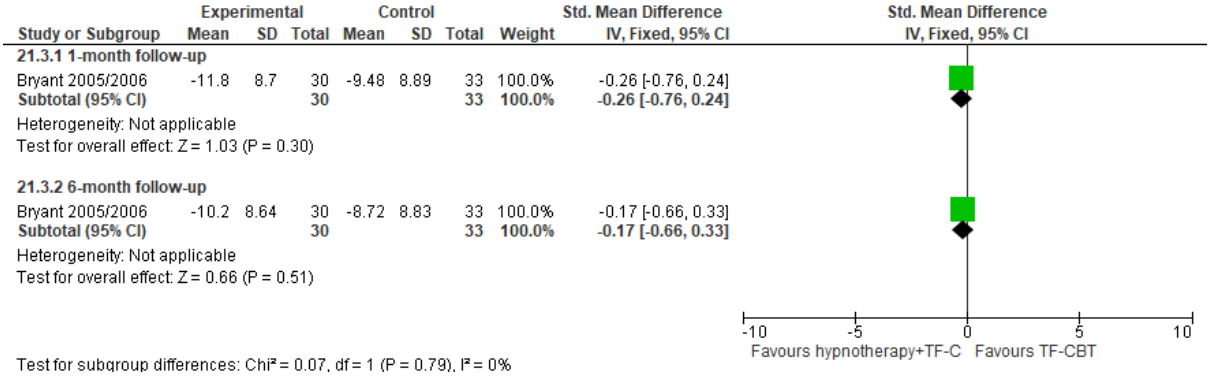


Figure 143: Hypnotherapy + trauma-focused CBT versus trauma-focused CBT for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Depression symptoms (BDI-II change score); Acute stress disorder diagnosis at baseline

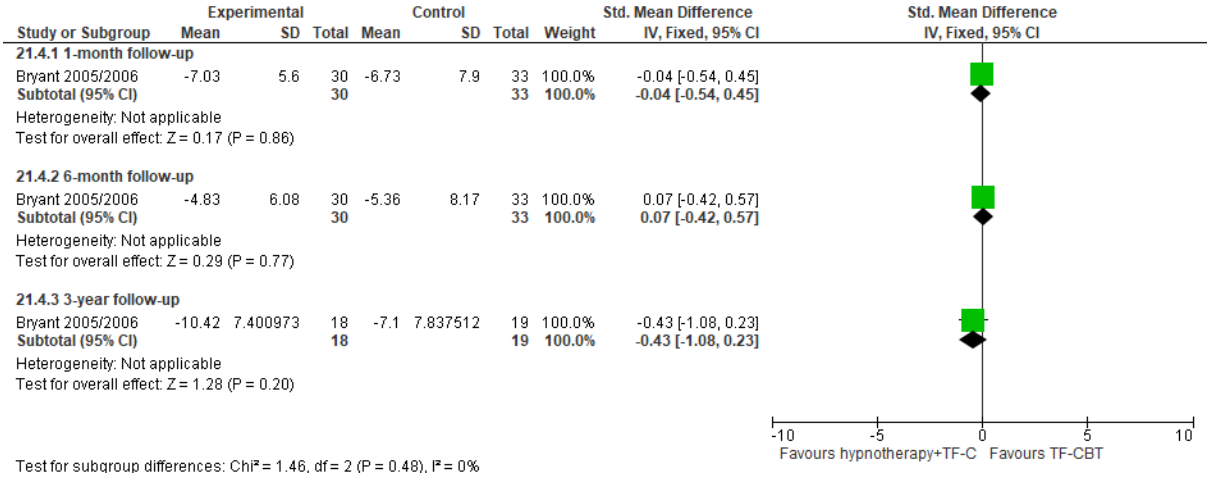
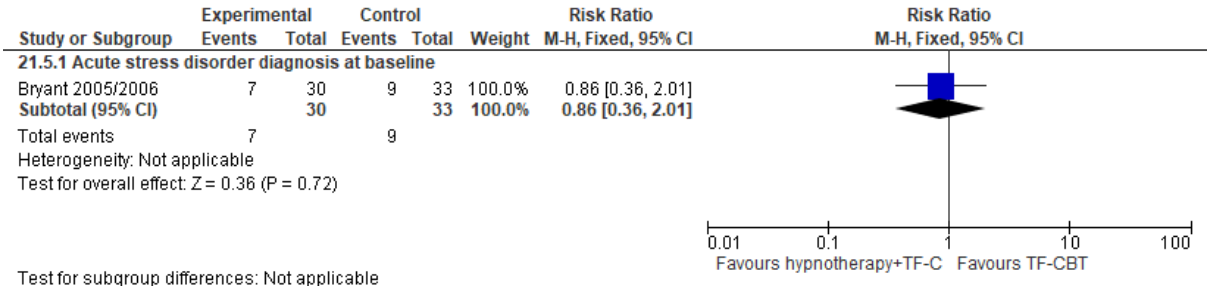


Figure 144: Hypnotherapy + trauma-focused CBT versus trauma-focused CBT for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Discontinuation (loss to follow-up)



Hypnotherapy + trauma-focused CBT versus supportive counselling for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Figure 145: Hypnotherapy + trauma-focused CBT versus supportive counselling for the early prevention (intervention initiated ≤1 month) of PTSD in adults: PTSD symptomatology clinician-rated at 3-year follow-up (CAPS endpoint score)

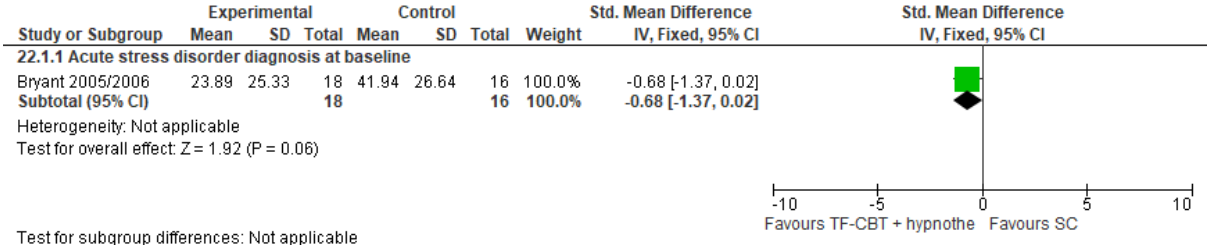


Figure 146: Hypnotherapy + trauma-focused CBT versus supportive counselling for the early prevention (intervention initiated ≤1 month) of PTSD in adults: TSD (number who met criteria for PTSD); Acute stress disorder diagnosis at baseline

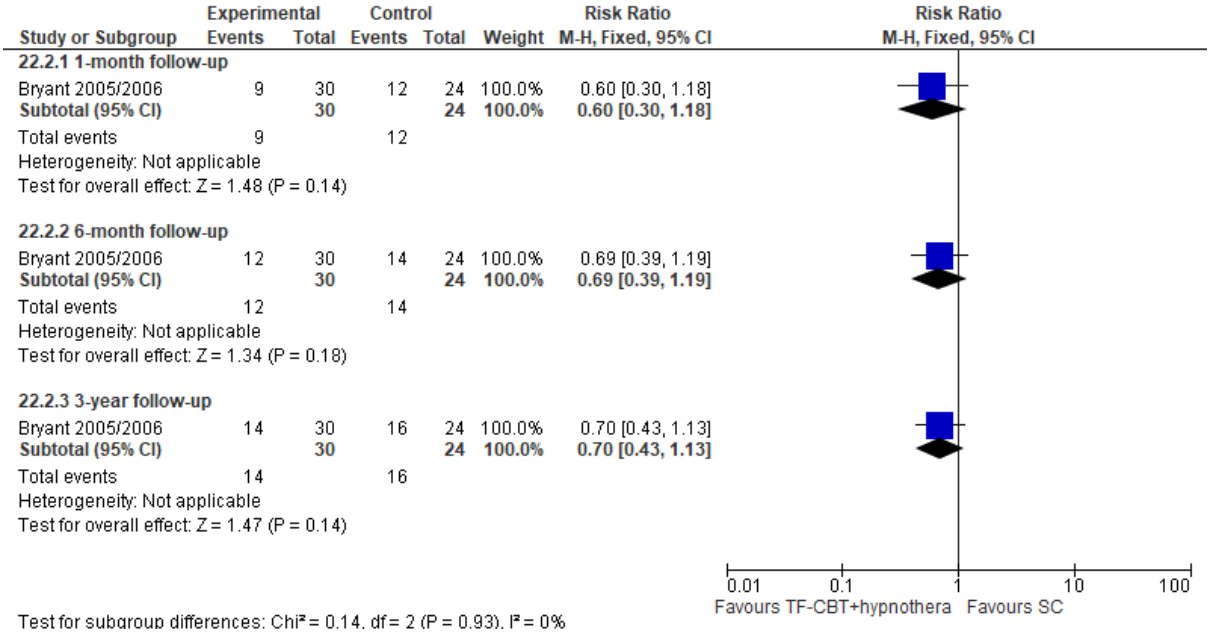


Figure 147: Hypnotherapy + trauma-focused CBT versus supportive counselling for the early prevention (intervention initiated ≤1 month) of PTSD in adults:

Anxiety symptoms (BAI change score); Acute stress disorder diagnosis at baseline

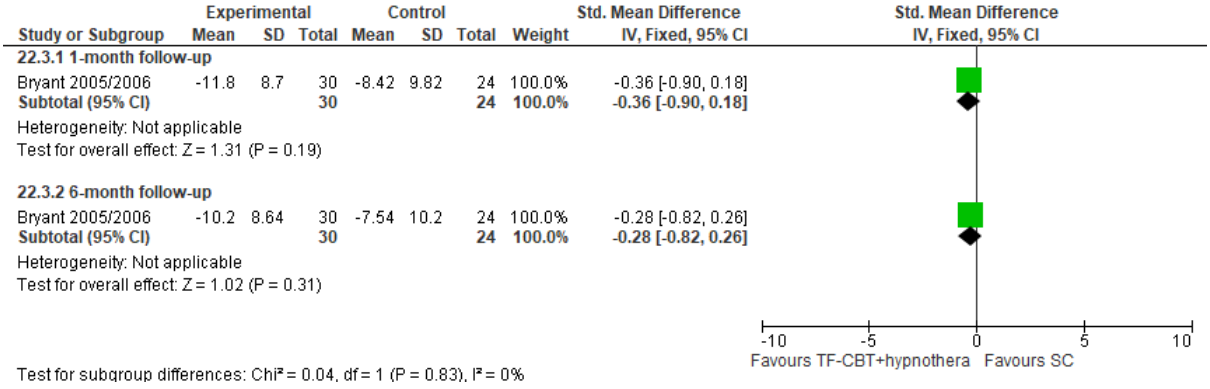


Figure 148: Hypnotherapy + trauma-focused CBT versus supportive counselling for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Depression symptoms (BDI-II change score); Acute stress disorder diagnosis at baseline

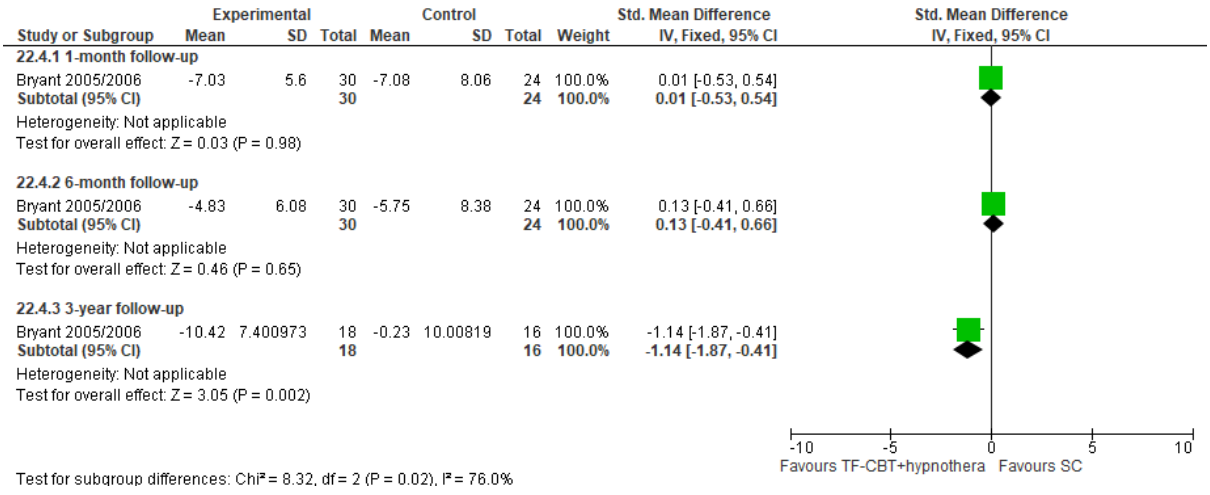
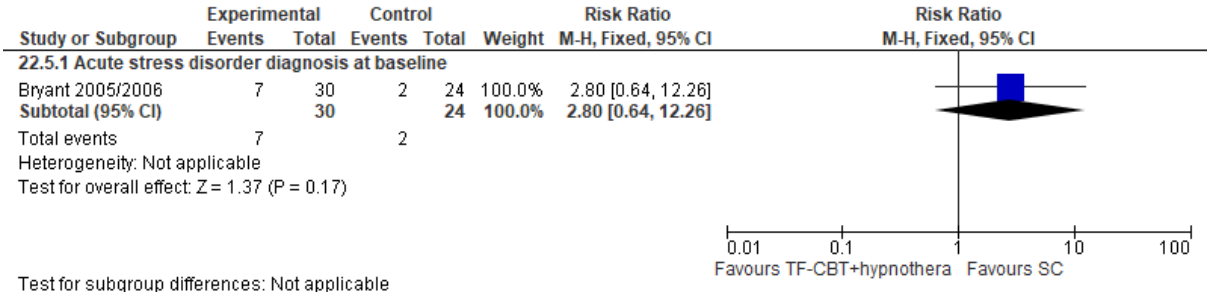


Figure 149: Hypnotherapy + trauma-focused CBT versus supportive counselling for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Discontinuation (loss to follow-up)



Psychological: Interpersonal psychotherapy

Interpersonal psychotherapy (IPT) versus TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Figure 150: Interpersonal psychotherapy (IPT) versus TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults: PTSD symptomatology self-rated (PCL change score); Non-significant PTSD symptoms at baseline

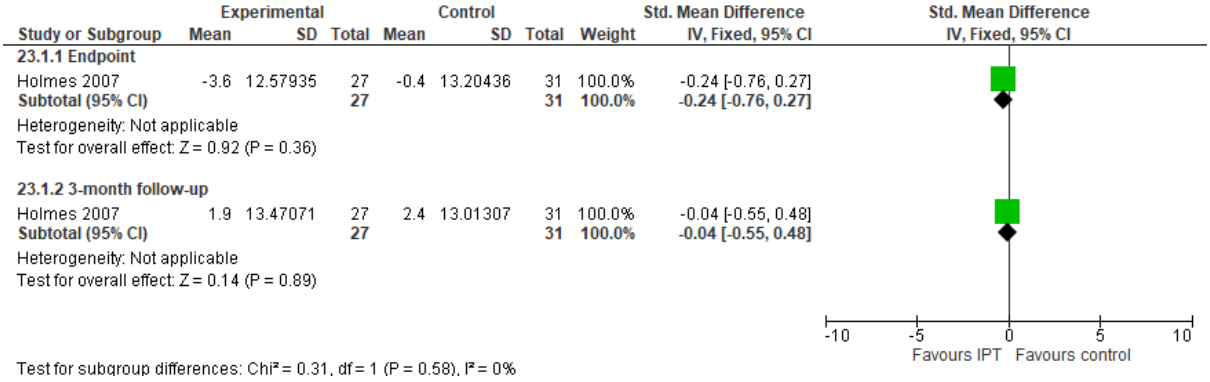


Figure 151: Interpersonal psychotherapy (IPT) versus TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults: PTSD diagnosis at 3-month follow-up

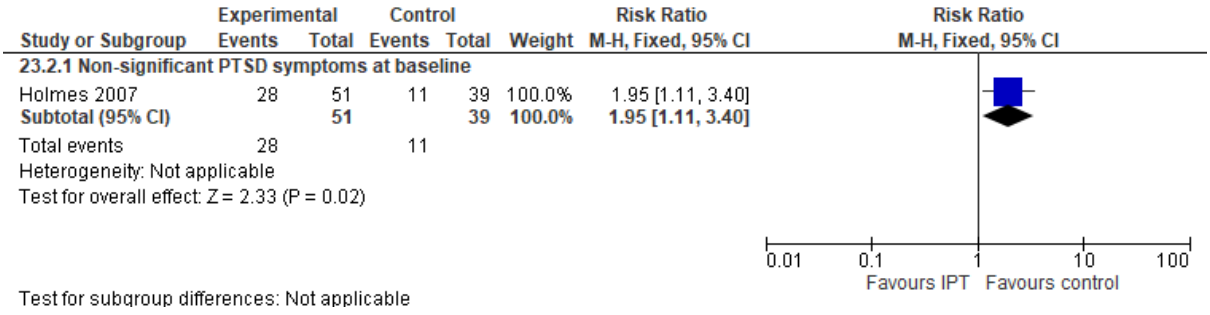


Figure 152: Interpersonal psychotherapy (IPT) versus TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Anxiety symptoms (HADS-A change score); Non-significant PTSD symptoms at baseline

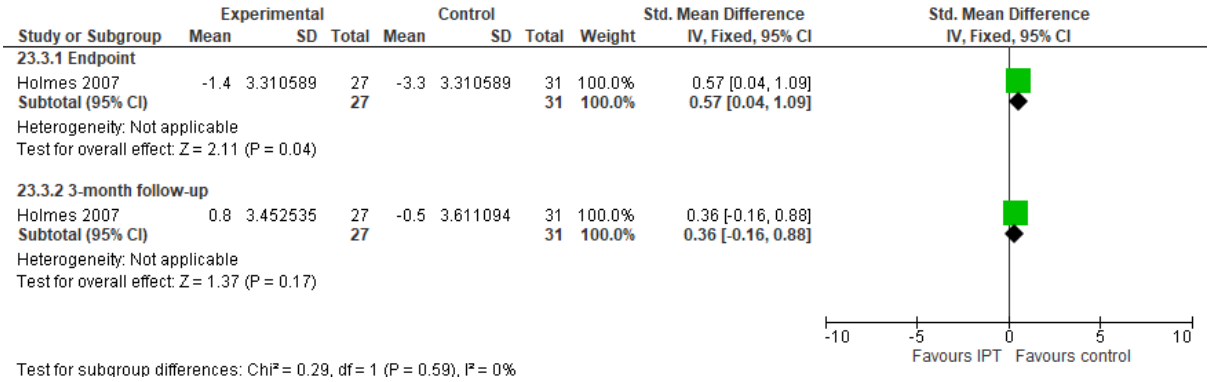


Figure 153: Interpersonal psychotherapy (IPT) versus TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Depression symptoms (BDI change score); Non-significant PTSD symptoms at baseline

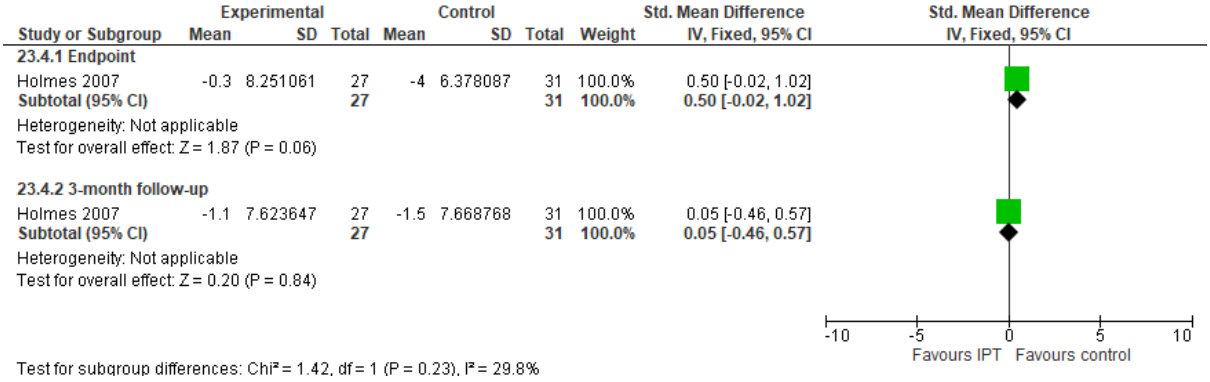


Figure 154: Interpersonal psychotherapy (IPT) versus TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Alcohol use disorder symptoms (AUDIT change score); Non-significant PTSD symptoms at baseline

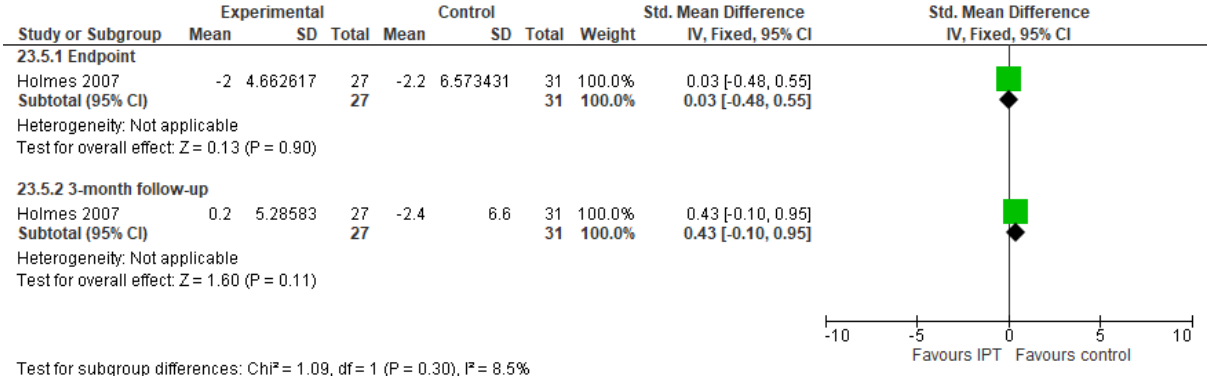
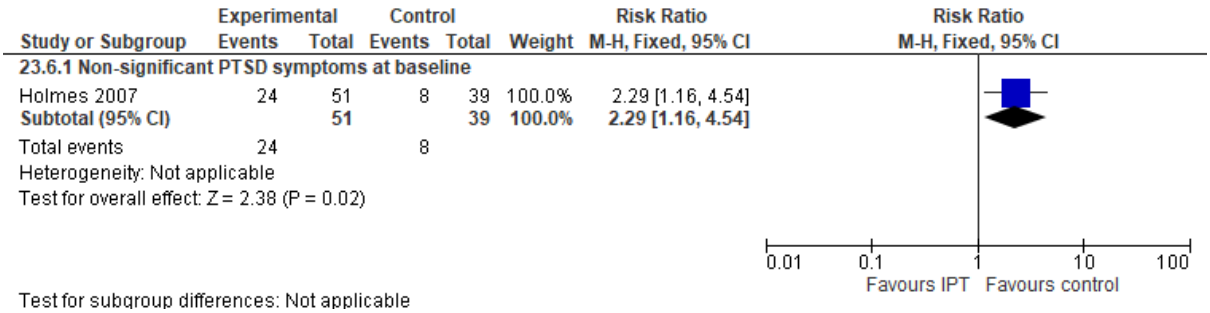


Figure 155: Interpersonal psychotherapy (IPT) versus TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Discontinuation (loss to follow-up)



Psychological: Counselling

Supportive counselling versus attention-placebo for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Figure 156: Supportive counselling versus attention-placebo for the early prevention (intervention initiated ≤1 month) of PTSD in adults: PTSD symptomatology self-rated (PSS-SR change score); clinically important PTSD symptoms at baseline

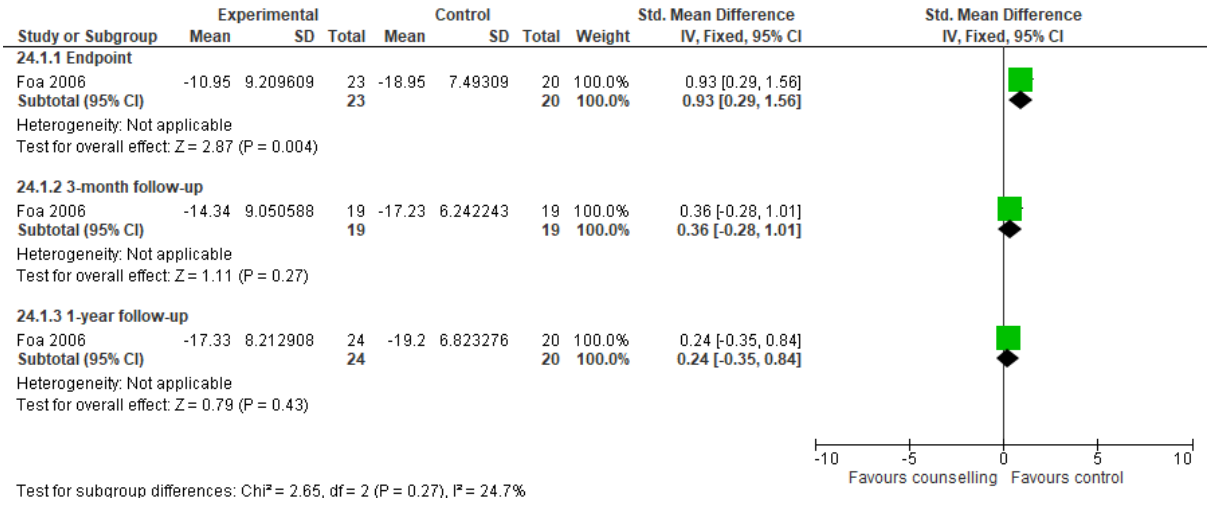


Figure 157: Supportive counselling versus attention-placebo for the early prevention (intervention initiated ≤1 month) of PTSD in adults: PTSD symptomatology clinician-rated (PSS-I change score); clinically important PTSD symptoms at baseline

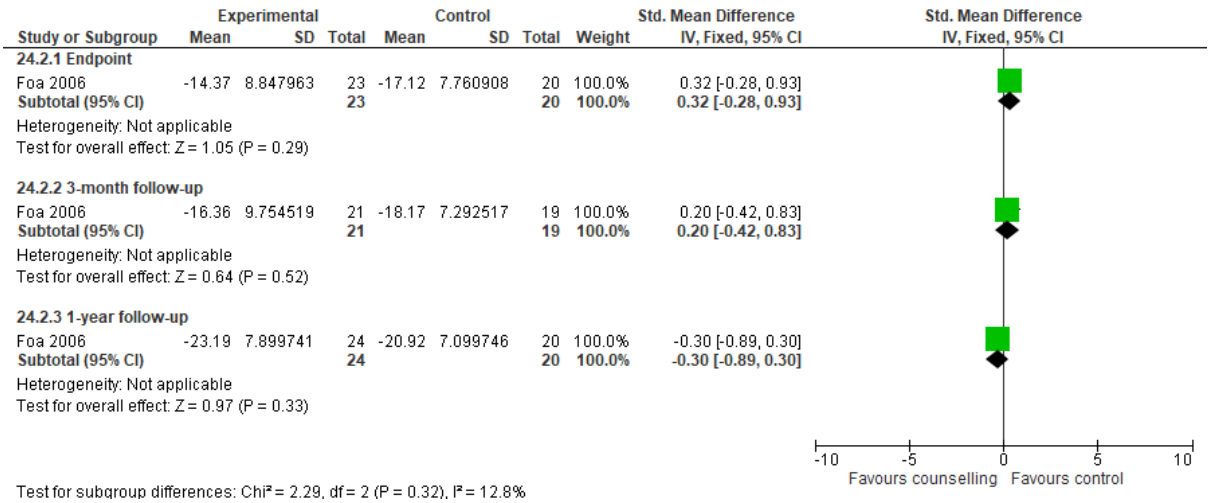


Figure 158: Supportive counselling versus attention-placebo for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Anxiety symptoms (BAI change score); clinically important PTSD symptoms at baseline

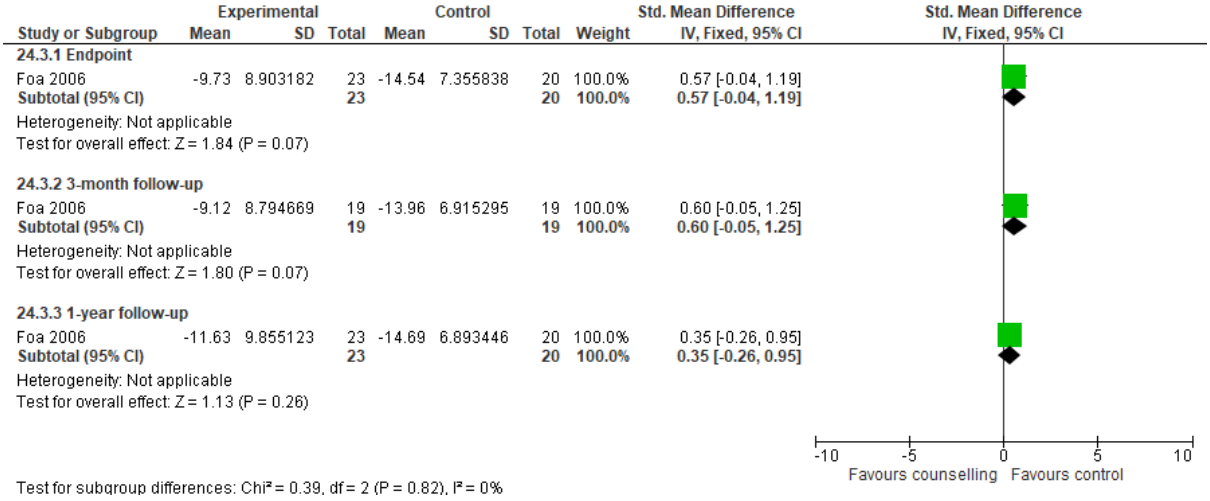


Figure 159: Supportive counselling versus attention-placebo for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Depression symptoms (BDI change score); clinically important PTSD symptoms at baseline

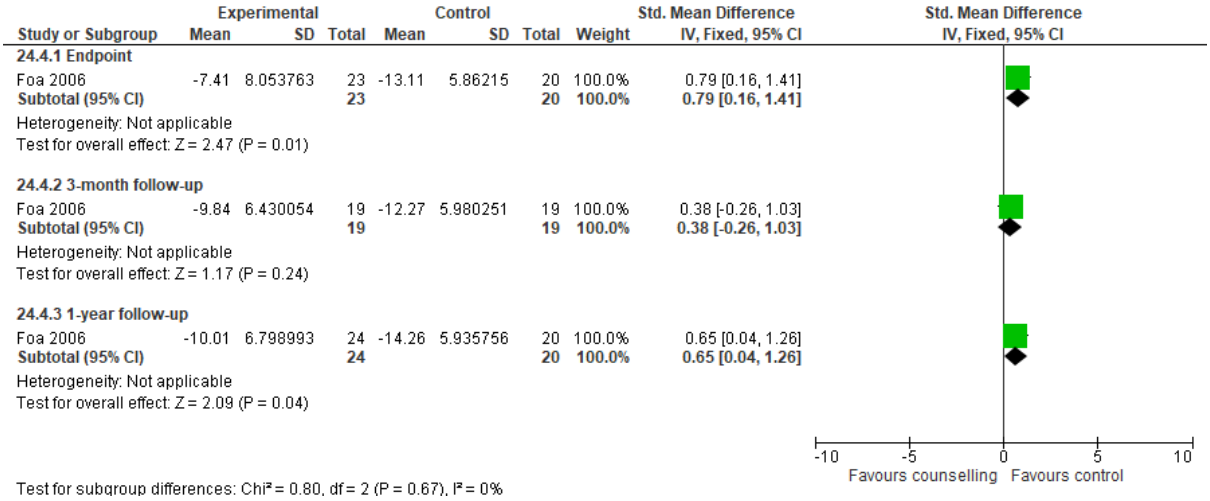
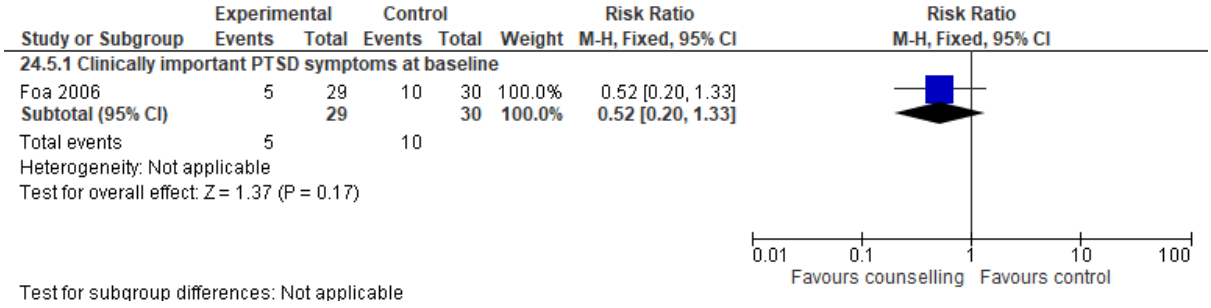


Figure 160: Supportive counselling versus attention-placebo for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Discontinuation (loss to follow-up)



Counselling versus no treatment for the early treatment (1-3 months) of below threshold PTSD symptoms in adults

Figure 161: Counselling versus no treatment for the early treatment (1-3 months) of below threshold PTSD symptoms in adults: PTSD symptomatology self-rated (IES change score)

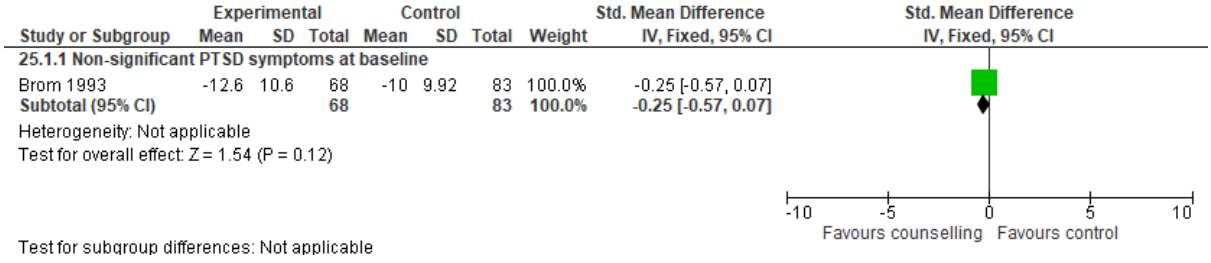
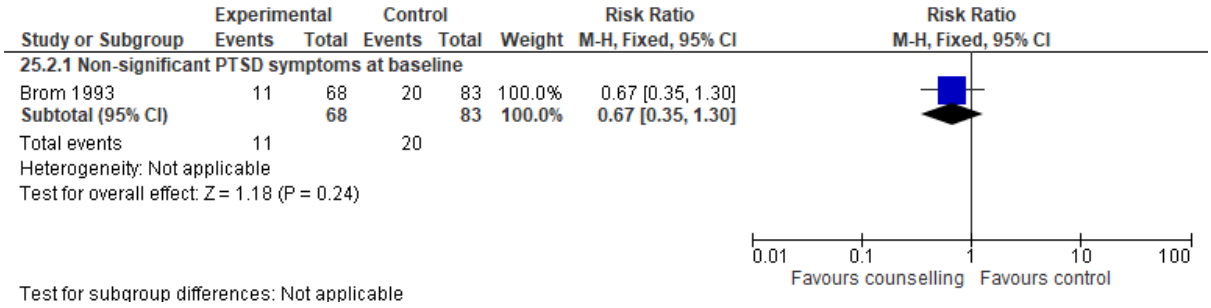


Figure 162: Counselling versus no treatment for the early treatment (1-3 months) of below threshold PTSD symptoms in adults: Discontinuation (loss to follow-up)



Psychological: Combined somatic and cognitive therapy

Brief cognitive-behavioural conjoint therapy versus waitlist for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Figure 163: Brief cognitive-behavioural conjoint therapy versus waitlist for the early prevention (intervention initiated ≤1 month) of PTSD in adults: PTSD

symptomatology self-rated (IES-R change score); clinically important PTSD symptoms at baseline

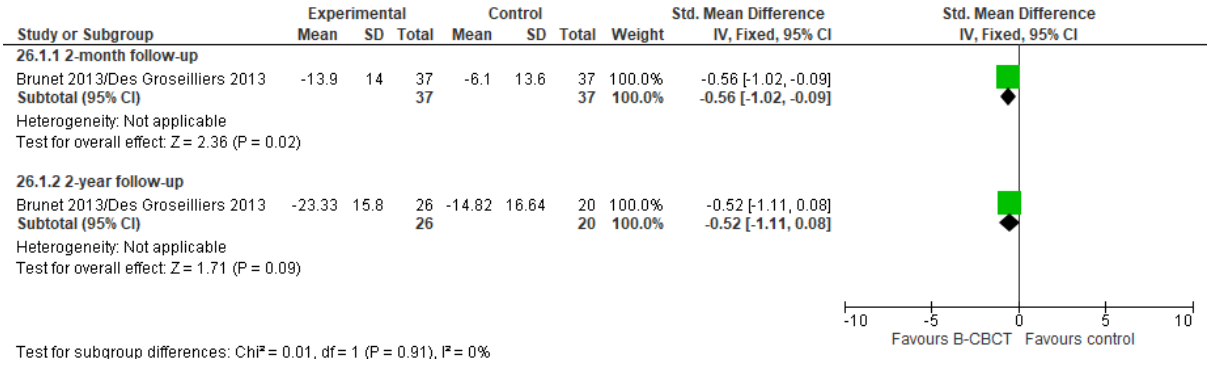
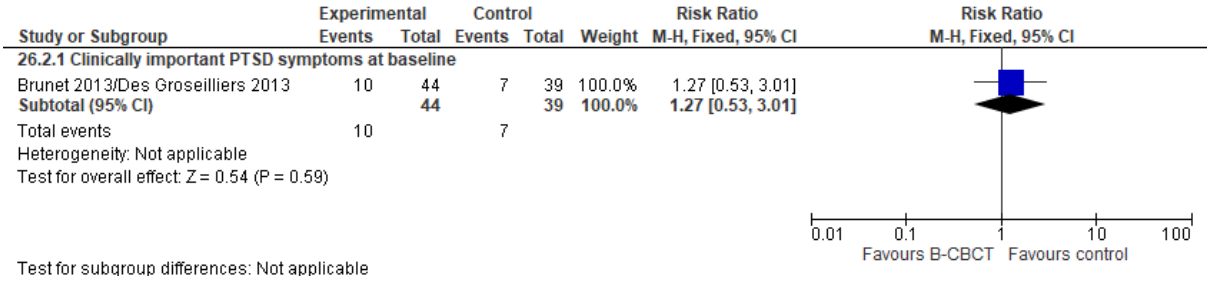


Figure 164: Brief cognitive-behavioural conjoint therapy versus waitlist for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Discontinuation (loss to follow-up)



Psychological: Parent training/family intervention

Family therapy (+ TAU) versus TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Figure 165: Family therapy (+ TAU) versus TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults: PTSD symptomatology self-rated at 1-month follow-up (IES-R endpoint score)

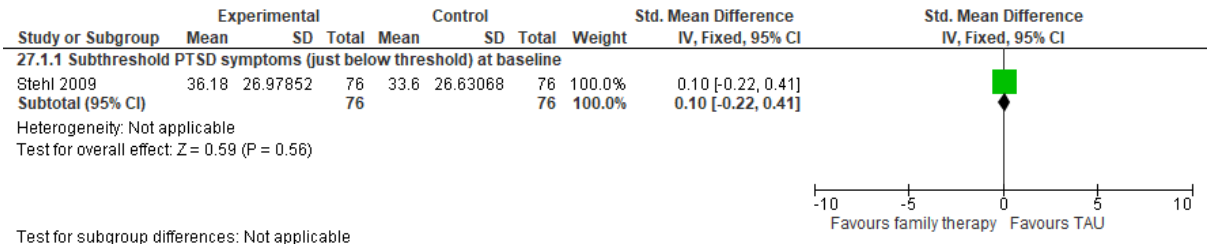


Figure 166: Family therapy (+ TAU) versus TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Anxiety symptoms at 1-month follow-up (STAI State endpoint score)

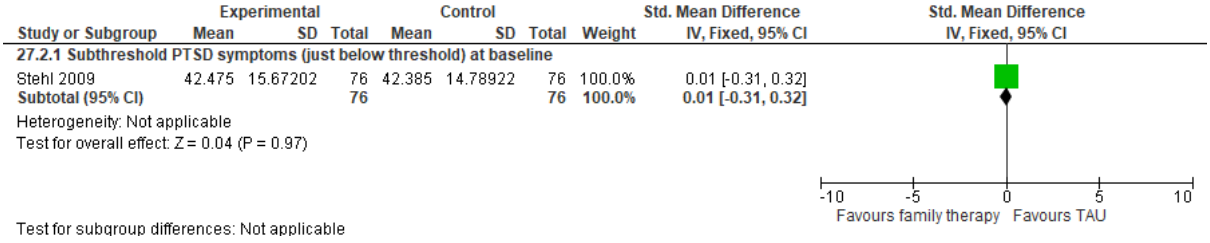
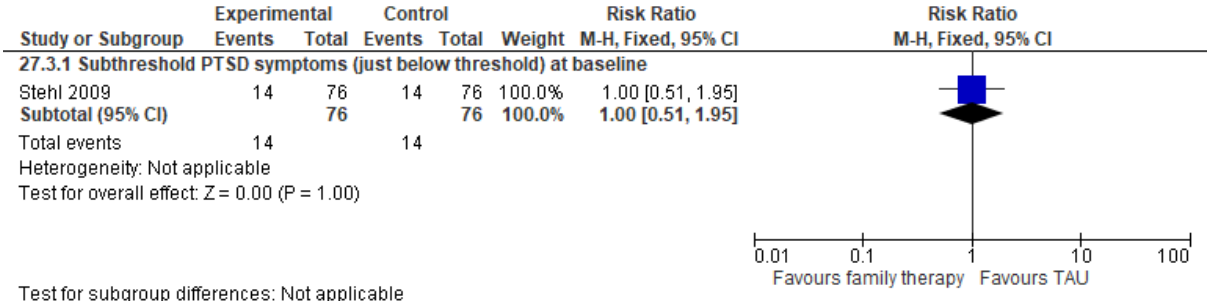


Figure 167: Family therapy (+ TAU) versus TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Discontinuation (loss to follow-up)



Psychological: Self-help (without support)

Self-help (without support) versus waitlist for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Figure 168: Self-help (without support) versus waitlist for the early prevention (intervention initiated ≤1 month) of PTSD in adults: PTSD symptomatology self-rated (IES-R change score); Non-significant PTSD symptoms at baseline

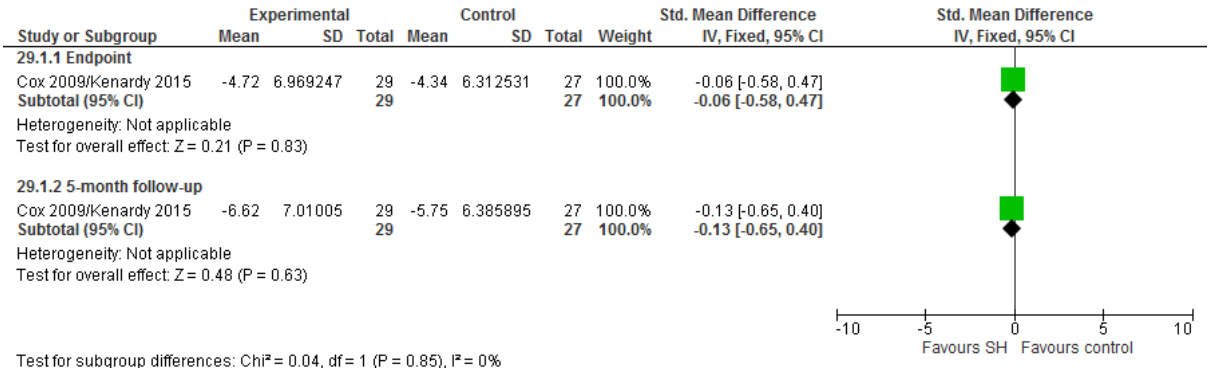
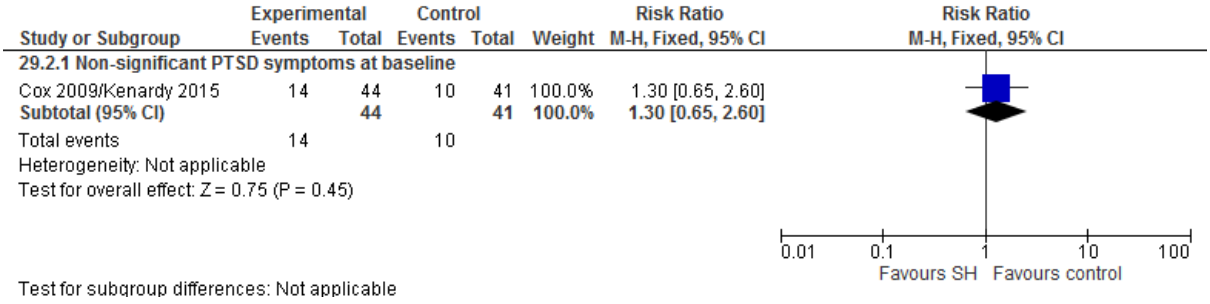


