



Systematic Review

# Promoting Recovery from Disasters, Pandemics, and Trauma: A Systematic Review of Brief Psychological Interventions to Reduce Distress in Adults, Children, and Adolescents

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**Abstract:** A substantial number of survivors of disasters, pandemics, and other severe stressors develop persistent distress that impairs mental health and well-being. However, only a few brief psychological interventions target distress or subclinical symptoms. This systematic review aimed to identify and describe brief psychological interventions to reduce distress or subclinical symptoms in survivors of disasters, pandemics, and other severe stressors. Based on a systematic literature search (MEDLINE, PsycINFO, PSYINDEX, PTSDpubs, and Web of Science), we reviewed published studies and study protocols on self-help, psychosocial support, or brief psychotherapeutic interventions to reduce distress and/or subclinical symptoms following natural hazards and man-made disasters, pandemics, or other traumatic events. We included 27 published studies or study protocols ( $n = 15$  RCTs,  $n = 3$  controlled pre–post studies, and  $n = 9$  uncontrolled pre–post studies) describing 22 interventions. We found evidence for reducing psychological distress and/or subclinical symptoms in 9 out of 15 RCTs, 2 out of 3 controlled pre–post studies, and 9 out of 9 uncontrolled pre–post studies. One RCT provided evidence of increasing well-being. Innovative brief interventions have been developed to reduce distress and/or subclinical symptoms that have an emerging evidence base.

**Keywords:** disaster; man-made disaster; natural hazard; pandemic; COVID-19; trauma; indicated prevention; low-intensity intervention; brief intervention; subclinical symptoms; psychological distress



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## 1. Introduction

Natural hazards and man-made disasters (e.g., floods and mass violence; [1]), pandemics (e.g., the COVID-19 pandemic; [2]), but also other traumatic events (e.g., train accidents; [3]) can lead to psychological harm. Children are a group particularly vulnerable to suffering the consequences of crises [4]. Most mental health problems following such severe stressors are of a subclinical severity, e.g., [5]. Consequently, there is a strong need for interventions that focus on reducing subclinical symptoms in individuals who have been exposed to a particular stressor but lack a formal mental health diagnosis [6].

Brief evidence-based interventions might be useful to promote recovery and prevent mental disorders. For example, psychological first aid (PFA) is widely known as an evidence-based approach to help individuals and communities cope in the immediate aftermath of a traumatic event [7]. Furthermore, interventions based on cognitive behavioral therapy (CBT) have been found to be effective in reducing distress and subclinical symptoms in individuals who have experienced traumatic events, e.g., [8,9]. The COVID-19 pandemic, which is an acute global challenge and has been shown to have a major impact on psychological stress levels, e.g., [10,11], also highlights the need for mental health treatments. For example, a study conducted in China in 2020 found that 53.8% of respondents

rated the psychological impact of the outbreak as moderate or severe [12]. Therefore, we chose to also include COVID-19-related studies within this systematic review.

However, developing and evaluating brief interventions to target subclinical distress after disaster and trauma is a relatively new research field. A couple of narrative or systematic reviews summarized brief interventions on the specific subtypes of disasters, e.g., mental health impacts in response to climate change [13] or the Indian Ocean Tsunami in 2004 [14], or were narrowed to particular age groups, e.g., children and adolescents [15]. There are also a number of reviews that summarize interventions for individuals with a diagnosed mental health disorder, such as PTSD, e.g., [16,17]. A comprehensive systematic review of studies describing or evaluating brief interventions to reduce psychological distress and/or subclinical symptoms in disaster-, pandemic-, or trauma-exposed individuals has not been conducted.

The aims of this systematic review were to (1) systematically identify brief interventions to reduce psychological distress and/or subclinical symptoms in survivors of disasters, pandemics, and other traumatic events and (2) describe their effectiveness.

## 2. Materials and Methods

Our report of this systematic review followed the ‘Preferred Reporting Items for Systematic Reviews and Meta-Analyses’ reporting guidelines, PRISMA; [18]. The review protocol was not published on PROSPERO.

### 2.1. Eligibility Criteria for Study Inclusion

We included published peer-reviewed studies or study protocols in the German or English language (1) that evaluated or planned to evaluate brief psychosocial support, self-help, or brief ( $\leq 12$  sessions) psychotherapeutic interventions for survivors of disasters, pandemics, and other traumatic events (2) that described or examined interventions to reduce psychological distress, subclinical symptoms of any type of mental disorder, or symptoms of adjustment disorder. To provide an overview not only of completed studies but also of planned or ongoing studies of brief interventions, we included study protocols in this review.

We excluded studies or study protocols that (1) aimed to treat a mental disorder except for adjustment disorder, and studies (2) published before 2010.

### 2.2. Data Sources

We performed a systematic literature search in five databases (MEDLINE, PsycINFO, PSYINDEX, PTSDpubs, and Web of Science) from 1 January 2010 to 1 October 2021. Additionally, we identified studies by hand searching reference lists and contacting researchers.

### 2.3. Search Strategy

The search strategy was based on the PICOS (participants, interventions, comparisons, outcomes, and study design) approach [19]: S1 Populations: Disaster-, pandemic-, or trauma-exposed (e.g., term/pandemics); S2 Interventions: Brief interventions (e.g., indicated or low-intensity or brief or behavioral or short-term or low-threshold).mp. adj2 (therap\* or treat\* or intervention\* or modification or train\* or program\*.ti,ab.); S3 Outcomes: Mental health outcomes relevant for disaster, pandemic, and trauma (e.g., psychological distress OR subclinical symptoms OR adjustment disorder\* OR depress\* or anxiet\* or psychosocial dysfunction\*.ti,ab.); S4 Study design: Feasibility or pilot studies, pre-post studies, controlled studies, randomized controlled trials (e.g., Clinical trials/).

### 2.4. Selection Process

Two reviewers (IL and AP) independently screened the titles and abstracts following the inclusion and exclusion criteria. The characteristics of the published studies or study protocols were extracted in an excel table (i.e., authors, year, title, journal, inclusion and exclusion criteria, and the final decision for eligibility). When disagreements occurred

between the two reviewers, a third reviewer (AL) was consulted to decide together to include or exclude the study or protocol.

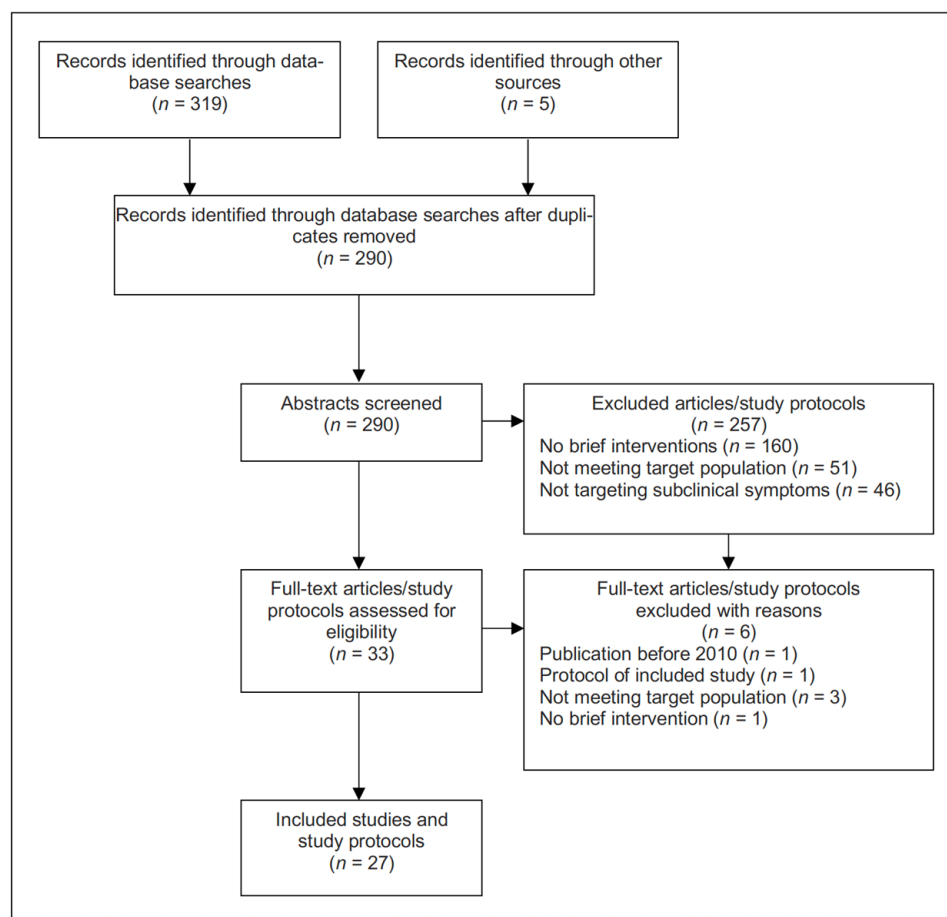
### 2.5. Data Collection Process and Synthesis

Data from the included studies were extracted independently by two reviewers (IL and AP) in an excel sheet. When disagreements in the extracted data occurred between the two reviewers, a third reviewer (AL) was consulted. The following data were extracted: study, intervention name and description, study design, timepoint of intervention after stressor exposure (e.g., 60 days or more), number of sessions, type of stressor, target population, delivery format, assessed outcomes, and results (see Appendix A).

## 3. Results

### 3.1. Study Selection

Database searches identified  $n = 319$  records; 5 additional records were found through searching reference lists and contacting researchers (Figure 1). After removing 34 duplicates, screening abstracts, and reviewing full articles and study protocols, 21 studies and 6 study protocols were included that reported on brief interventions to reduce distress and/or subclinical symptoms in survivors of disasters, pandemics, or trauma.



**Figure 1.** Flowchart of the review process.

### 3.2. Study Characteristics

The study characteristics are listed in Table 1. The 27 studies or study protocols were from 16 countries; most were from America or Asia. More than half of the described studies ( $n = 15$ ; 55.6%) were RCTs; nine studies (33.3%) used an uncontrolled pre-post study design, and three studies (11.1%) were designed as a controlled pre-post study. Out

of the 27 articles/study protocols, 11 articles/study protocols (40.7%) described studies on the survivors of natural hazards, 3 (11.1%) described studies on the survivors of man-made disasters, 8 (29.6%) described studies on the survivors of pandemics, and 5 (18.5%) described studies on survivors of other types of trauma. Twelve (44.4%) articles/protocols described studies examining the efficacy of psychosocial support interventions; nine (33.3%) articles/protocols described studies on the efficacy of brief psychotherapeutic treatments; and six (22.2%) articles/protocols reported on studies of self-help interventions.

**Table 1.** Characteristics of the included published articles/protocols on brief interventions ( $n = 27$ ).

| Characteristic                    | <i>n</i> | %            |
|-----------------------------------|----------|--------------|
| Continent/Country                 |          |              |
| Africa                            | <b>1</b> | <b>3.70</b>  |
| Kenya                             | 1        | 3.70         |
| Asia                              | <b>9</b> | <b>33.33</b> |
| China                             | 4        | 14.81        |
| Nepal                             | 2        | 7.41         |
| India                             | 1        | 3.70         |
| Japan                             | 1        | 3.70         |
| Pakistan                          | 1        | 3.70         |
| Oceania                           | <b>3</b> | <b>11.11</b> |
| Australia                         | 2        | 7.41         |
| Polynesia                         | 1        | 3.70         |
| Europe                            | <b>5</b> | <b>18.52</b> |
| Germany                           | 1        | 3.70         |
| Austria                           | 1        | 3.70         |
| France                            | 1        | 3.70         |
| Netherlands                       | 1        | 3.70         |
| United Kingdom (UK)               | 1        | 3.70         |
| America                           | <b>9</b> | <b>33.33</b> |
| United States (US)                | 7        | 25.93        |
| Canada                            | 1        | 3.70         |
| Haiti                             | 1        | 3.70         |
| Sample size of studies/protocols  |          |              |
| 1–50                              | 6        | 22.22        |
| 51–100 <sup>a</sup>               | 8        | 29.63        |
| 101–200 <sup>a</sup>              | 3        | 11.11        |
| 201–400 <sup>b</sup>              | 3        | 11.11        |
| 401–600                           | 3        | 11.11        |
| 601–1000                          | 2        | 7.41         |
| >1000 <sup>b</sup>                | 2        | 7.41         |
| Study design of studies/protocols |          |              |
| Randomized controlled trial       | 15       | 55.56        |
| Controlled pre–post study         | 3        | 11.11        |
| Uncontrolled pre–post study       | 9        | 33.33        |
| Type of stressor                  |          |              |
| Natural hazard                    | 11       | 40.74        |
| Pandemics                         | 8        | 29.63        |
| Another severe stressor           | 5        | 18.52        |
| Man-made disaster                 | 3        | 11.11        |
| Type of intervention              |          |              |
| Self-help                         | 6        | 22.22        |
| Brief psychotherapeutic treatment | 9        | 33.33        |
| Psychosocial support              | 12       | 44.44        |

Note. <sup>a</sup>  $n = 2$  included study protocols. <sup>b</sup>  $n = 1$  included study protocol.

#### 4. Intervention Characteristics and Study Results

The characteristics of the brief interventions described in the included articles/protocols are summarized in Table A1 of Appendix A. More detailed information on intervention characteristics and results (e.g., effect sizes) of the included studies/protocols are provided in Table A2 of Appendix A.

##### 4.1. Self-Help Programs

Five self-help programs targeted adults, and one intervention focused on adolescents and their parents. The interventions were mostly conducted online; only one intervention was designed in a hybrid format. Four of the six self-help interventions were developed in a pandemic context, and the remaining two interventions were designed to be applied after disasters. Three of the six interventions comprised additional psychotherapeutic or psychological support.

##### 4.1.1. Pandemic-Focused Interventions

Computerized CBT (cCBT) [20] is a one-week online self-help intervention based on cognitive behavioral therapy (CBT). cCBT aims to reduce acute psychological distress and symptoms of depression, anxiety, and insomnia in adults during the COVID-19 pandemic. Three modules cover cognitive training, cognitive consolidation, and behavioral interventions. The intervention was tested in an RCT during the COVID-19 pandemic in China with  $N = 252$  adult COVID-19-infected patients [20]. A significant decrease in depressive and anxiety symptoms was found at one-month follow-up in the cCBT + treatment as usual (TAU) group compared to a TAU-only group (psychological assessments, psychological support, consultations about well-being, and COVID-19).

The Individualized Short-term Training Program [21] is a self-help program that is combined with psychological support targeting depression and anxiety symptoms of emergency nurses during the COVID-19 pandemic. The program includes online and face-to-face elements. The length of the intervention and the number of sessions were not reported by the authors. The intervention covers knowledge about diagnosing COVID-19, handling and safety precautions with infected patients, and psychological support including mindfulness-based stress reduction. Psychologists provide online and practical face-to-face training and psychological support to nursing staff. The self-help online training is delivered asynchronously through videos, graphics, and texts. In an uncontrolled pre-post study, the authors of the intervention evaluated the Individualized Short-term Training Program in  $N = 71$  female Chinese nurses working in an emergency isolation department during the COVID-19 pandemic [21]. A significant anxiety reduction but not in depression was found post-training.

Online Psychotherapy Tool (OPTT) [22] is a 9-week program to reduce mental health problems in adults during the COVID-19 pandemic. OPTT consists of a self-help module and psychotherapeutic support, with the main focus on self-help. The intervention combines CBT, mindfulness therapy, and problem-based therapy. Weekly 40 min self-guided web-based online modules are available, participants can interact with their therapist through a chat function within the online platform, and a therapist provides individual written feedback. The authors plan to conduct a nonrandomized controlled trial with  $N = 80$  Canadian adults with anxiety symptoms during the COVID-19 pandemic [22]. The effects of the intervention on anxiety, depressive symptoms, resilience, and quality of life will be compared to a TAU control group. No study results have been reported yet.

“My Health too” [23] is a seven-session CBT-based online self-help program with an option for psychotherapeutic support (i.e., the possibility to call a CBT-trained psychologist). The program was designed for health care workers to reduce psychological distress during the COVID-19 pandemic and to prevent its long-term consequences. A total of 7 20 min asynchronous (i.e., the interaction does not happen in real time) video sessions cover psychoeducation on stressors, adaptive behavioral and cognitive coping strategies, mindfulness and acceptance of stressors, promoting action toward values, addressing

barriers and motivation, and self-compassion. Weiner et al. [23] is currently investigating whether the intervention reduces distress in  $N = 120$  French healthcare workers during the COVID-19 pandemic. In an RCT, the intervention group is compared to an active control group receiving bibliotherapy. No results have been published to date.

#### 4.1.2. Disaster-Focused Interventions

The web-based Bounce Back Now (BBN) [24] is a four-session self-help program for disaster-affected adolescents and parents aiming to reduce post-disaster mental and behavioral problems. Four modules provide skills and strategies to cope with stress- and trauma-related symptoms, smoking, and alcohol use, and mood-related symptoms. The stress and trauma module provides education about PTSD symptoms and evidence-based trauma-focused interventions, a reduction in the avoidance of traumatic cues, coping strategies, and anxiety management. An additional self-help intervention for adults (Adult Self-Help, ASH) can be added to BBN, BBN + ASH [24]. A pre–post-test study with  $N = 979$  US adolescents affected by tornadoes in Missouri and Alabama in 2011 [25] revealed a significant decline in PTSD symptoms in the BBN condition at 4- and 12-month follow-up compared to the control condition in which no education or recommendations were offered. Instead, participants were given quizzes and questions about myths and facts.