Figure 169: Self-help (without support) versus waitlist for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Discontinuation (loss to follow-up)



Self-help (without support; +/- TAU) versus TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Figure 170: Self-help (without support; +/- TAU) versus TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults: PTSD symptomatology self-rated at endpoint (PDS/IES/IES-R change score)

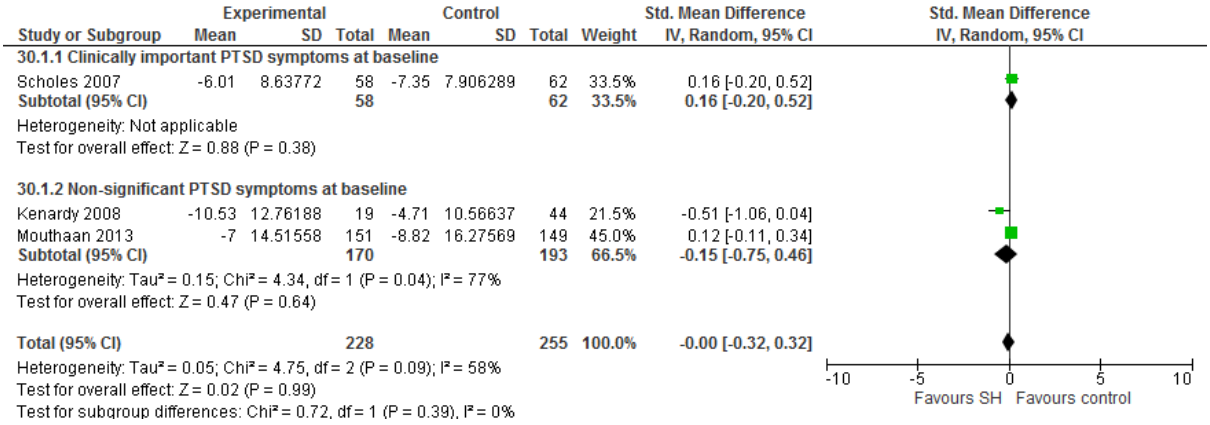


Figure 171: Self-help (without support; +/- TAU) versus TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults: PTSD symptomatology self-rated at 6-8 week follow-up (PCL/IES-R change score)

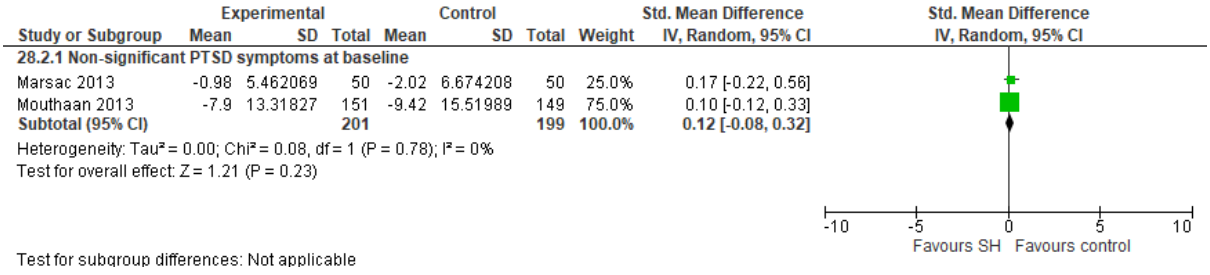


Figure 172: Self-help (without support; +/- TAU) versus TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults: PTSD symptomatology self-rated at 5-6 month follow-up (PDS/IES/IES-R change score)

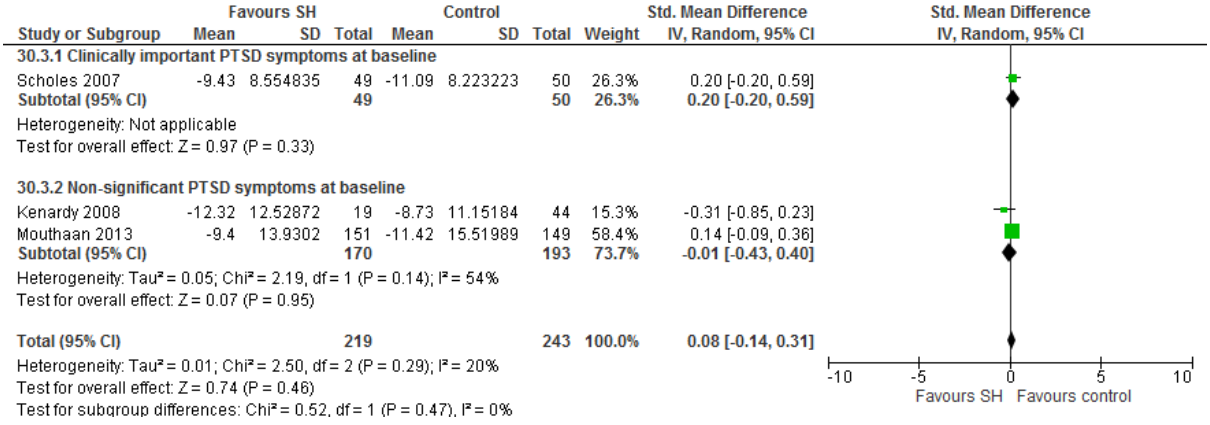


Figure 173: Self-help (without support; +/- TAU) versus TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults: PTSD symptomatology self-rated at 11-month follow-up (IES-R change score)

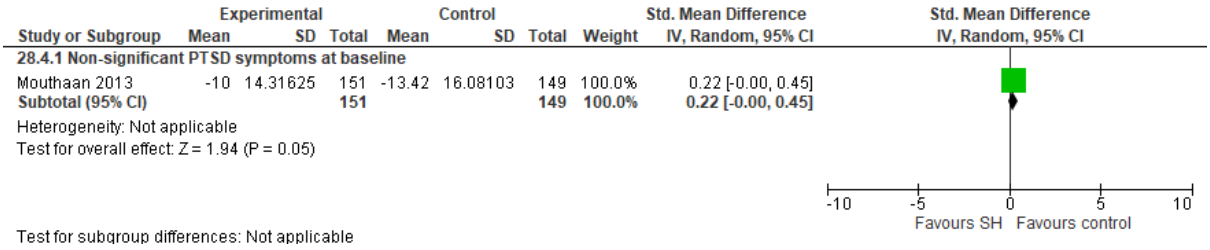


Figure 174: Self-help (without support; +/- TAU) versus TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults: PTSD symptomatology

clinician-rated (CAPS endpoint score); Non-significant PTSD symptoms at baseline

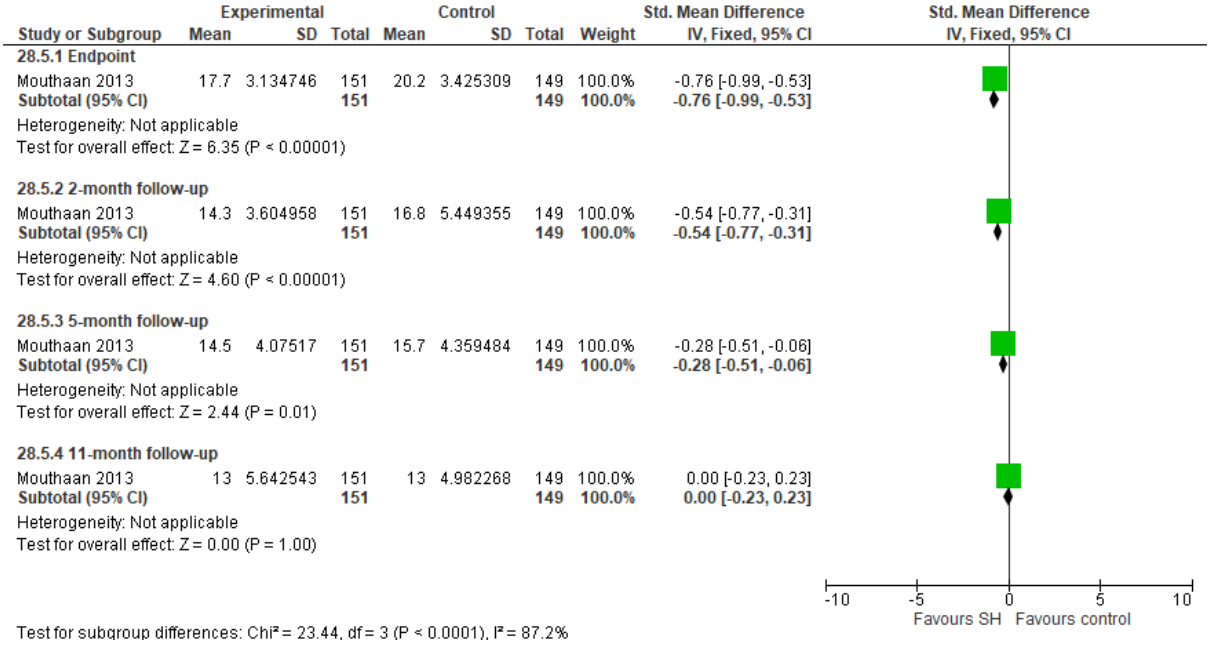


Figure 175: Self-help (without support; +/- TAU) versus TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults: PTSD at 5-month follow-up (number scoring above clinical cut-off on scale)

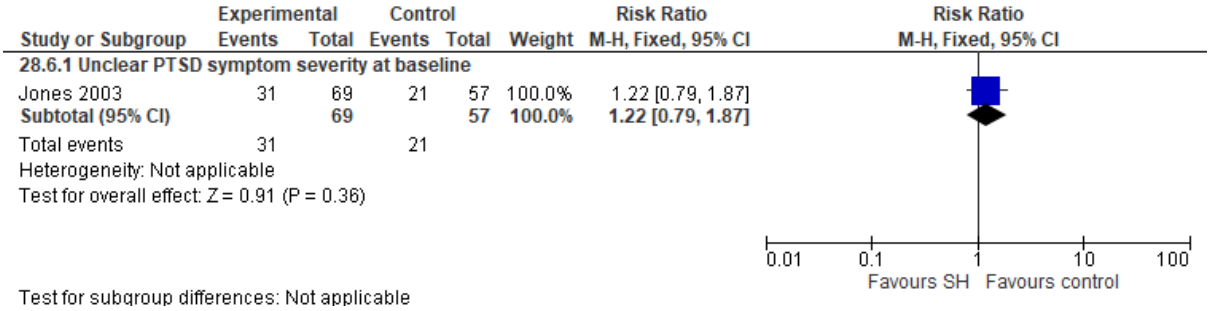


Figure 176: Self-help (without support; +/- TAU) versus TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Anxiety symptoms at endpoint (HADS-A/DASS Anxiety change score)

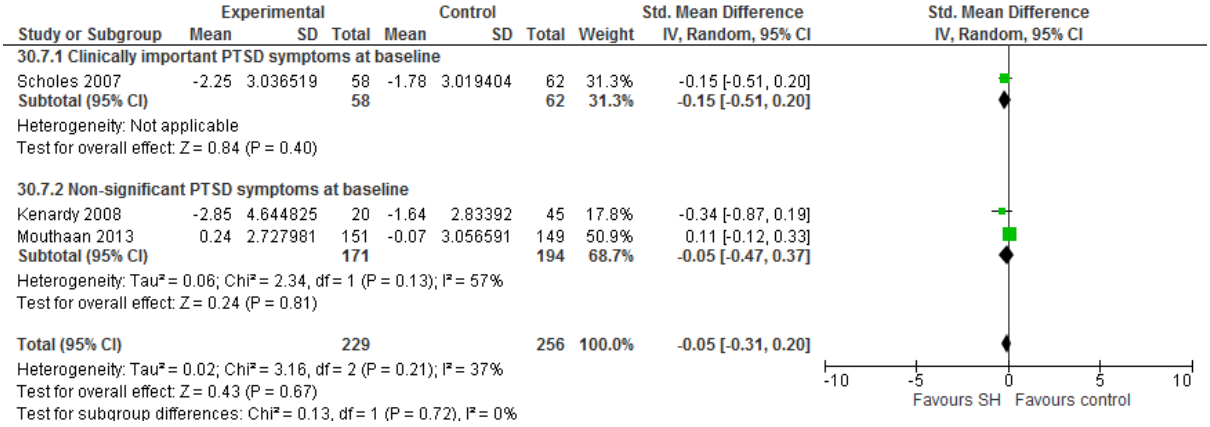


Figure 177: Self-help (without support; +/- TAU) versus TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Anxiety symptoms at 2-month follow-up (HADS-A change score)

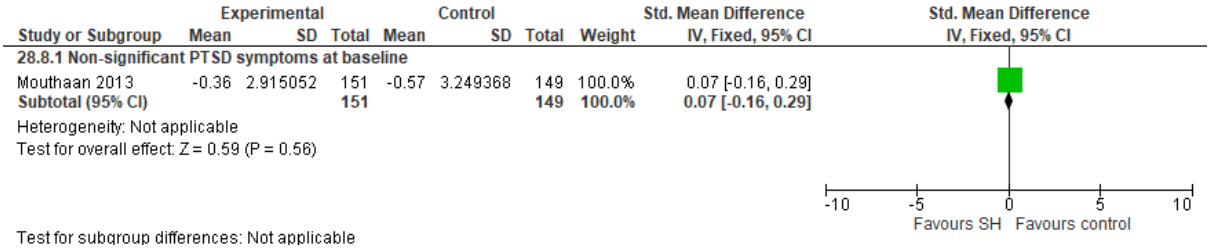


Figure 178: Self-help (without support; +/- TAU) versus TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Anxiety symptoms at 5-6 month follow-up (HADS-A/DASS Anxiety change score)

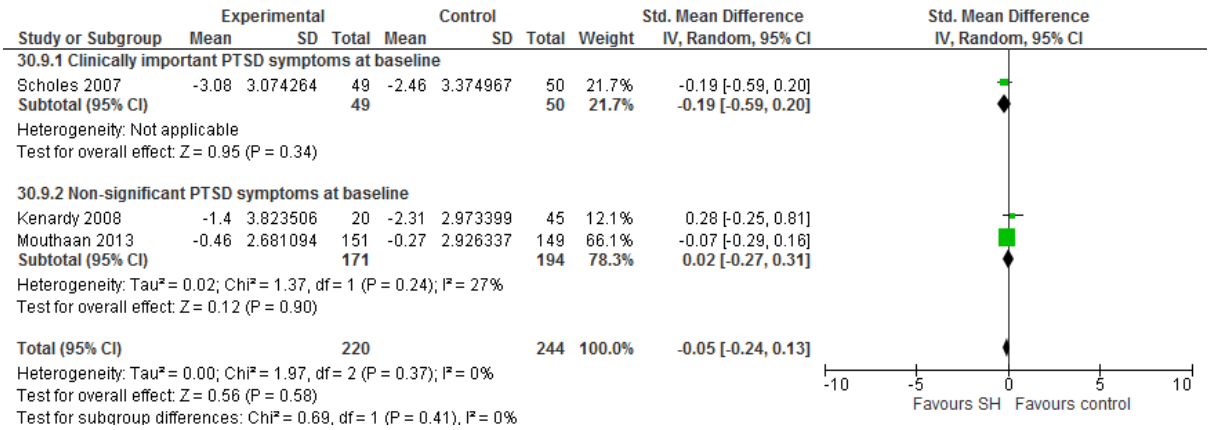


Figure 179: Self-help (without support; +/- TAU) versus TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Anxiety symptoms at 11-month follow-up (HADS-A change score)

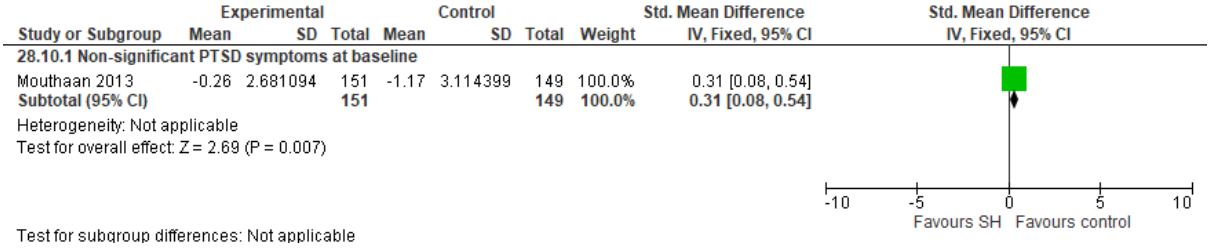


Figure 180: Self-help (without support; +/- TAU) versus TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Depression symptoms at endpoint (HADS-D/DASS Depression change score)

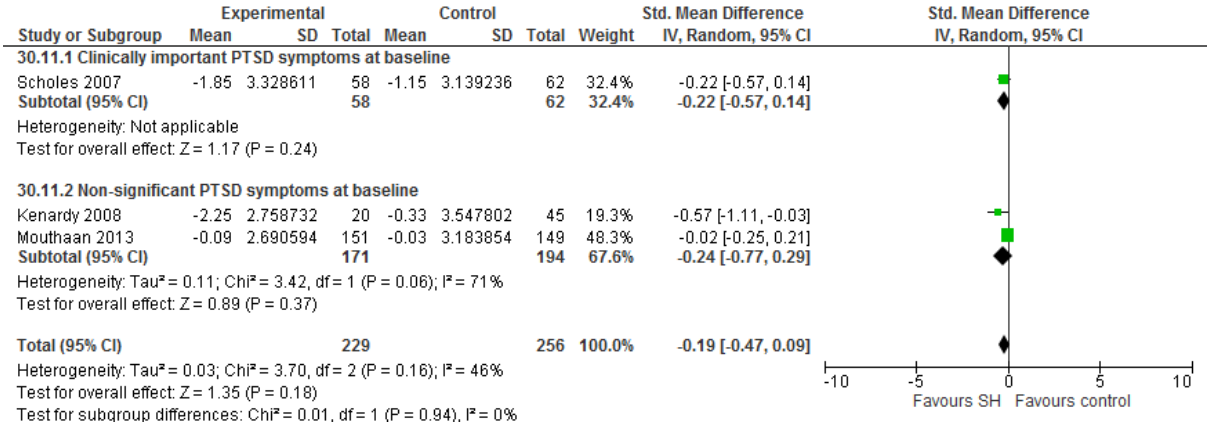


Figure 181: Self-help (without support; +/- TAU) versus TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Depression symptoms at 2-month follow-up (HADS-D change score)

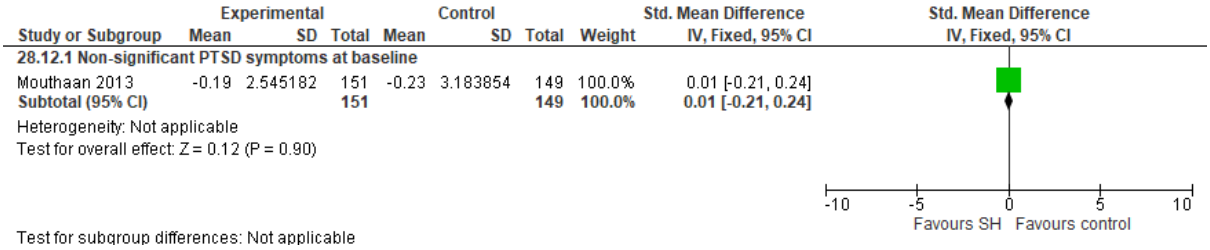


Figure 182: Self-help (without support; +/- TAU) versus TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Depression symptoms at 5-6 month follow-up (HADS-D/DASS Depression change score)

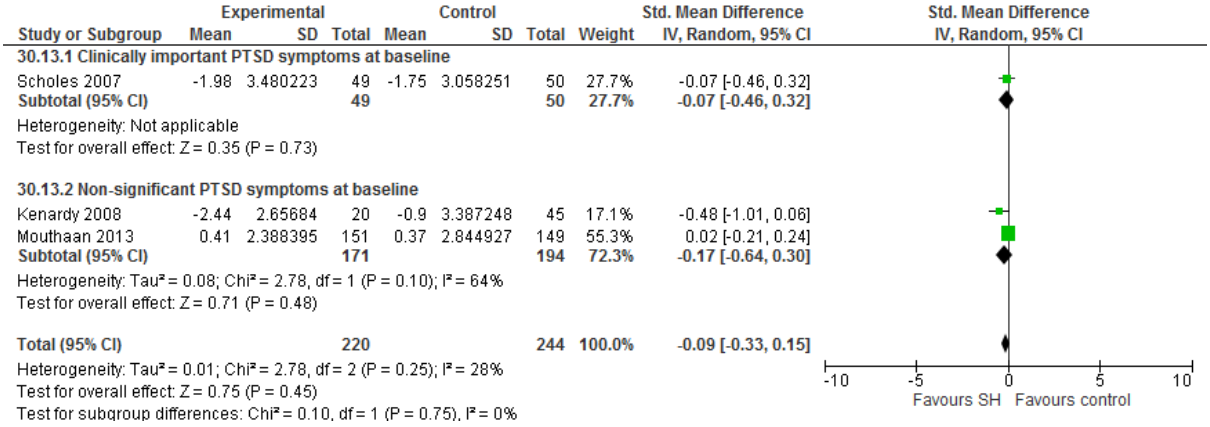


Figure 183: Self-help (without support; +/- TAU) versus TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Depression symptoms at 11-month follow-up (HADS-D change score)

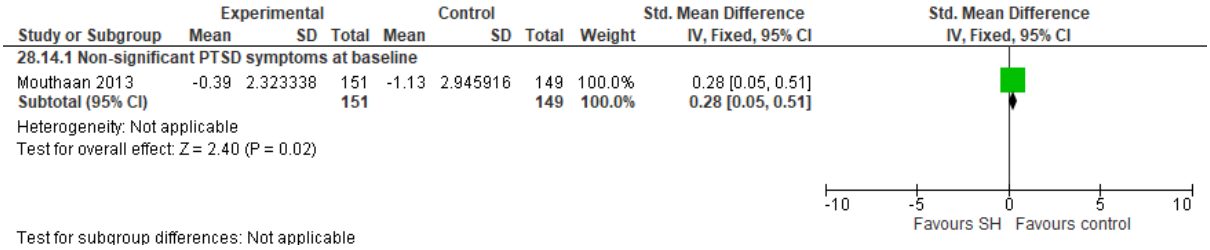
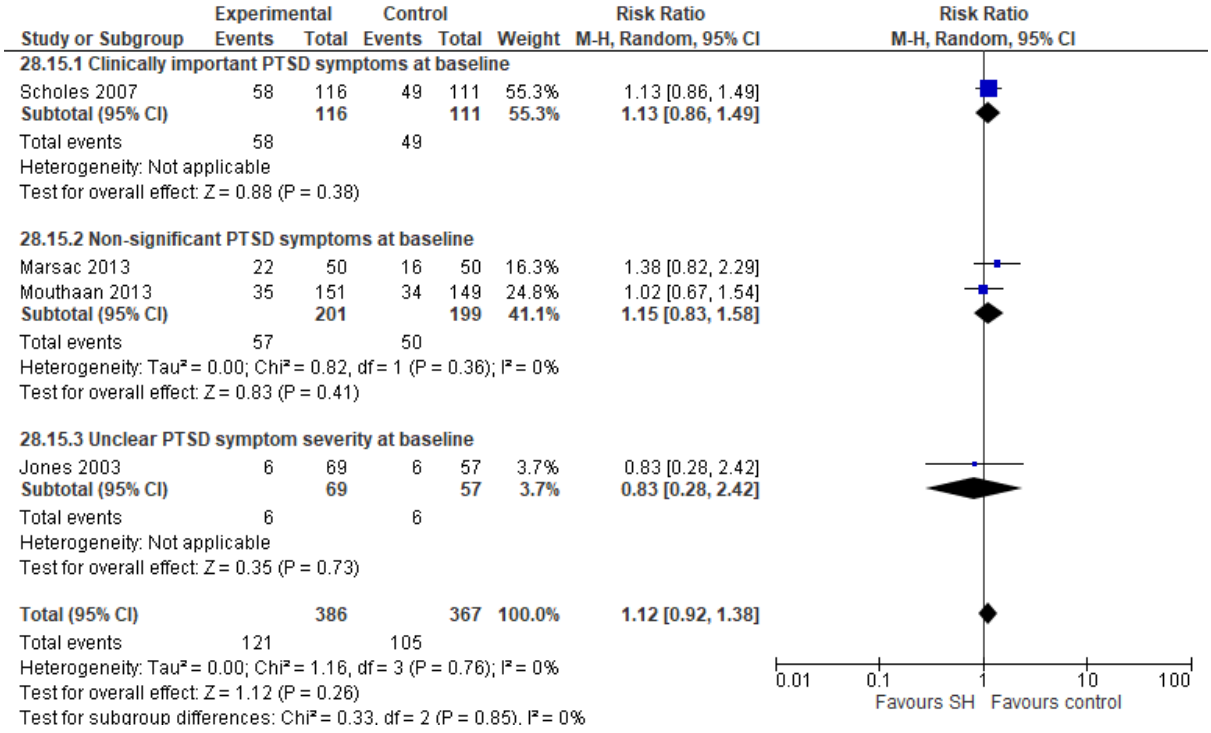


Figure 184: Self-help (without support; +/- TAU) versus TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Discontinuation (loss to follow-up)



Self-help (without support) versus waitlist for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Figure 185: Self-help (without support) versus waitlist for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: PTSD symptomatology self-rated at endpoint (PSS-SR endpoint score/PCL change score)

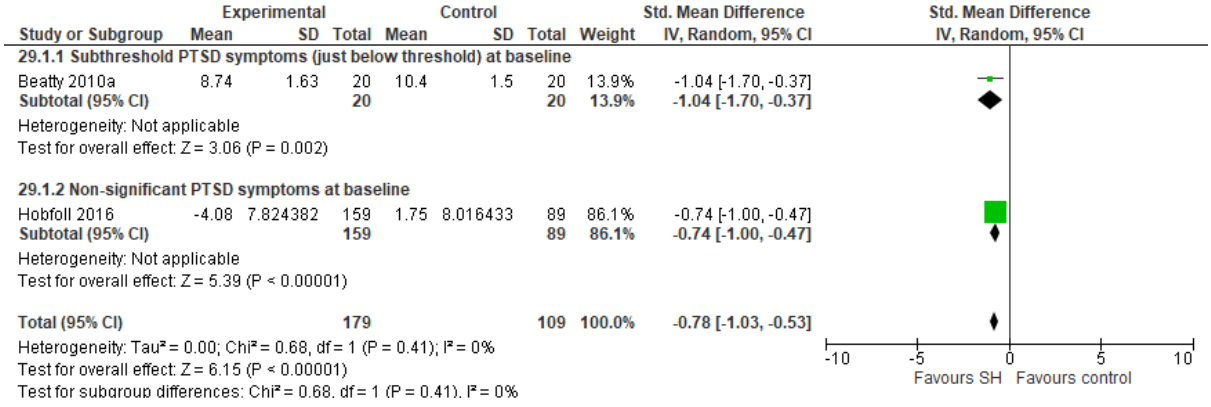


Figure 186: Self-help (without support) versus waitlist for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: PTSD

symptomatology self-rated at 1-3 month follow-up (PSS-SR endpoint score/PCL change score)

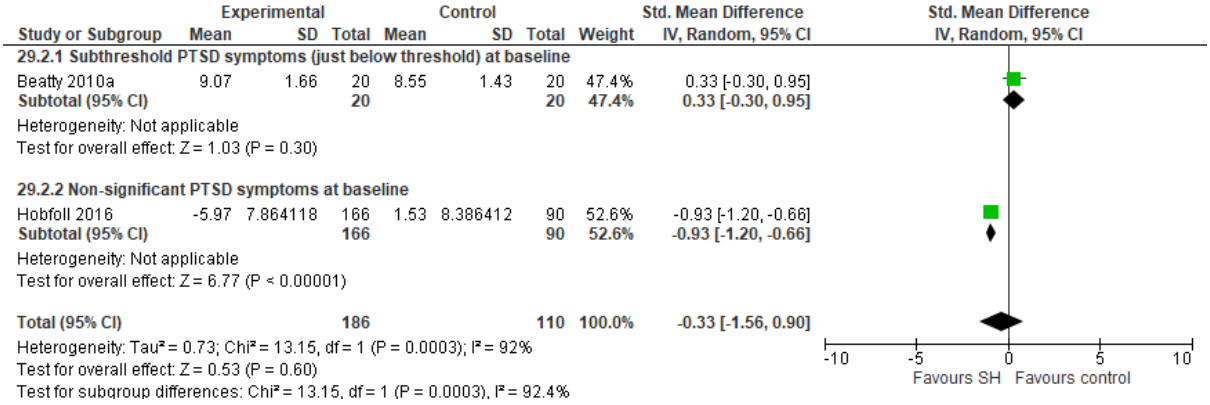


Figure 187: Self-help (without support) versus waitlist for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: Response at 3-month follow-up (number of people showing clinically significant improvement based on reliable change indices [RCI on PSS-SR])

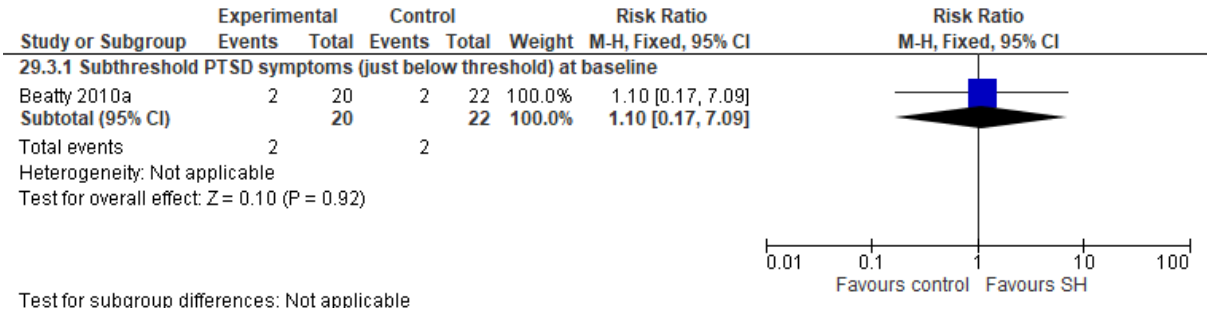


Figure 188: Self-help (without support) versus waitlist for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: Depression symptoms (CES-D change score); Non-significant PTSD symptoms at baseline

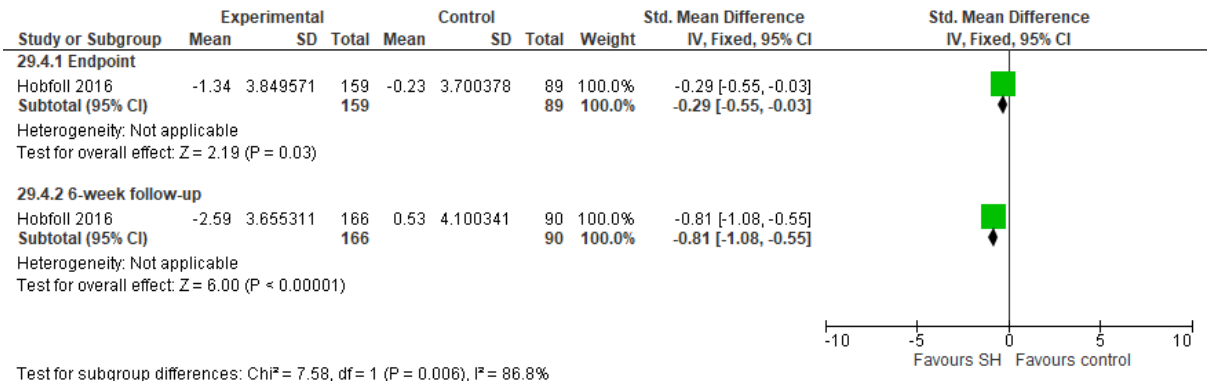


Figure 189: Self-help (without support) versus waitlist for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: Quality of life

(EORTC QLQ endpoint score); Sub-threshold PTSD symptoms (just below threshold) at baseline

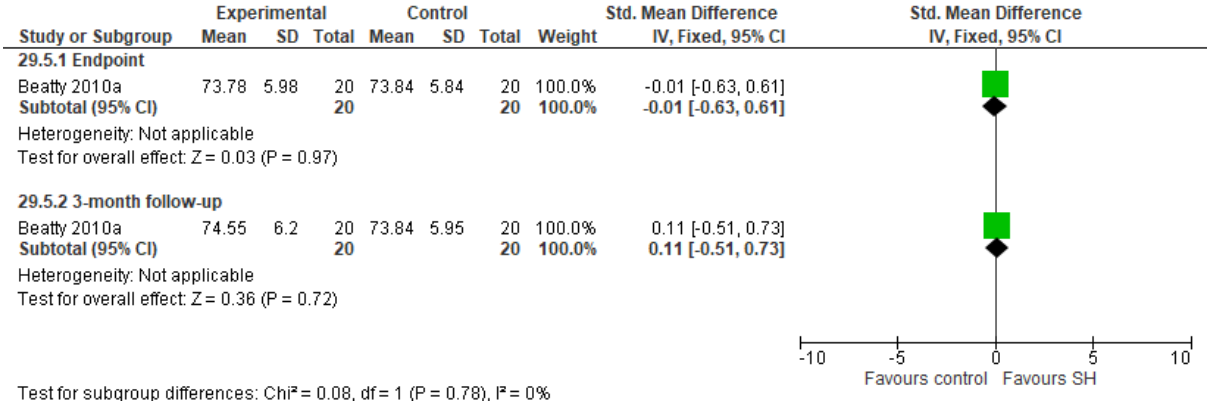
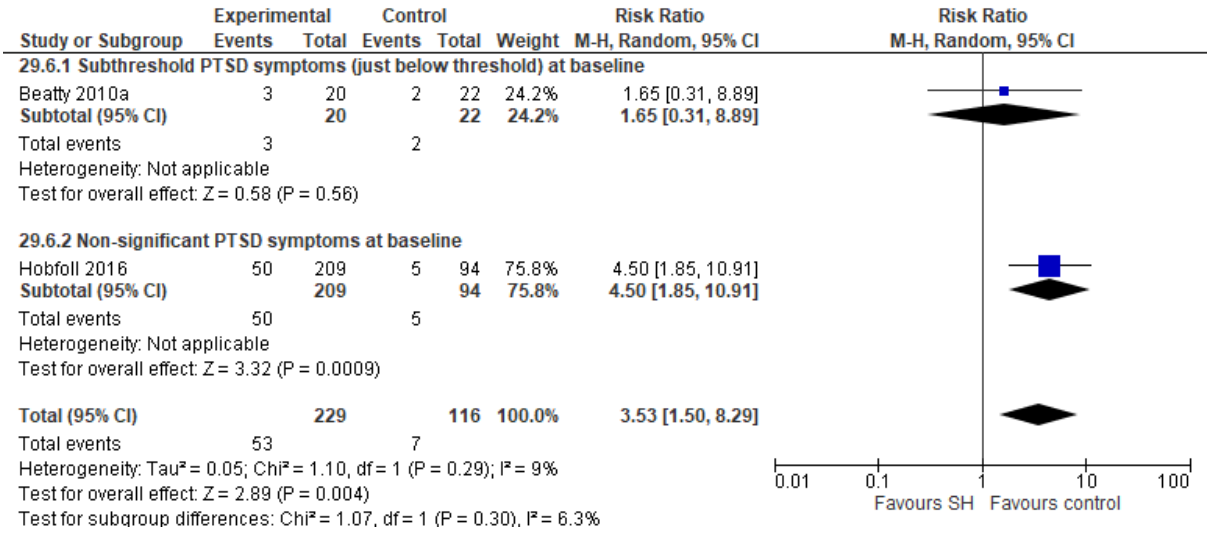


Figure 190: Self-help (without support) versus waitlist for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: Discontinuation (loss to follow-up)



Self-help (without support; +/- TAU) versus attention-placebo or TAU for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Figure 191: Self-help (without support; +/- TAU) versus attention-placebo or TAU for the delayed treatment (>3 months) of below threshold PTSD symptoms in

adults: PTSD symptomatology self-rated at endpoint (PCL/DTS change score)

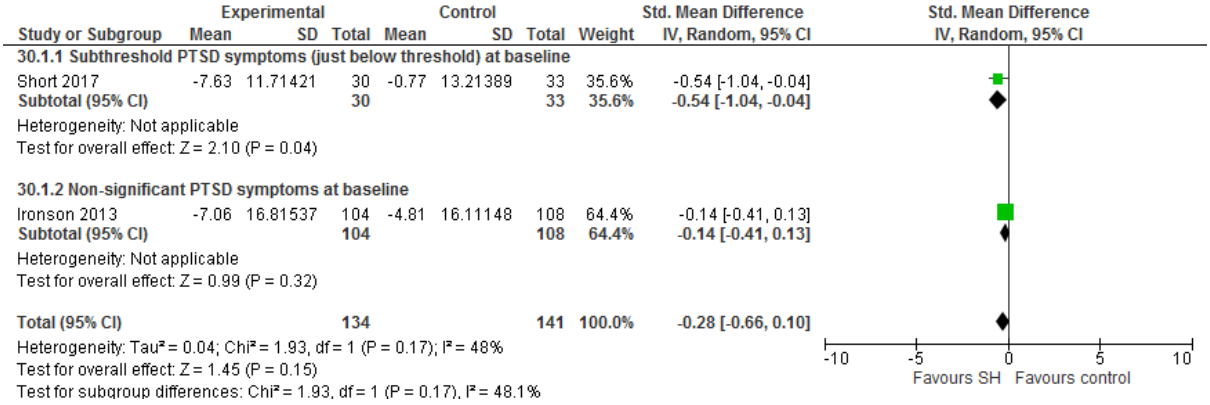


Figure 192: Self-help (without support; +/- TAU) versus attention-placebo or TAU for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: PTSD symptomatology self-rated at 1-5 month follow-up (PCL/DTS change score)

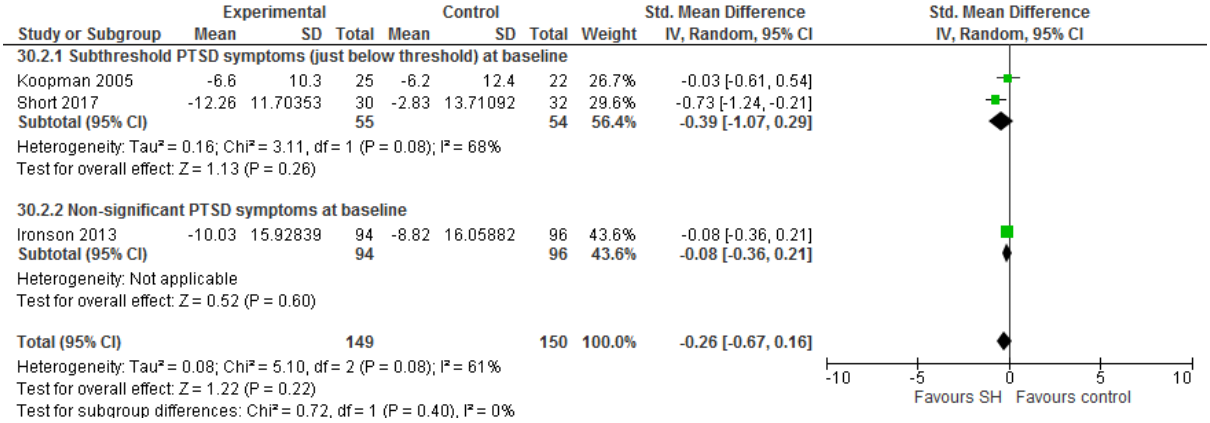


Figure 193: Self-help (without support; +/- TAU) versus attention-placebo or TAU for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: PTSD symptomatology self-rated at 11-month follow-up (DTS change score)

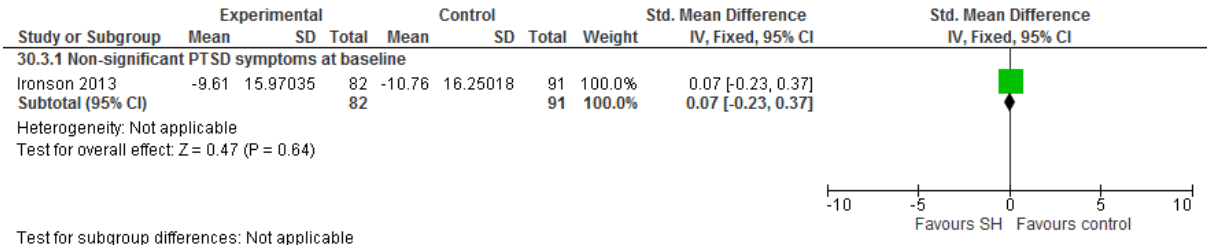


Figure 194: Self-help (without support; +/- TAU) versus attention-placebo or TAU for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: Depression symptoms at endpoint (HAM-D change score)

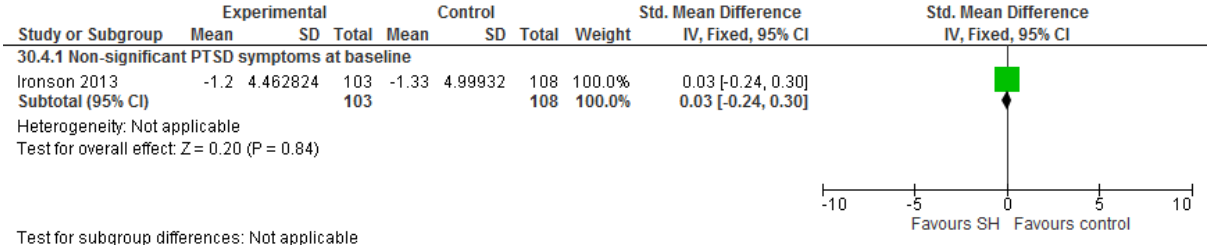


Figure 195: Self-help (without support; +/- TAU) versus attention-placebo or TAU for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: Depression symptoms at 4-5 month follow-up (BDI/HAMD change score)

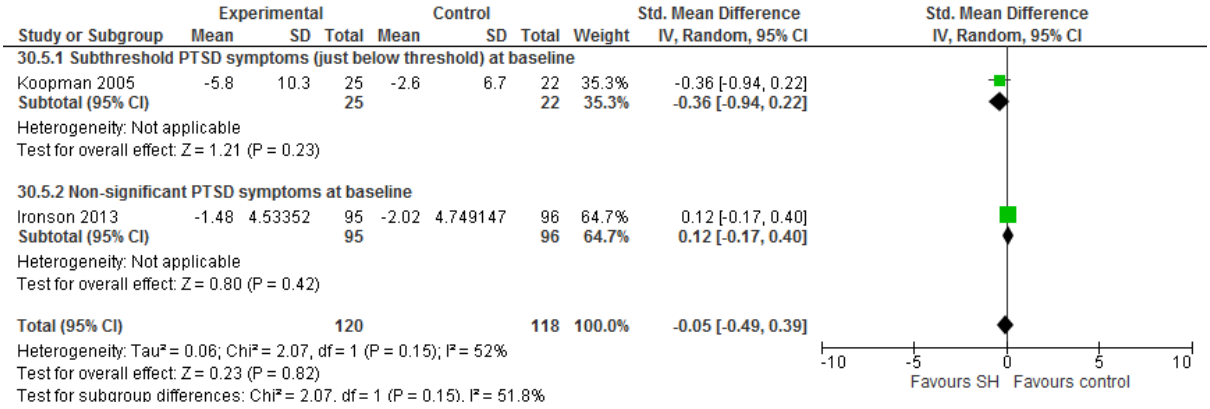


Figure 196: Self-help (without support; +/- TAU) versus attention-placebo or TAU for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: Depression symptoms at 11-month follow-up (HAM-D change score)

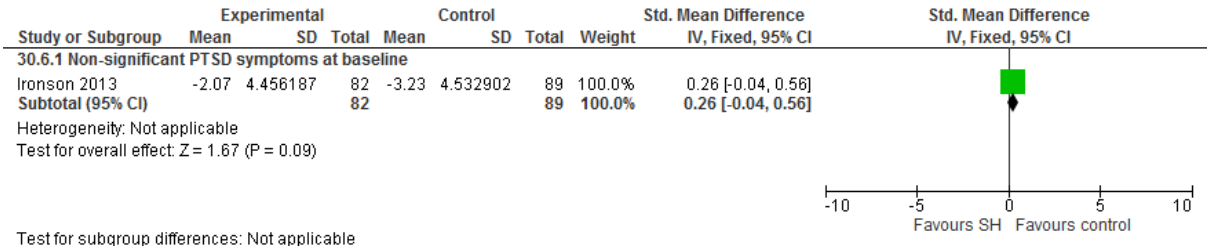
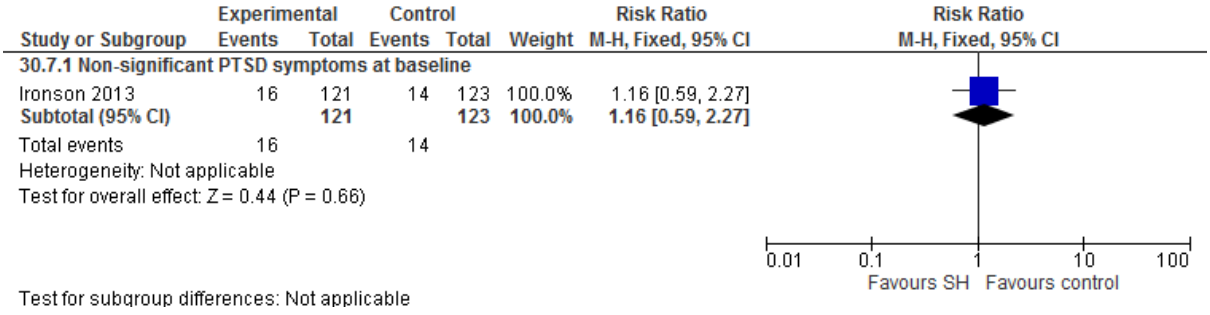