The Disaster Recovery Web (DRW) Project [26] is a self-help web-based program for adults affected by natural hazards to reduce symptoms of PTSD, depression, and anxiety. It is applied in the acute aftermath of a disaster and consists of four web modules educating about post-traumatic stress, depressed mood, generalized anxiety, and panic. There is no interaction with a therapist. A pre–post-test study without a control group conducted after Hurricane Ike in Texas with  $N = 1249$  adult survivors [27] found no significant reduction in depressive symptoms or PTSD symptoms 4-months post-intervention.

#### 4.2. Psychosocial Support Programs

Five psychosocial support programs targeted adults, and one intervention was developed for children and their parents. Two of the six psychosocial support programs were pandemic-focused, one intervention was disaster-focused, and three interventions targeted other types of trauma. Four interventions were designed as face-to-face interventions, although two of them could be applied either in a face-to-face or online format. The remaining two interventions were designed as online or phone-based interventions.

##### 4.2.1. Pandemic-Focused Interventions

Grief Counseling for Adults [28] is a psychosocial support program to promote better life adaptation after loss. The program was developed to support bereaved Chinese people during COVID-19. A trained counselor delivers 8 to 10 online sessions lasting 1 h. Grief counseling for adults is based on current grief treatment approaches, including meaning reconstruction [29]; complicated grief treatment, CGT; [30], and cognitive behavioral therapy for complicated grief, CBT-CG; [31]. It covers understanding and managing grief reactions; managing painful emotions; learning self-care; increasing contact with others; coping with difficult days; and adapting to a new life. Grief counseling for adults will be evaluated in a single-blinded RCT among  $N = 160$  bereaved Chinese adults who have lost their first-degree relative during the COVID-19 pandemic [28]. The researchers aim to evaluate the effects of the intervention on prolonged grief symptoms, PTSD, and depression at baseline, post-intervention, and at 3-month follow-up relative to a wait list control group. The results of this study have not yet been published.

Resiliency Engagement and Care in Health (REaCH) [32] is a 4-week psychosocial intervention for people with socioeconomic vulnerability during the COVID-19 pandemic. REaCH targets mental well-being, depressive symptoms, and perceived social support by providing proactive engagement and crisis intervention, problem-solving-oriented support therapy, and assertive linkage with community resources. It involves a synchronous telephonic befriending program consisting of 4 phone calls, each 0.5 to 1 h, delivered by lay



workers and nonhealth professionals. The authors plan a cluster-randomized controlled trial (cRCT) to examine the REaCH intervention with  $N = 1440$  economically disadvantaged and vulnerable Indian adults during the COVID-19 pandemic [32]. The intervention group will be compared with a control group receiving four phone calls informing about COVID-19.

#### 4.2.2. Disaster-Focused Interventions

The Mental Health Integrated Disaster Preparedness (MHIDP) intervention [33] is aimed at improving disaster preparedness, reducing mental health symptoms, and fostering community cohesion in adults affected by natural hazards in Haiti. MHIDP includes establishing safety and practicing skills to cope with disaster-related distress, the provision of space for sharing personal experiences, and training in disaster preparedness (e.g., creating preparedness kits comprised of basic supplies). The content is provided within 3 sessions lasting 6 h. MHIDP intervention was evaluated in an RCT among  $N = 480$  adults exposed to earthquakes and floods in Haiti [33]. The program was delivered by 2 trained lay mental health workers in groups of up to 20 participants. The intervention group was compared to a wait list control group across three timepoints (i.e., baseline, 3–4-month, and 7–8-month follow-up). Disaster preparedness behavior significantly increased among intervention participants, while depressive, anxiety, and PTSD symptoms significantly decreased at both follow-ups. A significant reduction in functional impairment was evident at 3–4-month follow-up but disappeared at 7–8-month follow-up.

#### 4.2.3. Interventions Focusing on Other Severe Stressors

Problem Management Plus (PM+) [34] is a brief five-session program to reduce distress in adults living in communities affected by adversity or crises. PM+ includes managing stress, managing problems, behavioral activation (i.e., get going and keep doing), and strengthening social support. Trained nonspecialist lay providers deliver the intervention. PM+ was tested in a cRCT in  $N = 121$  participants [35] in earthquake-affected communities in Nepal. Participants in the treatment group received five sessions of PM+ in a group setting, and participants in the control group received enhanced TAU (which entailed brief psychoeducation and the provision of referral options to primary care services). Depressive symptoms, daily functioning, psychological distress, PTSD symptoms, and psychosocial problems improved more in the PM+ arm than the enhanced TAU arm at 8 weeks post-intervention. A cRCT [36] investigated an adapted PM+ program with six to eight participants per group, which was compared to enhanced usual care (psychoeducation and a referral option to primary care providers trained in mental healthcare).  $N = 611$  adults from disaster-prone regions in Nepal received 5 weekly sessions of approximately 2.5 h. The PM+ group showed lower psychological distress and depression symptoms, and had fewer “heart-mind” problems compared to the control group at 3-months post-treatment. However, the PM+ group did not show an improvement in functional impairment and PTSD symptoms. An adapted version of PM+ for participants living in conflict-affected Peshawar in Pakistan was tested in a pilot RCT [37] in  $N = 60$  participants, compared to enhanced TAU (mental health care management by trained general care practitioners). Functioning and PTSD symptoms improved more in the PM+ group post-intervention, but no significant changes in psychological distress could be observed between the groups. The effects of PM+ were compared to facility-based enhanced TAU provided by community nurses in an RCT in  $N = 421$  Kenyan women exposed to physical or sexual abuse [38]. The PM+ group showed significant improvements in psychological distress, daily functioning, PTSD symptoms, and personally identified problems in the change from baseline to 3-month follow-up. An RCT [39] is planned to examine an adapted version of videoconferencing PM+ in  $N = 240$  adults in a group context of 3–4 participants in Sydney, Australia. The intervention will be delivered over 6 weekly 60 min sessions and will specifically target COVID-19-related distress. The control group will receive enhanced TAU (emailed handouts with PM+ strategies and no expert assistance). In addition to psychological

distress, rumination, sleep problems, anhedonia, social support, and COVID-19-related stress will be examined.

The Skills fOr Life Adjustment and Resilience program (SOLAR) [6] is a brief five-session psychosocial support program to reduce persistent distress or subclinical symptoms in adults impacted by a disaster or trauma. It is delivered by trained coaches that can be non-mental-health professionals. SOLAR covers six modules: healthy living, managing strong emotions, getting back into life, coming to terms with the disaster, managing worry and rumination, and maintaining healthy relationships. An uncontrolled pre–post 3-month follow-up pilot study in  $N = 15$  Australian bushfire survivors [6] demonstrated reductions in psychological distress, post-traumatic stress symptoms, and functional impairment at post-treatment. Another controlled pre–post pilot study [40] proved the acceptability, feasibility, and efficacy of a culturally adapted version of SOLAR with  $N = 99$  Pacific Islanders that were exposed to Tropical Cyclone Pam in 2015. SOLAR was administered in a group format of up to 10 participants compared to a TAU control group, which included informal familial, community, and church-based support. Reductions in psychological distress, PTSD symptoms, and functional impairment were found in the intervention group relative to the control group from pre- to post-intervention. The SOLAR group program was evaluated in a randomized controlled feasibility study in  $N = 30$  German survivors of different types of trauma [41]. Participants in the SOLAR group intervention showed a greater reduction in psychological distress, symptoms of insomnia, patient-centered outcomes, functional impairment, quality of life, and perceived social support post-intervention, compared to a wait list control group. Symptoms of PTSD did not decrease more greatly in the intervention group relative to the control group.

Listen Protect Connect (LPC) [42] is a school-based PFA program for children. LPC provides basic psychological support and aims to reduce the initial distress of students and parents following traumatic events, such as community disasters, emergencies, or personal trauma. LPC is delivered by non-mental-health professionals. It is based on the five-step crisis response strategy “Listen, Protect, Connect—Model & Teach” [42]. An adapted version of LPC (composed of three steps: listen, protect, and connect) was piloted in an uncontrolled pre–post study in  $N = 20$  US-American children impacted by the Great Flood of Iowa in 2008 to reduce PTSD symptoms [43]. The school nurse provided 1 on average 25 min LPC session to each student. Depressive symptoms and felt connectedness to their school improved at 4 weeks post-intervention. Perceived social support increased at 8 weeks post-intervention. PTSD symptoms (i.e., re-experiencing, avoidance, and arousal) did not significantly decrease at 8 weeks post-intervention.

#### 4.3. Brief Psychotherapeutic Programs

We identified ten brief psychotherapeutic interventions, of which four were developed for children or adolescents. Two brief psychotherapeutic interventions were disaster-focused; the remaining eight interventions addressed survivors of other types of trauma, although some of these interventions could also be applied in the aftermath of natural hazards and man-made disasters. There were no interventions specifically designed for use during a pandemic. All interventions were designed as face-to-face interventions.

##### 4.3.1. Disaster-Focused Interventions

The Brief School-Based Cognitive Behavioral Intervention [44] is a one-session psychotherapeutic intervention for disaster-affected adolescents to reduce PTSD and depressive symptoms. The intervention is based on the cognitive behavioral model of post-traumatic stress disorder [45] and consists of a single 90 min session, delivered by trained CBT clinical psychologists. It involves four steps: the identification of problems, psychoeducation, decreasing negative appraisal, and the practice of relaxation breathing. A pilot study [44] examined the intervention in the context of pre-, post-, and follow-up measurements without a control group.  $N = 22$  adolescents affected by the Great East Japan Earthquake in 2011 were divided into 2 groups, each with 11 adolescents. The results showed significant



improvements in PTSD symptoms post-intervention which were maintained at a 4-month follow-up. There was no significant reduction in depressive symptoms.

Strength after Trauma (StArT) [46] is a brief manual-based trauma-focused CBT intervention for disaster-exposed adolescents to reduce PTSD symptoms. StArT comprises five modules: psychoeducation, cognitive restructuring, exposure, problem solving, and relapse prevention. It includes 10 sessions of 1 h and is delivered by a psychotherapist. StArT was piloted in an uncontrolled pre–post study in  $N = 6$  American children exposed to Hurricane Katrina in 2005 [47]. The results suggest that the 10-session intervention was feasible when conducted in a school setting. Negative cognitions and PTSD symptoms significantly declined between pre- and post-treatment. No significant reduction in anxiety symptoms could be observed.

#### 4.3.2. Interventions Focusing on Other Severe Stressors

Cognitive Behavioral Therapy for Post-disaster Distress (CBT-PD) [48] is an 8- to 12-session CBT intervention for adults impacted by major disasters, terrorism, or traumatic events to reduce post-disaster distress. The intervention is delivered by trained therapists. CBT-PD includes psychoeducation, coping skills, and cognitive restructuring. Coping skills include breathing retraining and behavioral activation. In an uncontrolled pre–post-test study,  $N = 342$  adults from New York State, US, exposed to Hurricane Sandy in 2012 [49], were assessed at referral, baseline, intermediate treatment, as well as at post-treatment and 5-month follow-up. Significant reductions in distress throughout the intervention were found, with large improvements from pre- to post-treatment.

Exposure-based Cognitive Behavioral Therapy for children [50] aims to reduce PTSD symptoms in children in 4–8 60 min sessions with possible parent support. The intervention includes five elements: psychoeducation, repeated exposure to the trauma memory, cognitive restructuring, exploring and correcting undesired or unhelpful coping behavior, and relapse prevention. Eye Movement Desensitization and Reprocessing (EMDR) based on Shapiro [51] is typically delivered in 6–12 sessions to reduce PTSD symptoms in children, adolescents, and adults. EMDR applies an eight-phase approach: (phase 1) history taking, (phase 2) preparing the client, (phase 3) assessing the target memory, (phase 4–7) processing the memory to adaptive resolution, and (phase 8) evaluating treatment results. De Roos et al. [52] conducted an RCT comparing exposure-based CBT and EMDR in reducing disaster-related PTSD symptoms in  $N = 52$  children and adolescents aged from 4 to 18, 6 months after the explosion of a fireworks company in Enschede, Netherlands. Participants with disaster-related clinical symptoms were included in the study. They received up to 4 individual sessions delivered by a clinical psychologist over 4–8 weeks along with up to 4 sessions of parental guidance. Both treatment approaches produced significant reductions in PTSD symptoms, anxiety symptoms, depressive symptoms, and behavioral problems post-intervention. The study did not find significant differences in the outcomes between the groups.

The Preventive Resilience Training for Unaccompanied Refugee Minors [53] is a CBT intervention consisting of 6 90 min sessions to reduce trauma-related symptoms such as PTSD, depression, and anxiety in adolescent refugees with trauma exposure. The resilience training includes psychoeducation, cultural resources, and emotion regulation strategies. The intervention is a group-based program delivered by clinical psychologists or social workers with training in trauma therapy. The authors conducted an RCT in  $N = 55$  Australian male adolescent refugees from Afghanistan and Pakistan with flight experience [53]. The intervention group showed an increase in general well-being at 7 weeks post-intervention compared to the wait list control group. However, no reduction in anxiety, PTSD, and depressive symptoms could be found.

Mindfulness-Based Stress Reduction (MBSR) [54] is a transdiagnostic intervention to improve mindfulness. The intervention aims at developing four mindfulness practices (sitting meditation, walking meditation, mindful movement, and a body scan) to influence perceived distress, anxiety, depression, emotion dysregulation, and PTSD symptoms. It

consists of 8 weekly 120 min sessions and one 240 min retreat session delivered face-to-face by an experienced MBSR teacher in groups of up to 30 participants [55]. Gallegos et al. [56] piloted MBSR in an uncontrolled pre–post study in  $N = 50$  US-American adult women with a history of interpersonal childhood trauma. The results showed a significant reduction in perceived distress, depressive symptoms, anxiety, emotion dysregulation, and PTSD symptoms at post-intervention and 1-month follow-up compared to baseline. Mindfulness also significantly increased.

The Trauma Therapy Program [57] is an intervention comprising 6 sessions of 90 min to reduce work-related distress in health practitioners working in emergency services. The intervention aims to reduce symptoms of anxiety, depression, and PTSD. The program incorporates trauma-focused cognitive behavioral therapy, TF-CBT [58], and eye movement desensitization and reprocessing, EMDR [51]. The intervention is delivered by therapists trained in TF-CBT or EMDR. The program was tested in an uncontrolled pre–post-test study in  $N = 429$  emergency service professionals from the UK [57]. The intervention effectively reduced anxiety, depression, and PTSD symptoms post-treatment compared to pre-treatment.

Emotional Freedom Techniques (EFT) [59] is a brief psychotherapeutic intervention to reduce psychological distress and symptoms of depression, anxiety, and PTSD. The intervention has a flexible number of sessions depending on the type and severity of the problems. EFT includes trauma exposure, cognitive, and somatic therapeutic components; it combines the exposure to traumatic memories with self-acceptance statements derived from cognitive therapy while applying psychological acupressure (i.e., tapping) as a stress relief technique. EFT is delivered by EFT-certified therapists. The effect of 6 EFT sessions 60 min was examined in an RCT with  $N = 55$  US veterans from Iraq or Afghanistan war [60]. The EFT intervention focused on combat-related traumatic events and was delivered in combination with the TAU of a Veteran Administration (VA) hospital. The results showed significant reductions in PTSD, anxiety, depression, hostility, obsessive–compulsive behavior, paranoia, phobic anxiety, psychoticism, and somatization in the EFT group compared to the TAU group at post-intervention. Improvement in symptoms was maintained until the 3-month and 6-month follow-up. Interpersonal sensitivity did not significantly improve.

Solution Focused Brief Therapy (SFBT) [61] is a brief future- and goal-oriented psychotherapeutic intervention for adolescents and adults which can be applied to a wide range of issues. The intervention, comprising 5 sessions of 45 min., aims to explore current resources and future hopes [62]. An RCT assessed the effectiveness of SFBT in a group of  $N = 76$  Chinese adolescents to reduce anxiety symptoms during the COVID-19 pandemic [63]. The intervention group received 2–4 sessions of SFBT via videoconferencing within 2 weeks, whereas the wait list control group received 2–4 sessions of counseling service. It was hypothesized that participants assigned to SFBT would have better clinical outcomes in terms of anxiety symptoms, depressive symptoms, and coping strategies than participants in the control group. The study results have not been published yet.

## 5. Discussion

This systematic review aimed to identify and synthesize brief interventions to reduce distress and/or subclinical symptoms in individuals exposed to disasters, pandemics, or other traumatic events. We considered 27 published articles or study protocols (including 15 RCTs) that reported on 22 different brief interventions to reduce distress and/or subclinical symptoms. Out of the 27 included articles or protocols, 10 were published articles describing intervention studies, and 5 were study protocols.

### 5.1. Self-Help Programs

Six published articles or study protocols described studies on the efficacy of brief self-help interventions. Two articles reported on an RCT or an uncontrolled pre–post study evaluating self-help programs for COVID-19 survivors (cCBT and the Individualized

Short-term Training Program). Both studies reported significant reductions in anxiety at one-month follow-up after the application of cCBT [20] and post-training after the application of the Individualized Short-term Training Program [21]. Only the RCT on cCBT found reductions in depressive symptoms post-intervention [20]. Hence, there is the first evidence for two self-help interventions, namely cCBT and individualized short-term training, based on one RCT and one uncontrolled pre–post study, that these self-help programs may reduce anxiety in COVID-19 survivors in the short-term. Two additional study protocols on self-help programs for COVID-19 survivors were identified which might provide further evidence in the future [22,23].