Figure 197: Self-help (without support; +/- TAU) versus attention-placebo or TAU for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: Discontinuation (loss to follow-up)



Psychological: Self-help with support

Self-help with support versus attention-placebo for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Figure 198: Self-help with support versus attention-placebo for the early prevention (intervention initiated ≤1 month) of PTSD in adults: PTSD symptomatology self-rated (PDS endpoint score); Unclear PTSD symptom severity at baseline

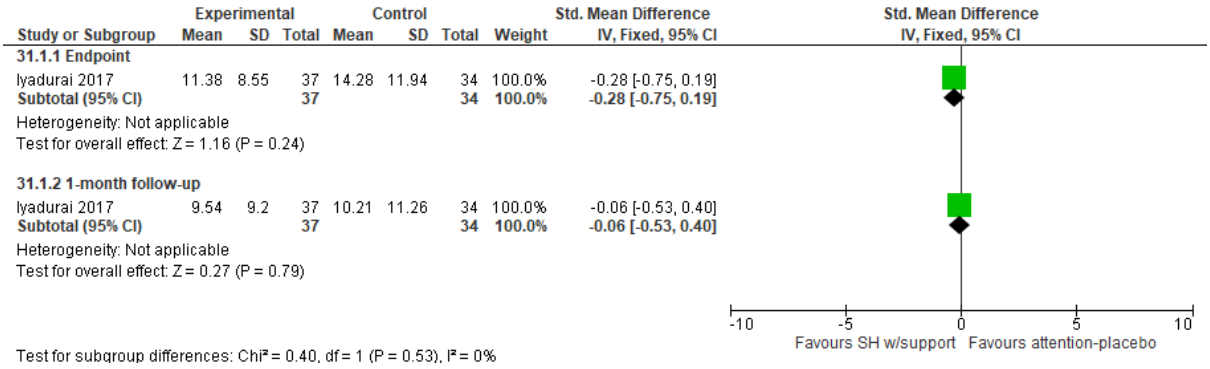


Figure 199: Self-help with support versus attention-placebo for the early prevention (intervention initiated ≤1 month) of PTSD in adults: PTSD at 1-month follow-up (number above clinical threshold on PDS)

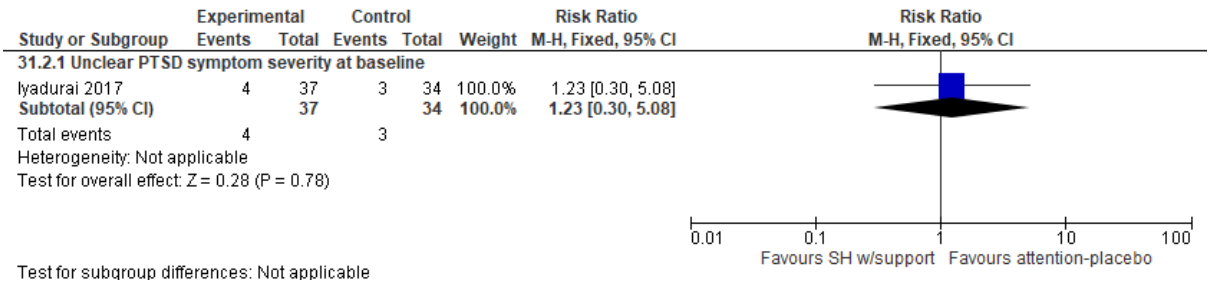
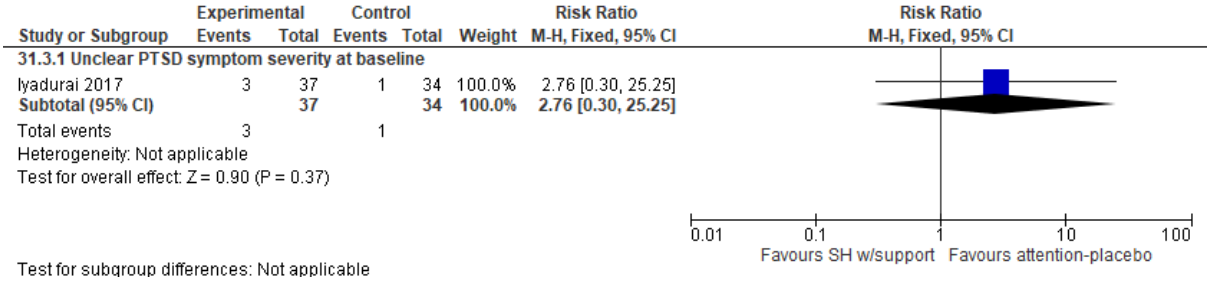


Figure 200: Self-help with support versus attention-placebo for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Discontinuation (loss to follow-up)



Self-help with support (+ TAU) versus TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Figure 201: Self-help with support (+ TAU) versus TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults: PTSD symptomatology self-rated (PDS change score); clinically important PTSD symptoms at baseline

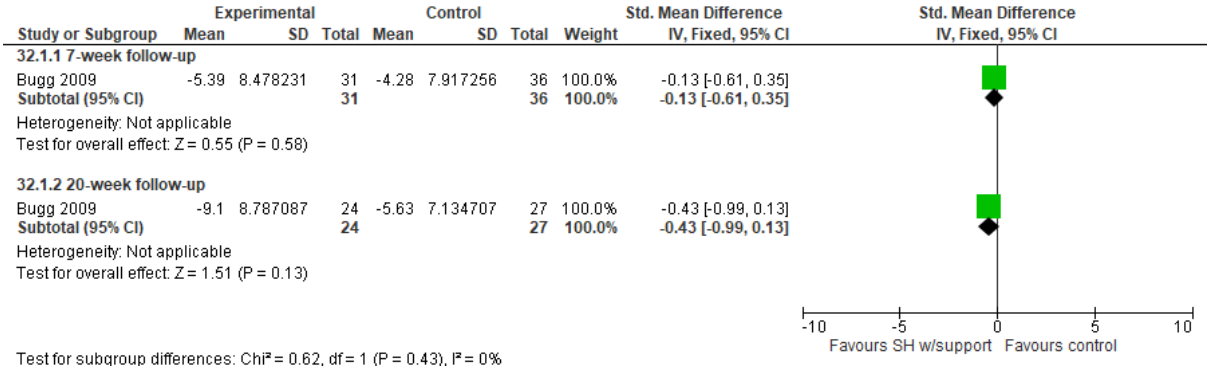


Figure 202: Self-help with support (+ TAU) versus TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Anxiety symptoms (HADS-A change score); clinically important PTSD symptoms at baseline

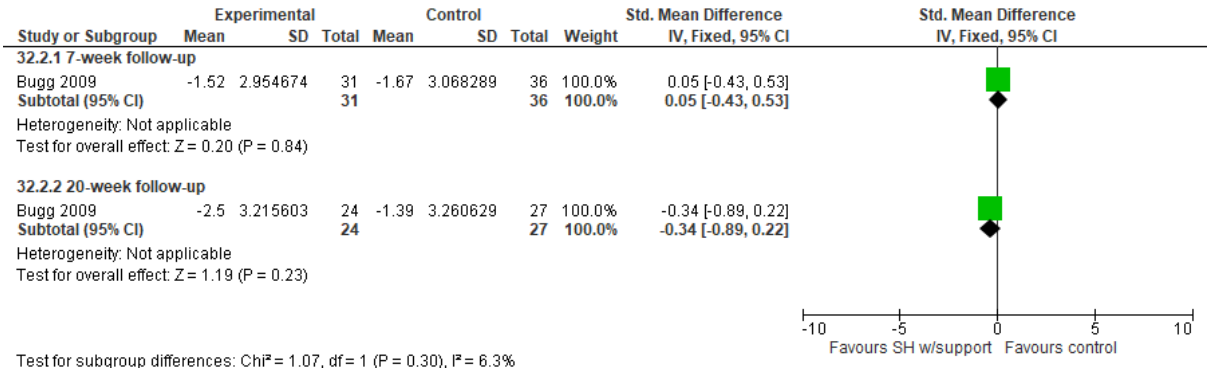


Figure 203: Self-help with support (+ TAU) versus TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Depression symptoms (HADS-D change score); clinically important PTSD symptoms at baseline

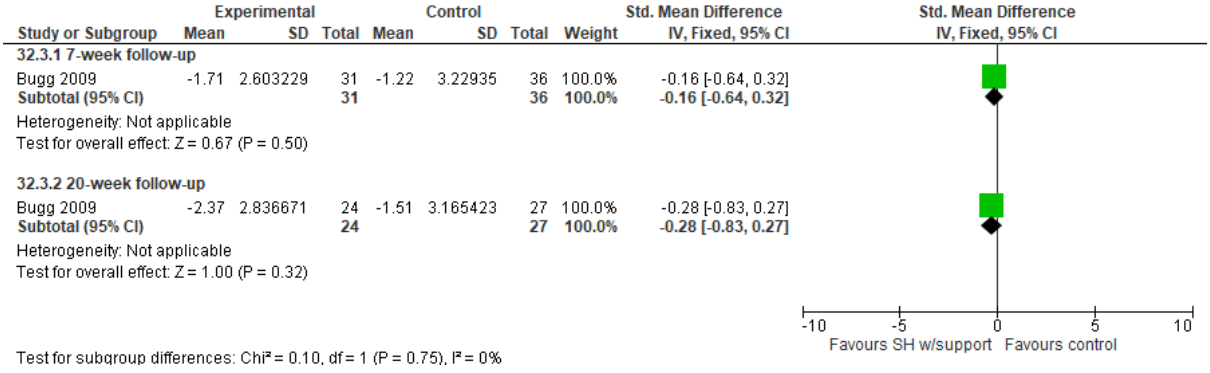


Figure 204: Self-help with support (+ TAU) versus TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Quality of life (WHO-QoL-BREF endpoint score); clinically important PTSD symptoms at baseline

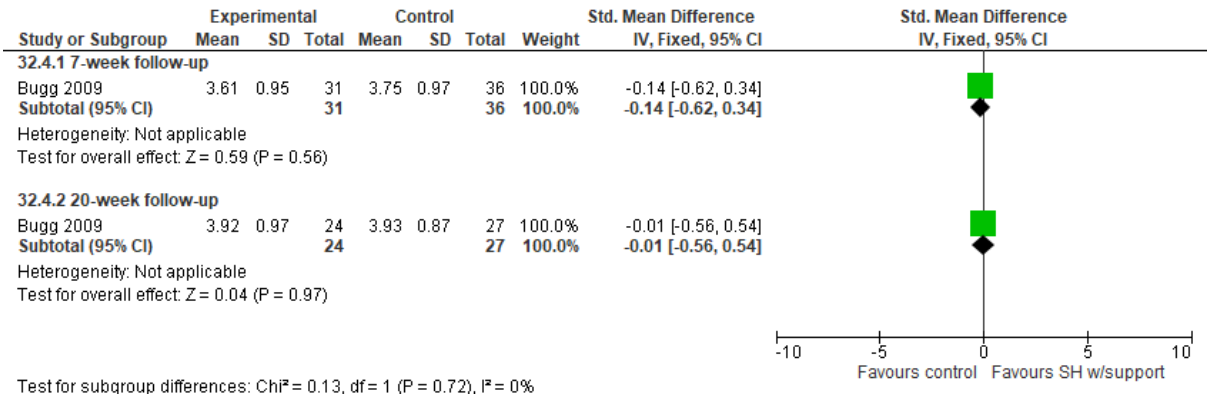
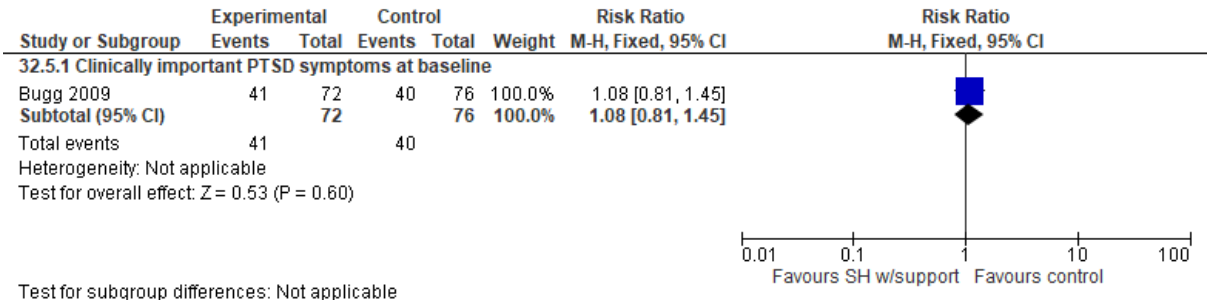


Figure 205: Self-help with support (+ TAU) versus TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Discontinuation (loss to follow-up)



Self-help with support versus waitlist for the early treatment (1-3 months) of below threshold PTSD symptoms in adults

Figure 206: Self-help with support versus waitlist for the early treatment (1-3 months) of below threshold PTSD symptoms in adults: PTSD symptomatology self-rated (PCL change score)

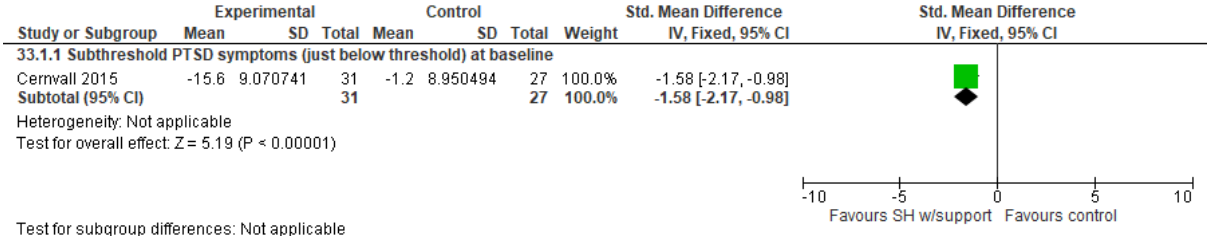


Figure 207: Self-help with support versus waitlist for the early treatment (1-3 months) of below threshold PTSD symptoms in adults: Anxiety symptoms (BAI change score)

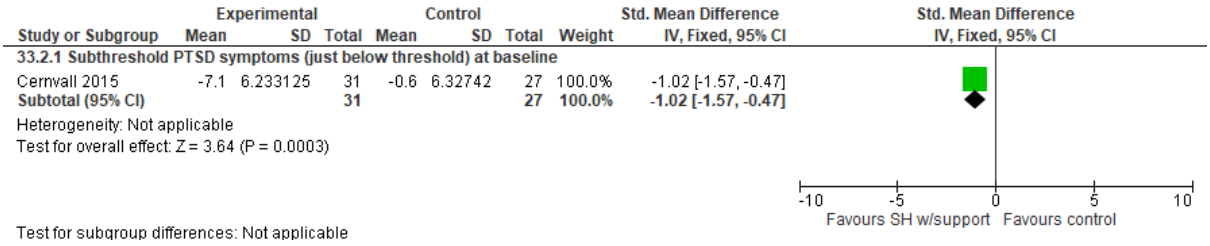


Figure 208: Self-help with support versus waitlist for the early treatment (1-3 months) of below threshold PTSD symptoms in adults: Depression symptoms (BDI-II change score)

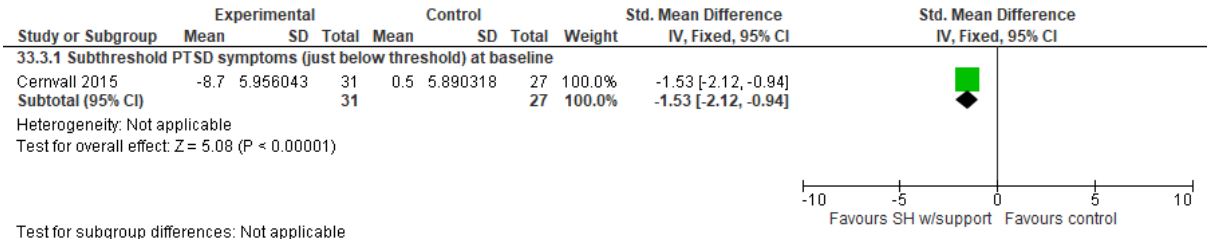
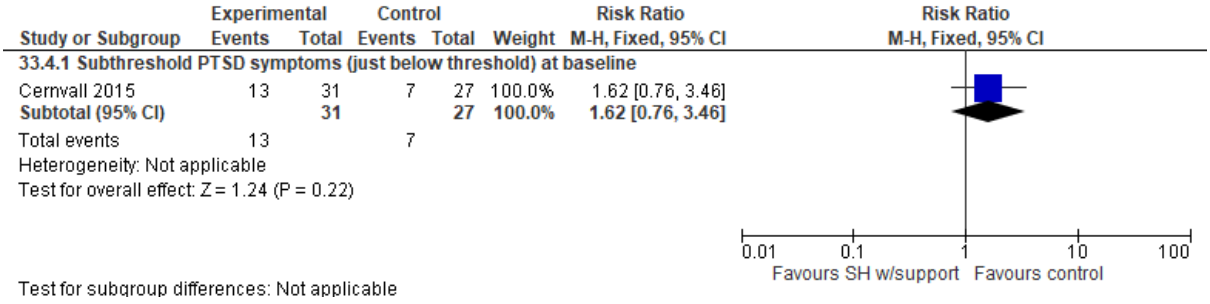


Figure 209: Self-help with support versus waitlist for the early treatment (1-3 months) of below threshold PTSD symptoms in adults: Discontinuation (loss to follow-up)



Self-help with support versus waitlist for the delayed treatment (>3 months) of below-threshold PTSD symptoms in adults

Figure 210: Self-help with support versus waitlist for the delayed treatment (>3 months) of below-threshold PTSD symptoms in adults: PTSD symptomatology self-rated (IES-R change score); Non-significant PTSD symptoms at baseline

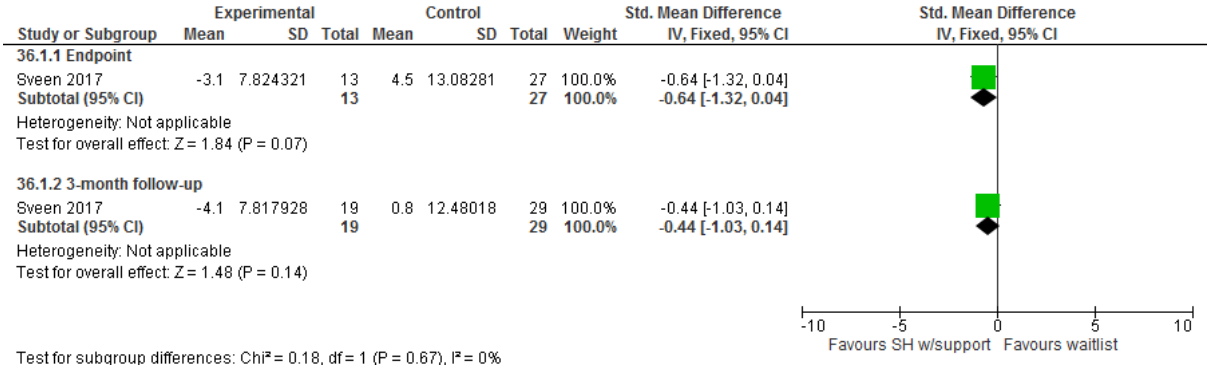


Figure 211: Self-help with support versus waitlist for the delayed treatment (>3 months) of below-threshold PTSD symptoms in adults: Depression symptoms at 3-month follow-up (MADRS change score)

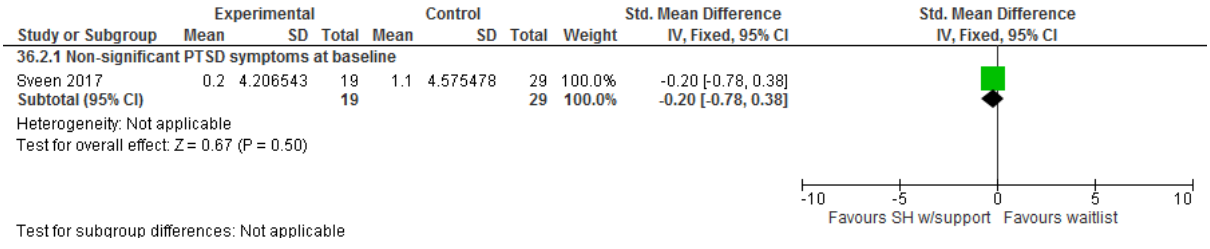


Figure 212: Self-help with support versus waitlist for the delayed treatment (>3 months) of below-threshold PTSD symptoms in adults: Relationship

difficulties (Parenting Stress Index Short Form [PSI-SF] change score); Non-significant PTSD symptoms at baseline

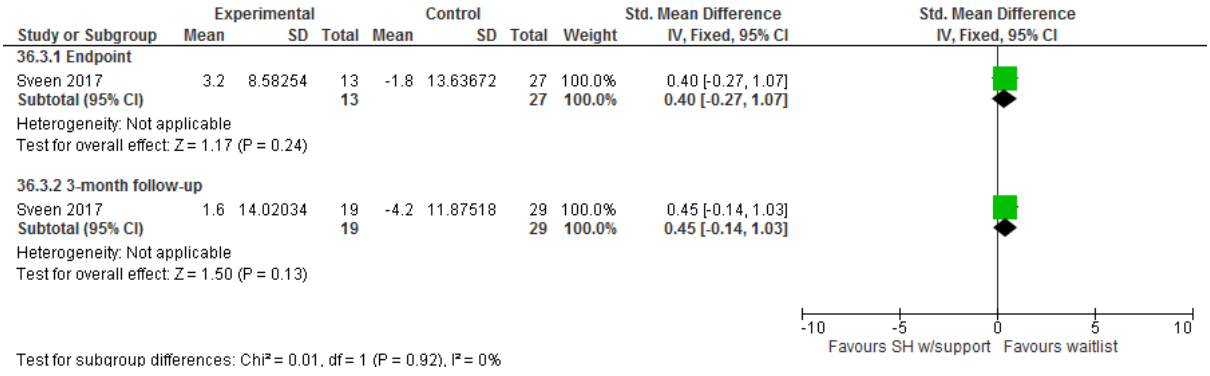
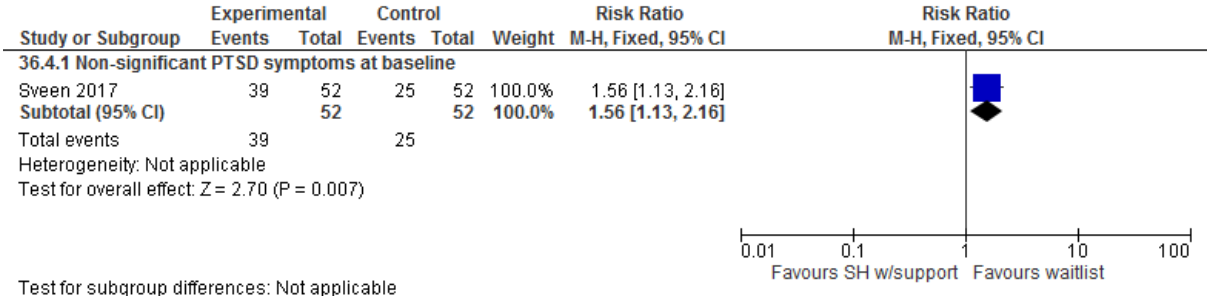


Figure 213: Self-help with support versus waitlist for the delayed treatment (>3 months) of below-threshold PTSD symptoms in adults: Discontinuation (loss to follow-up)



Self-help with support versus attention-placebo for the delayed treatment (>3 months) of below-threshold PTSD symptoms in adults

Figure 214: Self-help with support versus attention-placebo for the delayed treatment (>3 months) of below-threshold PTSD symptoms in adults: PTSD symptomatology self-rated (IES-R change score); Non-significant PTSD symptoms at baseline

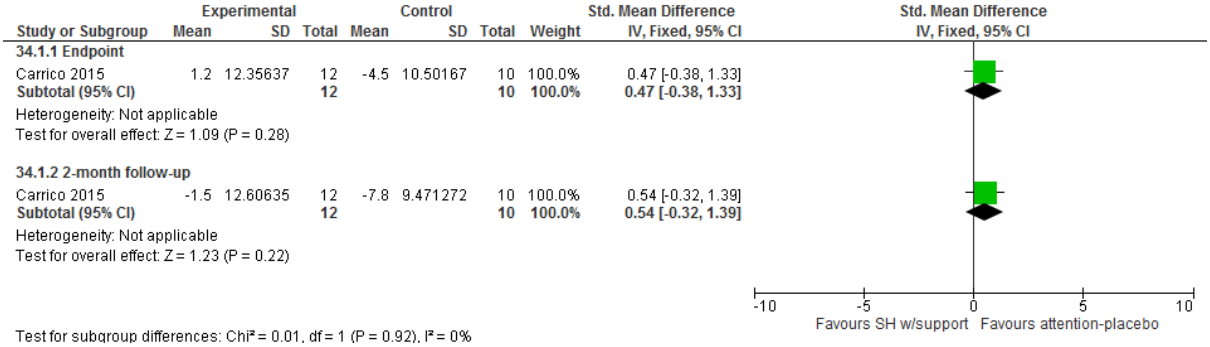
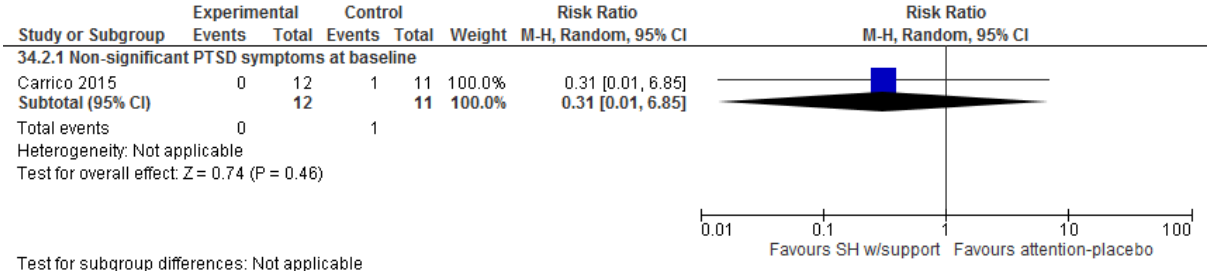


Figure 215: Self-help with support versus attention-placebo for the delayed treatment (>3 months) of below-threshold PTSD symptoms in adults: Discontinuation (loss to follow-up)



Psychosocial: Meditation/Mindfulness-based stress reduction

Meditation/MBSR (+/- TAU) versus no treatment, waitlist or TAU for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Figure 216: Meditation/MBSR (+/- TAU) versus no treatment, waitlist or TAU for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: PTSD symptomatology self-rated at endpoint (PCL/IES change score)

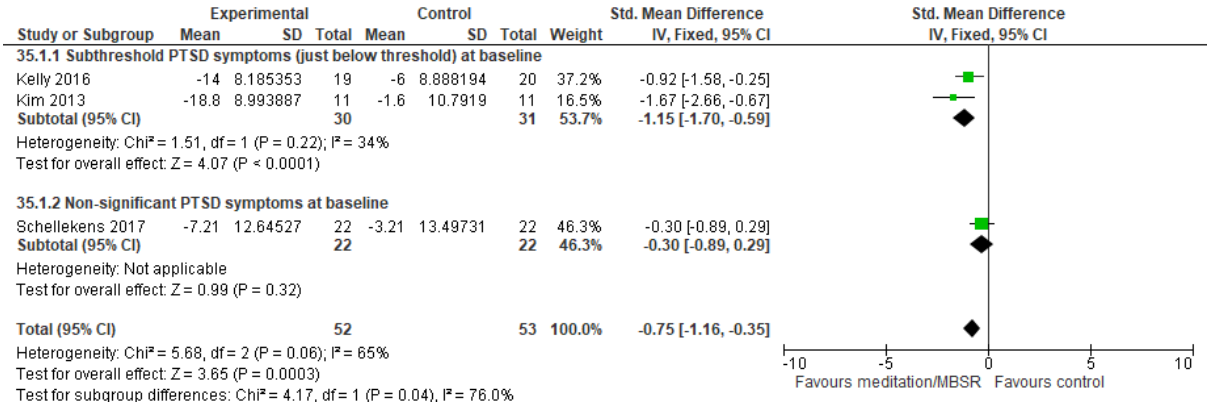


Figure 217: Meditation/MBSR (+/- TAU) versus no treatment, waitlist or TAU for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: PTSD symptomology self-rated at 3-month follow-up (IES change score)

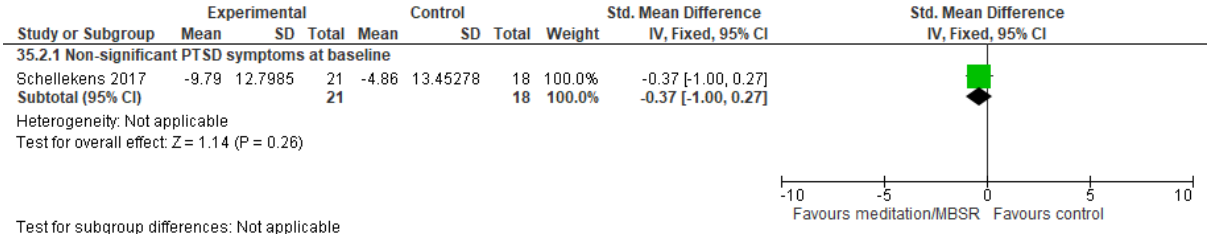


Figure 218: Meditation/MBSR (+/- TAU) versus no treatment, waitlist or TAU for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: Depression symptoms (BDI-II change score)

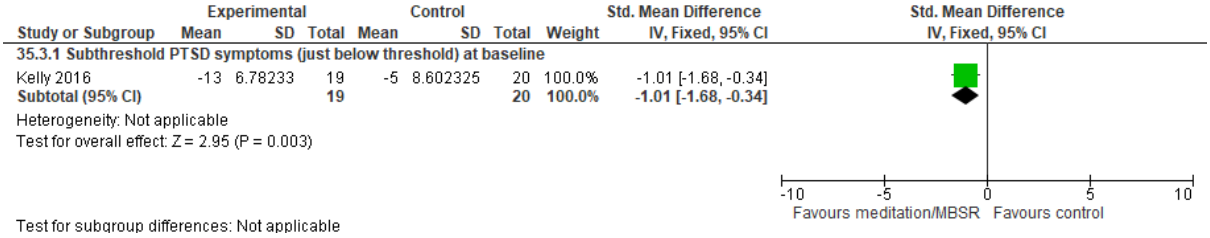


Figure 219: Meditation/MBSR (+/- TAU) versus no treatment, waitlist or TAU for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: Quality of life (QLQ-C30-GHS change score); Non-significant PTSD symptoms at baseline

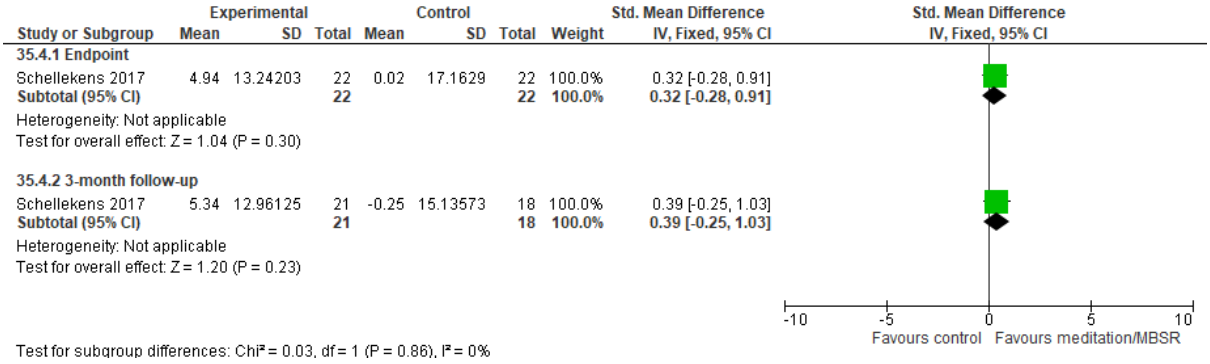
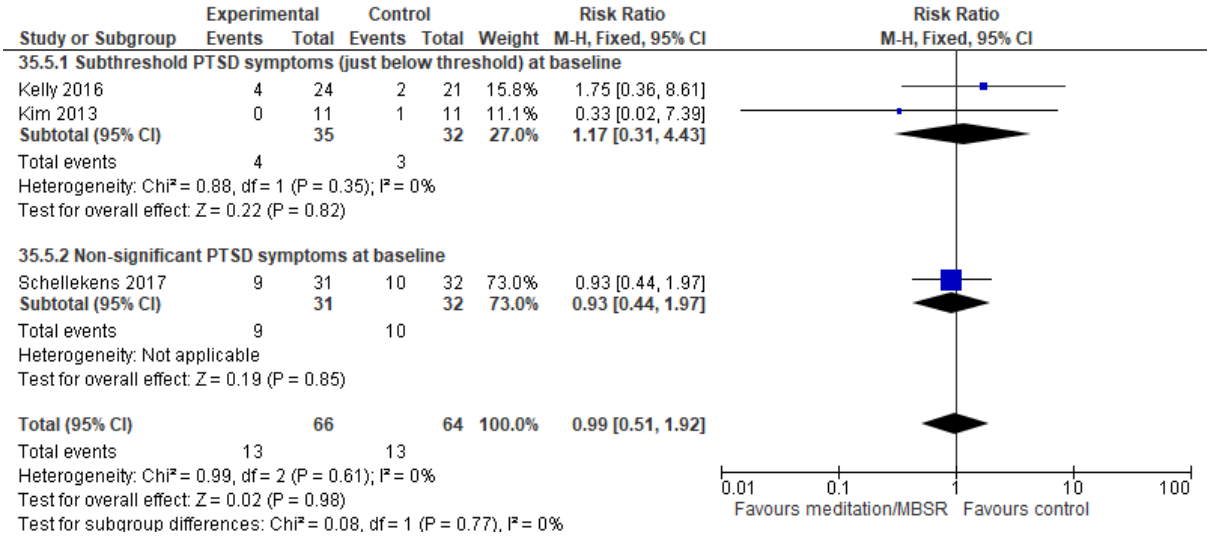


Figure 220: Meditation/MBSR (+/- TAU) versus no treatment, waitlist or TAU for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: Discontinuation (loss to follow-up)



Psychosocial: Intensive care diary

Intensive care diary versus waitlist for the early treatment (1-3 months) of below threshold PTSD symptoms in adults

Figure 221: Intensive care diary versus waitlist for the early treatment (1-3 months) of below threshold PTSD symptoms in adults: PTSD symptomatology self-rated (PTSS-14 change score)

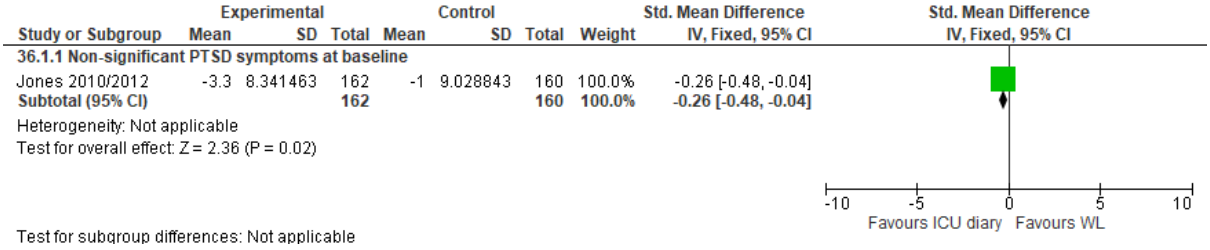


Figure 222: Intensive care diary versus waitlist for the early treatment (1-3 months) of below threshold PTSD symptoms in adults: PTSD (number meeting criteria for PTSD at endpoint)

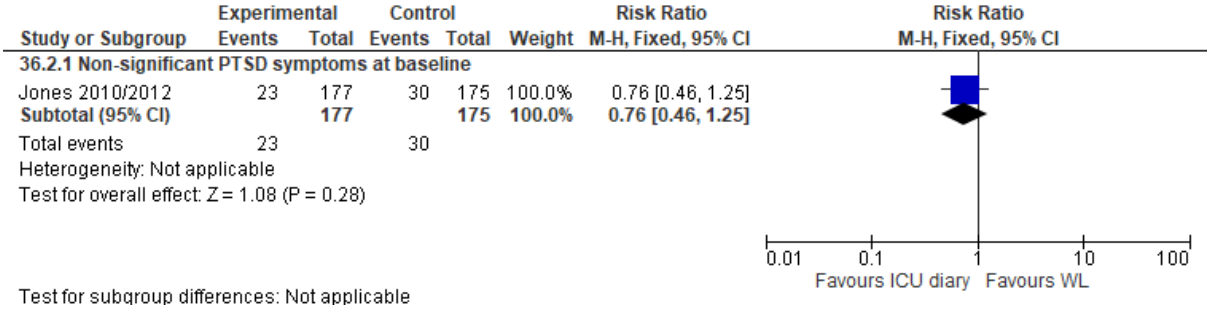
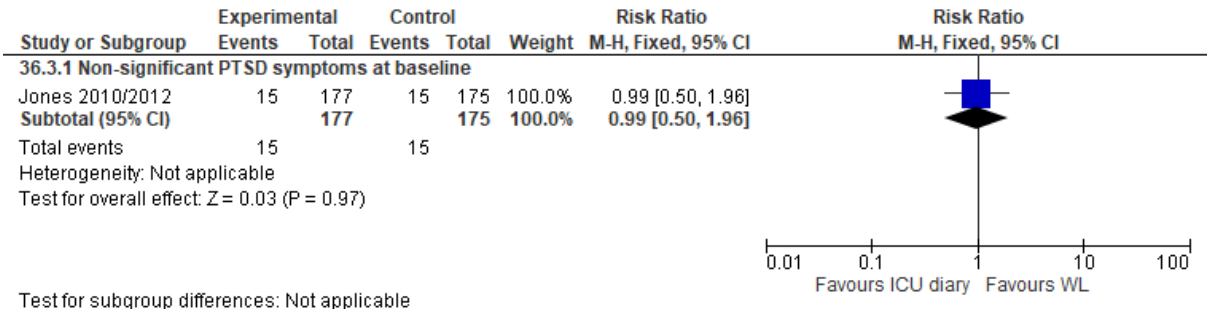


Figure 223: Intensive care diary versus waitlist for the early treatment (1-3 months) of below threshold PTSD symptoms in adults: Discontinuation (loss to follow-up)



Psychosocial: Psycho-education

Single psycho-education session (+/- TAU) versus TAU or no treatment for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Figure 224: Single psycho-education session (+/- TAU) versus TAU or no treatment for the early prevention (intervention initiated ≤1 month) of PTSD in adults: PTSD symptomatology self-rated at endpoint (PSS-SR/IES-R change score)

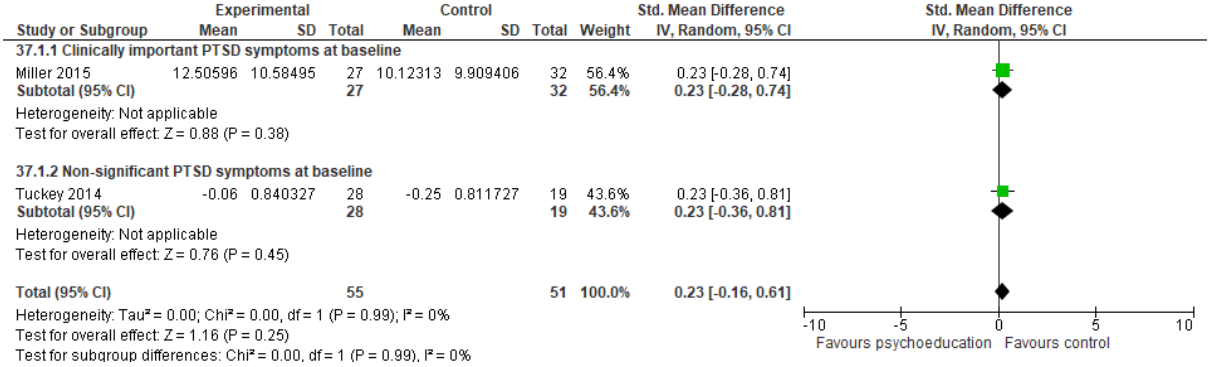


Figure 225: Single psycho-education session (+/- TAU) versus TAU or no treatment for the early prevention (intervention initiated ≤1 month) of PTSD in adults: PTSD symptomatology self-rated at 2-6 month follow-up (PSS-SR change score)

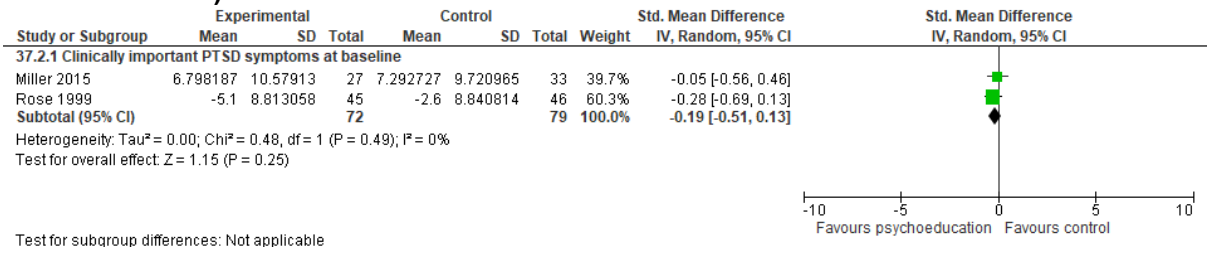


Figure 226: Single psycho-education session (+/- TAU) versus TAU or no treatment for the early prevention (intervention initiated ≤1 month) of PTSD in adults: PTSD at 6-month follow-up

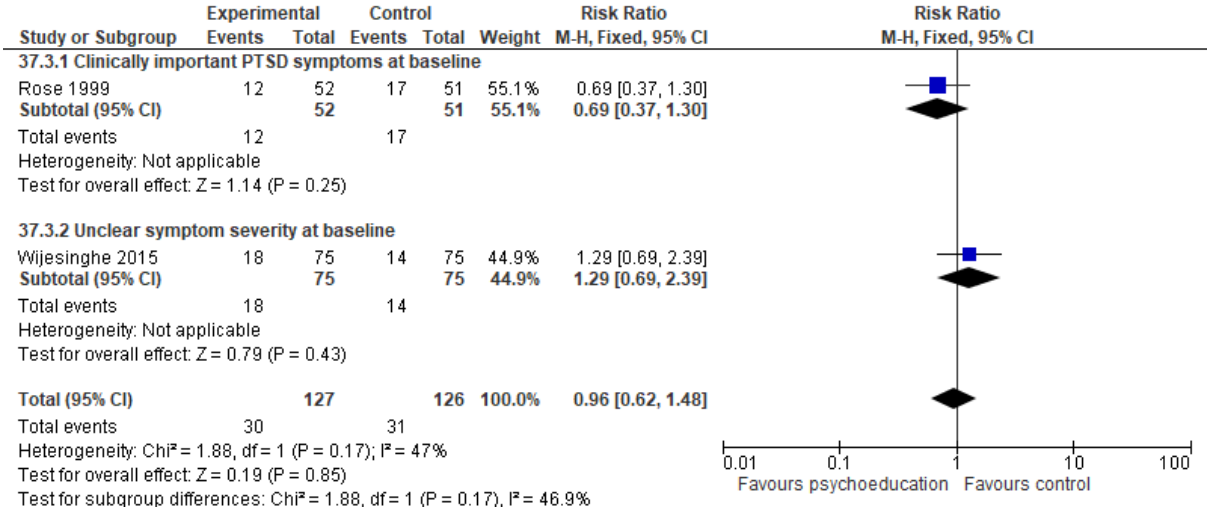


Figure 227: Single psycho-education session (+/- TAU) versus TAU or no treatment for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Anxiety symptoms (STAI State change score); clinically important PTSD symptoms at baseline

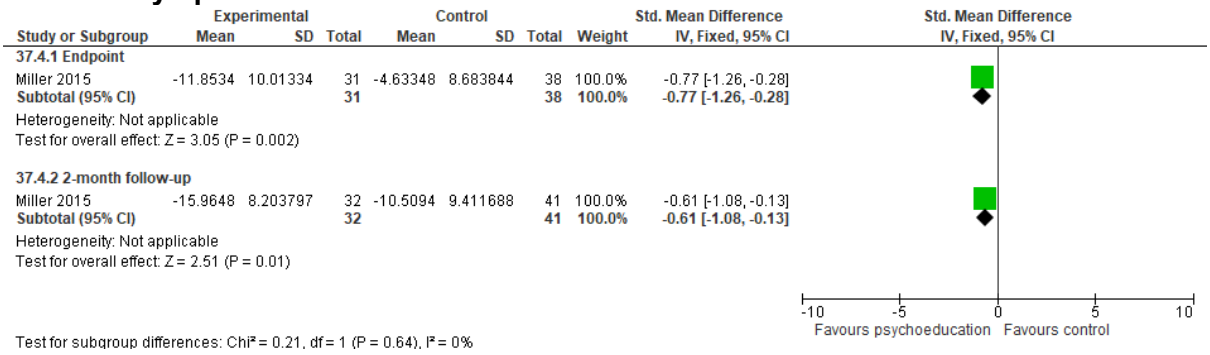


Figure 228: Single psycho-education session (+/- TAU) versus TAU or no treatment for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Depression symptoms (BDI endpoint score)

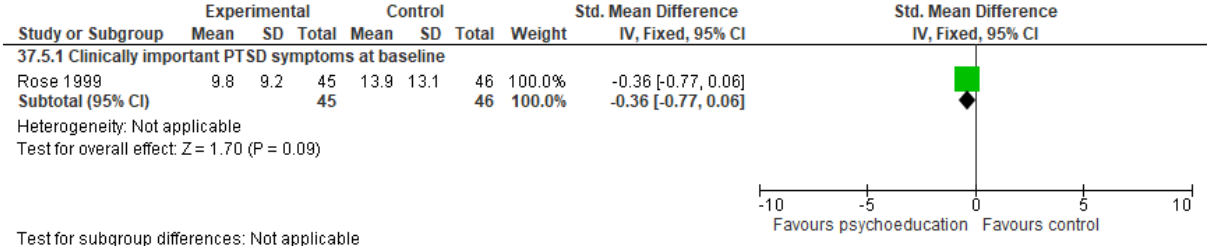
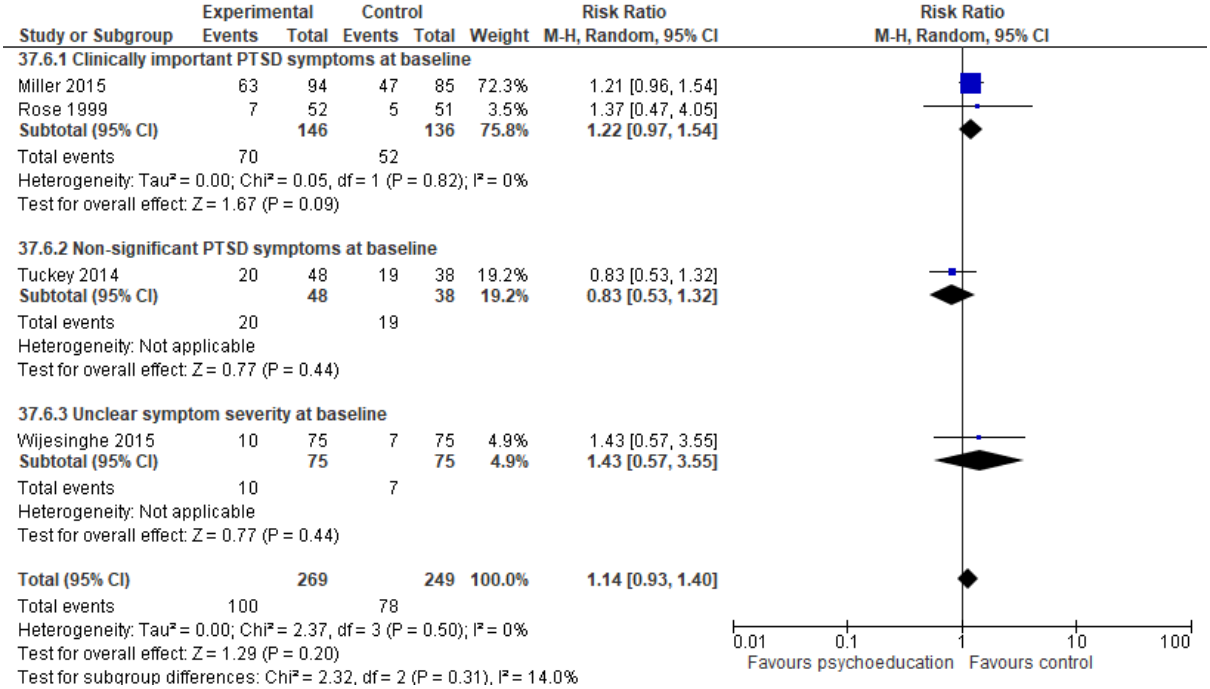


Figure 229: Single psycho-education session (+/- TAU) versus TAU or no treatment for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Discontinuation (loss to follow-up)



Psychosocial: Acupuncture

Acupuncture + trauma-focused CBT versus trauma-focused CBT for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Figure 230: Acupuncture + trauma-focused CBT versus trauma-focused CBT for the early prevention (intervention initiated ≤1 month) of PTSD in adults: PTSD symptomatology self-rated (OES-R change score)

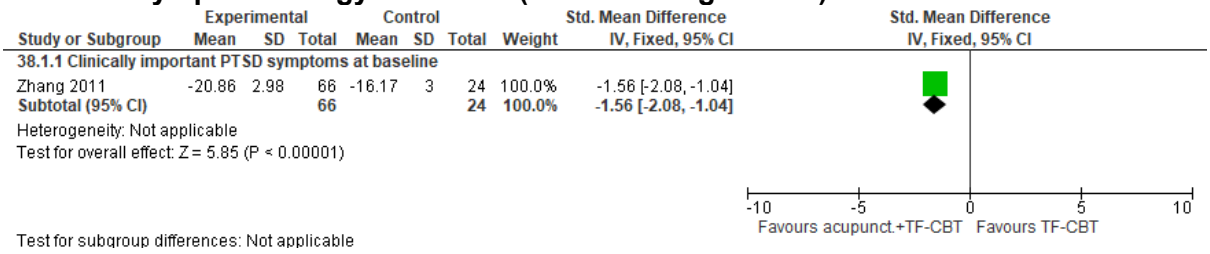
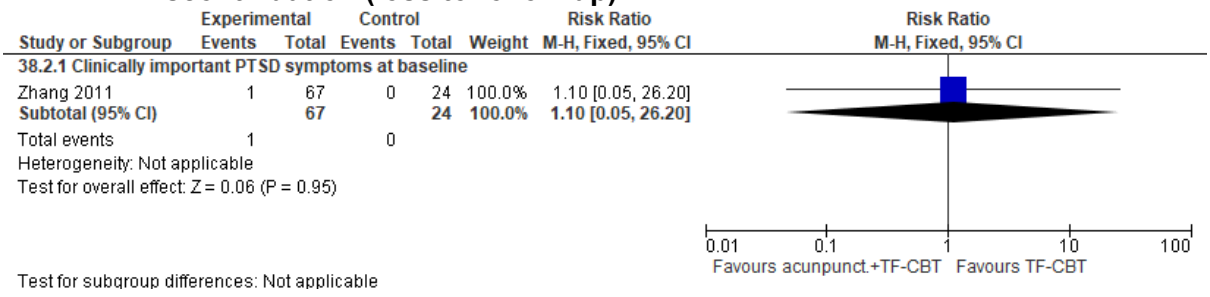


Figure 231: Acupuncture + trauma-focused CBT versus trauma-focused CBT for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Discontinuation (loss to follow-up)



Psychosocial: Yoga

Yoga versus attention-placebo for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Figure 232: Yoga versus attention-placebo for the early prevention (intervention initiated ≤1 month) of PTSD in adults: PTSD symptomatology self-rated (IES change score); Non-significant PTSD symptoms at baseline

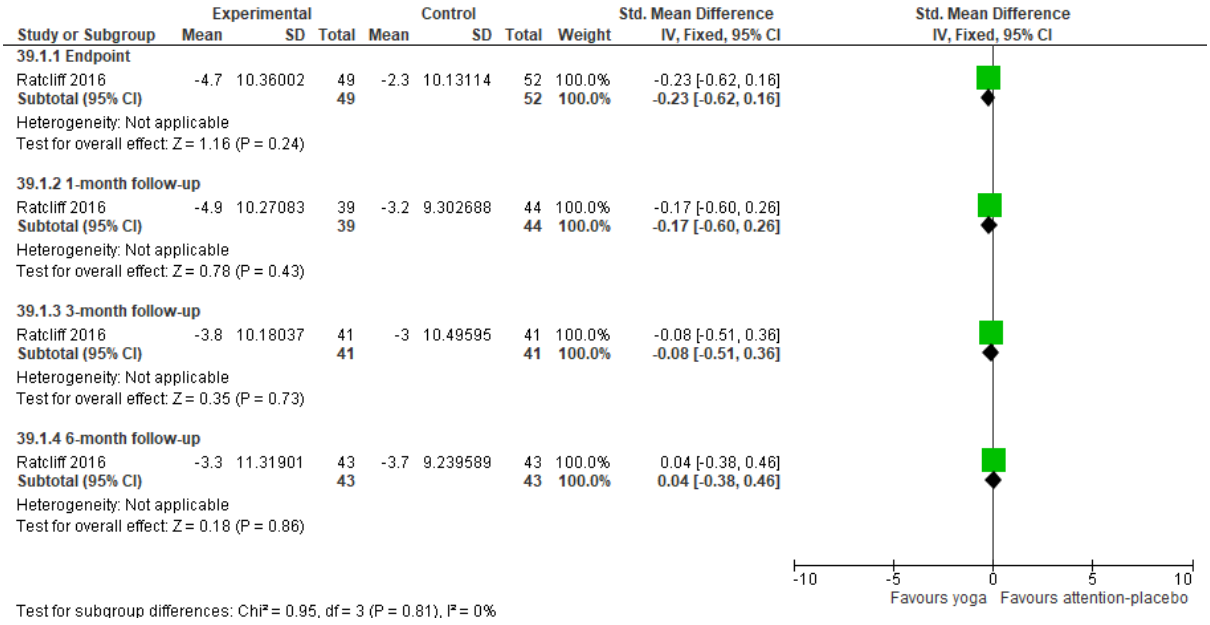


Figure 233: Yoga versus attention-placebo for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Depression symptoms (CES-D change score); Non-significant PTSD symptoms at baseline

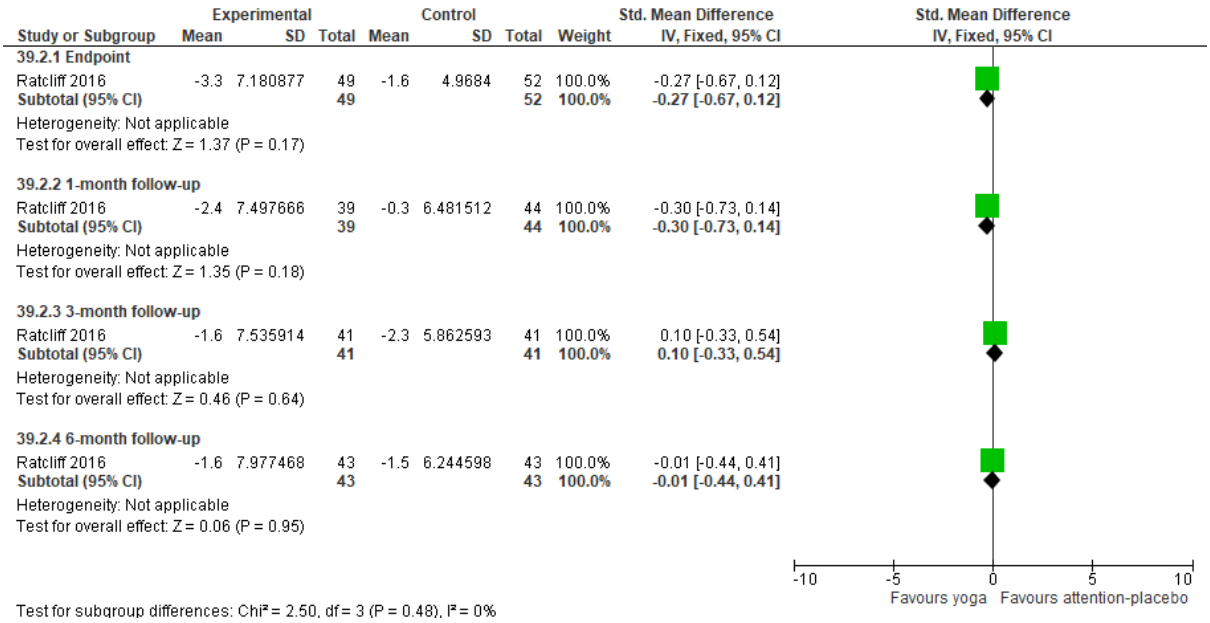


Figure 234: Yoga versus attention-placebo for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Sleeping difficulties (PSQI change score); Non-significant PTSD symptoms at baseline

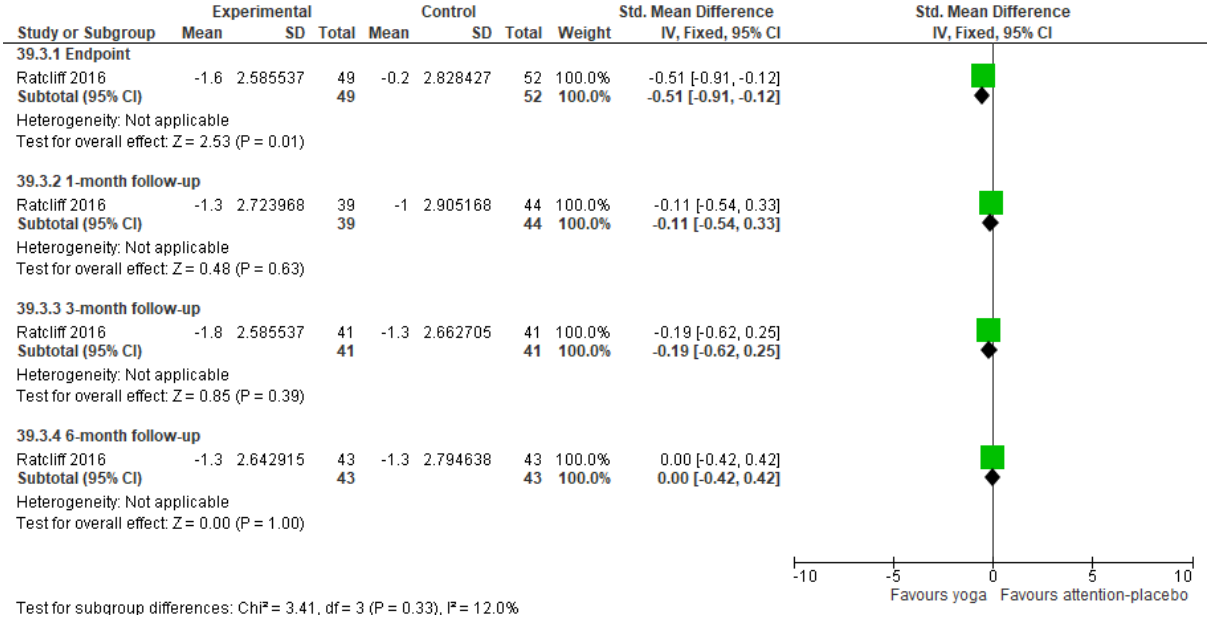
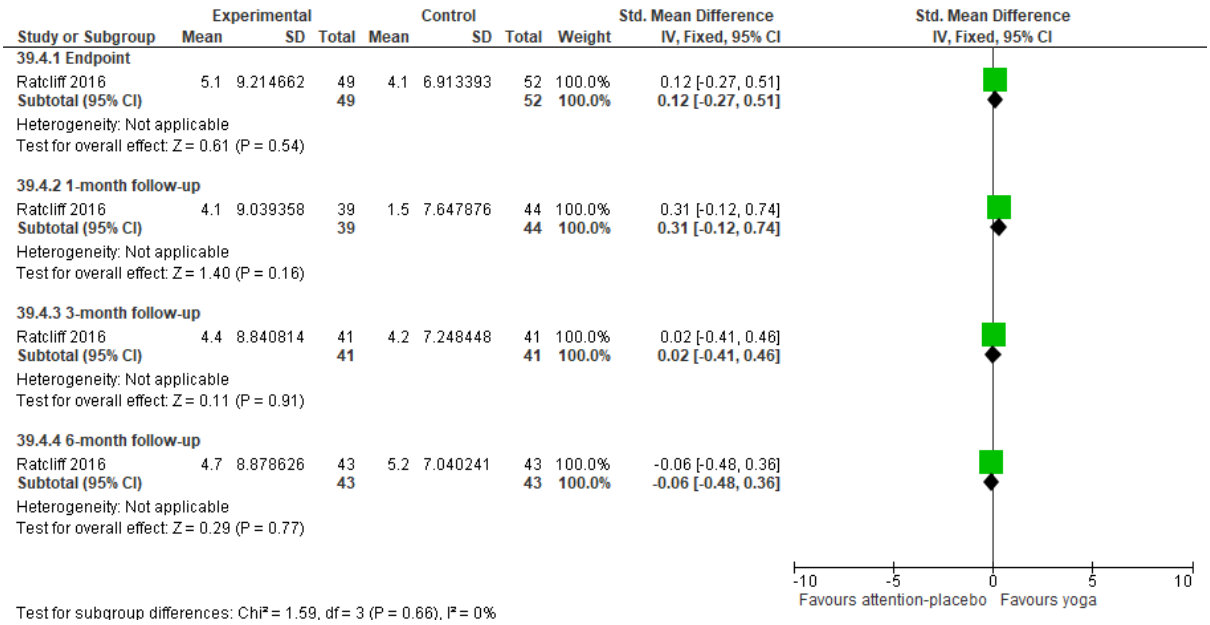


Figure 235: Yoga versus attention-placebo for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Quality of life (SF-36 MCS change score); Non-significant PTSD symptoms at baseline



Yoga versus TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Figure 236: Yoga versus TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults: PTSD symptomatology self-rated (IES change score); Non-significant PTSD symptoms at baseline

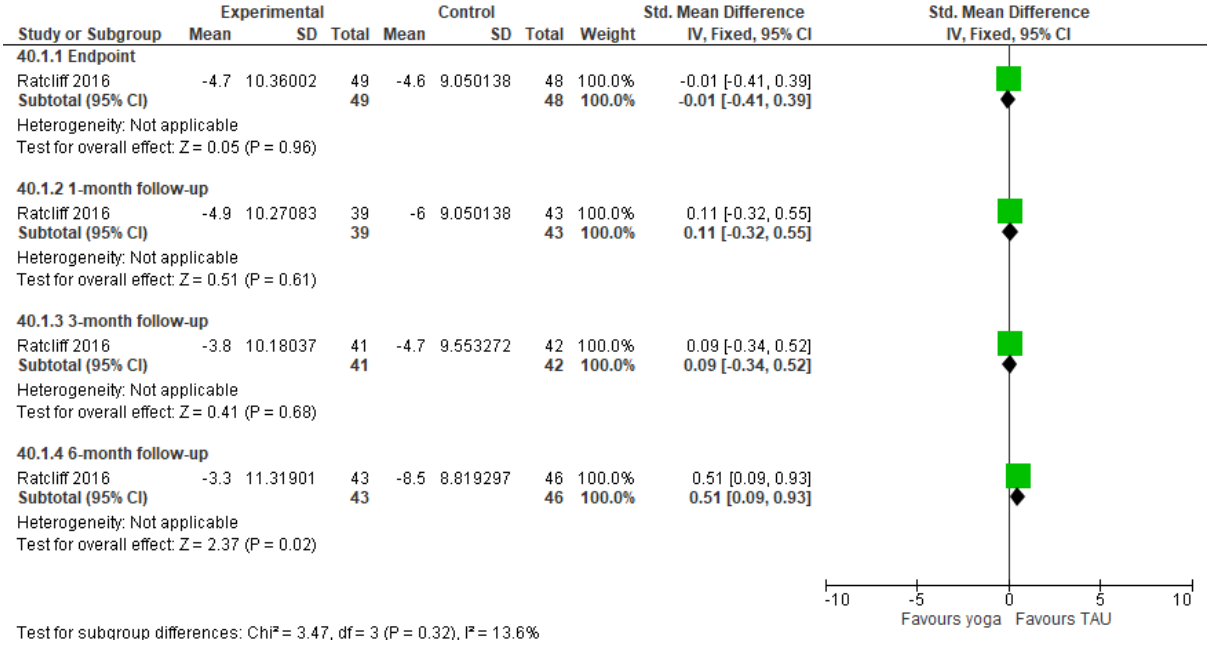


Figure 237: Yoga versus TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Depression symptoms (CES-D change score); Non-significant PTSD symptoms at baseline

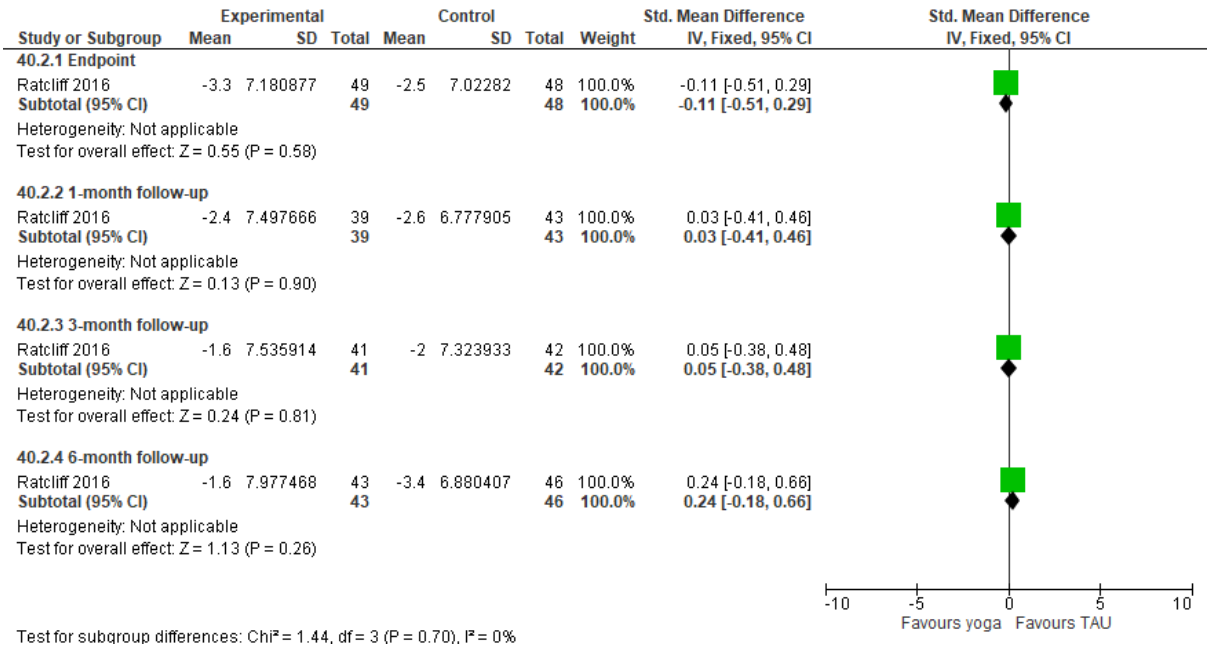


Figure 238: Yoga versus TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Sleeping difficulties (PSQI change score); Non-significant PTSD symptoms at baseline

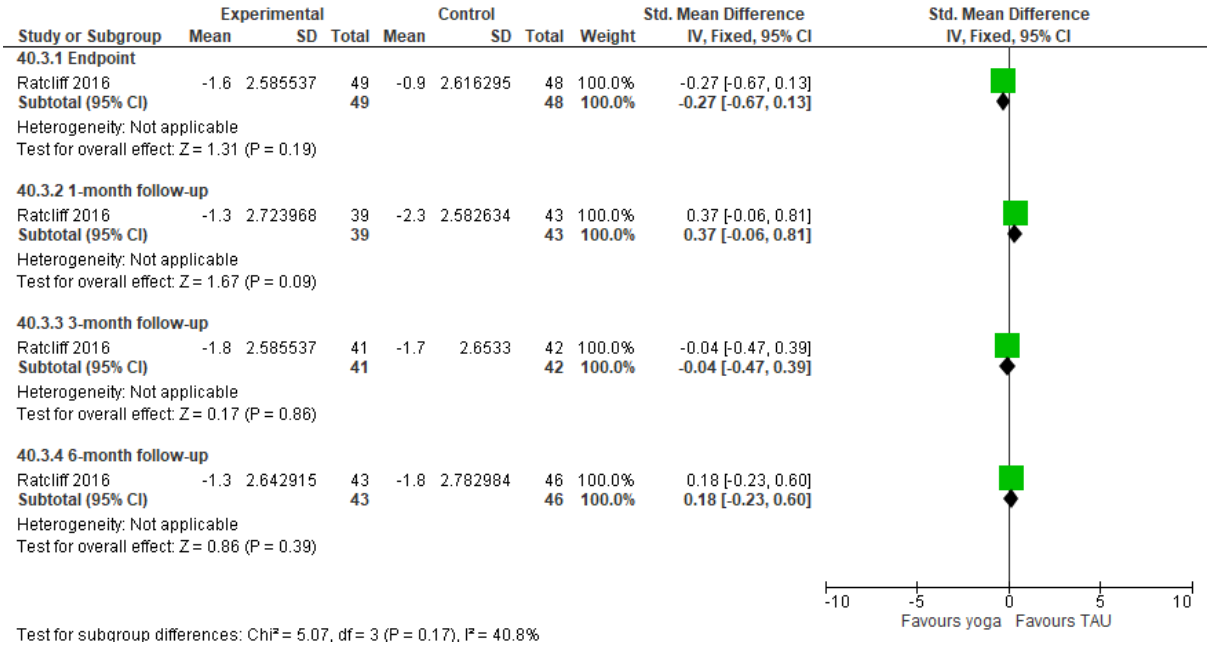
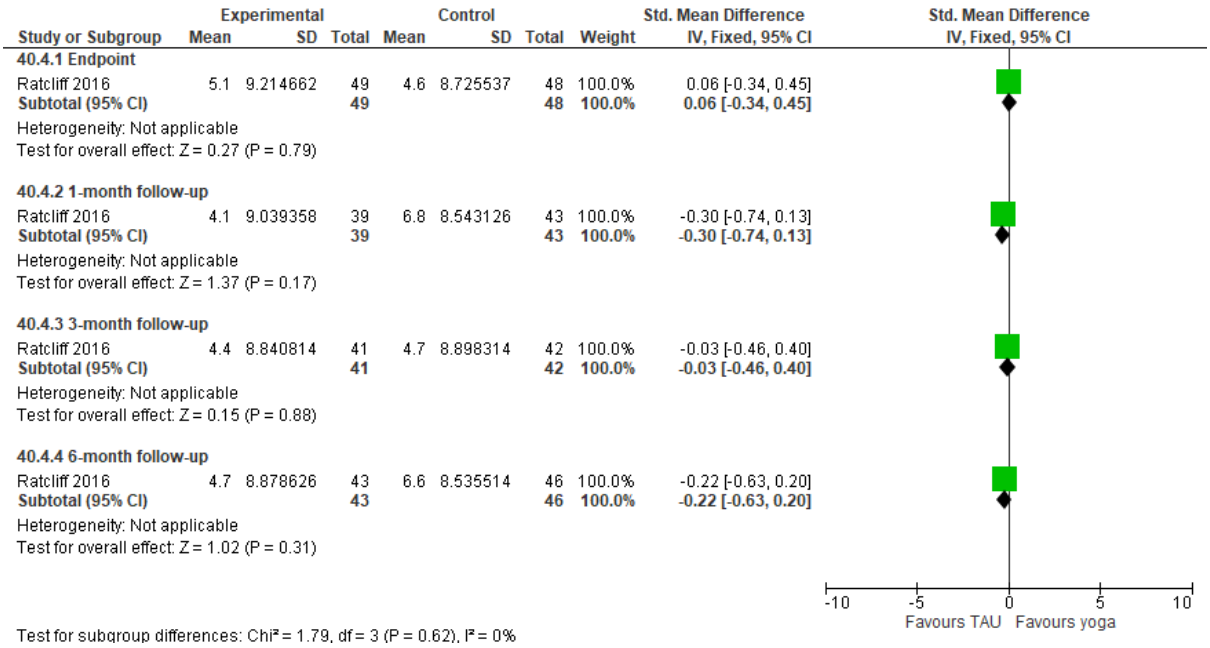


Figure 239: Yoga versus TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Quality of life (SF-36 MCS change score); Non-significant PTSD symptoms at baseline



Yoga versus waitlist for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Figure 240: Yoga versus waitlist for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: PTSD symptomatology self-rated (PCL change score)

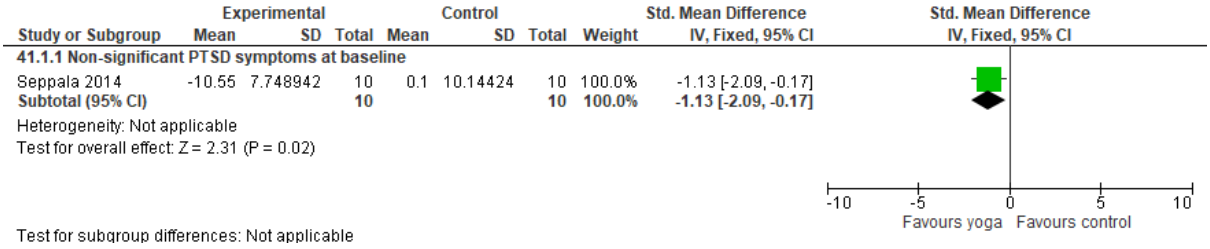
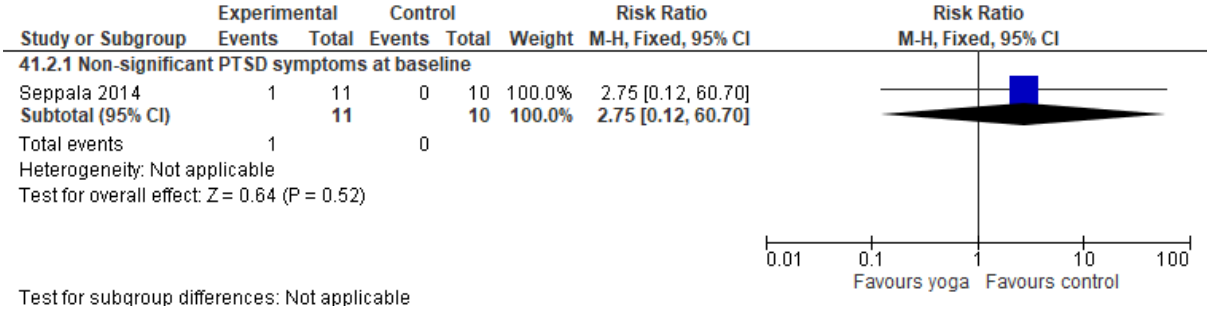


Figure 241: Yoga versus waitlist for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults: Discontinuation (loss to follow-up)



Psychosocial: Massage

Massage + relaxation for parent (+ massage + humour therapy targeted at child) versus TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Figure 242: Massage + relaxation for parent (+ massage + humour therapy targeted at child) versus TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults: PTSD symptomatology self-rated (IES-R change score) at 5-month follow-up

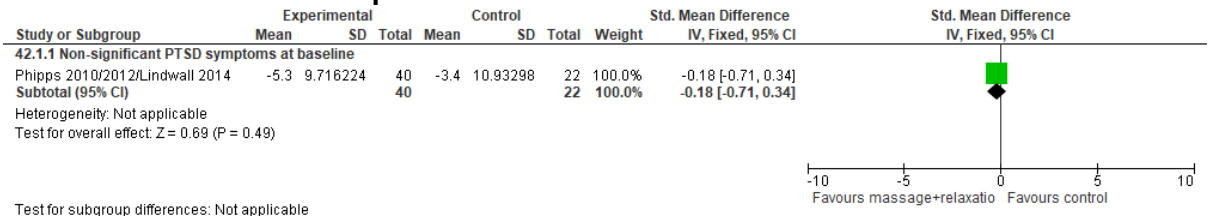


Figure 243: Massage + relaxation for parent (+ massage + humour therapy targeted at child) versus TAU for the early prevention (intervention initiated ≤1 month)

of PTSD in adults: Depression symptoms (CES-D change score) at 5-month follow-up

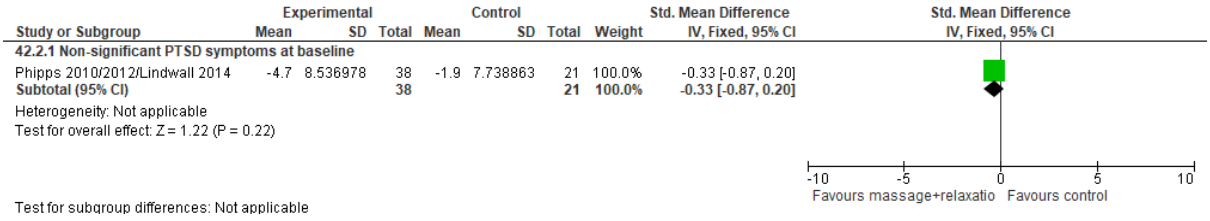
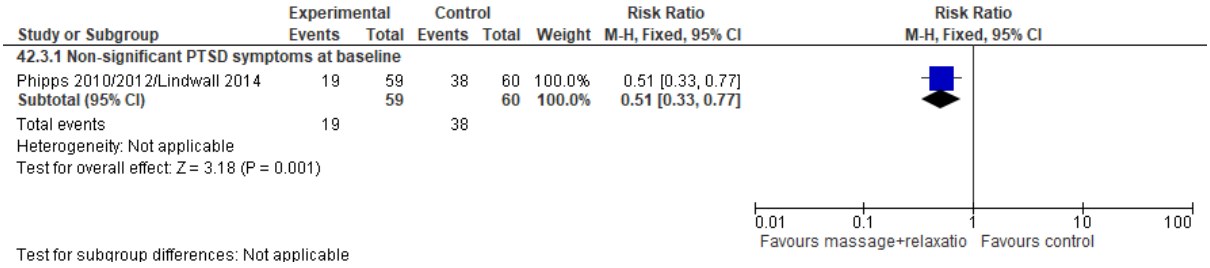


Figure 244: Massage + relaxation for parent (+ massage + humour therapy targeted at child) versus TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults: Discontinuation (loss to follow-up)



Appendix F – GRADE tables

GRADE tables for "For adults at risk of PTSD, what are the relative benefits and harms of psychological, psychosocial or other non-pharmacological interventions targeted at PTSD symptoms?"

Psychological: Trauma-focused CBT

Trauma-focused CBT (± psycho-education) versus waitlist or no treatment for the early prevention (intervention initiated ≤ 1 month) of PTSD in adults

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT (+/- psycho-education)	Waitlist or no treatment	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology self-rated (follow-up mean 3 weeks; measured with: PDS change score; Better indicated by lower values)												
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	serious[2]	none	69	68	-	SMD 2.79 lower (3.26 to 2.32 lower)	VERY LOW	CRITICAL
PTSD symptomatology clinician-rated at endpoint (follow-up 3-5 weeks; measured with: CAPS change score/PSS-I endpoint score; Better indicated by lower values)												
2	randomised trials	very serious [1]	very serious[3]	no serious indirectness	serious[2]	none	129	98	-	SMD 2.2 lower (3.9 to 0.51 lower)	VERY LOW	CRITICAL
PTSD symptomatology clinician-rated at 2-month follow-up (follow-up mean 2 months; measured with: PSS-I endpoint score; Better indicated by lower values)												
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	serious[2]	none	69	68	-	SMD 2.55 lower	VER	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT (+/- psycho-education)	Waitlist or no treatment	Relative (95% CI)	Absolute		
										(3.01 to 2.1 lower)	VERY LOW	
PTSD at endpoint (follow-up mean 3 weeks; assessed with: Number of people who met criteria for PTSD)												
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	very serious[4]	none	32/69 (46.4%)	35/68 (51.5%)	RR 0.9 (0.64 to 1.27)	51 fewer per 1000 (from 185 fewer to 139 more)	VERY LOW	CRITICAL
PTSD at 2-month follow-up (follow-up mean 2 months; assessed with: Number of people who met criteria for PTSD)												
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	serious[5]	none	18/69 (26.1%)	32/68 (47.1%)	RR 0.55 (0.35 to 0.89)	212 fewer per 1000 (from 52 fewer to 306 fewer)	VERY LOW	CRITICAL
PTSD at 6-month follow-up (follow-up mean 6 months; assessed with: Number of people who met criteria for PTSD)												
1	randomised trials	serious [1]	no serious inconsistency	no serious indirectness	very serious[4]	none	8/75 (10.7%)	14/75 (18.7%)	RR 0.57 (0.25 to 1.28)	80 fewer per 1000 (from 140 fewer to 52 more)	VERY LOW	

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT (+/- psycho-education)	Waitlist or no treatment	Relative (95% CI)	Absolute		
Anxiety symptoms (follow-up mean 5 weeks; measured with: BAI change score; Better indicated by lower values)												
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	serious[6]	none	60	30	-	SMD 0.43 lower (0.87 lower to 0.01 higher)	VERY LOW	IMPORTANT
Depression symptoms (follow-up 3-5 weeks; measured with: BDI-II change score; Better indicated by lower values)												
2	randomised trials	very serious [1]	very serious[3]	no serious indirectness	very serious[4]	none	129	98	-	SMD 1.94 lower (4.47 lower to 0.6 higher)	VERY LOW	IMPORTANT
Discontinuation (follow-up 3-26 weeks; assessed with: Number of participants lost to follow-up)												
3	randomised trials	serious [1]	no serious inconsistency	no serious indirectness	very serious[4]	none	40/204 (19.6%)	29/173 (16.8%)	RR 1.04 (0.56 to 1.93)	7 more per 1000 (from 74 fewer to 156 more)	VERY LOW	CRITICAL

BAI=Beck Anxiety Inventory; BDI=Beck Depression Inventory; CAPS=clinician-administered PTSD scale; CBT=cognitive behavioural therapy; CI=confidence interval: PDS=posttraumatic diagnostic scale; PSS-I=PTSD symptom scale-Interview; PTSD=post-traumatic stress disorder; RR=relative risk; SMD=standardised mean difference

[1] Risk of bias is high or unclear across multiple domains

[2] OIS not met (N<400)

[3] Considerable heterogeneity (I2>80%)

[4] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm

[5] OIS not met (events<300)

[6] 95% CI crosses both line of no effect and threshold for clinically important benefit

Trauma-focused CBT (+/- TAU/psycho-education) versus TAU, attention-placebo or psychoeducational session for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT (+/- TAU/psychoeducation)	TAU, attention-placebo or psychoeducational session	Relative (95% CI)	Absolute		
PTSD symptomatology self-rated at endpoint (follow-up 1-6 weeks; measured with: PCL/PSS-SR change score; Better indicated by lower values)												
2	randomised trials	serious[1]	serious[2]	no serious indirectness	serious[3]	none	45	42	-	SMD 0.25 lower (0.87 lower to 0.38 higher)	VERY LOW	CRITICAL
PTSD symptomatology self-rated at 3-month follow-up (follow-up mean 3 months; measured with: PCL/PSS-SR change score; Better indicated by lower values)												
2	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	43	41	-	SMD 0.36 lower (0.79 lower to 0.07 higher)	LOW	CRITICAL
PTSD symptomatology self-rated at 6-month follow-up (follow-up mean 6 months; measured with: PCL change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	24	22	-	SMD 0.3 lower (0.88 lower to 0.28 higher)	LOW	CRITICAL

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT (+/- TAU/psychoeducation)	TAU, attention-placebo or psychoeducational session	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology self-rated at 1-year follow-up (follow-up mean 1 years; measured with: PCL/PSS-SR change score; Better indicated by lower values)												
2	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	46	42	-	SMD 0.39 lower (0.82 lower to 0.03 higher)	LOW	CRITICAL
PTSD symptomatology clinician-rated at endpoint (follow-up 1-10 weeks; measured with: CAPS/PSS-I change score; Better indicated by lower values)												
4	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	115	117	-	SMD 0.29 lower (0.63 lower to 0.04 higher)	LOW	CRITICAL
PTSD symptomatology clinician-rated at 2-3 month follow-up (follow-up 2-3 months; measured with: CAPS/PSS-I change score; Better indicated by lower values)												
3	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	92	96	-	SMD 0.18 lower (0.47 lower to 0.11 higher)	LOW	CRITICAL
PTSD symptomatology clinician-rated at 6-month follow-up (follow-up mean 6 months; measured with: CAPS change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT (+/- TAU/psychoeducation)	TAU, attention-placebo or psychoeducational session	Relative (95% CI)	Absolute		
2	randomised trials	serious[1]	serious[2]	no serious indirectness	serious[3]	none	43	34	-	SMD 0.81 lower (1.88 lower to 0.26 higher)	VERY LOW	CRITICAL
PTSD symptomatology clinician-rated at 1-year follow-up (follow-up mean 1 years; measured with: CAPS/PSS-I change score; Better indicated by lower values)												
2	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	46	42	-	SMD 0.05 lower (0.47 lower to 0.37 higher)	LOW	CRITICAL
PTSD at endpoint (follow-up 6-10 weeks; assessed with: Number meeting criteria for PTSD)												
2	randomised trials	serious[1]	serious[2]	no serious indirectness	serious[3]	none	14/49 (28.6%)	26/44 (59.1%)	RR 0.47 (0.2 to 1.13)	313 fewer per 1000 (from 473 fewer to 77 more)	VERY LOW	CRITICAL
PTSD at 2-3 month follow-up (follow-up 2-3 months; assessed with: Number meeting criteria for PTSD)												
2	randomised trials	serious[1]	no serious inconsistency	no serious	serious[5]	none	40/93 (43%)	56/91 (61.5%)	RR 0.71 (0.53	178 fewer per	LOW	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT (+/- TAU/psychoeducation)	TAU, attention-placebo or psychoeducational session	Relative (95% CI)	Absolute		
				indirectness					to 0.95)	1000 (from 31 fewer to 289 fewer)		
PTSD at 6-month follow-up (follow-up mean 6 months; assessed with: Number meeting criteria for PTSD)												
2	randomised trials	serious[1]	serious[2]	no serious indirectness	very serious[6]	none	21/100 (21%)	28/97 (28.9%)	RR 0.74 (0.28 to 1.93)	75 fewer per 1000 (from 208 fewer to 268 more)	VERY LOW	CRITICAL
PTSD at 1-year follow-up (follow-up mean 1 years; assessed with: Number meeting criteria for PTSD)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[6]	none	13/25 (52%)	10/22 (45.5%)	RR 1.14 (0.63 to 2.07)	64 more per 1000 (from 168 fewer to 486 more)	VERY LOW	CRITICAL
Response at endpoint (follow-up mean 6 weeks; assessed with: Number of people showing improvement of at least 12 points on CAPS)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[6]	none	18/25 (72%)	15/22 (68.2%)	RR 1.06 (0.73 to 1.54)	41 more per 1000 (from 184	VERY LOW	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT (+/- TAU/psychoeducation)	TAU, attention-placebo or psychoeducational session	Relative (95% CI)	Absolute		
										fewer to 368 more)		
Response at 3-month follow-up (follow-up mean 3 months; assessed with: Number of people showing improvement of at least 12 points on CAPS)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[6]	none	13/25 (52%)	8/22 (36.4%)	RR 1.43 (0.73 to 2.79)	156 more per 1000 (from 98 fewer to 651 more)	VERY LOW	CRITICAL
Response at 6-month follow-up (follow-up mean 6 months; assessed with: Number of people showing improvement of at least 12 points on CAPS)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[6]	none	12/25 (48%)	11/22 (50%)	RR 0.96 (0.54 to 1.72)	20 fewer per 1000 (from 230 fewer to 360 more)	VERY LOW	CRITICAL
Response at 1-year follow-up (follow-up mean 1 years; assessed with: Number of people showing improvement of at least 12 points on CAPS)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[6]	none	14/25 (56%)	11/22 (50%)	RR 1.12 (0.65 to 1.93)	60 more per 1000 (from 175 fewer to 465 more)	VERY LOW	CRITICAL

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT (+/- TAU/psychoeducation)	TAU, attention-placebo or psychoeducational session	Relative (95% CI)	Absolute	Quality	Importance
Anxiety symptoms at endpoint (follow-up 1-10 weeks; measured with: BAI/HADS-A change score; Better indicated by lower values)												
2	randomised trials	very serious[1]	very serious[8]	no serious indirectness	serious[3]	none	42	40	-	SMD 0.98 lower (2.1 lower to 0.14 higher)	VERY LOW	IMPORTANT
Anxiety symptoms at 3-month follow-up (follow-up mean 3 months; measured with: BAI change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	19	19	-	SMD 0.60 lower (1.25 lower to 0.06 higher)	VERY LOW	IMPORTANT
Anxiety symptoms at 6-month follow-up (follow-up mean 6 months; measured with: HADS-A change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	19	12	-	SMD 0.8 lower (1.55 to 0.04 lower)	LOW	IMPORTANT
Anxiety symptoms at 1-year follow-up (follow-up mean 1 years; measured with: BAI change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	22	20	-	SMD 0.7 lower (1.32	VERY LOW	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT (+/- TAU/psychoeducation)	TAU, attention-placebo or psychoeducational session	Relative (95% CI)	Absolute		
										to 0.07 lower)		
Depression symptoms at endpoint (follow-up 1-10 weeks; measured with: BDI/BDI-II change score; Better indicated by lower values)												
3	randomised trials	serious[1]	very serious[7]	no serious indirectness	very serious[6]	none	67	62	-	SMD 0.76 lower (2.37 lower to 0.86 higher)	VERY LOW	IMPORTANT
Depression symptoms at 3-month follow-up (follow-up mean 3 months; measured with: BDI/BDI-II change score; Better indicated by lower values)												
2	randomised trials	serious[1]	serious[2]	no serious indirectness	very serious[6]	none	43	41	-	SMD 0.03 lower (0.73 lower to 0.66 higher)	VERY LOW	IMPORTANT
Depression symptoms at 6-month follow-up (follow-up mean 6 months; measured with: BDI/BDI-II change score; Better indicated by lower values)												
2	randomised trials	serious[1]	very serious[7]	no serious indirectness	serious[3]	none	43	34	-	SMD 1.32 lower (2.72 lower to 0.08 higher)	VERY LOW	IMPORTANT