Two published studies evaluated self-help programs (BBN and the DRW Project) for survivors of natural hazards (i.e., tornadoes and hurricanes). One article reported on a controlled pre–post study that found a significant decline in PTSD symptoms in adolescents and their parents at follow-up measurements after the application of BBN [25]; another article reported on an uncontrolled pre–post study that found no evidence for the efficacy of the DRW Project to reduce PTSD or depressive symptoms [27]. The lack of effectiveness of the DRW Project could be attributed to the fact that it was applied by the participants one year after the disaster. This may result in individuals being less motivated to engage with this intervention or having already recovered on their own.

We found no published articles or study protocols on studies evaluating a self-help program for survivors of other types of traumatic events.

### 5.2. Psychosocial Support Programs

Twelve published articles or study protocols described the evaluation of psychosocial support programs. We did not identify any evidence for the efficacy of psychosocial support programs for COVID-19 survivors. Two study protocols have been published [28,32] that describe evaluation studies on psychosocial support programs among COVID-19 survivors, but no results have been published yet.

We identified evidence for one psychosocial support program (MHIDP intervention) targeting survivors of natural hazards (i.e., earthquakes and floods) to improve depressive, anxiety, and PTSD symptoms at follow-up assessments [33].

Nine identified published articles or study protocols described psychosocial support programs originally developed for survivors of other severe stressors, e.g., exposure to community adversity, crises, or interpersonal abuse. However, most of these interventions could be applied to other types of stressors, such as natural hazards. An uncontrolled pre–post study [43] showed that the psychosocial support intervention LPC [42] for children after experiencing traumatic events, such as community disaster, emergency, or personal trauma, was successful in reducing PTSD and depressive symptoms at post-intervention.

We found five published articles or study protocols that described PM+ [34] for communities affected by adversity or crises. Two RCTs on PM+ [37,38] indicated a significant improvement in PTSD symptoms and daily functioning after the provision of PM+ using an individual format. Significant improvements in psychological distress at 3-month follow-up were only observed in the study of Bryant and colleagues [38]. The results of two cRCTs [35,36] indicated that PM+ applied in a group significantly reduced psychological distress and depressive symptoms post-intervention. However, only in the study of Sangraula and colleagues [35], were PTSD symptoms significantly reduced post-intervention. We found one study protocol [39] that has not yet published results. Overall, the results of a few studies indicate that PM+ leads to a significant decline in psychological distress and PTSD symptoms post-treatment. Our systematic literature search yielded three articles or study protocols reporting on studies on SOLAR [6]. A pilot RCT [41] reported significant reductions in psychological distress; PTSD symptoms did not significantly decrease in the SOLAR group relative to the control group, as PTSD symptoms declined in both groups. The results of one uncontrolled [6] and one controlled pre–post study [40] indicated significant reductions in psychological distress and PTSD symptoms. In sum, there is emerging evidence based on three studies that SOLAR leads to a significant decline in psychological

distress, and evidence based on two (un)controlled pre–post studies that SOLAR effectively reduces PTSD symptoms.

Overall, in the field of psychosocial support programs, most evidence for their efficacy is currently available for PM+, for which some RCTs have been conducted. SOLAR is another promising psychosocial support program with an emerging evidence base.

### 5.3. Brief Psychotherapeutic Programs

Nine studies examined or planned to examine the efficacy of brief (i.e., max. 12 sessions) psychotherapeutic interventions. No studies described interventions designed for an application during a pandemic. Two articles [44,47] described uncontrolled pre–post studies that examined brief psychotherapeutic interventions (Brief School-based Cognitive Behavioral Intervention and StArT) for survivors of natural hazards (i.e., earthquakes and hurricanes). Both studies conducted with children and/or adolescents found that PTSD symptoms significantly decreased post-intervention.

Seven published articles or study protocols described brief psychotherapeutic interventions originally developed for survivors of other severe stressors, such as terrorism or traumatic events. Most of these interventions can also be applied to other types of stressors, such as disasters or pandemics. Overall, the results of five studies showed that the interventions EFT, exposure-based CBT, EMDR, MBSR, CBT-PD, and the Trauma Therapy Program were successful in reducing psychological distress and/or subclinical symptoms [49,52,56,57,60]. One RCT on the Preventive Resilience Training for Unaccompanied Refugee Minors reported no reduction in anxiety, PTSD, and depressive symptoms at a seven-week follow-up, although well-being significantly increased [53]. The reasons for the lack of effectiveness could be that the treatment dose was too low or the assessment of outcomes at only 7 weeks post-intervention might not be enough time to observe significant changes in symptoms. One study protocol described planning to examine the efficacy of SFBT on anxiety and depressive symptoms during the COVID-19 pandemic [63].

Overall, these findings suggest that there is the first evidence, especially on the efficacy of exposure-based CBT, EMDR, and EFT based on one RCT each. Additionally, there is a preliminary indication based on one uncontrolled pre–post study each that CBT-PD, MBSR, and Trauma Therapy Program may be effective in reducing psychological distress and/or subclinical symptoms.

### 5.4. Limitations

The interpretation of results synthesized in this systematic review should be interpreted considering the quality of the included studies. Thus, this systematic review is not without limitations. Several studies consisted of small sample sizes; more than half of the included studies considered fewer than 100 participants. Although a larger sample size would be desirable to achieve greater statistical power and generalizability in the results, there are challenges such as resource limitations and participant dropout making this difficult. In addition to 15 RCTs, 9 uncontrolled pre–post studies and 3 controlled pre–post studies were included in this review. Pre–post studies suffer from impaired internal validity and the associated limited interpretability of results. Furthermore, the long-term effectiveness of some interventions cannot be assessed because ten completed studies on these interventions did not report follow-up measurements [21,27,35–37,40,41,47,53,57]. One study lacked reporting on the length of the intervention [21]; ten studies did not report on the timepoint of intervention after stressor exposure [33,35–38,41,53,56,57,60], making it difficult to interpret the effectiveness of these interventions. Although we performed an extensive systematic review covering multiple established literature databases, we might have missed some additional studies describing effective interventions. We included six study protocols that described novel interventions for which evaluation was planned or ongoing and for which no evidence on their efficacy was available yet. Another drawback might arise from the nature of a systematic review to summarize and synthesize study results descriptively. Thus, it was not possible to directly compare the different interven-

tions in terms of their efficacy, as could be performed in a meta-analysis. A strength of this review is the comprehensive reporting and discussion of the study's findings; however, no quality assessment of the included studies was undertaken.

This systematic review extends previous research since, to our knowledge, no systematic review of studies describing or evaluating brief interventions aiming at reducing psychological distress and/or subclinical symptoms has been conducted before. We considered different types of stressors (i.e., natural hazards and man-made disasters, pandemics, and other severe stressors) as well as different types of interventions (i.e., self-help, psychosocial support, and psychotherapeutic) to provide a broad overview of brief interventions for reducing distress and/or subclinical symptoms. Therefore, some of the interventions and target groups might not be directly comparable.

## 6. Conclusions

This systematic review identified novel brief self-help programs, psychosocial support programs, or brief psychotherapeutic interventions that addressed distress and/or subclinical symptoms in survivors of disasters, pandemics, and other severe stressors. A few interventions showed the first evidence of being effective in reducing psychological distress and/or subclinical PTSD symptoms. Effective interventions mostly covered psychosocial support programs and brief psychotherapeutic interventions that focused on disasters or other severe stressors. Interventions that focused on the COVID-19 pandemic mainly involved self-help programs that showed limited evidence of effectiveness. Future research should further investigate the effectiveness of psychosocial support interventions and brief psychotherapeutic interventions for COVID-19 survivors.

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## Appendix A



**Table A1.** Characteristics of brief interventions described in the included articles/protocols ( $n = 27$ ).

| Study                                | Intervention  | Design                      | Sample Size | Type of Stressor               | Aim of Intervention   | Delivery Format | Target Population       | No. of Sessions                   | Results   |
|--------------------------------------|---|-----------------------------|-------------|--------------------------------|---|-----------------|-------------------------|-----------------------------------|---|
| <b>Self-help programs</b>            |   |                             |             |                                |   |                 |                         |                                   |   |
| Liu et al. (2021) [20]               | Computerized cognitive behavioral therapy (cCBT) [20] | RCT                         | $N = 252$   | COVID-19 pandemic              | Reduction in psychological distress.  | Online          | Adults                  | A total of 7 for at least 10 min. | cCBT was effective in reducing depression and anxiety at 1-month follow-up.   |
| Zhou et al. (2020) [21]              | Individualized Short-term Training Program [21]       | Uncontrolled pre-post study | $N = 71$    | COVID-19 pandemic              | Reduction in depression and anxiety symptoms.                                 | Hybrid          | Adults                  | Not reported                      | The Individualized Short-term Training Program was effective in reducing anxiety but not depression at post-training. |
| Alavi et al. (2020) [22]             | Online psychotherapy tool (OPTT) [22]                 | Controlled pre-post study   | $N = 80$    | COVID-19 pandemic              | Reduction in mental health symptoms   | Online          | Adults                  | 9                                 | Not applicable (study protocol).  |
| Weiner et al. (2020) [23]            | “My health too” [23]                                  | RCT                         | $N = 120$   | COVID-19 pandemic              | Reduction in distress. Prevention of long-term distress consequences.         | Online          | Adults                  | 7                                 | Not applicable (study protocol).  |
| Gilmore et al. (2021) [25]           | Bounce Back Now (BBN) [24]                            | Controlled pre-post study   | $N = 979$   | Tornadoes                      | Improvement in post-disaster mental health. Reduction in behavioral problems. | Online          | Adolescents and parents | 4                                 | BBN was effective in reducing PTSD symptoms at 4- and 12-months follow-up.  |
| Price et al. (2013) [27]             | Disaster Recovery Web (DRW) Project [26]              | Uncontrolled pre-post study | $N = 1249$  | Hurricane                      | Reduction in symptoms of PTSD, depression, and anxiety.                       | Online          | Adults                  | 4                                 | The DRW Project was not effective in reducing depressive symptoms or PTSD symptoms at 4-month post-intervention.      |
| <b>Psychosocial support programs</b> |   |                             |             |                                |   |                 |                         |                                   |   |
| Tang et al. (2021) [28]              | Grief Counseling for Adults [28]                      | RCT                         | $N = 160$   | Loss and grief during COVID-19 | Promotion of life adaption after loss   | Online          | Adults                  | A total of 8–10 for 1 h each      | Not applicable (study protocol)   |
| Devassy et al. (2021) [32]           | Resiliency Engagement and Care in Health (REaCH) [32] | cRCT                        | $N = 1440$  | COVID-19 pandemic              | Reduction in mental health symptoms. Increase in social support               | Phone-based     | Adults                  | Four                              | Not applicable (study protocol)   |

Table A1. Cont.

| Study                        | Intervention   | Design | Sample Size    | Type of Stressor  | Aim of Intervention  | Delivery Format | Target Population | No. of Sessions               | Results  |
|------------------------------|--|--------|----------------|---|--|-----------------|-------------------|-------------------------------|--|
| <b>Self-help programs</b>    |  |        |                |   |  |                 |                   |                               |  |
| James et al. (2020) [33]     | Mental Health Integrated Disaster Preparedness (MHIDP) Intervention [33] | RCT    | <i>N</i> = 480 | Earthquakes and floods                                    | Improvement in disaster preparedness. Reduction in mental health symptoms. Promotion of community cohesion | Face-to-face    | Adults            | A total of 3 for 6 h each     | The MHIDP Intervention was effective in reducing depressive, anxiety, and PTSD symptoms at 3–4-month and 7–8-month follow-up.          |
| Sangraula et al. (2020) [35] | Problem Management Plus (PM+) [34]                                       | cRCT   | <i>N</i> = 121 | Earthquake  | Reduction in psychological distress  | Face-to-face    | Adults            | A total of 5 for 2.5–3 h each | Group PM+ was effective in reducing depressive and PTSD symptoms, as well as psychological distress at 8 weeks post-intervention.      |
| Jordans et al. (2021) [36]   | Problem Management Plus (PM+) [34]                                       | cRCT   | <i>N</i> = 611 | Disaster-prone communities (i.e., landslides or flooding) | Reduction in psychological distress  | Face-to-face    | Adults            | A total of 5 for 2.5 h each   | Group PM+ was effective in reducing depressive symptoms and psychological distress, but not PTSD symptoms, at 3-months post-treatment. |
| Rahman et al. (2016) [37]    | Problem Management Plus (PM+) [34]                                       | RCT    | <i>N</i> = 60  | Conflict-affected area                                    | Reduction in psychological distress  | Face-to-face    | Adults            | Five                          | PM+ was effective in reducing PTSD symptoms, but not psychological distress, at post-intervention.                                     |
| Bryant et al. (2017) [38]    | Problem Management Plus (PM+) [34]                                       | RCT    | <i>N</i> = 421 | Physical and sexual abuse                                 | Reduction in psychological distress  | Face-to-face    | Adults            | A total of 5 for 90 min each  | PM+ was effective in reducing psychological distress and PTSD symptoms at 3-months follow-up.  |
| Keyan et al. (2021) [39]     | Problem Management Plus (PM+) [34]                                       | RCT    | <i>N</i> = 240 | COVID-19 pandemic   | Reduction in psychological distress  | Online          | Adults            | A total of 6 for 60 min each  | Not applicable (study protocol)  |

**Table A1.** *Cont.*

| Study   | Intervention  | Design                       | Sample Size   | Type of Stressor | Aim of Intervention   | Delivery Format | Target Population | No. of Sessions                                       | Results  |
|---|---|------------------------------|---------------|------------------|---|-----------------|-------------------|---|--|
| O'Donnell et al. (2020) [6]   | Skills fOr Life Adjustment and Resilience (SOLAR) [6]     | Uncon-trolled pre–post study | <i>N</i> = 15 | Bushfire         | Reduction in post-disaster distress                         | Face-to-face    | Adults            | A total of 4 for 50 min each<br>The first for 80 min. | SOLAR was effective in reducing psychological distress and post-traumatic stress symptoms at post-treatment.   |
| Gibson et al. (2021) [40]   | Skills fOr Life Adjustment and Resilience (SOLAR) [6]     | Controlled pre–post study    | <i>N</i> = 99 | Tropical Cyclone | Reduction in post-disaster distress                         | Face-to-face    | Adults            | Five  | SOLAR was effective in reducing psychological distress and PTSD symptoms at post-intervention.   |
| Lotzin, Hinrichsen, Kennemich, Freyberg, Lau, & O'Donnell (2021) [41] | Skills fOr Life Adjustment and Resilience (SOLAR) [6]     | RCT                          | <i>N</i> = 30 | Traumatic events | Reduction in post-disaster distress                         | Face-to-face    | Adults            | Five  | SOLAR was effective in reducing psychological distress, but not PTSD symptoms, at post-intervention.   |
| Ramirez et al. (2013) [43]  | Listen Protect Connect (LPC) [42]                         | Uncontrolled pre–post study  | <i>N</i> = 20 | Flood            | Provision of psychological support<br>Reduction in distress | Face-to-face    | Children          | A total of 1 for 25 min on average                    | LPC marginally reduced PTSD symptoms at 8 weeks post-intervention and significantly reduced depressive symptoms at 4 weeks post-intervention.                              |
| <b>Brief psychotherapeutic programs</b>                               |   |                              |               |                  |   |                 |                   |   |  |
| Ito et al. (2016) [44]  | Brief School-Based Cognitive Behavioral Intervention [44] | Uncontrolled pre–post study  | <i>N</i> = 22 | Earthquake       | Reduction in PTSD and depressive symptoms                   | Face-to-face    | Adolescents       | A total of 1 for 90 min                               | The Brief School-Based Cognitive Behavioral Intervention was effective in reducing PTSD symptoms, but not depressive symptoms, at post-intervention and 4-month follow-up. |

Table A1. Cont.

| Study                       | Intervention  | Design                      | Sample Size    | Type of Stressor | Aim of Intervention                                    | Delivery Format | Target Population        | No. of Sessions                                   | Results   |
|-----------------------------|---|-----------------------------|----------------|------------------|--|-----------------|--------------------------|---|---|
| Taylor & Weems (2011) [47]  | Strength after Trauma, (StArT) [46]   | Uncontrolled pre–post study | <i>N</i> = 6   | Hurricane        | Reduction in PTSD symptoms                             | Face-to-face    | Children and adolescents | A total of 10 for 1 h each                        | StArT was effective in reducing PTSD symptoms, but not anxiety symptoms, at post-intervention.  |
| Hamblen et al. (2017) [49]  | Cognitive Behavioral Therapy for Post-disaster Distress (CBT-PD) [48]   | Uncontrolled pre–post study | <i>N</i> = 342 | Hurricane        | Reduction in post-disaster distress                    | Face-to-face    | Adults                   | A total of 10                                     | CBT-PD was effective in reducing psychological distress over the course of the intervention until 5-month follow-up.  |
| de Roos et al. (2011) [52]  | Exposure-based Cognitive Behavioral Therapy, CBT [50] and Eye Movement Desensitization and Reprocessing (EMDR) [51] | RCT                         | <i>N</i> = 52  | Explosion        | Reduction in trauma-related distress and PTSD symptoms | Face-to-face    | Children and adolescents | Up to 4 for 60 min.                               | Exposure-based CBT was effective in reducing PTSD, anxiety, and depressive symptoms at post-intervention. EMDR was effective in reducing PTSD, anxiety, and depressive symptoms at post-intervention. |
| Scheiber et al. (2019) [53] | Preventive Resilience Training for Unaccompanied Refugee Minors [53]  | RCT                         | <i>N</i> = 55  | Flight           | Reduction in symptoms of PTSD, depression, and anxiety | Face-to-face    | Adolescents              | A total of 6 for 90 min each                      | The Preventive Resilience Training was not effective in reducing anxiety, PTSD, and depressive symptoms at 7 weeks post-intervention.   |
| Gallegos et al. (2015) [56] | Mindfulness-Based Stress Reduction (MBSR) [54]  | Uncontrolled pre–post study | <i>N</i> = 50  | Childhood trauma | Improvement in mindfulness                             | Face-to-face    | Adults                   | A total of 8 for 120 min each and 1 retreat (4 h) | MBSR was effective in reducing perceived distress, depressive symptoms, anxiety, and PTSD symptoms at post-intervention and at 1-month follow-up.   |