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT (+/- TAU/psychoeducation)	TAU, attention-placebo or psychoeducational session	Relative (95% CI)	Absolute	Quality	Importance
Depression symptoms at 1-year follow-up (follow-up mean 1 years; measured with: BDI/BDI-II change score; Better indicated by lower values)												
2	randomised trials	serious[1]	very serious[7]	no serious indirectness	very serious[6]	none	46	42	-	SMD 0.01 higher (1.15 lower to 1.18 higher)	VERY LOW	IMPORTANT
Discontinuation (follow-up 1-10 weeks; assessed with: Number of participants lost to follow-up)												
5	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious[8]	none	54/223 (24.2%)	46/218 (21.1%)	RR 1.18 (0.84 to 1.66)	38 more per 1000 (from 34 fewer to 139 more)	MODERATE	CRITICAL

BAI=Beck Anxiety Inventory; BDI=Beck Depression Inventory; CAPS=Clinician-administered PTSD scale; CBT=cognitive behavioural therapy; CI=confidence interval; HADS-A=Hospital Anxiety and Depression Scale-Anxiety; PCL=PTSD Checklist; PSS-I/SR=PTSD symptom scale-interview/self-report; PTSD=post-traumatic stress disorder; RR=risk ratio; SMD=standard mean difference; TAU=treatment as usual

[1] Risk of bias is high or unclear across multiple domains

[2] Substantial heterogeneity (I2>50%)

[3] 95% CI crosses both line of no effect and threshold for clinically important benefit

[4] OIS not met (N<400)

[5] OIS not met (events<300)

[6] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm

[7] Considerable heterogeneity (I2>80%)

[8] 95% CI crosses both line of no effect and threshold for clinically important harm

Trauma-focused CBT versus supportive counselling for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT	Supportive counselling	Relative (95% CI)	Absolute		
PTSD symptomatology self-rated at endpoint (follow-up 1-10 weeks; measured with: IES-R endpoint/PCL/PDS/PSS-SR change score; Better indicated by lower values)												
4	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	71	62	-	SMD 0.71 lower (1.14 to 0.28 lower)	LOW	CRITICAL
PTSD symptomatology self-rated at 3-month follow-up (follow-up mean 3 months; measured with: PSS-SR change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	19	19	-	SMD 0.66 lower (1.32 to 0.01 lower)	VERY LOW	CRITICAL
PTSD symptomatology self-rated at 5-6 month follow-up (follow-up 5-6 months; measured with: IES-R endpoint/PCL change score; Better indicated by lower values)												
2	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	33	26	-	SMD 0.61 lower (1.14 to 0.08 lower)	LOW	CRITICAL
PTSD symptomatology self-rated at 11-12 month follow-up (follow-up 11-12 months; measured with: PCL/PSS-SR change score; Better indicated by lower values)												
2	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	43	38	-	SMD 0.5 lower (0.95 to 0.06 lower)	VERY LOW	CRITICAL
PTSD symptomatology clinician-rated at endpoint (follow-up 1-6 weeks; measured with: CAPS/PSS-I endpoint/change score; Better indicated by lower values)												
3	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	48	46	-	SMD 0.58 lower (1	LOW	CRITICAL

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT	Supportive counselling	Relative (95% CI)	Absolute	Quality	Importance
										to 0.17 lower)		
PTSD symptomatology clinician-rated at 3-6 month follow-up (follow-up 3-6 months; measured with: PSS-I/CAPS change score; Better indicated by lower values)												
2	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	33	33	-	SMD 0.38 lower (0.87 lower to 0.11 higher)	LOW	CRITICAL
PTSD symptomatology clinician-rated at 1-3 year follow-up (follow-up 1-3 years; measured with: PSS-I/CAPS change score; Better indicated by lower values)												
2	randomised trials	serious[1]	serious[4]	no serious indirectness	very serious[5]	none	41	40	-	SMD 0.21 lower (1.2 lower to 0.78 higher)	VERY LOW	CRITICAL
Diagnosis of PTSD at endpoint (follow-up 5-6 weeks; assessed with: Number of people who met diagnostic criteria for PTSD)												
2	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious[6]	none	17/54 (31.5%)	17/32 (53.1%)	RR 0.59 (0.35 to 0.98)	218 fewer per 1000 (from 11 fewer to 345 fewer)	MODERATE	CRITICAL
Diagnosis of PTSD at 1-month follow-up (follow-up mean 1 months; assessed with: Number of people who met criteria for PTSD)												
2	randomised trials	serious[1]	serious[4]	no serious indirectness	very serious[5]	none	13/45 (28.9%)	22/36 (61.1%)	RR 0.32 (0.04 to 2.64)	416 fewer per 1000 (from 587 fewer to 1000 more)	VERY LOW	CRITICAL
Diagnosis of PTSD at 6-month follow-up (follow-up mean 6 months; assessed with: Number of people who met criteria for PTSD)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT	Supportive counselling	Relative (95% CI)	Absolute		
4	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious[6]	none	34/94 (36.2%)	43/67 (64.2%)	RR 0.57 (0.39 to 0.83)	276 fewer per 1000 (from 109 fewer to 391 fewer)	MODERATE	CRITICAL
Diagnosis of PTSD at 3-4 year follow-up (follow-up 3-4 years; assessed with: Number of people who met criteria for PTSD)												
2	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	28/83 (33.7%)	26/54 (48.1%)	RR 0.69 (0.46 to 1.04)	149 fewer per 1000 (from 260 fewer to 19 more)	LOW	CRITICAL
Anxiety symptoms at endpoint (follow-up 1-10 weeks; measured with: BAI endpoint or change score/STAI State change score; Better indicated by lower values)												
4	randomised trials	serious[1]	serious[4]	no serious indirectness	serious[3]	none	82	65	-	SMD 0.5 lower (1.2 lower to 0.19 higher)	VERY LOW	IMPORTANT
Anxiety symptoms at 1-3 month follow-up (follow-up 1-3 months; measured with: BAI/STAI State change score; Better indicated by lower values)												
3	randomised trials	very serious[1]	serious[4]	no serious indirectness	serious[2]	none	64	55	-	SMD 0.71 lower (1.41 lower to 0 higher)	VERY LOW	IMPORTANT
Anxiety symptoms at 5-6 month follow-up (follow-up 5-6 months; measured with: STAI State change score/BAI endpoint/change score; Better indicated by lower values)												
5	randomised trials	serious[1]	serious[4]	no serious indirectness	serious[3]	none	104	77	-	SMD 0.47 lower (1.07 lower to 0.13 higher)	VERY LOW	IMPORTANT
Anxiety symptoms at 11-12 month follow-up (follow-up 11-12 months; measured with: BAI/STAI State change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT	Supportive counselling	Relative (95% CI)	Absolute	Quality	Importance
2	randomised trials	very serious[1]	serious[4]	no serious indirectness	serious[3]	none	43	37	-	SMD 0.52 lower (1.32 lower to 0.29 higher)	VERY LOW	IMPORTANT
Depression symptoms at endpoint (follow-up 1-10 weeks; measured with: BDI/BDI-II endpoint/change score; Better indicated by lower values)												
5	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	97	76	-	SMD 0.47 lower (0.78 to 0.16 lower)	LOW	IMPORTANT
Depression symptoms at 1-3 month follow-up (follow-up 1-3 months; measured with: BDI/BDI-II change score; Better indicated by lower values)												
3	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	64	55	-	SMD 0.19 lower (0.67 lower to 0.29 higher)	VERY LOW	IMPORTANT
Depression symptoms at 5-6 month follow-up (follow-up 5-6 months; measured with: BDI/BDI-II endpoint/change score; Better indicated by lower values)												
5	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	104	77	-	SMD 0.49 lower (0.89 to 0.1 lower)	LOW	IMPORTANT
Depression symptoms at 11-12 month follow-up (follow-up 11-12 months; measured with: BDI/BDI-II change score; Better indicated by lower values)												
2	randomised trials	very serious[1]	serious[4]	no serious indirectness	serious[3]	none	43	38	-	SMD 0.53 lower (1.48 lower to 0.42 higher)	VERY LOW	IMPORTANT
Depression symptoms at 3-year follow-up (follow-up mean 3 years; measured with: BDI-II change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT	Supportive counselling	Relative (95% CI)	Absolute		
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	19	16	-	SMD 0.76 lower (1.45 to 0.06 lower)	VERY LOW	IMPORTANT
Quality of life at endpoint (follow-up mean 10 weeks; measured with: FACT-G change score; Better indicated by higher values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[7]	none	21	14	-	SMD 0.31 lower (0.99 lower to 0.37 higher)	LOW	IMPORTANT
Quality of life at 5-month follow-up (follow-up mean 5 months; measured with: FACT-G change score; Better indicated by higher values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	21	14	-	SMD 0.51 higher (0.17 lower to 1.2 higher)	LOW	IMPORTANT
Quality of life at 11-month follow-up (follow-up mean 11 months; measured with: FACT-G change score; Better indicated by higher values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	21	14	-	SMD 0.78 higher (0.07 to 1.48 higher)	LOW	IMPORTANT
Discontinuation (follow-up 1-10 weeks; assessed with: Number of participants lost to follow-up)												
7	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[5]	none	36/163 (22.1%)	20/123 (16.3%)	RR 1.22 (0.74 to 2.01)	36 more per 1000 (from 42 fewer to 164 more)	LOW	CRITICAL

BAI=Beck Anxiety Inventory; BDI=Beck Depression Inventory; CAPS=clinician administered PTSD scale; CBT=cognitive behavioural therapy; CI=confidence interval; FACT-G=Functional Assessment of Cancer Therapy-General; IES-R=Impact of Event Scale-Revised; PCL=PTSD Checklist; PDS=PTSD diagnostic scale; PSS-I/SR=PTSD symptom scale-interview/self-report; PTSD=post-traumatic stress disorder; RR=risk ratio; SMD=standardised mean difference; STAI=State-Trait Anxiety Inventory
[1] Risk of bias is high or unclear across multiple domains
[2] OIS not met (N<400)
[3] 95% CI crosses both line of no effect and threshold for clinically important benefit
[4] Substantial heterogeneity (I2>50%)
[5] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm
[6] OIS not met (events<300)
[7] 95% CI crosses both line of no effect and threshold for clinically important harm

Trauma-focused CBT versus self-help (without support) for the early treatment (1-3 months) of below threshold PTSD symptoms in adults

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT	Self-help (without support)	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology self-rated at 1-month follow-up (follow-up mean 1 months; measured with: IES-R change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	17	20	-	SMD 0.75 lower (1.42 to 0.08 lower)	VERY LOW	CRITICAL
PTSD symptomatology self-rated at 4-month follow-up (follow-up mean 4 months; measured with: IES-R change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	19	24	-	SMD 0.67 lower (1.29 to 0.05 lower)	VERY LOW	CRITICAL
Anxiety symptoms at 1-month follow-up (follow-up mean 1 months; measured with: HADS-A change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	17	20	-	SMD 1.44 lower (2.17 to 0.7 lower)	VERY LOW	IMPORTANT
Anxiety symptoms at 4-month follow-up (follow-up mean 4 months; measured with: HADS-A change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Trauma-focused CBT**	**Self-help (without support)**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	19	24	-	SMD 1.32 lower (1.99 to 0.65 lower)	VERY LOW	IMPORTANT
Depression symptoms at 1-month follow-up (follow-up mean 1 months; measured with: HADS-D change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	17	20	-	SMD 0.75 lower (1.42 to 0.08 lower)	VERY LOW	IMPORTANT
Depression symptoms at 4-month follow-up (follow-up mean 4 months; measured with: HADS-D change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	19	24	-	SMD 1.28 lower (1.95 to 0.62 lower)	VERY LOW	IMPORTANT
Discontinuation (follow-up mean 4 weeks; assessed with: Number of participants lost to follow-up)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	12/29 (41.4%)	11/31 (35.5%)	RR 1.17 (0.61 to 2.22)	60 more per 1000 (from 138 fewer to 433 more)	VERY LOW	CRITICAL

CBT=cognitive behavioural therapy; CI=confidence interval; HADS-A/D=Hospital Anxiety and Depression Scale-Anxiety/Depression; IES-R=Impact of Event Scale-Revised; PTSD=post-traumatic stress disorder; RR=relative risk; SMD=standardised mean difference

[1] Risk of bias is high or unclear across multiple domains

[2] OIS not met (N<400)

[3] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm

Trauma-focused CBT versus waitlist/no treatment for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT	Waitlist/no treatment	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology self-rated at endpoint (follow-up mean 26 weeks; measured with: PCL change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	45	45	-	SMD 0.14 lower (0.55 lower to 0.27 higher)	VERY LOW	CRITICAL
PTSD symptomatology self-rated at 1-2 month follow-up (follow-up 1-2 months; measured with: PCL/HTQ change score; Better indicated by lower values)												
2	randomised trials	serious[1]	very serious[3]	no serious indirectness	no serious imprecision	none	229	199	-	SMD 1 lower (1.88 to 0.12 lower)	VERY LOW	CRITICAL
PTSD symptomatology self-rated at 5-6 month follow-up (follow-up 5-6 months; measured with: PCL change score; Better indicated by lower values)												
2	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	91	77	-	SMD 0.49 lower (0.8 to 0.18 lower)	VERY LOW	CRITICAL
PTSD symptomatology self-rated at 8-month follow-up (follow-up mean 8 months; measured with: PCL change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	47	34	-	SMD 0.52 lower (0.97 to 0.07 lower)	LOW	CRITICAL
PTSD symptomatology clinician-rated (follow-up mean 12 weeks; measured with: CAPS change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	21	21	-	SMD 1.55 lower (2.25 to 0.86 lower)	LOW	CRITICAL
PTSD at endpoint (follow-up mean 12 weeks; assessed with: Number who met criteria for PTSD)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT	Waitlist/no treatment	Relative (95% CI)	Absolute		
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	3/21 (14.3%)	8/21 (38.1%)	RR 0.38 (0.12 to 1.22)	236 fewer per 1000 (from 335 fewer to 84 more)	LOW	CRITICAL
Anxiety symptoms at 1-month follow-up (follow-up mean 1 months; measured with: HSCL-25 Anxiety change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	182	165	-	SMD 0.87 lower (1.09 to 0.65 lower)	LOW	IMPORTANT
Depression symptoms at 1-2 month follow-up (follow-up 1-2 months; measured with: HSCL-25/BSI Depression change score; Better indicated by lower values)												
2	randomised trials	serious[1]	very serious[3]	no serious indirectness	no serious imprecision	none	229	199	-	SMD 0.99 lower (1.86 to 0.12 lower)	VERY LOW	IMPORTANT
Depression symptoms at 5-month follow-up (follow-up mean 5 months; measured with: BSI Depression change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	47	34	-	SMD 0.64 lower (1.09 to 0.18 lower)	LOW	IMPORTANT
Depression symptoms at 8-month follow-up (follow-up mean 8 months; measured with: BSI Depression change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	47	34	-	SMD 0.54 lower (0.99 to 0.09 lower)	LOW	IMPORTANT
Alcohol use disorder symptoms at 1-month follow-up (follow-up mean 1 months; measured with: AUDIT change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT	Waitlist/no treatment	Relative (95% CI)	Absolute	Quality	Importance
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[5]	none	18	15	-	SMD 0.06 higher (0.62 lower to 0.75 higher)	VERY LOW	IMPORTANT
Alcohol use at endpoint (follow-up mean 26 weeks; measured with: Drug and Alcohol Use Interview: Total drinks in last 3 months change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	45	44	-	SMD 0.07 lower (0.48 lower to 0.35 higher)	VERY LOW	IMPORTANT
Alcohol use at 6-month follow-up (follow-up mean 6 months; measured with: Drug and Alcohol Use Interview: Total drinks in last 3 months change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[6]	none	39	44	-	SMD 0.21 higher (0.22 lower to 0.64 higher)	VERY LOW	IMPORTANT
Drug use at endpoint (follow-up mean 26 weeks; measured with: Drug and Alcohol Use Interview: Total joints in last 3 months change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	45	44	-	SMD 0.26 lower (0.68 lower to 0.15 higher)	VERY LOW	IMPORTANT
Drug use at 6-month follow-up (follow-up mean 6 months; measured with: Drug and Alcohol Use Interview: Total joints in last 3 months change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT	Waitlist/no treatment	Relative (95% CI)	Absolute	Quality	Importance
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[6]	none	39	44	-	SMD 0.25 higher (0.18 lower to 0.69 higher)	VERY LOW	IMPORTANT
Relationship difficulties at endpoint (follow-up mean 26 weeks; measured with: IIP change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	44	44	-	SMD 0.15 lower (0.57 lower to 0.27 higher)	VERY LOW	IMPORTANT
Relationship difficulties at 6-month follow-up (follow-up mean 6 months; measured with: IIP change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	45	43	-	SMD 0.36 lower (0.78 lower to 0.07 higher)	VERY LOW	IMPORTANT
Discontinuation (follow-up 10-26 weeks; assessed with: Number of participants lost to follow-up)												
3	randomised trials	no serious risk of bias	serious[7]	no serious indirectness	very serious[5]	none	62/289 (21.5%)	51/257 (19.8%)	RR 1.32 (0.55 to 3.15)	64 more per 1000 (from 89 fewer to 427 more)	VERY LOW	CRITICAL

AUDIT=alcohol use disorder identification test; BSI=brief symptom inventory; CAPS=clinician-administered PTSD scale; CBT=cognitive behavioural therapy; CI=confidence interval: HSCL-25=Hopkins Symptom Checklist; HTQ=Harvard trauma questionnaire; IIP=inventory of interpersonal problems; PCL=PTSD checklist; RR=risk ratio; SMD=standardised mean difference

[1] Risk of bias is high or unclear across multiple domains

[2] 95% CI crosses both line of no effect and threshold for clinically important benefit

[3] Considerable heterogeneity (I2>80%)

[4] OIS not met (N<400)
[5] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm
[6] 95% CI crosses both line of no effect and threshold for clinically important harm
[7] Substantial heterogeneity (I2>50%)

Trauma-focused CBT versus attention-placebo/psycho-education for the delayed treatment (>3 months) of below threshold PTSD

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT	Attention-placebo/psychoeducation	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology self-rated at endpoint (follow-up 0.4-13 weeks; measured with: PCL/IES change score; Better indicated by lower values)												
2	randomised trials	serious [1]	no serious inconsistency	no serious indirectness	serious[2]	none	182	173	-	SMD 0.03 lower (0.36 lower to 0.3 higher)	LOW	CRITICAL
PTSD symptomatology self-rated at 3-month follow-up (follow-up mean 3 months; measured with: IES change score; Better indicated by lower values)												
1	randomised trials	serious [1]	no serious inconsistency	no serious indirectness	serious[2]	none	132	140	-	SMD 0.13 lower (0.37 lower to 0.1 higher)	LOW	CRITICAL
PTSD symptomatology self-rated at 6-8 month follow-up (follow-up 6-8 months; measured with: PCL/IES change score; Better indicated by lower values)												
2	randomised trials	serious 1	very serious[3]	no serious indirectness	serious[4]	none	160	157	-	SMD 0.35 lower (1.14 lower to 0.43 higher)	VERY LOW	CRITICAL
Discontinuation (follow-up mean 13 weeks; assessed with: Number of participants lost to follow-up)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT	Attention-placebo/psychoeducation	Relative (95% CI)	Absolute		
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[5]	none	33/178 (18.5%)	29/176 (16.5%)	RR 1.13 (0.72 to 1.77)	21 more per 1000 (from 46 fewer to 127 more)	LOW	CRITICAL

CI=confidence interval; IES=impact of event scale; PCL=PTSD checklist; PTSD=post-traumatic stress disorder; RR=risk ratio; SMD=standardised mean difference
[1] Risk of bias is high or unclear across multiple domains
[2] OIS not met (N<400)
[3] Considerable heterogeneity (I2>80%)
[4] 95% CI crosses both line of no effect and threshold for clinically important benefit
[5] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm

Trauma-focused CBT versus present-centred therapy for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT	Present-centred therapy	Relative (95% CI)	Absolute		
PTSD symptomatology self-rated at endpoint (follow-up mean 26 weeks; measured with: PCL change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	45	45	-	SMD 0.08 higher (0.34 lower to 0.49 higher)	VERY LOW	CRITICAL

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT	Present-centred therapy	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology self-rated at 6-month follow-up (follow-up mean 6 months; measured with: PCL change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	44	43	-	SMD 0.08 lower (0.5 lower to 0.34 higher)	VERY LOW	CRITICAL
Alcohol use at endpoint (follow-up mean 26 weeks; measured with: Drug and Alcohol Use Interview: Total drinks in last 3 months change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	45	45	-	SMD 0.06 higher (0.35 lower to 0.48 higher)	VERY LOW	IMPORTANT
Alcohol use at 6-month follow-up (follow-up mean 6 months; measured with: Drug and Alcohol Use Interview: Total drinks in last 3 months change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	39	43	-	SMD 0.03 lower (0.46 lower to 0.41 higher)	VERY LOW	IMPORTANT
Drug use at endpoint (follow-up mean 26 weeks; measured with: Drug and Alcohol Use Interview: Total joints in last 3 months change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	45	45	-	SMD 0.25 lower (0.66 lower to 0.17 higher)	VERY LOW	IMPORTANT
Drug use at 6-month follow-up (follow-up mean 6 months; measured with: Drug and Alcohol Use Interview: Total joints in last 3 months change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT	Present-centred therapy	Relative (95% CI)	Absolute		
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	39	43	-	SMD 0.23 higher (0.2 lower to 0.67 higher)	VERY LOW	IMPORTANT
Relationship difficulties at endpoint (follow-up mean 26 weeks; measured with: IIP change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	44	44	-	SMD 0.06 lower (0.48 lower to 0.36 higher)	VERY LOW	IMPORTANT
Relationship difficulties at 6-month follow-up (follow-up mean 6 months; measured with: IIP change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	45	43	-	SMD 0.01 higher (0.41 lower to 0.42 higher)	VERY LOW	IMPORTANT
Discontinuation (follow-up mean 26 weeks; assessed with: Number of participants lost to follow-up)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	23/55 (41.8%)	18/56 (32.1%)	RR 1.3 (0.8 to 2.13)	96 more per 1000 (from 64 fewer to 363 more)	LOW	CRITICAL

CBT=cognitive behavioural therapy; CI=confidence interval; IIP=inventory of interpersonal problems; PCL=PTSD Checklist; PTSD=post-traumatic stress disorder; RR=risk ratio; SMD=standardised mean difference

[1] Risk of bias was high or unclear across multiple domains

[2] OIS not met (N<400)

[3] 95% CI crosses both line of no effect and threshold for clinically important benefit

[4] 95% CI crosses both line of no effect and threshold for clinically important harm

Trauma-focused CBT group versus peer support group for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT group	Peer support group	Relative (95% CI)	Absolute		
PTSD symptomatology self-rated at endpoint (measured with: SCL-90-R Posttraumatic Symptom Scale change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	21	23	-	SMD 0.37 lower (0.97 lower to 0.22 higher)	VERY LOW	CRITICAL
PTSD symptomatology self-rated at 3-month follow-up (follow-up mean 3 months; measured with: SCL-90-R Posttraumatic Symptom Scale change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	21	23	-	SMD 0.73 lower (1.35 to 0.12 lower)	VERY LOW	CRITICAL

CBT=cognitive behavioural therapy; CI=confidence interval; PTSD=post-traumatic stress disorder; SCL-90-R=Symptom Checklist-90-Revised; SMD=standardised mean difference

[1] Risk of bias is high or unclear across multiple outcomes

[2] 95% CI crosses both line of no effect and threshold for clinically important benefit

[3] OIS not met (N<400)

Psychological: Non-trauma focused CBT

Non-trauma-focused CBT (+ TAU) versus TAU for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Non-trauma-focused CBT (+ TAU)	TAU	Relative (95% CI)	Absolute		
PTSD symptomatology self-rated (follow-up 2-12 weeks; measured with: PCL/IES-R change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Non-trauma-focused CBT (+ TAU)	TAU	Relative (95% CI)	Absolute	Quality	Importance
2	randomised trials	serious [1]	no serious inconsistency	no serious indirectness	serious[2]	none	58	45	-	SMD 0.31 lower (0.7 lower to 0.09 higher)	LOW	CRITICAL
PTSD at endpoint (follow-up mean 12 weeks; assessed with: Number who criteria for PTSD)												
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	very serious[3]	none	8/26 (30.8%)	8/20 (40%)	RR 0.77 (0.35 to 1.69)	92 fewer per 1000 (from 260 fewer to 276 more)	VERY LOW	CRITICAL
Anxiety symptoms (follow-up mean 12 weeks; measured with: HADS-A change score; Better indicated by lower values)												
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	very serious[3]	none	25	20	-	SMD 0.06 lower (0.65 lower to 0.53 higher)	VERY LOW	IMPORTANT
Depression symptoms (follow-up 2-12 weeks; measured with: CES-D/HADS-D change score; Better indicated by lower values)												
2	randomised trials	serious [1]	no serious inconsistency	no serious indirectness	serious[2]	none	60	48	-	SMD 0.36 lower (0.74 lower to 0.02 higher)	LOW	IMPORTANT
Anger (follow-up mean 12 weeks; measured with: STAXI-2 change score; Better indicated by lower values)												
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	serious[2]	none	25	20	-	SMD 0.29 lower (0.88 lower to 0.3 higher)	VERY LOW	IMPORTANT
Sleeping difficulties (follow-up mean 2 weeks; measured with: MOS-SS: Sleep Problems Index II change score; Better indicated by lower values)												
1	randomised trials	serious [1]	no serious	no serious	serious[4]	none	33	25	-	SMD 0.96 lower (1.51 to 0.41 lower)	LOW	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Non-trauma-focused CBT (+ TAU)	TAU	Relative (95% CI)	Absolute		
			inconsistency	indirectness								
Quality of life (follow-up 2-12 weeks; measured with: SF-36 total/EuroQol change score; Better indicated by higher values)												
2	randomised trials	serious [1]	no serious inconsistency	no serious indirectness	serious[2]	none	59	48	-	SMD 0.24 higher (0.14 lower to 0.63 higher)	LOW	IMPORTANT
Discontinuation (follow-up 2-12 weeks; assessed with: Number of participants lost to follow-up)												
2	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[3]	none	3/61 (4.9%)	3/48 (6.3%)	RR 0.75 (0.17 to 3.38)	16 fewer per 1000 (from 52 fewer to 149 more)	LOW	CRITICAL

CBT=cognitive behavioural therapy; CES-D=Center for Epidemiological Studies Depression; CI=confidence interval; EuroQoL=an instrument for measuring quality of life; HADS-A/D=Hospital Anxiety and Depression Inventory-Anxiety/Depression; IES-R=Impact of Event Scale-Revised; MOS-SS=Medical Outcomes Study-Sleep Scale; PTSD=post-traumatic stress disorder; RR=risk ratio; SF-36=short form survey-36; SMD=standardised mean difference; STAXI-2=State Trait Anger Expression Inventory-2; TAU=treatment as usual

[1] Risk of bias was high or unclear across multiple domains

[2] 95% CI crosses both line of no effect and threshold for clinically important benefit

[3] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm

[4] OIS not met (N<400)

Present-centred therapy versus waitlist for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Present-centred therapy	Waitlist	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology self-rated at endpoint (follow-up mean 26 weeks; measured with: PCL change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	45	45	-	SMD 0.23 lower (0.65 lower to 0.18 higher)	VERY LOW	CRITICAL
PTSD symptomatology self-rated at 6-month follow-up (follow-up mean 6 months; measured with: PCL change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	43	43	-	SMD 0.31 lower (0.74 lower to 0.11 higher)	VERY LOW	CRITICAL
Alcohol use at endpoint (follow-up mean 26 weeks; measured with: Drug and Alcohol Use Interview: Total drinks in last 3 months change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	45	44	-	SMD 0.12 lower (0.54 lower to 0.3 higher)	VERY LOW	IMPORTANT
Alcohol use at 6-month follow-up (follow-up mean 6 months; measured with: Drug and Alcohol Use Interview: Total drinks in last 3 months change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	43	44	-	SMD 0.24 higher (0.18 lower to 0.66 higher)	VERY LOW	IMPORTANT
Drug use at endpoint (follow-up mean 26 weeks; measured with: Drug and Alcohol Use Interview: Total joints in last 3 months change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	45	44	-	SMD 0.02 higher (0.4 lower to 0.43 higher)	VERY LOW	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Present-centred therapy	Waitlist	Relative (95% CI)	Absolute		
Drug use at 6-month follow-up (follow-up mean 6 months; measured with: Drug and Alcohol Use Interview: Total joints in last 3 months change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	43	44	-	SMD 0.02 higher (0.4 lower to 0.44 higher)	VERY LOW	IMPORTANT
Relationship difficulties at endpoint (follow-up mean 26 weeks; measured with: IIP change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	44	44	-	SMD 0.1 lower (0.51 lower to 0.32 higher)	VERY LOW	IMPORTANT
Relationship difficulties at 6-month follow-up (follow-up mean 6 months; measured with: IIP change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	43	43	-	SMD 0.36 lower (0.78 lower to 0.07 higher)	VERY LOW	IMPORTANT
Discontinuation (follow-up mean 26 weeks; assessed with: Number of participants lost to follow-up)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	18/56 (32.1%)	9/55 (16.4%)	RR 1.96 (0.97 to 3.99)	157 more per 1000 (from 5 fewer to 489 more)	LOW	CRITICAL

CI=confidence interval; IIP=Inventory of Interpersonal Problems; PCL=PTSD Checklist; PTSD=post-traumatic stress disorder; RR=risk ratio; SMD=standardised mean difference

[1] Risk of bias is high or unclear across multiple domains

[2] 95% CI crosses both line of no effect and threshold for clinically important benefit

[3] 95% CI crosses both line of no effect and threshold for clinically important harm

[4] OIS not met (N<400)

Psychological: Behavioural therapies

Brief behavioural intervention versus enhanced TAU for the prevention of PTSD in adults exposed to ongoing trauma (e.g. in a war zone)

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Brief behavioural intervention	Enhanced TAU	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology self-rated at endpoint (follow-up mean 5 weeks; measured with: PCL change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	114	95	-	SMD 0.78 lower (1.06 to 0.5 lower)	VERY LOW	CRITICAL
PTSD symptomatology self-rated at 2-month follow-up (follow-up mean 2 months; measured with: PCL change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	146	160	-	SMD 0.77 lower (1 to 0.53 lower)	VERY LOW	CRITICAL
Anxiety symptoms at endpoint (follow-up mean 5 weeks; measured with: HADS-A change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	112	97	-	SMD 1.3 lower (1.6 to 1 lower)	VERY LOW	IMPORTANT
Anxiety symptoms at 2-month follow-up (follow-up mean 2 months; measured with: HADS-A change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	146	160	-	SMD 1.31 lower (1.56 to 1.06 lower)	VERY LOW	IMPORTANT
Depression symptoms at endpoint (follow-up mean 5 weeks; measured with: PHQ-9 change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Brief behavioural intervention	Enhanced TAU	Relative (95% CI)	Absolute	Quality	Importance
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	114	95	-	SMD 1.4 lower (1.7 to 1.09 lower)	VERY LOW	IMPORTANT
Depression symptoms at 2-month follow-up (follow-up mean 2 months; measured with: PHQ-9 change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	145	158	-	SMD 1.16 lower (1.41 to 0.92 lower)	VERY LOW	IMPORTANT
Functional impairment at endpoint (follow-up mean 5 weeks; measured with: WHODAS change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	114	96	-	SMD 0.49 lower (0.77 to 0.22 lower)	VERY LOW	IMPORTANT
Functional impairment at 2-month follow-up (follow-up mean 2 months; measured with: WHODAS change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	143	160	-	SMD 0.3 lower (0.53 to 0.08 lower)	VERY LOW	IMPORTANT
Discontinuation (follow-up mean 5 weeks; assessed with: Number of participants lost to follow-up)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	112/172 (65.1%)	97/174 (55.7%)	RR 1.17 (0.98 to 1.39)	95 more per 1000 (from 11 fewer to 217 more)	LOW	CRITICAL

CI=confidence interval; HADS-A=Hospital Anxiety and Depression Scale-Anxiety; PCL=PTSD Checklist; PHQ-9=Patient Health Questionnaire-9; PTSD=post-traumatic stress disorder; RR=risk ratio; SMD=standardised mean difference; TAU=treatment as usual; WHODAS=WHO disability assessment schedule
[1] Risk of bias is high or unclear across multiple domains
[2] OIS not met (N<400)
[3] 95% CI crosses both line of no effect and threshold for clinically important harm

Brief behavioural intervention versus enhanced TAU for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Brief behavioural intervention	Enhanced TAU	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology self-rated at endpoint (follow-up mean 5 weeks; measured with: PCL change score; Better indicated by lower values)												
1	randomised trials	serious [1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	209	212	-	SMD 0.95 lower (1.15 to 0.75 lower)	MODERATE	CRITICAL
PTSD symptomatology self-rated at 3-month follow-up (follow-up mean 3 months; measured with: PCL change score; Better indicated by lower values)												
1	randomised trials	serious [1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	209	212	-	SMD 0.54 lower (0.74 to 0.35 lower)	MODERATE	CRITICAL
Functional impairment at endpoint (follow-up mean 5 weeks; measured with: WHODAS change score; Better indicated by lower values)												
1	randomised trials	serious [1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	209	212	-	SMD 1.09 lower (1.29 to 0.88 lower)	MODERATE	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Brief behavioural intervention	Enhanced TAU	Relative (95% CI)	Absolute		
Functional impairment at 3-month follow-up (follow-up mean 3 months; measured with: WHODAS change score; Better indicated by lower values)												
1	randomised trials	serious [1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	209	212	-	SMD 0.69 lower (0.89 to 0.5 lower)	MODERATE	IMPORTANT
Discontinuation (follow-up mean 5 weeks; assessed with: Number of participants lost to follow-up)												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[2]	none	41/209 (19.6%)	37/212 (17.5%)	RR 1.12 (0.75 to 1.68)	21 more per 1000 (from 44 fewer to 119 more)	LOW	CRITICAL

CI=confidence interval; PCL=PTSD Checklist; PTSD=post-traumatic stress disorder; RR=risk ratio; SMD=standardised mean difference; TAU=treatment as usual; WHODAS=WHO disability assessment schedule

[1] Risk of bias is high or unclear across multiple domains

[2] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm

Behavioural sleep intervention versus pill placebo or attention-placebo for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Behavioural sleep intervention	Pill placebo or attention-placebo	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology self-rated at endpoint (follow-up 4-8 weeks; measured with: PCL change score; Better indicated by lower values)												
2	randomised trials	serious[1]	very serious[2]	no serious indirectness	very serious[3]	none	32	29	-	SMD 0.23 lower (1.57 lower to 1.1 higher)	VERY LOW	CRITICAL
PTSD symptomatology self-rated at 4-month follow-up (follow-up mean 4 months; measured with: PCL change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	12	11	-	SMD 0.68 lower (1.53 lower to 0.16 higher)	LOW	CRITICAL
Anxiety symptoms at endpoint (follow-up 4-8 weeks; measured with: BAI change score; Better indicated by lower values)												
2	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[5]	none	32	28	-	SMD 0.41 higher (0.1 lower to 0.92 higher)	LOW	IMPORTANT
Anxiety symptoms at 4-month follow-up (follow-up mean 4 months; measured with: BAI change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	12	11	-	SMD 0.07 lower (0.88 lower to	VERY LOW	IMPORTANT

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Behavioural sleep intervention	Pill placebo or attention-placebo	Relative (95% CI)	Absolute	Quality	Importance
										0.75 higher)		
Depression symptoms at endpoint (follow-up 4-8 weeks; measured with: BDI change score; Better indicated by lower values)												
2	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	32	29	-	SMD 0.38 lower (0.89 lower to 0.13 higher)	LOW	IMPORTANT
Depression symptoms at 4-month follow-up (follow-up mean 4 months; measured with: BDI change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	12	11	-	SMD 0.37 lower (1.2 lower to 0.46 higher)	LOW	IMPORTANT
Functional impairment at endpoint (follow-up mean 8 weeks; measured with: SDS change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	12	13	-	SMD 0.12 lower (0.91 lower to 0.66 higher)	VERY LOW	IMPORTANT
Functional impairment at 4-month follow-up (follow-up mean 4 months; measured with: SDS change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	12	11	-	SMD 0.3 higher (0.52 lower to 1.13 higher)	VERY LOW	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Behavioural sleep intervention	Pill placebo or attention-placebo	Relative (95% CI)	Absolute		
Sleeping difficulties at endpoint (follow-up 4-8 weeks; measured with: PSQI change score; Better indicated by lower values)												
2	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[6]	none	33	29	-	SMD 1.12 lower (1.67 to 0.58 lower)	LOW	IMPORTANT
Sleeping difficulties at 4-month follow-up (follow-up mean 4 months; measured with: PSQI change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	12	11	-	SMD 0.66 lower (1.51 lower to 0.18 higher)	LOW	IMPORTANT
Discontinuation (follow-up 4-8 weeks; assessed with: Number of participants lost to follow-up)												
2	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[3]	none	10/39 (25.6%)	8/36 (22.2%)	RR 1.15 (0.51 to 2.62)	33 more per 1000 (from 109 fewer to 360 more)	LOW	CRITICAL

BAI=Beck Anxiety Inventory; BDI=Beck Depression Inventory; CI=confidence interval; PCL=PTSD Checklist; PSQI=Pittsburgh Sleep Quality Index; PTSD=post-traumatic stress disorder; RR=risk ratio; SDS=Sheehan Disability Scale; SMD=standardised mean difference

[1] Risk of bias is high or unclear across multiple domains

[2] Considerable heterogeneity (I2>80%)

[3] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm

[4] 95% CI crosses both line of no effect and threshold for clinically important benefit

[5] 95% CI crosses both line of no effect and threshold for clinically important harm

[6] OIS not met (N<400)

Behavioural sleep intervention versus prazosin for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Behavioural sleep intervention	Prazosin	Relative (95% CI)	Absolute		
PTSD symptomatology self-rated at endpoint (follow-up mean 8 weeks; measured with: PCL change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	12	15	-	SMD 0.11 higher (0.65 lower to 0.87 higher)	VERY LOW	CRITICAL
PTSD symptomatology self-rated at 4-month follow-up (follow-up mean 4 months; measured with: PCL change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	12	12	-	SMD 0.52 higher (0.29 lower to 1.34 higher)	LOW	CRITICAL
Anxiety symptoms at endpoint (follow-up mean 8 weeks; measured with: BAI change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	12	15	-	SMD 0.65 higher (0.14 lower to 1.43 higher)	LOW	IMPORTANT
Anxiety symptoms at 4-month follow-up (follow-up mean 4 months; measured with: BAI change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	12	12	-	SMD 0.75 higher (0.09 lower to	LOW	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Behavioural sleep intervention	Prazosin	Relative (95% CI)	Absolute		
										1.58 higher)		
Depression symptoms at endpoint (follow-up mean 8 weeks; measured with: BDI change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	12	15	-	SMD 0.24 higher (0.52 lower to 1 higher)	VERY LOW	IMPORTANT
Depression symptoms at 4-month follow-up (follow-up mean 4 months; measured with: BDI change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	12	12	-	SMD 0.8 higher (0.04 lower to 1.63 higher)	LOW	IMPORTANT
Functional impairment at endpoint (follow-up mean 8 weeks; measured with: SDS change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	12	15	-	SMD 0.14 higher (0.62 lower to 0.9 higher)	VERY LOW	IMPORTANT
Functional impairment at 4-month follow-up (follow-up mean 4 months; measured with: SDS change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	12	11	-	SMD 0.9 higher (0.04 to 1.77 higher)	LOW	IMPORTANT
Sleeping difficulties at endpoint (follow-up mean 8 weeks; measured with: PSQI change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Behavioural sleep intervention	Prazosin	Relative (95% CI)	Absolute		
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[5]	none	13	14	-	SMD 0.35 lower (1.11 lower to 0.41 higher)	LOW	IMPORTANT
Sleeping difficulties at 4-month follow-up (follow-up mean 4 months; measured with: PSQI change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	12	12	-	SMD 0.36 higher (0.45 lower to 1.17 higher)	LOW	IMPORTANT
Discontinuation (follow-up mean 8 weeks; assessed with: Number of participants lost to follow-up)												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[2]	none	7/19 (36.8%)	5/18 (27.8%)	RR 1.33 (0.51 to 3.43)	92 more per 1000 (from 136 fewer to 675 more)	LOW	CRITICAL

BAI=Beck Anxiety Inventory; BDI=Beck Depression Inventory; CI=confidence interval; PCL=PTSD checklist; PSQI=Pittsburgh Sleep Quality Assessment; PTSD=post-traumatic stress disorder; RR=risk ratio; SDS=Sheehan Disability Scale; SMD=standardised mean difference

[1] Risk of bias is high or unclear across multiple domains

[2] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm

[3] 95% CI crosses both line of no effect and threshold for clinically important harm

[4] OIS not met (N<400)

[5] 95% CI crosses both line of no effect and threshold for clinically important benefit

Psychological: Psychologically-focused debriefing

Single/two session debriefing (+/- psychoeducation) versus no treatment for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Single/two session debriefing (+/- psychoeducation)	No treatment	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology self-rated at 1-4 month follow-up (follow-up 1-4 months; measured with: IES endpoint/change score; Better indicated by lower values)												
5	randomised trials	serious [1]	no serious inconsistency	no serious indirectness	serious[2]	none	187	205	-	SMD 0.13 higher (0.11 lower to 0.37 higher)	LOW	CRITICAL
PTSD symptomatology self-rated at 6-month follow-up (follow-up mean 6 months; measured with: IES endpoint score/PSS-SR change score; Better indicated by lower values)												
2	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	serious[2]	none	78	84	-	SMD 0.02 higher (0.29 lower to 0.32 higher)	VERY LOW	CRITICAL
PTSD symptomatology self-rated at 1-year follow-up (follow-up mean 1 years; measured with: IES change score; Better indicated by lower values)												
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	serious[2]	none	57	46	-	SMD 0.65 higher (0.25 to 1.05 higher)	VERY LOW	CRITICAL
PTSD symptomatology clinician-rated at endpoint (follow-up mean 0.1 weeks; measured with: SI–PTSD change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Single/two session debriefing (+/- psychoeducation)	No treatment	Relative (95% CI)	Absolute	Quality	Importance
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	serious[2]	none	126	63	-	SMD 0.11 lower (0.42 lower to 0.19 higher)	VERY LOW	CRITICAL
PTSD symptomatology clinician-rated at 1-3 month follow-up (follow-up 1-3 months; measured with: SI–PTSD/CAPS change score; Better indicated by lower values)												
2	randomised trials	very serious [1]	very serious[3]	no serious indirectness	very serious[4]	none	131	86	-	SMD 0.44 lower (1.52 lower to 0.64 higher)	VERY LOW	CRITICAL
PTSD symptomatology clinician-rated at 6-month follow-up (follow-up mean 6 months; measured with: SI–PTSD change score; Better indicated by lower values)												
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	serious[5]	none	110	59	-	SMD 0.25 lower (0.57 lower to 0.06 higher)	VERY LOW	CRITICAL
Diagnosis of PTSD at 1-month follow-up (follow-up mean 1 months; assessed with: Number of participants who met diagnostic criteria)												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[4]	none	3/33 (9.1%)	1/42 (2.4%)	RR 3.82 (0.42 to 35.04)	67 more per 1000 (from 14 fewer to	LOW	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Single/two session debriefing (+/- psychoeducation)	No treatment	Relative (95% CI)	Absolute		
										810 more)		
Diagnosis of PTSD at 3-6 month follow-up (follow-up 3-6 months; assessed with: Number of participants who met diagnostic criteria)												
3	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	serious[6]	none	52/164 (31.7%)	35/149 (23.5%)	RR 1.21 (0.85 to 1.73)	49 more per 1000 (from 35 fewer to 171 more)	VERY LOW	CRITICAL
Diagnosis of PTSD at 1-year follow-up (follow-up mean 1 years; assessed with: Number of participants who met diagnostic criteria)												
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	serious[7]	none	36/77 (46.8%)	14/56 (25%)	RR 1.87 (1.12 to 3.12)	218 more per 1000 (from 30 more to 530 more)	VERY LOW	CRITICAL
Anxiety symptoms at endpoint (follow-up mean 0.1 weeks; measured with: HAM-A change score; Better indicated by lower values)												
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	serious[2]	none	125	65	-	SMD 0.1 higher (0.2 lower to 0.4 higher)	VERY LOW	IMPORTANT
Anxiety symptoms at 1-3 month follow-up (follow-up 1-3 months; measured with: HADS-A endpoint/change score; HAM-A change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Single/two session debriefing (+/- psychoeducation)	No treatment	Relative (95% CI)	Absolute		
3	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	serious[2]	none	218	158	-	SMD 0.08 higher (0.13 lower to 0.29 higher)	VERY LOW	IMPORTANT
Anxiety symptoms at 6-month follow-up (follow-up mean 6 months; measured with: HADS-A endpoint/HAM-A change score; Better indicated by lower values)												
2	randomised trials	serious [1]	no serious inconsistency	no serious indirectness	serious[2]	none	146	99	-	SMD 0.03 lower (0.29 lower to 0.22 higher)	LOW	IMPORTANT
Anxiety symptoms at 1-year follow-up (follow-up mean 1 years; measured with: HADS-A change score; Better indicated by lower values)												
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	serious[2]	none	57	46	-	SMD 0.56 higher (0.16 to 0.96 higher)	VERY LOW	IMPORTANT
Depression symptoms at endpoint (follow-up mean 0.1 weeks; measured with: HAM-D change score; Better indicated by lower values)												
1	randomised trials	serious [1]	no serious inconsistency	no serious indirectness	serious[2]	none	124	64	-	SMD 0.09 higher (0.21 lower to 0.39 higher)	LOW	IMPORTANT
Depression symptoms at 1-3 month follow-up (follow-up 1-3 months; measured with: HADS-D endpoint/change score; HAM-D change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Single/two session debriefing (+/- psychoeducation)**	**No treatment**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
3	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	serious[2]	none	218	158	-	SMD 0.04 lower (0.25 lower to 0.17 higher)	VERY LOW	IMPORTANT
Depression symptoms at 6-month follow-up (follow-up mean 6 months; measured with: HADS-D/BDI endpoint score/HAM-D change score; Better indicated by lower values)												
3	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	serious[2]	none	193	144	-	SMD 0.06 lower (0.28 lower to 0.16 higher)	VERY LOW	IMPORTANT
Depression symptoms at 1-year follow-up (follow-up mean 1 years; measured with: HADS-D change score; Better indicated by lower values)												
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	serious[2]	none	57	46	-	SMD 0.39 higher (0 to 0.79 higher)	VERY LOW	IMPORTANT
Discontinuation (follow-up 0.1-1 weeks; assessed with: Number of participants lost to follow-up)												
7	randomised trials	serious [1]	no serious inconsistency	no serious indirectness	serious[7]	none	102/440 (23.2%)	57/355 (16.1%)	RR 1.45 (1.01 to 2.1)	72 more per 1000 (from 2 more to 177 more)	LOW	CRITICAL