**Table A1.** *Cont.*

| Study                     | Intervention                               | Design                      | Sample Size    | Type of Stressor                      | Aim of Intervention   | Delivery Format | Target Population | No. of Sessions              | Results   |
|---------------------------|--|-----------------------------|----------------|---------------------------------------|---|-----------------|-------------------|------------------------------|---|
| Tehrani (2019) [57]       | Trauma Therapy Program [57]                | Uncontrolled pre–post study | <i>N</i> = 429 | Traumatic events in emergency service | Reduction in work-related psychological symptoms                                  | Face-to-face    | Adults            | A total of 6 for 90 min each | The Trauma Therapy Program was effective in reducing anxiety, depression, and PTSD symptoms at post-treatment.        |
| Church et al. (2013) [60] | Emotional Freedom Techniques (EFT) [59]    | RCT                         | <i>N</i> = 55  | War                                   | Reduction in psychological distress and symptoms of depression, anxiety, and PTSD | Face-to-face    | Adults            | A total of 6 for 60 min each | EFT was effective in reducing PTSD, anxiety, and depression at post-intervention until 3-month and 6-month follow-up. |
| Chen (2020) [63]          | Solution-Focused Brief Therapy (SFBT) [61] | RCT                         | <i>N</i> = 76  | COVID-19 pandemic                     | Reduction n mental health symptoms  | Online          | Adolescents       | A total of 2–4               | Not applicable (study protocol)   |



**Table A2.** Detailed overview of intervention characteristics and results of the included studies/protocols ( $n = 27$ ).

| Study                     | Intervention Name and Description  | Study Design                     | Timepoint of Intervention after Stressor Exposure | No. of Sessions                   | Type of Stressor | Target Population  | Delivery Format | Assessed Outcomes  | Results   |
|---------------------------|--|----------------------------------|---|-----------------------------------|------------------|--|-----------------|--|---|
| <b>Self-help programs</b> |  |                                  |   |                                   |                  |  |                 |  |   |
| Liu et al. (2021) [20]    | Computerized Cognitive Behavioral Therapy (cCBT) [20]: Online self-help cCBT targeting patients with COVID-19<br>A total of three modules: cognitive training, cognitive consolidation, and behavioral therapy<br>Introduction to the program by a therapist | RCT (Intervention + TAU vs. TAU) | During COVID-19                                   | A total of 7 at least for 10 min. | COVID-19         | $N = 252$ adults with COVID-19<br>Mild to moderate depressive or anxiety symptoms (HAMD, score $\geq 7$ ; HAMA score $\geq 7$ )<br>Age (range: 18–75 years)<br>cCBT + TAU ( $n = 126$ ): 56% female<br>TAU ( $n = 126$ ): 46% female | Online          | Primary outcomes:<br>Symptoms of depression: Hamilton Depression Rating Scale, HAMD [64]<br>Symptoms of Anxiety: Hamilton Anxiety Scale, HAMA [65]<br>Secondary outcomes:<br>Depression: Self-Rating Depression Scale, SDS [66]<br>Anxiety: Self-Rating Anxiety Scale, SAS [67]<br>Insomnia: Athens Insomnia Scale, AIS [68] | Significantly decreased score of the cCBT + TAU group on the HAMD, HAMA, SDS, SAS, and AIS at post-intervention compared to the TAU group (all $p < 0.001$ )<br>HAMD<br>cCBT + TAU: $T_0$ : $M = 15.28$ ; Post: $M = 7.86$ ; 1-month FU: $M = 6.68$ ; TAU: $T_0$ : $M = 15.70$ ; Post: $M = 15.46$ ; 1-month FU: $M = 15.26$<br>HAMA<br>cCBT + TAU: $T_0$ : $M = 14.26$ ; Post: $M = 7.38$ ; 1-month FU: $M = 6.10$ ; TAU: $T_0$ : $M = 13.88$ ; Post: $M = 13.24$ ; 1-month FU: $M = 13.20$<br>SDS<br>cCBT + TAU: $T_0$ : $M = 46.10$ ; Post: $M = 32.56$ ; 1-month FU: $M = 31.14$ ; TAU: $T_0$ : $M = 45.22$ ; Post: $M = 45.56$ ; 1-month FU: $M = 44.70$<br>SAS<br>cCBT + TAU: $T_0$ : $M = 44.30$ ; Post: $M = 29.66$ ; 1-month FU: $M = 29.12$ ; TAU: $T_0$ : $M = 45.56$ ; Post: $M = 45.52$ ; 1-month FU: $M = 44.92$<br>AIS<br>cCBT + TAU: $T_0$ : $M = 8.58$ ; Post: $M = 6.98$ ; 1-month FU: $M = 6.88$ ; TAU: $T_0$ : $M = 8.20$ ; Post: $M = 8.00$ ; 1-month FU: $M = 7.82$ |

Table A2. Cont.

| Study                     | Intervention Name and Description   | Study Design                                     | Timepoint of Intervention after Stressor Exposure | No. of Sessions | Type of Stressor | Target Population   | Delivery Format               | Assessed Outcomes   | Results   |
|---------------------------|---|--|---|-----------------|------------------|---|-------------------------------|---|---|
| <b>Self-help programs</b> |   |  |   |                 |                  |   |                               |   |   |
| Zhou et al. (2020) [21]   | Individualized Short-term Training Program [21]: Short-term online and in-person emergency training<br>Covers knowledge about diagnosing COVID-19, handling and safety precautions with infected patients, and psychological support including mindfulness-based stress reduction<br>Delivered by psychologists | Uncontrolled pre–post study                      | During COVID-19                                   | Not reported    | COVID-19         | <i>N</i> = 71 female nursing staff working in the emergency isolation department<br>Age ( <i>M</i> = 31.31; <i>SD</i> = 4.85) | Hybrid (online and in-person) | Primary outcomes: Symptoms of anxiety: Self-rating Anxiety Scale, SAS [67]<br>Symptoms of depression: Self-rating Depression Scale, SDS [66]  | Comparison of in-person and online + in-person training: Better evaluation of theoretical training ( <i>p</i> = 0.042) and drill training ( <i>p</i> = 0.002) using online + in-person training method. No difference in evaluation of operation training between the two methods ( <i>p</i> = 0.081).<br>Lower SAS score post-training ( <i>p</i> = 0.019)<br>Mean difference in SAS scores between <i>T</i> <sub>0</sub> and post-training: <i>M</i> = −3.06<br>No significant reduction in SDS score ( <i>p</i> = 0.31)<br>Mean difference in SDS scores between <i>T</i> <sub>0</sub> and post-training: <i>M</i> = −1.99 |
| Alavi et al. (2020) [22]  | Online Psychotherapy Tool (OPTT) [22]: CBT-program via an online platform<br>Combination of CBT, mindfulness therapy, and problem-based therapy<br>Weekly self-guided modules and written feedback from trained therapists  | Controlled pre–post study (Intervention vs. TAU) | During COVID-19                                   | Nine            | COVID-19         | <i>N</i> = 80 adults aged 18–65 years with a primary diagnosis of GAD or MDD  | Online                        | Primary outcomes: Anxiety: Generalized Anxiety Disorder-7, GAD-7 [69]<br>Depressive symptoms: Patient Health Questionnaire-9 Item, PHQ-9 [70]<br>Resilience: Resilience Scale-14 Item Questionnaire, RS-14 [71]<br>Quality of life: Quality of Life and Enjoyment Questionnaire, Q-LES-Q [72] | Not applicable (study protocol)   |

Table A2. Cont.