CI=confidence interval; CAPS=Clinician administered PTSD scale; HADS-A/D=Hospital Anxiety and Depression-Anxiety/Depression; HAM-A =Hamilton Anxiety Rating Scale; HAM-D=Hamilton Depression Scale; IES=Impact of Event Scale; PSS-SR=PTSD symptom scale-self-report; PTSD=post-traumatic stress disorder; RR=risk ratio; SI-PTSD=Structured Interview-PTSD; SMD=standardised mean difference
[1] Risk of bias is high or unclear across multiple domains
[2] OIS not met (N<400)
[3] Considerable heterogeneity (I2>80%)
[4] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm
[5] 95% CI crosses both line of no effect and threshold for clinically important benefit
[6] 95% CI crosses both line of no effect and threshold for clinically important harm
[7] OIS not met (events<300)

Group debriefing versus no treatment for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Group debriefing	No treatment	Relative (95% CI)	Absolute		
PTSD symptomatology self-rated (follow-up mean 0.1 weeks; measured with: IES-R change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	20	19	-	SMD 0.28 lower (0.91 lower to 0.35 higher)	LOW	CRITICAL
Discontinuation (follow-up mean 0.1 weeks; assessed with: Number of participants lost to follow-up)												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[3]	none	16/36 (44.4%)	19/38 (50%)	RR 0.89 (0.55 to 1.44)	55 fewer per 1000 (from 225 fewer to 220 more)	LOW	CRITICAL

CI=confidence interval; IES-R=Impact of Event Scale-Revised; PTSD=post-traumatic stress disorder; RR=risk ratio; SMD=standardised mean difference
[1] Risk of bias is high or unclear across multiple domains
[2] 95% CI crosses both line of no effect and threshold for clinically important benefit
[3] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm

Group debriefing versus attention-placebo or psychoeducational session for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Group debriefing	Attention-placebo or psychoeducational session	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology self-rated (follow-up 0.1-5 weeks; measured with: IES-R endpoint/change score; Better indicated by lower values)												
2	randomised trials	very serious[1]	very serious[2]	no serious indirectness	very serious[3]	none	46	54	-	SMD 0.08 higher (0.95 lower to 1.12 higher)	VERY LOW	CRITICAL
Discontinuation (follow-up 0.1-5 weeks; assessed with: Number of participants lost to follow-up)												
2	randomised trials	no serious risk of bias	serious[4]	no serious indirectness	very serious[3]	none	20/62 (32.3%)	20/75 (26.7%)	RR 2.06 (0.26 to 16.58)	283 more per 1000 (from 197 fewer to 1000 more)	VERY LOW	CRITICAL

CI=confidence interval; IES-R=Impact of event scale-revised; PTSD=post-traumatic stress disorder; RR=risk ratio; SMD=standardised mean difference

[1] Risk of bias is high or unclear across multiple domains

[2] Considerable heterogeneity (I2>80%)

[3] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm

[4] Substantial heterogeneity (I2>50%)

Single session debriefing + psycho-education versus single psycho-education session for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Single session debriefing + psychoeducation	Single psychoeducation session	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology self-rated at 6-month follow-up (follow-up mean 6 months; measured with: PSS-SR change score; Better indicated by lower values)												
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	serious [2]	none	47	45	-	SMD 0.23 higher (0.18 lower to 0.64 higher)	VERY LOW	CRITICAL
Diagnosis of PTSD at 6-month follow-up (follow-up mean 6 months; assessed with: Number of people who met diagnostic criteria)												
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	very serious [3]	none	18/54 (33.3%)	12/52 (23.1%)	RR 1.44 (0.77 to 2.69)	102 more per 1000 (from 53 fewer to 390 more)	VERY LOW	CRITICAL
Depression symptoms at 6-month follow-up (follow-up mean 6 months; measured with: BDI endpoint score; Better indicated by lower values)												
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	serious [2]	none	47	45	-	SMD 0.2 higher (0.21 lower to 0.61 higher)	VERY LOW	IMPORTANT
Discontinuation (follow-up mean 6 months; assessed with: Number of participants lost to follow-up)												
1	randomised trials	serious [1]	no serious inconsistency	no serious indirectness	very serious [3]	none	7/54 (13%)	7/52 (13.5%)	RR 0.96 (0.36	5 fewer per 1000	VER	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Single session debriefing + psychoeducation	Single psychoeducation session	Relative (95% CI)	Absolute		
									to 2.56)	(from 86 fewer to 210 more)	Y LOW	

BDI=Beck Depression Inventory; CI=confidence interval; PSS-SR=PTSD symptom scale-self-report; PTSD=post-traumatic stress disorder; RR=risk ratio; SMD=standardised mean difference
[1] Risk of bias is high or unclear across multiple domains
[2] 95% CI crosses both line of no effect and threshold for clinically important harm
[3] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm

Psychological: Eye movement desensitisation and reprocessing

Eye movement desensitisation and reprocessing (EMDR) versus TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Eye movement desensitisation and reprocessing (EMDR)	TAU	Relative (95% CI)	Absolute		
PTSD at 3-month follow-up (follow-up mean 13 months; assessed with: Number of participants who met DSM-IV criteria for PTSD)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	1/34 (2.9%)	7/37 (18.9%)	RR 0.16 (0.02 to 1.2)	159 fewer per 1000 (from 185 fewer to 38 more)	LOW	CRITICAL
Discontinuation (follow-up mean 13 weeks; assessed with: Number of participants lost to follow-up)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	8/42 (19%)	4/41 (9.8%)	RR 1.95 (0.64 to 5.99)	93 more per 1000 (from 35	VERY LOW	CRITICAL

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Eye movement desensitisation and reprocessing (EMDR)	TAU	Relative (95% CI)	Absolute	Quality	Importance
										fewer to 487 more)		

DSM-IV= Diagnostic and Statistical Manual of Mental Disorders, 4th Edition; CI=confidence interval; PTSD=post-traumatic stress disorder; RR=risk ratio
[1] *Risk of bias was high across multiple outcomes*
[2] *95% CI crosses both line of no effect and threshold for clinically important benefit*
[3] *95% CI crosses line of no effect and thresholds for both clinically important benefit and harm*

Eye movement desensitisation and reprocessing (EMDR) versus supportive counselling for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Eye movement desensitisation and reprocessing (EMDR)	Supportive counselling	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology self-rated (follow-up mean 0.1 weeks; measured with: IES change score; Better indicated by lower values)												
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	serious[2]	none	15	15	-	SMD 0.22 lower (0.94 lower to 0.49 higher)	VERY LOW	CRITICAL
Depression symptoms (follow-up mean 0.1 weeks; measured with: BDI change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Eye movement desensitisation and reprocessing (EMDR)	Supportive counselling	Relative (95% CI)	Absolute		
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	serious[3]	none	15	15	-	SMD 0.37 higher (0.35 lower to 1.1 higher)	VERY LOW	IMPORTANT

BDI=Beck Depression Inventory; CI=confidence interval; IES=Impact of event scale; PTSD=post-traumatic stress disorder; RR=risk ratio; SMD=standardised mean difference
[1] Risk of bias is high or unclear across multiple domains
[2] 95% CI crosses both line of no effect and threshold for clinically important benefit
[3] 95% CI crosses both line of no effect and threshold for clinically important harm

Eye movement desensitisation and reprocessing (EMDR) versus eye fixation desensitisation (EFD) for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Eye movement desensitisation and reprocessing (EMDR)	Eye fixation desensitisation (EFD)	Relative (95% CI)	Absolute		
PTSD symptomatology self-rated (follow-up mean 0.1 weeks; measured with: IES change score; Better indicated by lower values)												
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	serious[2]	none	15	15	-	SMD 0.5 higher	VER	CRITICAL

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Eye movement desensitisation and reprocessing (EMDR)	Eye fixation desensitisation (EFD)	Relative (95% CI)	Absolute	Quality	Importance
										(0.23 lower to 1.23 higher)	Y LOW	
Depression symptoms (follow-up mean 0.1 weeks; measured with: BDI change score; Better indicated by lower values)												
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	very serious[3]	none	15	15	-	SMD 0.06 lower (0.78 lower to 0.65 higher)	VERY LOW	IMPORTANT

BDI=Beck Depression Inventory; CI=confidence interval; IES=Impact of event scale; PTSD=post-traumatic stress disorder; RR=risk ratio; SMD=standardised mean difference
[1] Risk of bias is high or unclear across multiple domains
[2] 95% CI crosses both line of no effect and threshold for clinically important harm
[3] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm

Eye fixation desensitisation (EFD) versus supportive counselling for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Eye fixation desensitisation (EFD)	Supportive counselling	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology self-rated (follow-up mean 0.1 weeks; measured with: IES change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Eye fixation desensitisation (EFD)	Supportive counselling	Relative (95% CI)	Absolute		
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	serious[2]	none	15	15	-	SMD 0.81 lower (1.56 to 0.06 lower)	VERY LOW	CRITICAL
Depression symptoms (follow-up mean 0.1 weeks; measured with: BDI change score; Better indicated by lower values)												
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	serious[3]	none	15	15	-	SMD 0.49 higher (0.24 lower to 1.21 higher)	VERY LOW	IMPORTANT

BDI=Beck Depression Inventory; CI=confidence interval; IES=Impact of event scale; PTSD=post-traumatic stress disorder; RR=risk ratio; SMD=standardised mean difference
[1] Risk of bias is high or unclear across multiple domains
[2] OIS not met (N<400)
[3] 95% CI crosses both line of no effect and threshold for clinically important harm

Psychological: Hypnotherapy

Hypnotherapy + trauma-focused CBT versus trauma-focused CBT for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Hypnotherapy + trauma-focused CBT	Trauma-focused CBT	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology clinician-rated at 3-year follow-up (follow-up mean 3 years; measured with: CAPS endpoint score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	18	19	-	SMD 0.03 higher (0.62 lower to 0.67 higher)	VERY LOW	CRITICAL
PTSD at 1-month follow-up (follow-up mean 1 months; assessed with: Number of people who met criteria for PTSD)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	9/30 (30%)	12/33 (36.4%)	RR 0.82 (0.41 to 1.68)	65 fewer per 1000 (from 215 fewer to 247 more)	VERY LOW	CRITICAL
PTSD at 6-month follow-up (follow-up mean 6 months; assessed with: Number of people who met criteria for PTSD)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	12/30 (40%)	14/33 (42.4%)	RR 0.94 (0.52 to 1.7)	25 fewer per 1000 (from 204 fewer to 297 more)	VERY LOW	CRITICAL
PTSD at 3-year follow-up (follow-up mean 3 years; assessed with: Number of people who met criteria for PTSD)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Hypnotherapy + trauma-focused CBT	Trauma-focused CBT	Relative (95% CI)	Absolute		
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	14/30 (46.7%)	13/33 (39.4%)	RR 1.18 (0.67 to 2.1)	71 more per 1000 (from 130 fewer to 433 more)	VERY LOW	CRITICAL
Anxiety symptoms a 1-month follow-up (follow-up mean 1 months; measured with: BAI change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	30	33	-	SMD 0.26 lower (0.76 lower to 0.24 higher)	VERY LOW	IMPORTANT
Anxiety symptoms at 6-month follow-up (follow-up mean 6 months; measured with: BAI change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	30	33	-	SMD 0.17 lower (0.66 lower to 0.33 higher)	VERY LOW	IMPORTANT
Depression symptoms at 1-month follow-up (follow-up mean 1 months; measured with: BDI-II change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	30	33	-	SMD 0.04 lower (0.54 lower to 0.45 higher)	VERY LOW	IMPORTANT
Depression symptoms at 6-month follow-up (follow-up mean 6 months; measured with: BDI-II change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Hypnotherapy + trauma-focused CBT	Trauma-focused CBT	Relative (95% CI)	Absolute		
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	30	33	-	SMD 0.07 higher (0.42 lower to 0.57 higher)	VERY LOW	IMPORTANT
Depression symptoms at 3-year follow-up (follow-up mean 3 years; measured with: BDI-II change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	18	19	-	SMD 0.43 lower (1.08 lower to 0.23 higher)	VERY LOW	IMPORTANT
Discontinuation (follow-up mean 0.1 weeks; assessed with: Number of participants lost to follow-up)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	7/30 (23.3%)	9/33 (27.3%)	RR 0.86 (0.36 to 2.01)	38 fewer per 1000 (from 175 fewer to 275 more)	VERY LOW	CRITICAL

BAI=Beck Anxiety Inventory; BDI=Beck Depression Inventory; CI=confidence interval; CAPS=clinician-administered PTSD scale; PTSD=post-traumatic stress disorder; RR=risk ratio; SMD=standardised mean difference

[1] Risk of bias is high or unclear across multiple domains

[2] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm

[3] 95% CI crosses both line of no effect and threshold for clinically important benefit

[4] 95% CI crosses both line of no effect and threshold for clinically important harm

Hypnotherapy + trauma-focused CBT versus supportive counselling for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Hypnotherapy + trauma-focused CBT	Supportive counselling	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology clinician-rated at 3-year follow-up (follow-up mean 3 years; measured with: CAPS endpoint score; Better indicated by lower values)												
1	randomised trials	serious [1]	no serious inconsistency	no serious indirectness	serious[2]	none	18	16	-	SMD 0.68 lower (1.37 lower to 0.02 higher)	LOW	CRITICAL
PTSD at 1-month follow-up (follow-up mean 1 months; assessed with: Number of people who met criteria for PTSD)												
1	randomised trials	serious [1]	no serious inconsistency	no serious indirectness	serious[2]	none	9/30 (30%)	12/24 (50%)	RR 0.6 (0.3 to 1.18)	200 fewer per 1000 (from 350 fewer to 90 more)	LOW	CRITICAL
PTSD at 6-month follow-up (follow-up mean 6 months; assessed with: Number of people who met criteria for PTSD)												
1	randomised trials	serious [1]	no serious inconsistency	no serious indirectness	serious[2]	none	12/30 (40%)	14/24 (58.3%)	RR 0.69 (0.39 to 1.19)	181 fewer per 1000 (from 356 fewer to 111 more)	LOW	CRITICAL
PTSD at 3-year follow-up (follow-up mean 3 years; assessed with: Number of people who met criteria for PTSD)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Hypnotherapy + trauma-focused CBT	Supportive counselling	Relative (95% CI)	Absolute		
1	randomised trials	serious [1]	no serious inconsistency	no serious indirectness	serious[2]	none	14/30 (46.7%)	16/24 (66.7%)	RR 0.7 (0.43 to 1.13)	200 fewer per 1000 (from 380 fewer to 87 more)	LOW	CRITICAL
Anxiety symptoms at 1-month follow-up (follow-up mean 1 months; measured with: BAI change score; Better indicated by lower values)												
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	serious[2]	none	30	24	-	SMD 0.36 lower (0.9 lower to 0.18 higher)	VERY LOW	IMPORTANT
Anxiety symptoms at 6-month follow-up (follow-up mean 6 months; measured with: BAI change score; Better indicated by lower values)												
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	serious[2]	none	30	24	-	SMD 0.28 lower (0.82 lower to 0.26 higher)	VERY LOW	IMPORTANT
Depression symptoms at 1-month follow-up (follow-up mean 1 months; measured with: BDI-II change score; Better indicated by lower values)												
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	very serious[3]	none	30	24	-	SMD 0.01 higher (0.53 lower to 0.54 higher)	VERY LOW	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Hypnotherapy + trauma-focused CBT	Supportive counselling	Relative (95% CI)	Absolute		
Depression symptoms at 6-month follow-up (follow-up mean 6 months; measured with: BDI-II change score; Better indicated by lower values)												
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	serious[4]	none	30	24	-	SMD 0.13 higher (0.41 lower to 0.66 higher)	VERY LOW	IMPORTANT
Depression symptoms at 3-year follow-up (follow-up mean 3 years; measured with: BDI-II change score; Better indicated by lower values)												
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	serious[5]	none	18	16	-	SMD 1.14 lower (1.87 to 0.41 lower)	VERY LOW	IMPORTANT
Discontinuation (follow-up mean 0.1 weeks; assessed with: Number of participants lost to follow-up)												
1	randomised trials	serious [1]	no serious inconsistency	no serious indirectness	very serious[3]	none	7/30 (23.3%)	2/24 (8.3%)	RR 2.8 (0.64 to 12.26)	150 more per 1000 (from 30 fewer to 938 more)	VERY LOW	CRITICAL

BAI=Beck Anxiety Inventory; BDI=Beck Depression Inventory; CAPS=Clinician administered PTSD scale; CBT=cognitive behavioural therapy; CI=confidence interval; PTSD=post-traumatic stress disorder; RR=risk ratio; SMD=standardised mean difference

[1] Risk of bias is high or unclear across multiple domains

[2] 95% CI crosses both line of no effect and threshold for clinically important benefit

[3] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm

[4] 95% CI crosses both line of no effect and threshold for clinically important harm

[5] OIS not met (N<400)

Psychological: Interpersonal psychotherapy

Interpersonal psychotherapy (IPT) versus TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Interpersonal psychotherapy (IPT)	TAU	Relative (95% CI)	Absolute		
PTSD symptomatology self-rated at endpoint (follow-up mean 13 weeks; measured with: PCL change score; Better indicated by lower values)												
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	serious[2]	none	27	31	-	SMD 0.24 lower (0.76 lower to 0.27 higher)	VERY LOW	CRITICAL
PTSD symptomatology self-rated at 3-month follow-up (follow-up mean 3 months; measured with: PCL change score; Better indicated by lower values)												
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	serious[2]	none	27	31	-	SMD 0.04 lower (0.55 lower to 0.48 higher)	VERY LOW	CRITICAL
PTSD diagnosis at 3-month follow-up (follow-up mean 3 months; assessed with: Number of people who met diagnostic criteria)												
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	serious[3]	none	28/51 (54.9%)	11/39 (28.2 %)	RR 1.95 (1.11 to 3.4)	268 more per 1000 (from 31 more to 677 more)	VERY LOW	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Interpersonal psychotherapy (IPT)	TAU	Relative (95% CI)	Absolute		
Anxiety symptoms at endpoint (follow-up mean 13 weeks; measured with: HADS-A change score; Better indicated by lower values)												
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	serious[4]	none	27	31	-	SMD 0.57 higher (0.04 to 1.09 higher)	VERY LOW	IMPORTANT
Anxiety symptoms at 3-month follow-up (follow-up mean 3 months; measured with: HADS-A change score; Better indicated by lower values)												
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	serious[5]	none	27	31	-	SMD 0.36 higher (0.16 lower to 0.88 higher)	VERY LOW	IMPORTANT
Depression symptoms at endpoint (follow-up mean 13 weeks; measured with: BDI change score; Better indicated by lower values)												
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	serious[5]	none	27	31	-	SMD 0.5 higher (0.02 lower to 1.02 higher)	VERY LOW	IMPORTANT
Depression symptoms at 3-month follow-up (follow-up mean 3 months; measured with: BDI change score; Better indicated by lower values)												
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	serious[5]	none	27	31	-	SMD 0.05 higher (0.46 lower to 0.57 higher)	VERY LOW	IMPORTANT
Alcohol use disorder symptoms at endpoint (follow-up mean 13 weeks; measured with: AUDIT change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Interpersonal psychotherapy (IPT)	TAU	Relative (95% CI)	Absolute		
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	serious[5]	none	27	31	-	SMD 0.03 higher (0.48 lower to 0.55 higher)	VERY LOW	IMPORTANT
Alcohol use disorder symptoms at 3-month follow-up (follow-up mean 3 months; measured with: AUDIT change score; Better indicated by lower values)												
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	serious[5]	none	27	31	-	SMD 0.43 higher (0.1 lower to 0.95 higher)	VERY LOW	IMPORTANT
Discontinuation (follow-up mean 13 weeks; assessed with: Number of participants lost to follow-up)												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious[3]	none	24/51 (47.1%)	8/39 (20.5 %)	RR 2.29 (1.16 to 4.54)	265 more per 1000 (from 33 more to 726 more)	MODERATE	CRITICAL

AUDIT=Alcohol use disorder identification test; BDI=Beck Depression Inventory; CI=confidence interval; HADS-A=Hospital Anxiety and Depression Scale-Anxiety; PCL=PTSD Checklist; PTSD=post-traumatic stress disorder; RR=risk ratio; SMD=standardised mean difference; TAU=treatment as usual

[1] Risk of bias is high or unclear across multiple domains

[2] 95% CI crosses both line of no effect and threshold for clinically important benefit

[3] OIS not met (events<300)

[4] OIS not met (N<400)

[5] 95% CI crosses both line of no effect and threshold for clinically important harm

Psychological: Counselling

Supportive counselling versus attention-placebo for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Supportive counselling	Attention-placebo	Relative (95% CI)	Absolute		
PTSD symptomatology self-rated at endpoint (follow-up mean 1 weeks; measured with: PSS-SR change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	23	20	-	SMD 0.93 higher (0.29 to 1.56 higher)	VERY LOW	CRITICAL
PTSD symptomatology self-rated at 3-month follow-up (follow-up mean 3 months; measured with: PSS-SR change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	19	19	-	SMD 0.36 higher (0.28 lower to 1.01 higher)	VERY LOW	CRITICAL
PTSD symptomatology self-rated at 1-year follow-up (follow-up mean 1 years; measured with: PSS-SR change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	24	20	-	SMD 0.24 higher (0.35 lower to 0.84 higher)	VERY LOW	CRITICAL
PTSD symptomatology clinician-rated at endpoint (follow-up mean 1 weeks; measured with: PSS-I change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	23	20	-	SMD 0.32 higher (0.28 lower to	LOW	CRITICAL

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Supportive counselling	Attention-placebo	Relative (95% CI)	Absolute	Quality	Importance
										0.93 higher)		
PTSD symptomatology clinician-rated at 3-month follow-up (follow-up mean 3 months; measured with: PSS-I change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	21	19	-	SMD 0.2 higher (0.42 lower to 0.83 higher)	LOW	CRITICAL
PTSD symptomatology clinician-rated at 1-year follow-up (follow-up mean 1 years; measured with: PSS-I change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	24	20	-	SMD 0.3 lower (0.89 lower to 0.3 higher)	LOW	CRITICAL
Anxiety symptoms at endpoint (follow-up mean 1 weeks; measured with: BAI change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	23	20	-	SMD 0.57 higher (0.04 lower to 1.19 higher)	VERY LOW	IMPORTANT
Anxiety symptoms at 3-month follow-up (follow-up mean 3 months; measured with: BAI change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	19	19	-	SMD 0.6 higher (0.05 lower to 1.25 higher)	VERY LOW	IMPORTANT
Anxiety symptoms at 1-year follow-up (follow-up mean 1 years; measured with: BAI change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Supportive counselling	Attention-placebo	Relative (95% CI)	Absolute		
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	23	20	-	SMD 0.35 higher (0.26 lower to 0.95 higher)	VERY LOW	IMPORTANT
Depression symptoms at endpoint (follow-up mean 1 weeks; measured with: BDI change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	23	20	-	SMD 0.79 higher (0.16 to 1.41 higher)	VERY LOW	IMPORTANT
Depression symptoms at 3-month follow-up (follow-up mean 3 months; measured with: BDI change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	19	19	-	SMD 0.38 higher (0.26 lower to 1.03 higher)	VERY LOW	IMPORTANT
Depression symptoms at 1-year follow-up (follow-up mean 1 years; measured with: BDI change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	24	20	-	SMD 0.65 higher (0.04 to 1.26 higher)	VERY LOW	IMPORTANT
Discontinuation (follow-up mean 1 weeks; assessed with: Number of participants lost to follow-up)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[4]	none	5/29 (17.2%)	10/30 (33.3%)	RR 0.52	160 fewer per 1000	VERY LOW	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Supportive counselling	Attention-placebo	Relative (95% CI)	Absolute		
									(0.2 to 1.33)	(from 267 fewer to 110 more)		

BAI=Beck Anxiety Inventory; BDI=Beck Depression Inventory; CI=confidence interval; PSS-I/SR=PTSD symptom scale-interview/self-report; RR=risk ratio; SMD=standardised mean difference
[1] Risk of bias is high or unclear across multiple domains
[2] OIS not met (N<400)
[3] 95% CI crosses both line of no effect and threshold for clinically important harm
[4] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm

Counselling versus no treatment for the early treatment (1-3 months) of below threshold PTSD symptoms in adults

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Counselling	No treatment	Relative (95% CI)	Absolute		
PTSD symptomatology self-rated (follow-up mean 22 weeks; measured with: IES change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	68	83	-	SMD 0.25 lower (0.57 lower to 0.07 higher)	VERY LOW	CRITICAL
Discontinuation (follow-up mean 22 weeks; assessed with: Number of participants lost to follow-up)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Counselling	No treatment	Relative (95% CI)	Absolute		
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	11/68 (16.2%)	20/83 (24.1%)	RR 0.67 (0.35 to 1.3)	80 fewer per 1000 (from 157 fewer to 72 more)	VERY LOW	CRITICAL

CI=confidence interval; IES=Impact of event scale; PTSD=post-traumatic stress disorder; RR=risk ratio; SMD=standardised mean difference
[1] Risk of bias is high or unclear across multiple domains
[2] 95% CI crosses both line of no effect and threshold for clinically important benefit
[3] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm

Psychological: Combined somatic and cognitive therapy

Brief cognitive-behavioural conjoint therapy versus waitlist for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Brief cognitive-behavioural conjoint therapy	Waitlist	Relative (95% CI)	Absolute		
PTSD symptomatology self-rated at 2-month follow-up (follow-up mean 2 months; measured with: IES-R change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	37	37	-	SMD 0.56 lower (1.02 to 0.09 lower)	LOW	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Brief cognitive-behavioural conjoint therapy	Waitlist	Relative (95% CI)	Absolute		
PTSD symptomatology self-rated at 2-year follow-up (follow-up mean 2 years; measured with: IES-R change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	26	20	-	SMD 0.52 lower (1.11 lower to 0.08 higher)	LOW	CRITICAL
Discontinuation (follow-up mean 2 weeks; assessed with: Number of participants lost to follow-up)												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[4]	none	10/44 (22.7%)	7/39 (17.9%)	RR 1.27 (0.53 to 3.01)	48 more per 1000 (from 84 fewer to 361 more)	LOW	CRITICAL

CI=confidence interval; IES-R=Impact of event scale-revised; PTSD=post-traumatic stress disorder; RR=risk ratio; SMD=standardised mean difference
[1] Risk of bias is high or unclear across multiple domains
[2] OIS not met (N<400)
[3] 95% CI crosses both line of no effect and threshold for clinically important benefit
[4] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm

Psychological: Parent training/family intervention

Family therapy (+ TAU) versus TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Family therapy (+ TAU)	TAU	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology self-rated at 1-month follow-up (follow-up mean 1 months; measured with: IES-R endpoint score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	76	76	-	SMD 0.1 higher (0.22 lower to 0.41 higher)	LOW	CRITICAL
Anxiety symptoms at 1-month follow-up (follow-up mean 1 months; measured with: STAI State endpoint score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	76	76	-	SMD 0.01 higher (0.31 lower to 0.32 higher)	LOW	IMPORTANT
Discontinuation (follow-up mean 4 weeks; assessed with: Number of participants lost to follow-up)												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[3]	none	14/76 (18.4%)	14/76 (18.4%)	RR 1 (0.51 to 1.95)	0 fewer per 1000 (from 90 fewer to 175 more)	LOW	CRITICAL

CI=confidence interval; IES-R=Impact of event scale-revised; RR=risk ratio; SMD=standardised mean difference; STAI=State-Trait Anxiety Inventory; TAU=treatment as usual

[1] Risk of bias is high or unclear across multiple outcomes

[2] OIS not met (N<400)

[3] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm

Psychological: Self-help (without support)

Self-help (without support) versus waitlist for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Self-help (without support)	Waitlist	Relative (95% CI)	Absolute		
PTSD symptomatology self-rated at endpoint (follow-up 2-22 weeks; measured with: IES-R change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	29	27	-	SMD 0.06 lower (0.58 lower to 0.47 higher)	VERY LOW	CRITICAL
PTSD symptomatology self-rated at 5-month follow-up (follow-up mean 5 months; measured with: IES-R change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	29	27	-	SMD 0.13 lower (0.65 lower to 0.4 higher)	VERY LOW	CRITICAL
Discontinuation (follow-up 2-22 weeks; assessed with: Number of participants lost to follow-up)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	14/44 (31.8%)	10/41 (24.4%)	RR 1.3 (0.65 to 2.6)	73 more per 1000 (from 85 fewer to 390 more)	VERY LOW	CRITICAL

CI=confidence interval; IES-R=Impact of Event Scale-Revised; PTSD=post-traumatic stress disorder; RR=risk ratio; SMD=standardised mean difference
[1] Risk of bias is high or unclear across multiple domains
[2] 95% CI crosses both line of no effect and threshold for clinically important benefit
[3] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm

Self-help (without support; +/- TAU) versus TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Self-help (without support; +/- TAU)	TAU	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology self-rated at endpoint (follow-up 4-13 weeks; measured with: PDS/IES/IES-R change score; Better indicated by lower values)												
3	randomised trials	serious[1]	serious[5]	no serious indirectness	no serious imprecision	none	228	255	-	SMD 0.00 lower (0.32 lower to 0.32 higher)	LOW	CRITICAL
PTSD symptomatology self-rated at 6-8 week follow-up (follow-up 6-8 weeks; measured with: PCL/IES-R change score; Better indicated by lower values)												
2	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	201	199	-	SMD 0.12 higher (0.08 lower to 0.32 higher)	MODERATE	CRITICAL
PTSD symptomatology self-rated at 5-6 month follow-up (follow-up mean 5-6 months; measured with: PDS/IES/IES-R change score; Better indicated by lower values)												
3	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	219	243	-	SMD 0.08 higher (0.14 lower to 0.31 higher)	MODERATE	CRITICAL
PTSD symptomatology self-rated at 11-month follow-up (follow-up mean 11 months; measured with: IES-R change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	151	149	-	SMD 0.22 higher (0 to 0.45 higher)	LOW	CRITICAL
PTSD symptomatology clinician-rated at endpoint (follow-up mean 4 weeks; measured with: CAPS endpoint score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	151	149	-	SMD 0.76 lower (0.99 to	LOW	CRITICAL

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Self-help (without support; +/- TAU)	TAU	Relative (95% CI)	Absolute	Quality	Importance
										0.53 lower)		
PTSD symptomatology clinician-rated at 2-month follow-up (follow-up mean 2 months; measured with: CAPS endpoint score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	151	149	-	SMD 0.54 lower (0.77 to 0.31 lower)	LOW	CRITICAL
PTSD symptomatology clinician-rated at 5-month follow-up (follow-up mean 5 months; measured with: CAPS endpoint score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	151	149	-	SMD 0.28 lower (0.51 to 0.06 lower)	LOW	CRITICAL
PTSD symptomatology clinician-rated at 11-month follow-up (follow-up mean 11 months; measured with: CAPS endpoint score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	151	149	-	SMD 0 higher (0.23 lower to 0.23 higher)	LOW	CRITICAL
PTSD at 5-month follow-up (follow-up mean 5 months; assessed with: Number scoring above clinical cut-off on scale)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	31/69 (44.9%)	21/57 (36.8%)	RR 1.22 (0.79 to 1.87)	81 more per 1000 (from 77 fewer to 321 more)	VERY LOW	CRITICAL
Anxiety symptoms at endpoint (follow-up 4-13 weeks; measured with: HADS-A/DASS Anxiety change score; Better indicated by lower values)												
3	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	229	256	-	SMD 0.05 lower (0.31	MOD	IMPORTANT

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Self-help (without support; +/- TAU)	TAU	Relative (95% CI)	Absolute	Quality	Importance
										lower to 0.2 higher)	ERATE	
Anxiety symptoms at 2-month follow-up (follow-up mean 2 months; measured with: HADS-A change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	151	149	-	SMD 0.07 higher (0.16 lower to 0.29 higher)	LOW	IMPORTANT
Anxiety symptoms at 5-6 month follow-up (follow-up 5-6 months; measured with: HADS-A/DASS Anxiety change score; Better indicated by lower values)												
3	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	220	244	-	SMD 0.05 lower (0.24 lower to 0.13 higher)	MODERATE	IMPORTANT
Anxiety symptoms at 11-month follow-up (follow-up mean 11 months; measured with: HADS-A change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	151	149	-	SMD 0.31 higher (0.08 to 0.54 higher)	LOW	IMPORTANT
Depression symptoms at endpoint (follow-up 4-13 weeks; measured with: HADS-D/DASS Depression change score; Better indicated by lower values)												
3	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	229	256	-	SMD 0.19 lower (0.47 lower to 0.09 higher)	MODERATE	IMPORTANT
Depression symptoms at 2-month follow-up (follow-up mean 2 months; measured with: HADS-D change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	151	149	-	SMD 0.01 higher	LOW	IMPORTANT

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Self-help (without support; +/- TAU)	TAU	Relative (95% CI)	Absolute	Quality	Importance
										(0.21 lower to 0.24 higher)		
Depression symptoms at 5-6 month follow-up (follow-up 5-6 months; measured with: HADS-D/DASS Depression change score; Better indicated by lower values)												
3	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	220	244	-	SMD 0.09 lower (0.33 lower to 0.15 higher)	MODERATE	IMPORTANT
Depression symptoms at 11-month follow-up (follow-up mean 11 months; measured with: HADS-D change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	151	149	-	SMD 0.28 higher (0.05 to 0.51 higher)	LOW	IMPORTANT
Discontinuation (follow-up 4-13 weeks; assessed with: Number of participants lost to follow-up)												
4	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	121/386 (31.3%)	105/367 (28.6%)	RR 1.12 (0.92 to 1.38)	34 more per 1000 (from 23 fewer to 109 more)	LOW	CRITICAL

CAPS=clinician administered PTSD scale; CI=confidence interval; HADS-A=Hospital Anxiety and Depression Scale-Anxiety/Depression; IES-R=Impact of event scale-revised; PCL=PTSD Checklist; PTSD=post-traumatic stress disorder; RR=risk ratio; SMD=standardised mean difference

[1] Risk of bias is high or unclear across multiple outcomes

[2] OIS not met (N<400)

[3] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm

[4] 95% CI crosses both line of no effect and threshold for clinically important harm

[5] Substantial heterogeneity (I2>50%)

Self-help (without support) versus waitlist for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Self-help (without support)	Waitlist	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology self-rated at endpoint (follow-up 6-13 weeks; measured with: PSS-SR endpoint score/PCL change score; Better indicated by lower values)												
2	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	179	109	-	SMD 0.78 lower (1.03 to 0.53 lower)	LOW	CRITICAL
PTSD symptomatology self-rated at 1-3 month follow-up (follow-up 1-3 months; measured with: PSS-SR endpoint score/PCL change score; Better indicated by lower values)												
2	randomised trials	serious[1]	very serious[3]	no serious indirectness	very serious[4]	none	186	110	-	SMD 0.33 lower (1.56 lower to 0.9 higher)	VERY LOW	CRITICAL
Response at 3-month follow-up (follow-up mean 3 months; assessed with: Number of people showing clinically significant improvement based on reliable change indices (RCI on PSS-SR))												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[4]	none	2/20 (10%)	2/22 (9.1%)	RR 1.1 (0.17 to 7.09)	9 more per 1000 (from 75 fewer to 554 more)	VERY LOW	CRITICAL
Depression symptoms at endpoint (follow-up mean 6 weeks; measured with: CES-D change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	159	89	-	SMD 0.29 lower	LOW	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Self-help (without support)	Waitlist	Relative (95% CI)	Absolute		
										(0.55 to 0.03 lower)		
Depression symptoms at 6-week follow-up (follow-up mean 6 weeks; measured with: CES-D change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	166	90	-	SMD 0.81 lower (1.08 to 0.55 lower)	LOW	IMPORTANT
Quality of life at endpoint (follow-up mean 13 weeks; measured with: EORTC QLQ endpoint score; Better indicated by higher values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[4]	none	20	20	-	SMD 0.01 lower (0.63 lower to 0.61 higher)	VERY LOW	IMPORTANT
Quality of life at 3-month follow-up (follow-up mean 3 months; measured with: EORTC QLQ endpoint score; Better indicated by higher values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[4]	none	20	20	-	SMD 0.11 higher (0.51 lower to 0.73 higher)	VERY LOW	IMPORTANT
Discontinuation (follow-up 6-13 weeks; assessed with: Number of participants lost to follow-up)												
2	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious[5]	none	53/229 (23.1%)	7/116 (6%)	RR 3.53 (1.5 to 8.29)	153 more per 1000 (from 30 more to	MODERATE	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Self-help (without support)	Waitlist	Relative (95% CI)	Absolute		
										440 more)		

CES-D=Center for epidemiologic studies depression Scale; CI=confidence interval; EORTC QLQ=an integrated system for assessing health-related quality of life questionnaire; PCL=PTSD Checklist; PSS-SR=PTSD symptom scale-self-report: PTSD=post-traumatic stress disorder; RR=risk ratio; SMD=standardised mean difference
[1] Risk of bias is high or unclear across multiple outcomes
[2] OIS not met (N<400)
[3] Considerable heterogeneity (I2>80%)
[4] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm
[5] OIS not met (events<300)

Self-help (without support; +/- TAU) versus attention-placebo or TAU for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Self-help (without support; +/- TAU)	attention-placebo or TAU	Relative (95% CI)	Absolute		
PTSD symptomatology self-rated at endpoint (follow-up 2-4 weeks; measured with: PCL/DTS change score; Better indicated by lower values)												
2	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	134	141	-	SMD 0.28 lower (0.66 lower to 0.1 higher)	VERY LOW	CRITICAL
PTSD symptomatology self-rated at 1-5 month follow-up (follow-up 1-5 months; measured with: PCL/DTS change score; Better indicated by lower values)												
3	randomised trials	very serious[1]	serious[3]	no serious indirectness	serious[2]	none	149	150	-	SMD 0.26 lower (0.67 lower to 0.16 higher)	VERY LOW	CRITICAL
PTSD symptomatology self-rated at 11-month follow-up (follow-up mean 11 months; measured with: DTS change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	82	91	-	SMD 0.07 higher (0.23	VERY LOW	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Self-help (without support; +/- TAU)	attention-placebo or TAU	Relative (95% CI)	Absolute		
										lower to 0.37 higher)		
Depression symptoms at endpoint (follow-up 2-4 weeks; measured with: HAM-D change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	103	108	-	SMD 0.03 higher (0.24 lower to 0.3 higher)	VERY LOW	IMPORTANT
Depression symptoms at 4-5 month follow-up (follow-up 4-5 months; measured with: BDI/HAMD change score; Better indicated by lower values)												
2	randomised trials	very serious[1]	serious[3]	no serious indirectness	serious[4]	none	120	118	-	SMD 0.05 lower (0.49 lower to 0.39 higher)	VERY LOW	IMPORTANT
Depression symptoms at 11-month follow-up (follow-up mean 11 months; measured with: HAM-D change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[5]	none	82	89	-	SMD 0.26 higher (0.04 lower to 0.56 higher)	VERY LOW	IMPORTANT
Discontinuation (follow-up 2-4 weeks; assessed with: Number of participants lost to follow-up)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[6]	none	16/121 (13.2%)	14/123 (11.4%)	RR 1.16 (0.59 to 2.27)	18 more per 1000 (from 47 fewer to 145 more)	VERY LOW	CRITICAL

BDI=Beck Depression Inventory; CI=confidence interval; DTS= Davidson Trauma Scale; HAM-D= Hamilton Rating Scale for Depression; PCL=PTSD Checklist; PTSD=post-traumatic stress disorder; RR=risk ratio; SMD=standardised mean difference; TAU=treatment as usual

[1] Risk of bias is high or unclear across multiple outcomes

[2] 95% CI crosses line of no effect and threshold for clinically important benefit

[3] Substantial heterogeneity (I2>50%)

[4] OIS not met (N<400)

[5] 95% CI crosses both line of no effect and threshold for clinically important harm

[6] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm

Psychological: Self-help with support

Self-help with support versus attention-placebo for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Self-help with support	Attention-placebo	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology self-rated at endpoint (follow-up mean 1 weeks; measured with: PDS endpoint score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	37	34	-	SMD 0.28 lower (0.75 lower to 0.19 higher)	LOW	CRITICAL
PTSD symptomatology self-rated at 1-month follow-up (follow-up mean 1 months; measured with: PDS endpoint score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	37	34	-	SMD 0.06 lower (0.53 lower to 0.4 higher)	LOW	CRITICAL
PTSD at 1-month follow-up (follow-up mean 1 months; assessed with: Number above clinical threshold on PDS)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	4/37 (10.8%)	3/34 (8.8%)	RR 1.23 (0.3 to 5.08)	20 more per 1000 (from 62 fewer to 360 more)	VERY LOW	CRITICAL
Discontinuation (follow-up mean 1 weeks; assessed with: Number of participants lost to follow-up)												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[3]	none	3/37 (8.1%)	1/34 (2.9%)	RR 2.76 (0.3 to 25.25)	52 more per 1000 (from 21 fewer to 713 more)	LOW	CRITICAL

CI=confidence interval; PDS=PTSD Diagnostic Scale; PTSD=post-traumatic stress disorder; RR=risk ratio; SMD=standardised mean difference;

[1] Risk of bias is high or unclear across multiple outcomes
[2] 95% CI crosses both line of no effect and threshold for clinically important benefit
[3] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm

Self-help with support (+ TAU) versus TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Self-help with support (+ TAU)	TAU	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology self-rated at 7-week follow-up (follow-up mean 7 weeks; measured with: PDS change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	31	36	-	SMD 0.13 lower (0.61 lower to 0.35 higher)	VERY LOW	CRITICAL
PTSD symptomatology self-rated at 20-week follow-up (follow-up mean 20 weeks; measured with: PDS change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	24	27	-	SMD 0.43 lower (0.99 lower to 0.13 higher)	VERY LOW	CRITICAL
Anxiety symptoms at 7-week follow-up (follow-up mean 7 weeks; measured with: HADS-A change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	31	36	-	SMD 0.05 higher (0.43 lower to 0.53 higher)	VERY LOW	IMPORTANT
Anxiety symptoms at 20-week follow-up (follow-up mean 20 weeks; measured with: HADS-A change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	24	27	-	SMD 0.34 lower (0.89 lower to 0.22 higher)	VERY LOW	IMPORTANT

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Self-help with support (+ TAU)	TAU	Relative (95% CI)	Absolute	Quality	Importance
Depression symptoms at 7-week follow-up (follow-up mean 7 weeks; measured with: HADS-D change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	31	36	-	SMD 0.16 lower (0.64 lower to 0.32 higher)	VERY LOW	IMPORTANT
Depression symptoms at 20-week follow-up (follow-up mean 20 weeks; measured with: HADS-D change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	24	27	-	SMD 0.28 lower (0.83 lower to 0.27 higher)	VERY LOW	IMPORTANT
Quality of life at 7-week follow-up (follow-up mean 7 weeks; measured with: WHO-QoL-BREF endpoint score; Better indicated by higher values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	31	36	-	SMD 0.14 lower (0.62 lower to 0.34 higher)	VERY LOW	IMPORTANT
Quality of life at 20-week follow-up (follow-up mean 20 weeks; measured with: WHO-QoL-BREF endpoint score; Better indicated by higher values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[4]	none	24	27	-	SMD 0.01 lower (0.56 lower to 0.54 higher)	VERY LOW	IMPORTANT
Discontinuation (follow-up mean 7 weeks; assessed with: Number of participants lost to follow-up)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	41/72 (56.9%)	40/76 (52.6%)	RR 1.08 (0.81 to 1.45)	42 more per 1000 (from 100 fewer to 237 more)	LOW	CRITICAL

CI=confidence interval; HADS-A/D=Hospital Anxiety and Depression Scale-Anxiety/Depression; PDS=PTSD diagnostic scale; PTSD=post-traumatic stress disorder; RR=risk ratio; SMD=standardised mean difference; TAU=treatment as usual; WHO QoL BREF=WHO quality of life questionnaire

[1] Risk of bias is high or unclear across multiple outcomes
[2] 95% CI crosses both line of no effect and threshold for clinically important benefit
[3] 95% CI crosses both line of no effect and threshold for clinically important harm
[4] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm

Self-help with support versus waitlist for the early treatment (1-3 months) of below threshold PTSD symptoms in adults

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Self-help with support	Waitlist	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology self-rated (follow-up mean 10 weeks; measured with: PCL change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	31	27	-	SMD 1.58 lower (2.17 to 0.98 lower)	VERY LOW	CRITICAL
Anxiety symptoms (follow-up mean 10 weeks; measured with: BAI change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	31	27	-	SMD 1.02 lower (1.57 to 0.47 lower)	VERY LOW	IMPORTANT
Depression symptoms (follow-up mean 10 weeks; measured with: BDI-II change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	31	27	-	SMD 1.53 lower (2.12 to 0.94 lower)	VERY LOW	IMPORTANT
Discontinuation (follow-up mean 10 weeks; assessed with: Number of participants lost to follow-up)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	13/31 (41.9%)	7/27 (25.9%)	RR 1.62 (0.76 to 3.46)	161 more per 1000 (from 62 fewer to 638 more)	VERY LOW	CRITICAL

BAI=Beck Anxiety Inventory; BDI=Beck Depression Inventory; CI=confidence interval; PCL=PTSD Checklist; PTSD=post-traumatic stress disorders; RR=risk ratio; SMD=standardised mean difference
[1] Risk of bias is high or unclear across multiple outcomes
[2] OIS not met (N<400)
[3] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm

Self-help with support versus waitlist for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Self-help with support	Waitlist	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology self-rated at endpoint (follow-up mean 6 weeks; measured with: IES-R change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	13	27	-	SMD 0.64 lower (1.32 lower to 0.04 higher)	VERY LOW	CRITICAL
PTSD symptomatology self-rated at 3-month follow-up (follow-up mean 3 months; measured with: IES-R change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	19	29	-	SMD 0.44 lower (1.03 lower to 0.14 higher)	VERY LOW	CRITICAL
Depression symptoms at 3-month follow-up (follow-up mean 3 months; measured with: MADRS change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	19	29	-	SMD 0.2 lower (0.78 lower to 0.38 higher)	VERY LOW	IMPORTANT
Relationship difficulties at endpoint (follow-up mean 6 weeks; measured with: Parenting Stress Index Short Form (PSI-SF) change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	13	27	-	SMD 0.4 higher (0.27 lower to	VERY LOW	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Self-help with support	Waitlist	Relative (95% CI)	Absolute		
										1.07 higher)		
Relationship difficulties at 3-month follow-up (follow-up mean 3 months; measured with: Parenting Stress Index Short Form (PSI-SF) change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	19	29	-	SMD 0.45 higher (0.14 lower to 1.03 higher)	VERY LOW	IMPORTANT
Discontinuation (follow-up mean 6 weeks; assessed with: Number of participants lost to follow-up)												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious[4]	none	39/52 (75%)	25/52 (48.1%)	RR 1.56 (1.13 to 2.16)	269 more per 1000 (from 62 more to 558 more)	MODERATE	CRITICAL

CI=confidence interval; IES-R=Impact of event scale-Revised; MADRS=Montgomery-Asberg Depression Rating Scale; PSI-SF=Parenting Stress Index-Short Form; PTSD=post-traumatic stress disorders; RR=risk ratio; SMD=standardised mean difference

[1] Risk of bias is high or unclear across multiple domains

[2] 95% CI crosses both line of no effect and threshold for clinically important benefit

[3] 95% CI crosses both line of no effect and threshold for clinically important harm

[4] OIS not met (events<300)

Self-help with support versus attention-placebo for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Self-help with support	attention-placebo	Relative (95% CI)	Absolute		
PTSD symptomatology self-rated at endpoint (follow-up mean 4 weeks; measured with: IES-R change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	12	10	-	SMD 0.47 higher (0.38	LOW	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Self-help with support	attention-placebo	Relative (95% CI)	Absolute		
										lower to 1.33 higher)		
PTSD symptomatology self-rated at 2-month follow-up (follow-up mean 2 months; measured with: IES-R change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	12	10	-	SMD 0.54 higher (0.32 lower to 1.39 higher)	LOW	CRITICAL
Discontinuation (follow-up mean 4 weeks; assessed with: Number of participants lost to follow-up)												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[3]	none	0/12 (0%)	1/11 (9.1%)	RR 0.31 (0.01 to 6.85)	63 fewer per 1000 (from 90 fewer to 532 more)	LOW	CRITICAL

CI=confidence interval; IES-R=Impact of event scale-revised; PTSD=post-traumatic stress disorder; RR=risk ratio; SMD=standardised mean difference
[1] Risk of bias is high or unclear across multiple outcomes
[2] 95% CI crosses both line of no effect and threshold for clinically important harm
[3] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm

Psychosocial: Meditation/Mindfulness-based stress reduction

Meditation/MBSR (+/- TAU) versus no treatment, waitlist or TAU for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Meditation/MBSR (+/- TAU)	No treatment, waitlist or TAU	Relative (95% CI)	Absolute		
PTSD symptomatology self-rated at endpoint (follow-up mean 8 weeks; measured with: PCL/IES change score; Better indicated by lower values)												
3	randomised trials	serious[1]	serious[2]	no serious indirectness	serious[3]	none	52	53	-	SMD 0.75 lower (1.16 to	VERY LOW	CRITICAL

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Meditation/MBSR (+/- TAU)	No treatment, waitlist or TAU	Relative (95% CI)	Absolute	Quality	Importance
										0.35 lower)		
PTSD symptomatology self-rated at 3-month follow-up (follow-up mean 3 months; measured with: IES change score; Better indicated by lower values)												
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	serious[4]	none	21	18	-	SMD 0.37 lower (1 lower to 0.27 higher)	VERY LOW	CRITICAL
Depression symptoms (follow-up mean 8 weeks; measured with: BDI-II change score; Better indicated by lower values)												
1	randomised trials	serious [1]	no serious inconsistency	no serious indirectness	serious[3]	none	19	20	-	SMD 1.01 lower (1.68 to 0.34 lower)	LOW	IMPORTANT
Quality of life at endpoint (follow-up mean 8 weeks; measured with: QLQ-C30-GHS change score; Better indicated by higher values)												
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	serious[4]	none	22	22	-	SMD 0.32 higher (0.28 lower to 0.91 higher)	VERY LOW	IMPORTANT
Quality of life at 3-month follow-up (follow-up mean 3 months; measured with: QLQ-C30-GHS change score; Better indicated by higher values)												
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	serious[4]	none	21	18	-	SMD 0.39 higher (0.25 lower to 1.03 higher)	VERY LOW	IMPORTANT
Discontinuation (follow-up mean 8 weeks; assessed with: Number of participants lost to follow-up)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Meditation/MBSR (+/- TAU)	No treatment, waitlist or TAU	Relative (95% CI)	Absolute		
3	randomised trials	serious [1]	no serious inconsistency	no serious indirectness	very serious[5]	none	13/66 (19.7%)	13/64 (20.3%)	RR 0.99 (0.51 to 1.92)	2 fewer per 1000 (from 100 fewer to 187 more)	VERY LOW	CRITICAL

BDI=Beck Depression Inventory; CI=confidence interval; IES=Impact of event scale; MBSR=Mindfulness-based stress reduction; PCL=PTSD Checklist; PTSD=post-traumatic stress disorder; RR=risk ratio; SMD=standardised mean difference; TAU=treatment as usual; QLQ-C30-GHS=an instrument to measure quality of life of cancer patients
[1] Risk of bias is high or unclear across multiple outcomes
[2] Substantial heterogeneity (I2>50%)
[3] OIS not met (N<400)
[4] 95% CI crosses both line of no effect and threshold for clinically important benefit
[5] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm

Psychosocial: Practical support

Intensive care diary versus waitlist for the early treatment (1-3 months) of below threshold PTSD symptoms in adults

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Intensive care diary	Waitlist	Relative (95% CI)	Absolute		
PTSD symptomatology self-rated (follow-up mean 8 weeks; measured with: PTSS-14 change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	162	160	-	SMD 0.26 lower (0.48 to 0.04 lower)	VERY LOW	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Intensive care diary	Waitlist	Relative (95% CI)	Absolute		
PTSD at endpoint (follow-up mean 8 weeks; assessed with: Number meeting criteria for PTSD)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	23/177 (13%)	30/175 (17.1%)	RR 0.76 (0.46 to 1.25)	41 fewer per 1000 (from 93 fewer to 43 more)	VERY LOW	CRITICAL
Discontinuation (follow-up mean 8 weeks; assessed with: Number of participants lost to follow-up)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	15/177 (8.5%)	15/175 (8.6%)	RR 0.99 (0.5 to 1.96)	1 fewer per 1000 (from 43 fewer to 82 more)	VERY LOW	CRITICAL

CI=confidence interval; PTSD=post-traumatic stress disorder; PTSS-14=posttraumatic stress symptoms-14; RR=risk ratio; SMD=standardised mean difference
[1] Risk of bias is high or unclear across multiple outcomes
[2] OIS not met (N<400)
[3] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm

Psychosocial: Psycho-education

Single psycho-education session (+/- TAU) versus TAU or no treatment for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Single psychoeducation session (+/- TAU)	TAU or no treatment	Relative (95% CI)	Absolute		
PTSD symptomatology self-rated at endpoint (follow-up mean 0.1 weeks; measured with: PSS-SR/IES-R change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Single psychoeducation session (+/- TAU)	TAU or no treatment	Relative (95% CI)	Absolute		
2	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	serious[2]	none	55	51	-	SMD 0.23 higher (0.16 lower to 0.61 higher)	VERY LOW	CRITICAL
PTSD symptomatology self-rated at 2-6 month follow-up (follow-up 2-6 months; measured with: PSS-SR change score; Better indicated by lower values)												
2	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	serious[3]	none	72	79	-	SMD 0.19 lower (0.51 lower to 0.13 higher)	VERY LOW	CRITICAL
PTSD at 6-month follow-up (follow-up mean 6 months; assessed with: Number of people who met criteria for PTSD)												
2	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	very serious[4]	none	30/127 (23.6%)	31/126 (24.6%)	RR 0.96 (0.62 to 1.48)	10 fewer per 1000 (from 93 fewer to 118 more)	VERY LOW	CRITICAL
Anxiety symptoms at endpoint (follow-up mean 0.1 weeks; measured with: STAI State change score; Better indicated by lower values)												
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	serious[5]	none	31	38	-	SMD 0.77 lower (1.26 to 0.28 lower)	VERY LOW	IMPORTANT
Anxiety symptoms at 2-month follow-up (follow-up mean 2 months; measured with: STAI State change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Single psychoeducation session (+/- TAU)	TAU or no treatment	Relative (95% CI)	Absolute		
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	serious[5]	none	32	41	-	SMD 0.61 lower (1.08 to 0.13 lower)	VERY LOW	IMPORTANT
Depression symptoms (follow-up mean 0.1 weeks; measured with: BDI endpoint score; Better indicated by lower values)												
1	randomised trials	very serious [1]	no serious inconsistency	no serious indirectness	serious[3]	none	45	46	-	SMD 0.36 lower (0.77 lower to 0.06 higher)	VERY LOW	IMPORTANT
Discontinuation (follow-up mean 0.1 weeks; assessed with: Number of participants lost to follow-up)												
4	randomised trials	serious [1]	no serious inconsistency	no serious indirectness	serious[2]	none	100/269 (37.2%)	78/249 (31.3%)	RR 1.14 (0.93 to 1.4)	44 more per 1000 (from 22 fewer to 125 more)	LOW	CRITICAL

BDI=Beck Depression Inventory; CI=confidence interval; IES-R=Impact of event scale-revised; PSS-SR=PTSD symptom scale-self-report; PTSD=post-traumatic stress disorder; RR=risk ratio; SMD=standardised mean difference; STAI=State-Trait Anxiety Inventory

[1] Risk of bias is high or unclear across multiple outcomes

[2] 95% CI crosses both line of no effect and threshold for clinically important harm

[3] 95% CI crosses both line of no effect and threshold for clinically important benefit

[4] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm

[5] OIS not met (N<400)

Other non-pharmacological: Acupuncture

Acupuncture + trauma-focused CBT versus trauma-focused CBT for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Acupuncture + trauma-focused CBT	Trauma-focused CBT	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology self-rated (follow-up mean 1 weeks; measured with: OES-R change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	66	24	-	SMD 1.56 lower (2.08 to 1.04 lower)	LOW	CRITICAL
Discontinuation (follow-up mean 1 weeks; assessed with: Number of participants lost to follow-up)												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[3]	none	1/67 (1.5%)	0/24 (0%)	RR 1.1 (0.05 to 26.2)	-	LOW	CRITICAL

CBT=cognitive behavioural therapy; CI=confidence interval; OES-R=; PTSD=post-traumatic stress disorder;
[1] Risk of bias is high or unclear across multiple outcomes
[2] OIS not met (N<400)
[3] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm

Other non-pharmacological: Yoga

Yoga versus attention-placebo for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Yoga	Attention-placebo	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology self-rated at endpoint (follow-up mean 6 weeks; measured with: IES change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	49	52	-	SMD 0.23 lower (0.62 lower to 0.16 higher)	VERY LOW	CRITICAL
PTSD symptomatology self-rated at 1-month follow-up (follow-up mean 1 months; measured with: IES change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	39	44	-	SMD 0.17 lower (0.6 lower to 0.26 higher)	VERY LOW	CRITICAL
PTSD symptomatology self-rated at 3-month follow-up (follow-up mean 3 months; measured with: IES change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	41	41	-	SMD 0.08 lower (0.51 lower to 0.36 higher)	VERY LOW	CRITICAL
PTSD symptomatology self-rated at 6-month follow-up (follow-up mean 6 months; measured with: IES change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	43	43	-	SMD 0.04 higher (0.38 lower to 0.46 higher)	VERY LOW	CRITICAL
Depression symptoms at endpoint (follow-up mean 6 weeks; measured with: CES-D change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	49	52	-	SMD 0.27 lower (0.67 lower to 0.12 higher)	VERY LOW	IMPORTANT
Depression symptoms at 1-month follow-up (follow-up mean 1 months; measured with: CES-D change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Yoga	Attention-placebo	Relative (95% CI)	Absolute	Quality	Importance
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	39	44	-	SMD 0.3 lower (0.73 lower to 0.14 higher)	VERY LOW	IMPORTANT
Depression symptoms at 3-month follow-up (follow-up mean 3 months; measured with: CES-D change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	41	41	-	SMD 0.1 higher (0.33 lower to 0.54 higher)	VERY LOW	IMPORTANT
Depression symptoms at 6-month follow-up (follow-up mean 6 months; measured with: CES-D change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	43	43	-	SMD 0.01 lower (0.44 lower to 0.41 higher)	VERY LOW	IMPORTANT
Sleeping difficulties at endpoint (follow-up mean 6 weeks; measured with: PSQI change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	49	52	-	SMD 0.51 lower (0.91 to 0.12 lower)	VERY LOW	IMPORTANT
Sleeping difficulties at 1-month follow-up (follow-up mean 1 months; measured with: PSQI change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	39	44	-	SMD 0.11 lower (0.54 lower to 0.33 higher)	VERY LOW	IMPORTANT
Sleeping difficulties at 3-month follow-up (follow-up mean 3 months; measured with: PSQI change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	41	41	-	SMD 0.19 lower (0.62 lower to 0.25 higher)	VERY LOW	IMPORTANT
Sleeping difficulties at 6-month follow-up (follow-up mean 6 months; measured with: PSQI change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Yoga	Attention-placebo	Relative (95% CI)	Absolute		
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	43	43	-	SMD 0 higher (0.42 lower to 0.42 higher)	VERY LOW	IMPORTANT
Quality of life at endpoint (follow-up mean 6 weeks; measured with: SF-36 MCS change score; Better indicated by higher values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	49	52	-	SMD 0.12 higher (0.27 lower to 0.51 higher)	VERY LOW	IMPORTANT
Quality of life at 1-month follow-up (follow-up mean 1 months; measured with: SF-36 MCS change score; Better indicated by higher values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	39	44	-	SMD 0.31 higher (0.12 lower to 0.74 higher)	VERY LOW	IMPORTANT
Quality of life at 3-month follow-up (follow-up mean 3 months; measured with: SF-36 MCS change score; Better indicated by higher values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	41	41	-	SMD 0.02 higher (0.41 lower to 0.46 higher)	VERY LOW	IMPORTANT
Quality of life at 6-month follow-up (follow-up mean 6 months; measured with: SF-36 MCS change score; Better indicated by higher values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	43	43	-	SMD 0.06 lower (0.48 lower to 0.36 higher)	VERY LOW	IMPORTANT

CES-D=Centre for epidemiological studies-depression; CI=confidence interval; IES=Impact of event scale; PSQI=Pittsburgh Sleep Quality Index; PTSD=post-traumatic stress disorder; RR=risk ratio; SF-36 MCS=short form-36 (mental component summary); SMD=standardised mean difference

[1] Risk of bias is high or unclear across multiple outcomes

[2] 95% CI crosses both line of no effect and threshold for clinically important benefit

[3] OIS not met (N<400)

[4] 95% CI crosses both line of no effect and threshold for clinically important harm

Yoga versus TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Yoga	TAU	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology self-rated at endpoint (follow-up mean 6 weeks; measured with: IES change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	49	48	-	SMD 0.01 lower (0.41 lower to 0.39 higher)	VERY LOW	CRITICAL
PTSD symptomatology self-rated at 1-month follow-up (follow-up mean 1 months; measured with: IES change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	39	43	-	SMD 0.11 higher (0.32 lower to 0.55 higher)	VERY LOW	CRITICAL
PTSD symptomatology self-rated at 3-month follow-up (follow-up mean 3 months; measured with: IES change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	41	42	-	SMD 0.09 higher (0.34 lower to 0.52 higher)	VERY LOW	CRITICAL
PTSD symptomatology self-rated at 6-month follow-up (follow-up mean 6 months; measured with: IES change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	43	46	-	SMD 0.51 higher (0.09 to 0.93 higher)	VERY LOW	CRITICAL
Depression symptoms at endpoint (follow-up mean 6 weeks; measured with: CES-D change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	49	48	-	SMD 0.11 lower (0.51 lower to 0.29 higher)	VERY LOW	IMPORTANT
Depression symptoms at 1-month follow-up (follow-up mean 1 months; measured with: CES-D change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	39	43	-	SMD 0.03 higher (0.41 lower to 0.46 higher)	VERY LOW	IMPORTANT
Depression symptoms at 3-month follow-up (follow-up mean 3 months; measured with: CES-D change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Yoga	TAU	Relative (95% CI)	Absolute	Quality	Importance
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	41	42	-	SMD 0.05 higher (0.38 lower to 0.48 higher)	VERY LOW	IMPORTANT
Depression symptoms at 6-month follow-up (follow-up mean 6 months; measured with: CES-D change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	43	46	-	SMD 0.24 higher (0.18 lower to 0.66 higher)	VERY LOW	IMPORTANT
Sleeping difficulties at endpoint (follow-up mean 6 weeks; measured with: PSQI change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	49	48	-	SMD 0.27 lower (0.67 lower to 0.13 higher)	VERY LOW	IMPORTANT
Sleeping difficulties at 1-month follow-up (follow-up mean 1 months; measured with: PSQI change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	39	43	-	SMD 0.37 higher (0.06 lower to 0.81 higher)	VERY LOW	IMPORTANT
Sleeping difficulties at 3-month follow-up (follow-up mean 3 months; measured with: PSQI change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	41	42	-	SMD 0.04 lower (0.47 lower to 0.39 higher)	VERY LOW	IMPORTANT
Sleeping difficulties at 6-month follow-up (follow-up mean 6 months; measured with: PSQI change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	43	46	-	SMD 0.18 higher (0.23 lower to 0.6 higher)	VERY LOW	IMPORTANT
Quality of life at endpoint (follow-up mean 6 weeks; measured with: SF-36 MCS change score; Better indicated by higher values)												

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Yoga	TAU	Relative (95% CI)	Absolute	Quality	Importance
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	49	48	-	SMD 0.06 higher (0.34 lower to 0.45 higher)	VERY LOW	IMPORTANT
Quality of life at 1-month follow-up (follow-up mean 1 months; measured with: SF-36 MCS change score; Better indicated by higher values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	39	43	-	SMD 0.3 lower (0.74 lower to 0.13 higher)	VERY LOW	IMPORTANT
Quality of life at 3-month follow-up (follow-up mean 3 months; measured with: SF-36 MCS change score; Better indicated by higher values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	41	42	-	SMD 0.03 lower (0.46 lower to 0.4 higher)	VERY LOW	IMPORTANT
Quality of life at 6-month follow-up (follow-up mean 6 months; measured with: SF-36 MCS change score; Better indicated by higher values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	43	46	-	SMD 0.22 lower (0.63 lower to 0.2 higher)	VERY LOW	IMPORTANT

CES-D=Centre for epidemiological studies-depression; CI=confidence interval; IES=Impact of event scale; PSQI=Pittsburgh Sleep Quality Index; PTSD=post-traumatic stress disorder; RR=risk ratio; SMD=standardised mean difference; TAU=treatment as usual
[1] Risk of bias is high or unclear across multiple outcomes
[2] OIS not met (N<400)
[3] 95% CI crosses both line of no effect and threshold for clinically important harm
[4] 95% CI crosses both line of no effect and threshold for clinically important benefit

Yoga versus waitlist for the delayed treatment (>3 months) of below threshold PTSD symptoms in adults

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Yoga	Waitlist	Relative (95% CI)	Absolute		
PTSD symptomatology self-rated (follow-up mean 1 weeks; measured with: PCL change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	10	10	-	SMD 1.13 lower (2.09 to 0.17 lower)	LOW	CRITICAL
Discontinuation (follow-up mean 1 weeks; assessed with: Number of participants lost to follow-up)												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[3]	none	1/11 (9.1 %)	0/10 (0%)	RR 2.75 (0.12 to 60.7)	-	LOW	CRITICAL

CI=confidence interval; PCL=PTSD Checklist; PTSD=post-traumatic stress disorder; RR=risk ratio; SMD=standardised mean difference
[1] Risk of bias is high or unclear across multiple outcomes
[2] OIS not met (N<400)
[3] 95% CI crosses line of no effect and thresholds for both clinically important benefit and harm

Other non-pharmacological: Massage

Massage + relaxation for parent (+ massage + humour therapy targeted at child) versus TAU for the early prevention (intervention initiated ≤1 month) of PTSD in adults

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Massage + relaxation for parent (+ massage + humour therapy targeted at child)	TAU	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology self-rated at 5-month follow-up (follow-up mean 5 months; measured with: IES-R change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	40	22	-	SMD 0.18 lower (0.71 lower to 0.34 higher)	LOW	CRITICAL
Depression symptoms at 5-month follow-up (follow-up mean 5 months; measured with: CES-D change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	38	21	-	SMD 0.33 lower (0.87 lower to 0.2 higher)	LOW	IMPORTANT
Discontinuation (follow-up mean 4 weeks; assessed with: Number of participants lost to follow-up)												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious[3]	none	19/59 (32.2%)	38/60 (63.3%)	RR 0.51 (0.33 to 0.77)	310 fewer per 1000	MODERATE	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Massage + relaxation for parent (+ massage + humour therapy targeted at child)	TAU	Relative (95% CI)	Absolute		
										(from 146 fewer to 424 fewer)		

CES-D=Centre for epidemiological studies-depression; CI=confidence interval; IES-R=Impact of event scale-revised; PTSD=post-traumatic stress disorder; RR=risk ratio; SMD=standardised mean difference; TAU=treatment as usual

[1] Risk of bias is high or unclear across multiple outcomes

[2] 95% CI crosses both line of no effect and threshold for clinically important benefit

[3] OIS not met (events<300)

Appendix G – Economic evidence study selection

Economic evidence study selection for "For adults at risk of PTSD, what are the relative benefits and harms of psychological, psychosocial or other non-pharmacological interventions targeted at PTSD symptoms?"

A global health economics search was undertaken for all areas covered in the guideline. The flow diagram of economic article selection across all reviews is provided in Appendix A of Supplement 1 – Methods Chapter'.

Appendix H – Economic evidence tables

Economic evidence tables for "For adults at risk of PTSD, what are the relative benefits and harms of psychological, psychosocial or other non-pharmacological interventions targeted at PTSD symptoms?"

Psychological interventions – reference to included study

Chatterton ML, Chambers S, Occhipinti S (2016). Economic evaluation of a psychological intervention for high distress cancer patients and carers: costs and quality-adjusted life years. Psychooncology 25(7), 857-864

Study Country Study type	Intervention details	Study population Study design Data sources	Costs and outcomes: description and values	Results: Cost-effectiveness	Comments
Chatterton 2016 Australia Cost-utility analysis	Interventions: Individualised trauma-focused cognitive behavioural therapy comprising 5 sessions led by psychologists (TF-CBT) Psychoeducation comprising one session led by a nurse counsellor (PE) both interventions included carers' support	Distressed adults with cancer at risk of PTSD; participants divided into low and high distress, based on a cut-off point of BSI=63 (Brief Symptom Inventory) RCT (Chambers 2009) Source of efficacy and resource use data: RCT (N=336; 27% did not complete all follow-up assessments; multiple imputation used) Source of unit costs: national sources	Costs: intervention and other health-care resources (medical and psychological; psychiatrist, psychologist, social worker, GP, nurse) used by cancer patients and carers including out of pocket expenses such as co-payments for medical care or prescription medications Mean cost/person – patients high distress: TF-CBT $3773; PE $4095 Difference -$322 (95%CI -$2609 to $1964) Mean cost/person – patients low distress: TF-CBT $2729; PE $2394 Difference $335 (95% CI -$904 to $1574) Outcome measure: QALY based on the Assessment of Quality of Life measure	In patients with high distress: TF-CBT dominant over PE In patients with low distress: ICER of TF-CBT vs PE $20,938/QALY Probability of cost effectiveness of TF-CBT at WTP $50,000/QALY: • Patients with high distress: 0.81 low distress: 0.73	Perspective: health sector including patients' co-payments Currency: Aus$ Cost year: 2012 Time horizon: 1 year Discounting: NA Applicability: partially applicable Quality: minor limitations

Study Country Study type	Intervention details	Study population Study design Data sources	Costs and outcomes: description and values	Results: Cost-effectiveness	Comments
			(AQoL-8D), Australian values used Mean QALYs/person – patients high distress: TF-CBT 0.614; PE 0.577 Difference 0.037 (95% CI -0.045 to 0.118) Mean QALYs/person – patients low distress: TF-CBT 0.760; PE 0.744 Difference 0.016 (95% CI -0.027 to 0.060)		

Appendix I – Health economic evidence profiles

Health economic evidence profiles for "For adults at risk of PTSD, what are the relative benefits and harms of psychological, psychosocial or other non-pharmacological interventions targeted at PTSD symptoms?"

Psychological interventions for the prevention of PTSD in adults

Economic evidence profile: trauma-focused cognitive behavioural therapy (TF-CBT) versus psychoeducation for the prevention of PTSD in adults at risk							
Study and country	**Limitations**	**Applicability**	**Other comments**	**Incremental cost (£)[1]**	**Incremental effect**	**ICER (£/effect)[1]**	**Uncertainty[1]**
Chatterton 2016 Australia	Minor limitations[2]	Partially applicable[3]	Population: distressed adults with cancer at risk for PTSD; divided into low and high distress, based on a cut-off point of BSI=63 (Brief Symptom Inventory)	high distress: -£153 low distress: £159	high distress: 0.037 low distress: 0.016	high distress: TF-CBT dominant low distress: £9945	Probability of cost effectiveness of TF-CBT at WTP £23,750/QALY: high distress: 0.81 low distress: 0.73

Economic evidence profile: trauma-focused cognitive behavioural therapy (TF-CBT) versus psychoeducation for the prevention of PTSD in adults at risk							
			Outcome: QALY				
1. Costs converted and uplifted to 2016 UK pounds using purchasing power parity (PPP) exchange rates and the UK HCHS index (Curtis & Burns, 2016). 2. Time horizon 1 year; analysis based on RCT (N=336; loss to follow-up 27%, multiple imputation used); national unit costs used; bootstrapping conducted and CEACs presented 3. Australian study; health sector perspective; QALY estimates based on the Assessment of Quality of Life measure (AQoL-8D, Australian values used)							

Appendix J – Health economics analysis

Health economic analysis for "For adults at risk of PTSD, what are the relative benefits and harms of psychological, psychosocial or other non-pharmacological interventions targeted at PTSD symptoms?"

No health economic analysis was conducted for this review.

Appendix K – Excluded studies

Excluded studies for "For adults at risk of PTSD, what are the relative benefits and harms of psychological, psychosocial or other non-pharmacological interventions targeted at PTSD symptoms?"

Clinical studies

Psychological: Trauma-focused CBT

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Birur 2016	RQ 4.1-4.2 (maximizing sensitivity)	Systematic review with no new useable data and any	Birur B, Moore NC, Davis LL. An evidence-based review of early	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
		meta-analysis results not appropriate to extract	intervention and prevention of posttraumatic stress disorder. Community mental health journal. 2016 Jul 28:1-9.	
Bisson 2009	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Bisson, J. I., Roberts, N. P., Kitchiner, N. J., Kenardy, J. (2009) Systematic review and meta-analysis of multiple-session early interventions following traumatic events, American Journal of Psychiatry, 166, 293-301	
Bryant 2011b	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Population outside scope: Trials of people with traumatic grief	Bryant, R. A., Ekasawin, S., Chakrabhand, S., Suwanmitri, S., Duangchun, O., Chantaluckwong, T. (2011) A randomized controlled effectiveness trial of cognitive behavior therapy for post-traumatic stress disorder in terrorist-affected people in Thailand, World Psychiatry, 10, 205-209	
Foa 1995a	2004 GL (excluded)	Non-randomised group assignment	Foa, E. B., Hearst-Ikeda, D., & Perry, K. J. (1995).	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			Evaluation of a brief cognitive-behavioral program for the prevention of chronic PTSD in recent assault victims. Journal of Consulting & Clinical Psychology, 63, 948-955.	
Forneris 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Forneris CA, Gartlehner G, Brownley KA, Gaynes BN, Sonis J, Coker-Schwimmer E, Jonas DE, Greenblatt A, Wilkins TM, Woodell CL, Lohr KN. Interventions to prevent post-traumatic stress disorder: a systematic review. American journal of preventive medicine. 2013 Jun 30;44(6):635-50.	
Freyth 2010	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Non-randomised group assignment	Freyth C, Elsesser K, Lohrmann T, Sartory G. Effects of additional prolonged exposure to psychoeducation and relaxation in acute stress disorder. Journal of anxiety disorders. 2010 Dec 31;24(8):909-17.	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Gidron 2001	2004 GL (excluded)	Sample size (N<10/arm)	Gidron, Y., Gal, R., Freedman, S., Twiser, I., Lauden, A., Snir, Y. (2001). Translating research findings to PTSD prevention: results of a randomized-controlled pilot study. Journal of Traumatic Stress, 14, 773-780	
Gidron 2002	2004 GL (excluded)	Intervention not targeted at PTSD symptoms	Gidron, Y., Duncan, E., Lazar, A., Biderman, A., Tandeter, H., & Shvartzman, P. (2002). Effects of guided written disclosure of stressful experiences on clinic visits and symptoms in frequent clinic attenders. Family Practice, 19, 161-166.	
Horesh 2017	RQ 1.1-1.2 & 2.1-2.2 update	Subgroup/secondary analysis that is not relevant	Horesh D, Qian M, Freedman S, Shalev A. Differential effect of exposure-based therapy and cognitive therapy on post-traumatic stress disorder symptom clusters: A randomized controlled trial. Psychology and	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			Psychotherapy: Theory, Research and Practice. 2017 Jun 1;90(2):235-43.	
Horesh 2017	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Horesh, D., Qian, M., Freedman, S., Shalev, A. (2016) Differential effect of exposure-based therapy and cognitive therapy on post-traumatic stress disorder symptom clusters: A randomized controlled trial, Psychology and Psychotherapy: Theory, Research and Practice, http://dx.doi.org/10.1111/papt.12103	
Kleindienst 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Kleindienst N, Priebe K, Görg N, Dyer A, Steil R, Lyssenko L, Winter D, Schmahl C, Bohus M. State dissociation moderates response to dialectical behavior therapy for posttraumatic stress disorder in women with and without borderline personality disorder. European journal of	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			psychotraumatology. 2016 Dec 1;7(1):30375.	
Kornor 2008	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Kornor, H., Winje, D., Ekeberg, O., Weisaeth, L., Kirkehei, I., Johansen, K., Steiro, A. (2008) Early trauma-focused cognitive-behavioural therapy to prevent chronic post-traumatic stress disorder and related symptoms: A systematic review and meta-analysis, BMC Psychiatry, 8	
Linares 2017	RQ 1.1-1.2 & 2.1-2.2 update	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Linares IM, Corchs FD, Chagas MH, Zuardi AW, Martin-Santos R, Crippa JA. Early interventions for the prevention of PTSD in adults: a systematic literature review. Archives of Clinical Psychiatry (São Paulo). 2017 Feb;44(1):23-9.	
Moore 2009	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Population outside scope: No trauma or traumatic event does not meet criteria	Moore, S., Brody, L., Dierberger, A. (2009) Mindfulness and experiential avoidance as predictors and outcomes of the narrative emotional disclosure task, Journal of	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			Clinical Psychology, 65, 971-988	
Pirente 2007	Handsearch	Intervention not targeted at PTSD symptoms	Pirente N, Blum C, Wortberg S, Bostanci S, Berger E, Lefering R, Bouillon B, Rehm KE, Neugebauer EA. Quality of life after multiple trauma: the effect of early onset psychotherapy on quality of life in trauma patients. Langenbeck's Archives of Surgery. 2007 Nov 1;392(6):739-45.	
Ponniah 2009	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Ponniah, K., Hollon, S. D. (2009) Empirically supported psychological treatments for adult acute stress disorder and posttraumatic stress disorder: A review, Depression and Anxiety, 26, 1086-1109	
Reed 2006	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention outside protocol	Reed GL, Enright RD. The effects of forgiveness therapy on depression, anxiety, and posttraumatic stress for women after spousal emotional abuse. Journal of consulting and	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			clinical psychology. 2006 Oct;74(5):920.	
Regehr 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Regehr, C., Alaggia, R., Dennis, J., Pitts, A., Saini, M. (2013) Interventions to reduce distress in adult victims of rape and sexual violence: a systematic review (Provisional abstract), Research on Social Work Practice, 23, 257-265	
Resick 1988	2004 GL (excluded)	Efficacy or safety data cannot be extracted	Resick, P.A.; Jordan, C.G.; Girelli, S.A.; Hutter, C.K.; Marhoefer-Dvorak, S. (1988) A comparative outcome study of behavioral group therapy for sexual assault victims. Behavior Therapy, 19, 385- 401	
Sahler 2005	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Efficacy or safety data cannot be extracted	Sahler, O., Fairclough, D., Phipps, S., Mulhern, R., Dolgin, M., Noll, R., Katz, E., Varni, J., Copeland, D., Butler, R. (2005) Using problem-solving skills training to reduce negativity in mothers of children newly diagnosed with cancer: report of a	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			multisite randomised trial, Journal of Consulting and Clinical Psychology, 73, 272-283	
Scheenen 2017	RQ 1.1-1.2 & 2.1-2.2 update	Outcomes are not of interest	Scheenen ME, Visser-Keizer AC, de Koning ME, van der Horn HJ, van de Sande P, van Kessel M, van der Naalt J, Spikman JM. Cognitive behavioral intervention compared to telephone counseling early after mild traumatic brain injury: A randomized trial. Journal of neurotrauma. 2017 Oct 1;34(19):2713-20.	
Shalev 2012	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Non-randomised group assignment	Shalev AY, Ankri Y, Israeli-Shalev Y, Peleg T, Adessky R, Freedman S. Prevention of posttraumatic stress disorder by early treatment: results from the Jerusalem Trauma Outreach And Prevention study. Archives of general psychiatry. 2012 Feb 6;69(2):166-76.	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Shalev 2016	RQ 4.1-4.2 (maximizing sensitivity) AND Cochrane allRQ update	Non-randomised group assignment	Shalev AY, Ankri Y, Gilad M, Israeli-Shalev Y, Adessky R, Qian M, Freedman S. Long-term outcome of early interventions to prevent posttraumatic stress disorder. The Journal of clinical psychiatry. 2016 May 25;77(5):580-7.	Shalev, A., Ankri, Y., Israeli-Shalev, Y. et al (2012) Prevention of posttraumatic stress disorder by early treatment: results from the Jerusalem Trauma Outreach and Prevention study, Archives of General Psychiatry, 69, 166-176
Sikkema 2007/2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Efficacy or safety data cannot be extracted	Sikkema KJ, Hansen NB, Kochman A, Tarakeshwar N, Neufeld S, Meade CS, Fox AM. Outcomes from a group intervention for coping with HIV/AIDS and childhood sexual abuse: reductions in traumatic stress. AIDS and Behavior. 2007 Jan 1;11(1):49-60.	Sikkema KJ, Ranby KW, Meade CS, Hansen NB, Wilson PA, Kochman A. Reductions in traumatic stress following a coping intervention were mediated by decreases in avoidant coping for people living with HIV/AIDS and childhood sexual abuse. Journal of consulting and clinical psychology. 2013 Apr;81(2):274.
Zoellner 2011	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Zoellner, L. A., Feeny, N. C., Eftekhari, A., Foa, E. B. (2011) Changes in negative beliefs following three brief programs for facilitating recovery after	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			assault, Depression and Anxiety, 28, 532-540	

Psychological: Behavioural therapies

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Agorastos 2011	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Non-systematic review	Agorastos, A., Marmar, C., Otte, C. (2011) Immediate and early behavioural interventions for the prevention of acute and posttraumatic stress disorder, Current Opinion in Psychiatry, 24, 526-532	
Dawson 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined) AND Cochrane allRQ update	Preliminary report of RCT already included (Bryant 2017)	Dawson KS, Schafer A, Anjuri D, Ndogoni L, Musyoki C, Sijbrandij M, Van Ommeren M, Bryant RA. Feasibility trial of a scalable psychological intervention for women affected by urban adversity and gender-based violence in Nairobi. BMC psychiatry. 2016 Nov 18;16(1):410.	
Wagner 2007	ISTSS included lists	Sample size (N<10/arm)	Wagner AW, Zatzick DF, Ghesquiere A, Jurkovich	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			GJ. Behavioral activation as an early intervention for posttraumatic stress disorder and depression among physically injured trauma survivors. Cognitive and Behavioral Practice. 2007 Nov 30;14(4):341-9.	

Psychological: Cognitive therapies

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Bar-Haim 2012	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Population outside scope: Trials of soldiers on active service	Bar-Haim, Y., Fruchter, E. (2012) Prevention of Posttraumatic Symptoms in IDF Soldiers Using Attention Bias Modification (ABM): A Randomized Controlled Trial, clinicaltrials.gov, NCT01723215	
Birur 2017a	RQ 1.1-1.2 & 2.1-2.2 (searches combined) AND RQ 1.1-1.2 & 2.1-2.2 update	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Birur B, Moore NC, Davis LL. An evidence-based review of early intervention and prevention of posttraumatic stress disorder. Community mental health journal.	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			2017 Feb 1;53(2):183-201.	
Chan 2005	Handsearch	Intervention outside protocol	Chan, Y. M., Lee, P. W., Fong, D. Y., Fung, A. S., Wu, L. Y., Choi, A. Y., . . . Wong, L. C. (2005). Effect of individual psychological intervention in Chinese women with gynecologic malignancy: A randomized trial. Journal of Clinical Oncology, 23(22), 4913–4924.	Nenova, M., Morris, L., Paul, L., Li, Y., Applebaum, A., DuHamel, K. (2013) Psychosocial interventions with cognitive-behavioral components for the treatment of cancer-related traumatic stress symptoms: A review of randomized controlled trials, Journal of Cognitive Psychotherapy, 27, 258-284
Cicerone 2008	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention not targeted at PTSD symptoms	Cicerone, K. D., Mott, T., Azulay, J., Sharlow-Galella, M. A., Ellmo, W. J., Paradise, S., Friel, J. C. (2008) A randomized controlled trial of holistic neuropsychologic rehabilitation after traumatic brain injury, Archives of physical medicine and rehabilitation, 89, 2239-2249	
Cuijpers 2005	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any	Cuijpers, P., Van Straten, A., Smit, F. (2005)	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
		meta-analysis results not appropriate to extract	Preventing the Incidence of New Cases of Mental Disorders: A Meta-Analytic Review, Journal of Nervous and Mental Disease, 193, 119-125	
Garcia-Torres 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Non-English language paper	Garcia-Torres, F., Alos, F. J., Perez-Duenas, C. (2015) Posttraumatic stress disorder in cancer survivors: A review of the psychological treatments available, Psicooncologia, 12, 293-301	
Gartlehner 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Gartlehner, G., Forneris, C. A., Brownley, K. A., Gaynes, B. N., Sonis, J., Coker-Schwimmer, E., Jonas, D. E., Greenblatt, A., Wilkins, T. M., Woodell, C. L., Lohr, K. N. (2013) Interventions for the prevention of posttraumatic stress disorder (PTSD) in a	
Gidron 2007	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Efficacy or safety data cannot be extracted	Gidron Y, Gal R, Givati G, Lauden A, Snir Y, Benjamin J. Interactive effects of memory structuring and gender in preventing posttraumatic	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			stress symptoms. The Journal of nervous and mental disease. 2007 Feb 1;195(2):179-82.	
Johansson 2008	Handsearch	Non-randomised group assignment	Johansson, B., Brandberg, Y., Hellbom, M., Persson, C., Petersson, L. M., Berglund, G., & Glimelius, B. (2008). Health-related quality of life and distress in cancer patients: Results from a large randomized study. British Journal of Cancer, 99, 1975–1983.	Nenova, M., Morris, L., Paul, L., Li, Y., Applebaum, A., DuHamel, K. (2013) Psychosocial interventions with cognitive-behavioral components for the treatment of cancer-related traumatic stress symptoms: A review of randomized controlled trials, Journal of
Kamal 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Paper unavailable	Kamal, A. M., Fathy, H. (2013) Psychiatric assessment of disfigured burn patients following cognitive behavioral therapy program, Egyptian Journal of Neurology, Psychiatry and Neurosurgery, 50, 19-24	
Kliem 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Kliem, S., Kroger, C. (2013) Prevention of chronic PTSD with early cognitive behavioral therapy. A meta-analysis using mixed-effects	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			modeling, Behaviour Research and Therapy, 51, 753-761	
Knaevelsrud 2010	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Knaevelsrud, C., Liedl, A., Maercker, A. (2010) Posttraumatic growth, optimism and openness as outcomes of a cognitive-behavioural intervention for posttraumatic stress reactions, Journal of health psychology, 15, 1030-1038	
Lopes 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Lopes, A. P., Macedo, T. F., Coutinho, E. S., Figueira, I., Ventura, P. R. (2014) Systematic review of the efficacy of cognitive-behavior therapy related treatments for victims of natural disasters: a worldwide problem, PLoS ONE, 9, e109013	
Maia 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Maia, A. C. C. O., Braga, A. A., Soares-Filho, G., Pereira, V., Nardi, A. E., Silva, A. C. (2014) Efficacy of cognitive behavioral therapy in	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			reducing psychiatric symptoms in patients with implantable cardioverter defibrillator: An integrative review, Brazilian Journal of Medical and Biological Research, 47, 265-272	
Melnyk 2004	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Interventions not relevant to this review (to be considered for other relevant RQ)	Melnyk BM, Alpert-Gillis L, Feinstein NF, Crean HF, Johnson J, Fairbanks E, Small L, Rubenstein J, Slota M, Corbo-Richert B. Creating opportunities for parent empowerment: program effects on the mental health/coping outcomes of critically ill young children and their mothers. Pediatrics. 2004 Jun;113(6):e597-607.	
Moore 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Non-randomised group assignment	Moore, M., Winkelman, A., Kwong, S., Segal, S., Manley, G., Shumway, M. (2015) The emergency department social work intervention for mild traumatic brain injury (SWIFT-Acute): a pilot study, Brain Injury, 28, 448-455	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Patel 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Patel, N., Kellezi, B., Williams, A. C. (2014) Psychological, social and welfare interventions for psychological health and well-being of torture survivors, Cochrane Database of Systematic Reviews, CD009317	
Shea 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Population outside scope: Trials of soldiers on active service	Shea, M. T., Lambert, J., Reddy, M. K. (2013) A randomized pilot study of anger treatment for Iraq and Afghanistan veterans, Behaviour Research & Therapy, 51, 607-613	

Psychological: Counselling

Study ID	Search	Reason for exclusion	Ref 1
Bunn 1979	2004 GL (excluded)	Intervention not targeted at PTSD symptoms	Bunn, T.A. & Clarke, A.M. (1979) Crisis intervention: an experimental study of the effects of a brief period of counselling on the anxiety of relatives of seriously injured or ill hospital patients. British Journal of Medical Psychology, 52, 191-195
Doctor 1994	2004 GL (excluded)	Non-randomised group assignment	Doctor, R.S.; Curtis, D.; & Isaacs, G. (1994) Psychiatric morbidity in policemen and the effect of brief psychotherapeutic intervention - a pilot study. Stress Medicine, 10, 151-157

Study ID	Search	Reason for exclusion	Ref 1
Gillum 2009	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention not targeted at PTSD symptoms	Gillum, T. L., Sun, C. J., Woods, A. B. (2009) Can a health clinic-based intervention increase safety in abused women? Results from a pilot study, Journal of Women's Health, 18, 1259-1264
Hansen 2007	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Hansen, N., Kershaw, T., Kochman, A., Sikkema, K. (2007) A classification and regression trees analysis predicting treatment outcome following a group intervention randomized controlled trial for HIV-positive adult survivors of childhood sexual abuse, Psychotherapy Research, 17, 404-415
Hawkes 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention not targeted at PTSD symptoms	Hawkes, A. L., Pakenham, K. I., Chambers, S. K., Patrao, T. A., Courneya, K. S. (2014) Effects of a multiple health behavior change intervention for colorectal cancer survivors on psychosocial outcomes and quality of life: a randomized controlled trial, Annals of behavioral medicine : a publication of the Society of Behavioral Medicine, 48, 359-370
Kissane 2007	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Efficacy or safety data cannot be extracted	Kissane DW, Grabsch B, Clarke DM, Smith GC, Love AW, Bloch S, Snyder RD, Li Y. Supportive-expressive group therapy for women with metastatic breast cancer: survival and psychosocial outcome from a randomized controlled trial. Psycho-Oncology. 2007 Apr 1;16(4):277-86.
Lane 2005	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention not targeted at PTSD symptoms	Lane, L. G., Viney, L. L. (2005) The effects of personal construct group therapy on breast cancer survivors, Journal of Consulting & Clinical Psychology, 73, 284-292
Lee 2006	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention not targeted at PTSD symptoms	Lee, V., Robin Cohen, S., Edgar, L., Laizner, A. M., Gagnon, A. J. (2006) Meaning-making intervention during breast or colorectal cancer treatment improves self-esteem, optimism, and self-efficacy, Social Science & Medicine, 62, 3133-45
Small 2016	RQ 1.1-1.2 & 2.1-2.2 update	Comparison outside protocol	Small E, Kim YK, Praetorius RT, Mitschke DB. Mental health treatment for resettled refugees: A comparison of three

Study ID	Search	Reason for exclusion	Ref 1
			approaches. Social Work in Mental Health. 2016 Jul 3;14(4):342-59.
Viney 1985	2004 GL (excluded)	Intervention not targeted at PTSD symptoms	Viney, L.L.; Clarke, A.M.; Bunn, T.A.; Benjamin, Y.N. (1985) An evaluation of three crisis intervention programmes for general hospital patients. British Journal of Medical Psychology, 58, 75-86

Psychological: Couple interventions

Study ID	Search	Reason for exclusion	Ref 1
Heinrichs 2012	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention not targeted at PTSD symptoms	Heinrichs, N., Zimmermann, T., Huber, B., Herschbach, P., Russell, D. W., Baucom, D. H. (2012) Cancer distress reduction with a couple-based skills training: a randomized controlled trial, Annals of behavioral medicine : a publication of the Society of Behavioral Medicine, 43, 239-252

Psychological: EMDR

Study ID	Search	Reason for exclusion	Ref 1
Cvetek 2008	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Population outside scope: No trauma or traumatic event does not meet criteria	Cvetek, R. (2008) EMDR treatment of distressful experiences that fail to meet the criteria for PTSD, Journal of EMDR Practice and Research, 2, 2-14
Dunn 1996	2004 GL (excluded)	Non-randomised group assignment	Dunn, T. M., Schwartz, M., Hatfield, R. W., & Wiegele, M. (1996). Measuring effectiveness of eye movement desensitization and reprocessing (EMDR) in non-clinical anxiety: a multi-subject, yoked-control

Study ID	Search	Reason for exclusion	Ref 1
			design. Journal of Behavior Therapy & Experimental Psychiatry, 27, 231-239.
Novo 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Population outside scope: Trials of people with psychosis as a coexisting condition	Novo P, Landin-Romero R, Radua J, Vicens V, Fernandez I, Garcia F, Pomarol-Clotet E, McKenna PJ, Shapiro F, Amann BL. Eye movement desensitization and reprocessing therapy in subsyndromal bipolar patients with a history of traumatic events: A randomized, controlled pilot-study. Psychiatry research. 2014 Sep 30;219(1):122-8.
Shapiro 2015	ISTSS included lists	Sample size (N<10/arm)	Shapiro E, Laub B. Early EMDR intervention following a community critical incident: a randomized clinical trial. Journal of EMDR Practice and Research. 2015 Feb 1;9(1):17-27.
Wilson 2001	2004 GL (excluded)	Population outside scope: Inoculation interventions for people who may be at risk of experiencing but have not experienced, a traumatic event	Wilson, S. A. (2001). Stress management with law enforcement personnel: A controlled outcome study of EMDR versus a traditional stress management program. International Journal of Stress Management, 8, Jul-200.

Psychological: Hypnotherapy

Study ID	Search	Reason for exclusion	Ref 1
Shakibaei 2007	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Outcome measures are not validated	Shakibaei, F., Harandi, A., Gholamrezaei, A., Samoei, R., Salehi, P. (2007) Hypnotherapy in management of pain and reexperiencing of trauma in burn patients, International Journal of Clinical and Experimental Hypnosis, 56, epub

Psychological: Non-trauma focussed CBT

Study ID	Search	Reason for exclusion	Ref 1
Donta 2003	2004 GL (excluded)	Intervention not targeted at PTSD symptoms	Donta, S.T. et al (2003) Cognitive behavioral therapy and aerobic exercise for Gulf War veterans' illnesses. A randomized controlled trial. JAMA, 289, 11, 1396-1404
Farchi 2010	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Outcome measures are not validated	Farchi M, Gidron Y. The effects of “psychological inoculation” versus ventilation on the mental resilience of Israeli citizens under continuous war stress. The Journal of nervous and mental disease. 2010 May 1;198(5):382-4.
Garland 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined) AND Cochrane allRQ update	Intervention not targeted at PTSD symptoms	Garland EL, Roberts-Lewis A, Tronnier CD, Graves R, Kelley K. Mindfulness-Oriented Recovery Enhancement versus CBT for co-occurring substance dependence, traumatic stress, and psychiatric disorders: proximal outcomes from a pragmatic randomized trial. Behaviour research and therapy. 2016 Feb 29;77:7-16.
Irvine 2010	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Efficacy or safety data cannot be extracted	Irvine, J., Stanley, J., Ong, L., Cribbie, R., Ritvo, P., Katz, J., Dorian, P., O'Donnell, S., Harris, L., Cameron, D., Hill, A., Newman, D., Johnson, S. N., Bilanovic, A., Sears Jr, S. F. (2010) Acceptability of a cognitive behavior therapy intervention to implantable cardioverter defibrillator recipients, Journal of cognitive psychotherapy, 24, 246-264
Irvine 2011	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Population outside scope: Inoculation interventions for people who may be at risk of experiencing but have not experienced, a traumatic event	Irvine, J., Firestone, J., Ong, L., Cribbie, R., Dorian, P., Harris, L., Ritvo, P., Katz, J., Newman, D., Cameron, D., Johnson, S., Bilanovic, A., Hill, A., O'Donnell, S., Sears, S., Jr. (2011) A randomized controlled trial of cognitive behavior therapy tailored to psychological adaptation to an implantable cardioverter defibrillator, Psychosomatic Medicine, 73, 226-233
Khan 2017b	Cochrane allRQ update	Intervention not targeted at PTSD symptoms	Khan MN, Hamdani SU, Chiumento A, Dawson K, Bryant RA, Sijbrandij M, Nazir H, Akhtar P, Masood A, Wang D, Wang E. Evaluating feasibility and acceptability of a group WHO trans-diagnostic intervention for women with common mental disorders

Study ID	Search	Reason for exclusion	Ref 1
			in rural Pakistan: A cluster randomised controlled feasibility trial. Epidemiology and psychiatric sciences. 2017 Jul:1-1.
Kunze 2017	RQ 1.1-1.2 & 2.1-2.2 update	Intervention not targeted at PTSD symptoms	Kunze AE, Arntz A, Morina N, Kindt M, Lancee J. Efficacy of imagery rescripting and imaginal exposure for nightmares: A randomized wait-list controlled trial. Behaviour research and therapy. 2017 Oct 1;97:14-25.
Ponsford 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention not targeted at PTSD symptoms	Ponsford, J., Lee, N., Wong, D., McKay, A., Haines, K., Always, Y., Downing, M., Furtado, C., O'Donnell, M. (2015) Efficacy of motivational interviewing and cognitive behavioural therapy for anxiety and depression symptoms following traumatic brain injury, Psychological Medicine, 46, 1079-1090
van Schagen 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention not targeted at PTSD symptoms	van Schagen AM, Lancee J, de Groot IW, Spoormaker VI, van den Bout J. Imagery rehearsal therapy in addition to treatment as usual for patients with diverse psychiatric diagnoses suffering from nightmares: a randomized controlled trial. The Journal of clinical psychiatry. 2015 Sep;76(9):e1105-13.
Vitriol 2009	RQ 1.1-1.2 & 2.1-2.2 (searches combined)		
Ye 2017	RQ 1.1-1.2 & 2.1-2.2 update		

Psychological: Problem solving

Study ID	Search	Reason for exclusion	Ref 1
Bell 2017	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Population outside scope: Trials of soldiers on active service	Bell, K. R., Fann, J. R., Brockway, J. A., Cole, W. R., Bush, N. E., Dikmen, S., Hart, T., Lang, A. J., Grant, G., Gahm, G., Reger, M. A., St De Lore, J., Machamer, J, Ernstrom, K., Raman, R., Jain, S., Stein, M. B., Temkin, N. (2017) Telephone Problem Solving for Service

Study ID	Search	Reason for exclusion	Ref 1
			Members with Mild Traumatic Brain Injury: A Randomized, Clinical Trial, Journal of Neurotrauma, 34, 313-321
Larson 2000	Handsearch	Efficacy or safety data cannot be extracted	Larson, M. R., Duberstein, P. R., Talbot, N. L., Galdwell, C, & Moynihan, J. A. (2000). A presurgical psychosocial intervention for breast cancer patients: Psychological distress and the immune response. Journal of Psychosomatic Research, 48, 187–194.

Psychological: Psychoeducation

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Acierno 2003	Handsearch	Intervention not targeted at PTSD symptoms	Acierno, R., Resnick, H., Flood, A., Holmes, M. (2003) An acute post-rape intervention to prevent substance use and abuse, Addictive Behaviours, 28, 1701-1715	
Acierno 2004	Handsearch	Efficacy or safety data cannot be extracted	Acierno, R., Rheingold, A., Resnick, H., Stark-Reimer, W. (2004) Preliminary evaluation of a video-based intervention for older adults victims of violence, Journal of Traumatic Stress, 17, 535-541	Gartlehner, G., Forneris, C. A., Brownley, K. A., Gaynes, B. N., Sonis, J., Coker-Schwimmer, E., Jonas, D. E., Greenblatt, A., Wilkins, T. M., Woodell, C. L., Lohr, K. N. (2013) Interventions for the prevention of posttraumatic stress disorder (PTSD) in a
Als 2015	RQ 1.1-1.2 & 2.1-2.2	Sample size (N<10/arm)	Als, L. C., Nadel, S., Cooper, M., Vickers, B., Garralda, M. E. (2015) A supported	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
	(searches combined)		psychoeducational intervention to improve family mental health following discharge from paediatric intensive care: feasibility and pilot randomised controlled trial, BMJ Open, 5, e009581	
Bell 2008	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Non-randomised group assignment	Bell, K., Hoffman, J., Temkin, N., Powell, J., Fraser, R., Esselman, P., Barber, J., Dikmen, S. (2008) The effect of telephone counselling on reducing posttraumatic symptoms after mild traumatic brain injury: A randomised trial, Journal of Neurology, Neurosurgery & Psychiatry, 79, 1275-1281	
Bell 2011	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention not targeted at PTSD symptoms	Bell, K. R., Brockway, J. A., Hart, T., Whyte, J., Sherer, M., Fraser, R. T., Temkin, N. R., Dikmen, S. S. (2011) Scheduled telephone intervention for traumatic brain injury: a multicenter randomized controlled trial, Archives of physical medicine and rehabilitation, 92, 1552-60	
Castro 2012	RQ 1.1-1.2 & 2.1-2.2	Population outside scope: Trials of soldiers on active service	Castro, C. A., Adler, A. B., McGurk, D., Bliese, P. D. (2012) Mental health training	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
	(searches combined)		with soldiers four months after returning from Iraq: randomization by platoon, Journal of traumatic stress, 25, 376-83	
Chevillon 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention not targeted at PTSD symptoms	Chevillon, C., Hellyar, M., Madani, C., Kerr, K., Kim, S. C. (2015) Preoperative education on postoperative delirium, anxiety, and knowledge in pulmonary thromboendarterectomy patients, American journal of critical care : an official publication, American Association of Critical-Care Nurses, 24, 164-171	
Franzen 2009	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention not targeted at PTSD symptoms	Franzén, C., Brulin, C., Stenlund, H., Björnstig, U. (2009) Injured road users' health-related quality of life after telephone intervention: a randomised controlled trial, Journal of clinical nursing, 18, 108-116	
Gouweloos 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Gouweloos, J., Duckers, M., te Brake, H., Kleber, R., Drogendijk, A. (2014) Psychosocial care to affected citizens and communities in case of CBRN incidents: a	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			systematic review, Environment International, 72, 46-65	
Guest 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Guest, R., Tran, Y., Gopinath, B., Cameron, I. D., Craig, A. (2016) Psychological distress following a motor vehicle crash: A systematic review of preventative interventions, Injury, 47, 2415-2423	
Guo 2012	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention not targeted at PTSD symptoms	Guo, P., East, L., Arthur, A. (2012) A preoperative education intervention to reduce anxiety and improve recovery among Chinese cardiac patients: a randomized controlled trial, International journal of nursing studies, 49, 129-137	
Hoekstra-Weebers 1998	Handsearch	Intervention not targeted at PTSD symptoms	Hoekstra-Weebers JE, Heuvel F, Jaspers JP, Kamps WA, Klip EC. Brief report: an intervention program for parents of pediatric cancer patients: a randomized controlled trial. Journal of Pediatric Psychology. 1998 Jun 1;23(3):207-14.	
Mulligan 2011	RQ 1.1-1.2 & 2.1-2.2	Systematic review with no new useable data and any meta-	Mulligan, K., Fear, N. T., Jones, N., Wessely, S., Greenberg, N. (2011) Psycho-	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
	(searches combined)	analysis results not appropriate to extract	educational interventions designed to prevent deployment-related psychological ill-health in Armed Forces personnel: a review, Psychological medicine, 41, 673-686	
Neves 2009	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention not targeted at PTSD symptoms	Neves, A., Alves, A., Ribeiro, F., Gomes, J., Oliveira, J. (2009) The effecr of cardiac rehabilitation with relaxation therapy on psychological, hemodynamic, and hospital admission outcome variables, Journal of Cardiopulmonary Rehabilitation and Prevention, 29, 304-309	
Resnick 2007	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Non-randomised group assignment	Resnick, H., Acierno, R., Waldrop, A., King, L., King, D., Danielson, C., Ruggiero, K., Kilpatrick, D. (2007) Randomised controlled evaluation of an early intervention to prevent post-rape psychopathology, Behaviour Research and Therapy, 45, 2432-2447	
Salem 2017	Cochrane allRQ update	Outcomes are not of interest	Salem H, Johansen C, Schmiegelow K, Winther JF, Wehner PS, Hasle H, Rosthøj S, Kazak AE, E. Bidstrup P.	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			FAMily-Oriented Support (FAMOS): development and feasibility of a psychosocial intervention for families of childhood cancer survivors. Acta Oncologica. 2017 Feb 1;56(2):367-74.	
Stanton 2005	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention not targeted at PTSD symptoms	Stanton, A. L., Ganz, P. A., Kwan, L., Meyerowitz, B. E., Bower, J. E., Krupnick, J. L., Rowland, J. H., Leedham, B., Belin, T. R. (2005) Outcomes from the Moving Beyond Cancer psychoeducational, randomized, controlled trial with breast cancer patients, Journal of clinical oncology : official journal of the American Society of Clinical Oncology, 23, 6009-6018	
Wade 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Wade, D. M., Moon, Z., Windgassen, S. S., Harrison, A. M., Morris, L., Weinman, J. A. (2016) Non-pharmacological interventions to reduce ICU-related psychological distress: A systematic review, Minerva Anestesiologica, 82, 465-478	

Psychological: Psychologically-focussed debriefing

Study ID	Search	Reason for exclusion	Ref 1
Adler 2009	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Population outside scope: Trials of soldiers on active service	Adler, A., Bliese, P., McGurk, D., Hoge, C., Castro, C. (2009) Battlemind debriefing and battlemind training as early interventions with soldiers returning from iraq: Randomization by platoon, Journal of Consulting and Clinical Psychology, 77, 928-940
Armstrong 1991	2004 GL (excluded)	Non-randomised group assignment	Armstrong, K.; O'Callahan, W. & Marmar, C. (1991) Debriefing red cross disaster personnel: The multiple stressor debriefing model. Journal of Traumatic Stress, 4, 4, 581-593
Busuttil 1995	2004 GL (excluded)	Non-RCT (no control group)	Busuttil, W.; Turnbull, G.J.; Neal, L.A.; Rollins, J.; West, A.G.; Blanch, N. & Herepath, R. (1995) Incorporating psychological debriefing techniques within a brief group psychotherapy programme for the treatment of Post-Traumatic Stress Disorder. British Journal of Psychiatry, 167, 495-502
Campfield 2001	2004 GL (included)	Comparison outside protocol	Campfield, K. M. & Hills, A. M. (2001). Effect of timing of critical incident stress debriefing (CISD) on posttraumatic symptoms. Journal of Traumatic Stress, 14, 327-340.
Carlier 1998	2004 GL (excluded)	Non-randomised group assignment	Carlier, I.V.E.; Lamberts, R.D.; Uchelen, A.J.V.; Gersons, B.P.R. (1998) Disaster-related post-traumatic stress disorder inpolice officers: a field study of the impact of debriefing. Stress Medicine, 14, 143-148
Carlier 2000	2004 GL (excluded)	Non-randomised group assignment	Carlier, I.V.E.; Voerman, A.E. & Gersons, B.P.R. (2000) The influence of occupational debriefing on post-traumatic stress symptomatology in traumatized police officers. British Journal of Medical Psychology, 73, 87-98
Chemtob 1997a	2004 GL (excluded)	Non-randomised group assignment	Chemtob, C.M.; Tomas, S.; Law, W. & Cremniter, D. (1997) Postdisaster psychosocial intervention: a field study on the impact of debriefing on psychological distress. Americal Journal of Psychiatry, 154, 3, 415-417
Deahl 1994	2004 GL (excluded)	Non-randomised group assignment	Deahl, M.P.; Gillham, A.B.; Thomas, J.; Searle, M.M. & Srinivasan, M. (1994) Psychological sequelae following the Gulf war factors. Factors

Study ID	Search	Reason for exclusion	Ref 1
			associated with subsequent morbidity and the effectiveness of psychological debriefing. British Journal of Psychiatry, 165, 60-65
Deahl 2000	2004 GL (excluded)	Setting outside scope: Treatment provided to troops on operational deployment or exercise	Deahl, M., Srinivasan, M., Jones, N., Thomas, J., Neblett, C., & Jolly, A. (2000). Preventing psychological trauma in soldiers: the role of operational stress training and psychological debriefing. British Journal of Medical Psychology, 73, 77-85.
Gilbert 2009	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Conference abstract	Gilbert, E., Wahlquist, A. (2009) Early treatment for PTSD, Journal of the National Medical Association, 101, 742
Jenkins 1996	2004 GL (excluded)	Non-RCT (no control group)	Jenkins, S.R. (1996) Social support and debriefing efficacy among emergency medical workers after a mass shooting incident. Journal of Social Behavior and Personality, 11, 3, 477-492
Kenardy 1996	2004 GL (excluded)	Non-randomised group assignment	Kenardy JA, Webster RA, Lewin TJ, Carr VJ, Hazell PL, Carter GL.(1996). Stress debriefing and patterns of recovery following a natural disaster.J Trauma Stress. 1996 Jan;9(1):37-49
Lavender 1998	2004 GL (excluded)	Population outside scope: Trials of women with PTSD during pregnancy or in the first year following childbirth	Lavender T, Walkinshaw S (1998) Can Midwives Reduce Postpartum Psychological Morbidity? A Randomized Trial. Birth, 25: 215-219
Lee 1996	2004 GL (included)	Population outside scope: Trials of women with PTSD during pregnancy or in the first year following childbirth	Lee, C.; Slade, P.; Lygo, V. (1996) The influence of psychological debriefing on emotional adaptation in women following early miscarriage: A preliminary study. British Journal of Medical Psychology, 69, 47-58

Study ID	Search	Reason for exclusion	Ref 1
Litz (unpublised)	2004 GL (excluded)	Paper unavailable	Litz et al. (unpublished). Randomised controlled trial of single session Critical Incident Stress Debriefing with a single session stress management vs no intervention for Kosovo Peacekeepers.
Macnab 1999	2004 GL (excluded)	Non-RCT (no control group)	Macnab, A.J.; Russell. J.A.; Lowe, J.P. & Gaggnon, F. (1999) Critical incident stress intervention after loss of an air ambulance: two-year follow up. Prehospital and Disaster Medicine, 14, 1, 15/8- 19/12
Matthews 1998	2004 GL (excluded)	Non-randomised group assignment	Matthews, L. R. (1998). Effect of staff debriefing on posttraumatic stress symptoms after assaults by community housing residents. Psychiatric Services, 49, 207-212.
Mayou 2000	2004 GL (included)	Efficacy or safety data cannot be extracted	Mayou, R. A., Ehlers, A., & Hobbs, M. (2000). Psychological debriefing for road traffic accident victims. Three-year follow-up of a randomised controlled tria#l. British Journal of Psychiatry, 176, 589-593
NCT00455390	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Unpublished (registered on clinical trials.gov and author contacted for full trial report but not provided)	NCT00455390. Evaluation of the Effects of Post-Immediate Psychotherapeutic Interventions in Secondary Prevention of Psychotraumatic Disorders (IPPI A).
Richards 2001	2004 GL (excluded)	Non-randomised group assignment	Richards, D. (2001). A field study of critical incident stress debriefing versus critical incident stress management. Journal of Mental Health, 10, 351-362.
Roberts 2009	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Roberts N., Kitchiner N., Kenardy, J., Bisson J. (2009) Multiple session early psychological interventions for the prevention of post-traumatic stress disorder, Cochrane Database of Systematic Reviews,
Roberts 2010	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-	Roberts N., Kitchiner N., Kenardy, J., Bisson J. (2010) Early psychological interventions to treat acute traumatic stress symptoms, Cochrane Database of Systematic Reviews

Study ID	Search	Reason for exclusion	Ref 1
		analysis results not appropriate to extract	
Robinson 1993	2004 GL (excluded)	Non-RCT (no control group)	Robinson, R.C. & Mitchell, J.T. (1993) Evaluation of psychological debriefings. Journal of Traumatic Stress, 6, 3, 367-382
Shalev 1998	2004 GL (excluded)	Non-RCT (no control group)	Shalev, A.Y.; Peri, T.; Rogel-Fuchs, Y. Ursano, R.J. & Marlowe, D. (1998) Historical group debriefing after combat exposure. Military Medicine, 163, 494-498
Skeffington 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Population outside scope: Inoculation interventions for people who may be at risk of experiencing but have not experienced, a traumatic event	Skeffington, P. M., Rees, C. S., Kane, R. (2013) The Primary Prevention of PTSD: A Systematic Review, Journal of Trauma and Dissociation, 14, 404-422
Wu 2012	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Population outside scope: Trials of soldiers on active service	Wu, S., Zhu, X., Zhang, Y., Liang, J., Liu, X., Yang, Y., Yang, H., Miao, D. (2012) A new psychological intervention: "512 Psychological Intervention Model" used for military rescuers in Wenchuan Earthquake in China, Social Psychiatry & Psychiatric Epidemiology, 47, 1111-1119

Psychological: Self-help (without support)

Study ID	Search	Reason for exclusion	Ref 1
Beatty 2010b	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Comparison outside protocol	Beatty, L. J., Koczwara, B., Rice, J., Wade, T. D. (2010) A randomised controlled trial to evaluate the effects of a self-help workbook intervention on distress, coping and quality of life after breast cancer diagnosis, The Medical journal of Australia, 193, S68-73

Study ID	Search	Reason for exclusion	Ref 1
Callinan 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention not targeted at PTSD symptoms	Callinan S, Johnson D, Wells A. A randomised controlled study of the effects of the attention training technique on traumatic stress symptoms, emotional attention set shifting and flexibility. Cognitive Therapy and Research. 2015 Feb 1;39(1):4-13.
Held 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Comparison outside protocol	Held P, Owens GP. Effects of self-compassion workbook training on trauma-related guilt in a sample of homeless veterans: A pilot study. Journal of clinical psychology. 2015 Jun 1;71(6):513-26.
Kahn 2016	RQ 1.1-1.2 & 2.1-2.2 update	Population outside scope: <80% of the study's participants are eligible for the review and disaggregated data cannot be obtained	Kahn JR, Collinge W, Soltysik R. Post-9/11 veterans and their partners improve mental health outcomes with a self-directed mobile and web-based wellness training program: a randomized controlled trial. Journal of medical internet research. 2016 Sep;18(9).
Meston 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Comparison outside protocol	Meston CM, Lorenz TA, Stephenson KR. Effects of expressive writing on sexual dysfunction, depression, and PTSD in women with a history of childhood sexual abuse: Results from a randomized clinical trial. The journal of sexual medicine. 2013 Sep 1;10(9):2177-89.
Possemato 2011	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Efficacy or safety data cannot be extracted	Possemato K, Ouimette P, Knowlton P. A brief self-guided telehealth intervention for post-traumatic stress disorder in combat veterans: a pilot study. Journal of telemedicine and telecare. 2011 Jul;17(5):245-50.
Sayer 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Efficacy or safety data cannot be extracted	Sayer NA, Noorbaloochi S, Frazier PA, Pennebaker JW, Orazem RJ, Schnurr PP, Murdoch M, Carlson KF, Gravely A, Litz BT. Randomized controlled trial of online expressive writing to address readjustment difficulties among US Afghanistan and Iraq war veterans. Journal of traumatic stress. 2015 Oct 1;28(5):381-90.

Study ID	Search	Reason for exclusion	Ref 1
Stevens 2017	RQ 1.1-1.2 & 2.1-2.2 update	Subgroup/secondary analysis of RCT already included	Stevens NR, Holmgreen L, Walt L, Gengler R, Hobfoll SE. Web-based trauma intervention for veterans has physical health payoff in randomized trial. Psychological Trauma: Theory, Research, Practice, and Policy. 2017 Aug;9(S1):42.

Psychological: Self-help with support

Study ID	Search	Reason for exclusion	Ref 1
Cernvall 2017	RQ 1.1-1.2 & 2.1-2.2 update	Efficacy or safety data cannot be extracted	Cernvall M, Carlbring P, Wikman A, Ljungman L, Ljungman G, von Essen L. Twelve-Month Follow-Up of a Randomized Controlled Trial of Internet-Based Guided Self-Help for Parents of Children on Cancer Treatment. Journal of medical Internet research. 2017 Jul;19(7).
Mulligan 2012	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Population outside scope: Trials of soldiers on active service	Mulligan, K., Fear, N., Jones, N., Alvarez, H., Hull, L., Naumann, U., Wessely, S., Greenberg, N. (2012) Postdeployment battlemind training for the UK armed forces: a cluster randomised controlled trial, Journal of Consulting and Clinical Psychology, 80, 331-341

Psychosocial: Meditation

Study ID	Search	Reason for exclusion	Ref 1
Harris 2011	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention outside protocol	Harris JI, Erbes CR, Engdahl BE, Thuras P, Murray-Swank N, Grace D, Ogden H, Olson RH, Winskowski AM, Bacon R, Malec C. The effectiveness of a trauma focused spiritually integrated intervention for veterans exposed to trauma. Journal of clinical psychology. 2011 Apr 1;67(4):425-38.

Study ID	Search	Reason for exclusion	Ref 1
Hsiao 2012	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention not targeted at PTSD symptoms	Hsiao FH, Jow GM, Kuo WH, Chang KJ, Liu YF, Ho RT, Ng SM, Chan CL, Lai YM, Chen YT. The effects of psychotherapy on psychological well-being and diurnal cortisol patterns in breast cancer survivors. Psychotherapy and psychosomatics. 2012;81(3):173-82.
Levine 2005	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Efficacy or safety data cannot be extracted	Levine EG, Eckhardt J, Targ E. Change in post-traumatic stress symptoms following psychosocial treatment for breast cancer. Psycho-Oncology. 2005 Aug 1;14(8):618-35.
Nunes 2007	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention not targeted at PTSD symptoms	Nunes, D., Rodriguez, A., Hoffman, F., Luz, C., Filho, A., Muller, M., Bauer, M. (2007) Relaxation and guided imagery program in patients with breast cancer undergoing radiotherapy is not associated with neuroimmunomodulatory effects, Journal of Psychosomatic Research, 63, 647-655
Victorson 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention not targeted at PTSD symptoms	Victorson, D., Hankin, V., Burns, J., Weiland, R., Maletich, C., Sufrin, N., Schuette, S., Gutierrez, B., Brendler, C. (2016) Feasibility, acceptability and preliminary psychological benefits of mindfulness meditation training in a sample of men diagnosed with prostate cancer on active surveillance: Results from a randomized controlled pilot trial, Psycho Oncology., In Press
Yun 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention not targeted at PTSD symptoms	Yun, M. R., Song, M., Jung, K. H., Yu, B. J., Lee, K. J. (2016) The Effects of Mind Subtraction Meditation on Breast Cancer Survivors' Psychological and Spiritual Well-being and Sleep Quality: A Randomized Controlled Trial in South Korea, Cancer Nursing., 4

Psychosocial: Mindfulness-based Stress Reduction

Study ID	Search	Reason for exclusion	Ref 1
Grossman 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Non-randomised group assignment	Grossman, P., Zwahlen, D., Halter, J. P., Passweg, J. R., Steiner, C., Kiss, A. (2015) A mindfulness-based program for improving quality of life among

Study ID	Search	Reason for exclusion	Ref 1
			hematopoietic stem cell transplantation survivors: feasibility and preliminary findings, Supportive Care in Cancer, 23, 1105-1112
Lengacher 2009	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention not targeted at PTSD symptoms	Lengacher, C. A., Johnson-Mallard, V., Post-White, J., Moscoso, M. S., Jacobsen, P. B., Klein, T. W., Widen, R. H., Fitzgerald, S. G., Shelton, M. M., Barta, M., Goodman, M., Cox, C. E., Kip, K. E. (2009) Randomized controlled trial of mindfulness-based stress reduction (MBSR) for survivors of breast cancer, Psycho-oncology, 18, 1261-1272
Lengacher 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention not targeted at PTSD symptoms	Lengacher, C. A., Reich, R. R., Kip, K. E., Barta, M., Ramesar, S., Paterson, C. L., Moscoso, M. S., Carranza, I., Budhrani, P. H., Kim, S. J., Park, H. Y., Jacobsen, P. B., Schell, M. J., Jim, H. S., Post-White, J., Farias, J. R., Park, J. Y. (2014) Influence of mindfulness-based stress reduction (MBSR) on telomerase activity in women with breast cancer (BC), Biological research for nursing, 16, 438-447
Monti 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention not targeted at PTSD symptoms	Monti DA, Kash KM, Kunkel EJ, Moss A, Mathews M, Brainard G, Anne R, Leiby BE, Pequinot E, Newberg AB. Psychosocial benefits of a novel mindfulness intervention versus standard support in distressed women with breast cancer. Psycho-Oncology. 2013 Nov 1;22(11):2565-75.
Zernicke 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention not targeted at PTSD symptoms	Zernicke, K. A., Campbell, T. S., Speca, M., McCabe-Ruff, K., Flowers, S., Carlson, L. E. (2014) A randomized wait-list controlled trial of feasibility and efficacy of an online mindfulness-based cancer recovery program: the eTherapy for cancer applying mindfulness trial, Psychosomatic medicine, 76, 257-67
Zhang 2017	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention not targeted at PTSD symptoms	Zhang, J-Z., Zhou, Y-Q., Feng, Z-W., Fan, Y-N., Zeng, G-C., Wei, L. (2017) Randomized controlled trial of mindfulness-based stress reduction (MBSR) on posttraumatic growth of Chinese breast cancer survivors, Psychology, Health & Medicine, 22, 94-109

Psychosocial: Peer support

Study ID	Search	Reason for exclusion	Ref 1
Giese-Davis 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Efficacy or safety data cannot be extracted	Giese-Davis J, Bliss-Isberg C, Wittenberg L, White J, Star P, Zhong L, Cordova MJ, Houston D, Spiegel D. Peer-counseling for women newly diagnosed with breast cancer: A randomized community/research collaboration trial. Cancer. 2016 Aug 1;122(15):2408-17.
Hanks 2012	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention not targeted at PTSD symptoms	Hanks, R. A., Rapport, L. J., Wertheimer, J., Koviak, C. (2012) Randomized controlled trial of peer mentoring for individuals with traumatic brain injury and their significant others, Archives of physical medicine and rehabilitation, 93, 1297-304
Lipinski 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Lipinski, Kyle, Liu, Lucia L., Wong, Paul W. (2016) The effectiveness of psychosocial interventions implemented after the Indian Ocean Tsunami: A systematic review, International Journal of Social Psychiatry, 62, 271-280

Psychosocial: Practical support

Study ID	Search	Reason for exclusion	Ref 1
Brysiewicz 2006	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Brysiewicz, P., Chipps, J. (2006) The effectiveness of in-hospital psychological intervention programmes for families of critically ill patients - A systematic review, Southern African Journal of Critical Care, 22, 68-76
Porritt 1980	2004 GL (excluded)	Intervention not targeted at PTSD symptoms	Porritt, D. & Bordow, S. (1980). Effects of crisis intervention in road-injury patients. Patient Counselling & Health Education, 2, 178-183.

Psychosocial: Psycho-education

Study ID	Search	Reason for exclusion	Ref 1
Acierno 2003	Handsearch	Intervention not targeted at PTSD symptoms	Acierno, R., Resnick, H., Flood, A., Holmes, M. (2003) An acute post-rape intervention to prevent substance use and abuse, Addictive Behaviours, 28, 1701-1715
Acierno 2004	Handsearch	Efficacy or safety data cannot be extracted	Acierno, R., Rheingold, A., Resnick, H., Stark-Reimer, W. (2004) Preliminary evaluation of a video-based intervention for older adults victims of violence, Journal of Traumatic Stress, 17, 535-541
Als 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Sample size (N<10/arm)	Als, L. C., Nadel, S., Cooper, M., Vickers, B., Garralda, M. E. (2015) A supported psychoeducational intervention to improve family mental health following discharge from paediatric intensive care: feasibility and pilot randomised controlled trial, BMJ Open, 5, e009581
Bell 2008	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Non-randomised group assignment	Bell, K., Hoffman, J., Temkin, N., Powell, J., Fraser, R., Esselman, P., Barber, J., Dikmen, S. (2008) The effect of telephone counselling on reducing posttraumatic symptoms after mild traumatic brain injury: A randomised trial, Journal of Neurology, Neurosurgery & Psychiatry, 79, 1275-1281
Bell 2011	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention not targeted at PTSD symptoms	Bell, K. R., Brockway, J. A., Hart, T., Whyte, J., Sherer, M., Fraser, R. T., Temkin, N. R., Dikmen, S. S. (2011) Scheduled telephone intervention for traumatic brain injury: a multicenter randomized controlled trial, Archives of physical medicine and rehabilitation, 92, 1552-60
Castro 2012	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Population outside scope: Trials of soldiers on active service	Castro, C. A., Adler, A. B., McGurk, D., Bliese, P. D. (2012) Mental health training with soldiers four months after returning from Iraq: randomization by platoon, Journal of traumatic stress, 25, 376-83
Chevillon 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention not targeted at PTSD symptoms	Chevillon, C., Hellyar, M., Madani, C., Kerr, K., Kim, S. C. (2015) Preoperative education on postoperative delirium, anxiety, and knowledge in pulmonary thromboendarterectomy patients, American journal of critical care : an official publication, American Association of Critical-Care Nurses, 24, 164-171

Study ID	Search	Reason for exclusion	Ref 1
Franzen 2009	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention not targeted at PTSD symptoms	Franzén, C., Brulin, C., Stenlund, H., Björnstig, U. (2009) Injured road users' health-related quality of life after telephone intervention: a randomised controlled trial, Journal of clinical nursing, 18, 108-116
Gouweloos 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Gouweloos, J., Duckers, M., te Brake, H., Kleber, R., Drogendijk, A. (2014) Psychosocial care to affected citizens and communities in case of CBRN incidents: a systematic review, Environment International, 72, 46-65
Guest 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Guest, R., Tran, Y., Gopinath, B., Cameron, I. D., Craig, A. (2016) Psychological distress following a motor vehicle crash: A systematic review of preventative interventions, Injury, 47, 2415-2423
Guo 2012	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention not targeted at PTSD symptoms	Guo, P., East, L., Arthur, A. (2012) A preoperative education intervention to reduce anxiety and improve recovery among Chinese cardiac patients: a randomized controlled trial, International journal of nursing studies, 49, 129-137
Hoekstra-Weebers 1998	Handsearch	Intervention not targeted at PTSD symptoms	Hoekstra-Weebers JE, Heuvel F, Jaspers JP, Kamps WA, Klip EC. Brief report: an intervention program for parents of pediatric cancer patients: a randomized controlled trial. Journal of Pediatric Psychology. 1998 Jun 1;23(3):207-14.
Mulligan 2011	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Mulligan, K., Fear, N. T., Jones, N., Wessely, S., Greenberg, N. (2011) Psycho-educational interventions designed to prevent deployment-related psychological ill-health in Armed Forces personnel: a review, Psychological medicine, 41, 673-686
Neves 2009	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Population outside scope: Trials of people without PTSD	Neves, A., Alves, A., Ribeiro, F., Gomes, J., Oliveira, J. (2009) The effecr of cardiac rehabilitation with relaxation therapy on psychological, hemodynamic, and hospital admission outcome variables, Journal of Cardiopulmonary Rehabilitation and Prevention, 29, 304-309

Study ID	Search	Reason for exclusion	Ref 1
Resnick 2007	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Non-randomised group assignment	Resnick, H., Acierno, R., Waldrop, A., King, L., King, D., Danielson, C., Ruggiero, K., Kilpatrick, D. (2007) Randomised controlled evaluation of an early intervention to prevent post-rape psychopathology, Behaviour Research and Therapy, 45, 2432-2447
Salem 2017	Cochrane allRQ update	Outcomes are not of interest	Salem H, Johansen C, Schmiegelow K, Winther JF, Wehner PS, Hasle H, Rosthøj S, Kazak AE, E. Bidstrup P. FAMily-Oriented Support (FAMOS): development and feasibility of a psychosocial intervention for families of childhood cancer survivors. Acta Oncologica. 2017 Feb 1;56(2):367-74.
Stanton 2005	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention not targeted at PTSD symptoms	Stanton, A. L., Ganz, P. A., Kwan, L., Meyerowitz, B. E., Bower, J. E., Krupnick, J. L., Rowland, J. H., Leedham, B., Belin, T. R. (2005) Outcomes from the Moving Beyond Cancer psychoeducational, randomized, controlled trial with breast cancer patients, Journal of clinical oncology : official journal of the American Society of Clinical Oncology, 23, 6009-6018
Wade 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Wade, D. M., Moon, Z., Windgassen, S. S., Harrison, A. M., Morris, L., Weinman, J. A. (2016) Non-pharmacological interventions to reduce ICU-related psychological distress: A systematic review, Minerva Anestesiologica, 82, 465-478

Other non-pharm: Acupuncture

Study ID	Search	Reason for exclusion	Ref 1
Engel 2006	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Paper unavailable	Engel, C., Armstrong, D. (2006) Acupuncture for the treatment of trauma survivors, controlled-trials.com

Other non-pharm: Repetitive Transcranial Magnetic Stimulation

Study ID	Search	Reason for exclusion	Ref 1
Hendler 2012	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Paper unavailable	Hendler, T. (2012) Early EEG-NF Intervention for the Prevention of PTSD in First Time ACS Patients, Http://clinicaltrials.gov/show/NCT01729780

Other non-pharm: Yoga

Study ID	Search	Reason for exclusion	Ref 1
Telles 2010	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention not targeted at PTSD symptoms	Telles, S., Singh, N., Joshi, M., Balkrishna, A. (2010) Post traumatic stress symptoms and heart rate variability in Bihar flood survivors following yoga: A randomized controlled study, BMC Psychiatry, 10
Tiwari 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention not targeted at PTSD symptoms	Tiwari, A., Chan, C. L., Ho, R. T., Tsao, G. S., Deng, W., Hong, A. W., Fong, D. Y., Fung, H. Y., Pang, E. P., Cheung, D. S., Ma, J. L. (2014) Effect of a qigong intervention program on telomerase activity and psychological stress in abused Chinese women: a randomized, wait-list controlled trial, BMC Complementary & Alternative Medicine, 14, 300

Service delivery: Case management and coordination

Study ID	Search	Reason for exclusion	Ref 1
Cuthbertson 2009	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention not targeted at PTSD symptoms	Cuthbertson BH, Rattray J, Campbell MK, Gager M, Roughton S, Smith A, Hull A, Breeman S, Norrie J, Jenkinson D, Hernandez R, Johnston M, Wilson E, Waldmann C (2009) The PRaCTICaL study of nurse led, intensive care follow-up programmes for improving long term outcomes from critical illness: a pragmatic randomised controlled trial. BMJ 339:b3723
Douglas 2007	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention not targeted at PTSD symptoms	Douglas SL, Daly BJ, Kelley CG, O'Toole E, Montenegro H (2007) Chronically critically ill patients: health-related quality of life and

Study ID	Search	Reason for exclusion	Ref 1
			resource use after a disease management intervention. Am J Crit Care 16:447–457
Walters 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention not targeted at PTSD symptoms	Walters, J., Cameron-Tucker, H., Wills, K., Schuz, N., Scott, J., Robinson, A., Nelson, M., Turner, P., Wood-Baker, R., Walters, E. H. (2013) Effects of telephone health mentoring in community-recruited chronic obstructive pulmonary disease on self-management capacity, quality of life and psychological morbidity: A randomised controlled trial, BMJ Open, 3,

Service delivery: Collaborative care

Study ID	Search	Reason for exclusion	Ref 1
Faux 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Non-RCT (no control group)	Faux, S., Kohler, F., Mozer, R., Klein, L., Courtenay, S., D'Amours, S., Chapman, J., Estell, J. (2015) The ROARI project - Road Accident Acute Rehabilitation Initiative: a randomised clinical trial of two targeted early interventions for road-related trauma, Clinical Rehabilitation, 29, 639-652

Service delivery: Engagement strategies

Study ID	Search	Reason for exclusion	Ref 1
Jabre 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Interventions not relevant to this review (to be considered for other relevant RQ)	Jabre, P., Tazarourte, K., Azoulay, E., Borron, S. W., Belpomme, V., Jacob, L., Bertrand, L., Lapostolle, F., Combes, X., Galinski, M., Pinaud, V., Destefano, C., Normand, D., Beltramini, A., Assez, N., Vivien, B., Vicaut, E., Adnet, F. (2014) Offering the opportunity for family to be present during cardiopulmonary resuscitation: 1-Year assessment, Intensive Care Medicine, 40, 981-987

Service delivery: Stepped care

Study ID	Search	Reason for exclusion	Ref 1
Zatzick 2012	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Interventions not relevant to this review (to be considered for other relevant RQ)	Zatzick, D., McFadden, C. (2012) Integrating Information Technology Advancements Into Early PTSD Interventions, ClinicalTrials.gov [www.clinicaltrials.gov]

Economic studies

No economic studies were reviewed at full text and excluded from this review.

Appendix L – Research Recommendations

Research recommendations for "For adults at risk of PTSD, what are the relative benefits and harms of psychological, psychosocial or other non-pharmacological interventions targeted at PTSD symptoms?"

No research recommendations were made for this review question.