| Study                     | Intervention Name and Description   | Study Design                   | Timepoint of Intervention after Stressor Exposure | No. of Sessions | Type of Stressor | Target Population   | Delivery Format | Assessed Outcomes   | Results                         |
|---------------------------|---|--------------------------------|---|-----------------|------------------|---|-----------------|---|---------------------------------|
| Weiner et al. (2020) [23] | “My health too” [23]: Online self-help CBT program<br>Seven asynchronous video sessions: psychoeducation, functional behavioral and cognitive coping strategies, mindfulness, mindfulness/acceptance, promoting action toward values, addressing barriers and motivation, and self-compassion<br>Optional psychotherapeutic support | RCT (Intervention vs. Control) | During COVID-19                                   | Seven           | COVID-19         | N = 120 healthcare workers with stress levels > 16 on the Perceived Stress Scale (PSS-10) | Online          | Primary outcome: Stress: Perceived Stress Scale, PSS-10 [73]<br>Secondary outcomes: Depressive symptoms: Patient Health Questionnaire, PHQ-2 [74]<br>PTSD symptoms: Short Form Post-traumatic Stress Disorder Checklist 5, SF-PCL-5 [75]<br>Resilience: Connor-Davidson Resilience Scale, CD-RISC2 [76]<br>Insomnia: Insomnia Severity Index, ISI [77]<br>Rumination: Affective Rumination Questionnaire, ARQ [78]<br>Credibility of treatment: Credibility and Expectancy Questionnaire, CEQ [79]<br>Satisfaction: Client Satisfaction Questionnaire, CSQ-8 [80] | Not applicable (study protocol) |

Table A2. Cont.

| Study                      | Intervention Name and Description  | Study Design   | Timepoint of Intervention after Stressor Exposure | No. of Sessions | Type of Stressor  | Target Population  | Delivery Format | Assessed Outcomes  | Results  |
|----------------------------|--|--|---|-----------------|---|--|-----------------|--|--|
| Gilmore et al. (2021) [25] | Bounce Back Now (BBN) [24]: Web-based self-help intervention for disaster-affected adolescents and parents<br>Four modules: PTSD, depression (mood), smoking, and alcohol use<br>BBN+ ASH (Bounce Back Now plus a seven-module adult self-help (ASH) intervention) | Controlled pre–post study (Intervention vs. Control) | $M = 8.8$ ( $SD = 2.6$ ) months after tornado     | Four            | Tornadoes in Joplin, Missouri, and several areas of Alabama, 2011 | $N = 979$ adolescents<br>52.9% female<br>Age ( $M = 14.3$ ; $SD = 1.7$ )   | Online          | Primary outcome: PTSD symptoms: National Survey of Adolescents (NSA) PTSD module [81]  | BBN > Control<br>Significant decline in PTSD symptoms in BBN condition over time ( $b = -0.02$ , $p = 0.04$ , OR = 0.98) with adolescents who had caregivers who were concerned for loved ones during the disaster<br>No significant decline in PTSD symptoms in control condition over time ( $b = 0.02$ , $p = 0.26$ , OR = 1.02)<br>PTSD symptoms BBN: $T_0$ : $M = 1.35$ ( $SD = 2.43$ ); 4-Month FU: $M = 1.25$ ( $SD = 2.59$ ); 12-Month FU $M = 1.12$ ( $SD = 2.54$ )<br>PTSD symptoms control: $T_0$ : $M = 1.45$ ( $SD = 2.45$ ); 4-Month FU $M = 1.18$ ( $SD = 2.47$ ); 12-Month FU $M = 1.26$ ( $SD = 2.15$ ) |
| Price et al. (2013) [27]   | Disaster Recovery Web (DRW) Project [26]: Web-based self-help intervention<br>Four modules: post-traumatic stress, depressed mood, generalized anxiety, and panic  | Uncontrolled pre–post study                          | 1 year after the stressor                         | Four            | Hurricane Ike in Texas, 2008                                      | $N = 1249$ adults who survived Hurricane Ike with symptoms of PTSD, depression, and anxiety.<br>Equally distributed across genders<br>Age ( $M = 46$ ; $SD = 17$ ) | Online          | Primary outcomes: Symptoms of PTSD: The PTSD Checklist-Civilian version, PCL-C [82]<br>Depressive Symptoms: Center for Epidemiologic Studies-Depressed Mood Scale-10, CES-D [83] | No significant reduction in PTSD symptoms and depressive symptoms between $T_0$ and 4-month post-intervention  |

Table A2. Cont.

| Study                                | Intervention Name and Description   | Study Design                                | Timepoint of Intervention after Stressor Exposure | No. of Sessions              | Type of Stressor | Target Population   | Delivery Format | Assessed Outcomes  | Results                         |
|--------------------------------------|---|---|---|------------------------------|------------------|---|-----------------|--|---------------------------------|
| <b>Psychosocial support programs</b> |   |   |   |                              |                  |   |                 |  |                                 |
| Tang et al. (2021) [28]              | Grief Counseling [28]:<br>Online Grief Counseling based on CBT<br>Topics: understanding and managing grief reactions, managing painful emotions, learning to care for yourself, increasing contact with others, coping with difficult days, and adapting to a new life<br>Delivered by psychologists, social workers, or trained counselors | RCT<br>(Intervention vs. Wait list control) | After stressor at any timepoint                   | A total of 8–10 for 1 h each | COVID-19         | N = 160 participants aged > 18 who have lost their first-degree relatives during COVID-19 | Online          | Primary outcomes:<br>Symptoms of PTSD: PTSD Checklist for DSM-5, PCL-5 [84]<br>Post-traumatic Growth Inventory, PTGI [85]<br>Depressive, anxiety, and stress symptoms: Depression Anxiety and Stress Scale, DASS-21 [86]<br>Grief symptoms: Prolonged Grief Questionnaire, PG-13 [87]<br>Secondary outcomes:<br>Suicidal intention: Scale for Suicidal Intention, SSI [88]<br>Maladaptive cognitions: Typical Beliefs Questionnaire, TBQ [89]<br>Avoidance behavior: Grief-related Avoidance Questionnaire, GRAQ [90]<br>Functioning in relationships: The Work and Social Adjustment Scale, WSAS [91] | Not applicable (study protocol) |



Table A2. Cont.

| Study                      | Intervention Name and Description  | Study Design                    | Timepoint of Intervention after Stressor Exposure | No. of Sessions | Type of Stressor | Target Population   | Delivery Format | Assessed Outcomes   | Results                         |
|----------------------------|--|---------------------------------|---|-----------------|------------------|---|-----------------|---|---------------------------------|
| Devassy et al. (2021) [32] | Resiliency Engagement and Care in Health (REaCH) [32]:<br>Telephonic befriending psychosocial intervention<br>Four phone calls for 30 min–1 h consisting of proactive engagement and crisis intervention, problem-solving-oriented support therapy and assertive linkage with community resources<br>Delivered by lay workers and non-health professionals | cRCT (Intervention vs. Control) | During COVID-19                                   | Four            | COVID-19         | N = 1440 adults aged 18–35 years from economically disadvantaged and vulnerable sections of society | Phone-based     | Primary outcomes:<br>Mental well-being: World Health Organization-Five Well-Being Index, WHO-5 [92]<br>Depressive symptoms: Patient Health Questionnaire, PHQ-9 [70]<br>Perceived social support: Multidimensional Scale of Perceived Social Support, MSPSS-12 [93] | Not applicable (study protocol) |

Table A2. Cont.

| Study                    | Intervention Name and Description   | Study Design                             | Timepoint of Intervention after Stressor Exposure | No. of Sessions           | Type of Stressor               | Target Population  | Delivery Format | Assessed Outcomes   | Results   |
|--------------------------|---|--|---|---------------------------|--------------------------------|--|-----------------|---|---|
| James et al. (2020) [33] | Mental Health Integrated Disaster Preparedness (MHIDP) Intervention [33]: Community-based mental health intervention Topics: establishing safety and practicing coping skills targeting disaster-related distress, providing space for sharing personal experiences, and giving hands-on training in disaster preparedness Delivered by lay mental health workers | RCT (Intervention vs. wait list control) | Not reported                                      | A total of 3 for 6 h each | Earthquakes or floods in Haiti | <i>N</i> = 480 adults drawn from disaster-affected communities 49.8% female Age ( <i>M</i> = 37; <i>SD</i> = 13.6) | Face-to-face    | Primary outcomes: Disaster preparedness: Twenty-item disaster preparedness checklist [33] Symptoms of PTSD: Modified PTSD Symptom Scale, MPSS [94] Symptoms of depression: Zanmi Lasante Depression Symptom Inventory, ZLDSI [95] Symptoms of anxiety: Beck Anxiety Inventory, BAI [96] Functional impairment [96] Social cohesion [97] | Highly significant unstandardized regression coefficients ( $p < 0.001$ ) to indicate the change in scale values in the intervention group relative to control from $T_0$ to 3–4-month FU Disaster preparedness: 4.18 ( $d = 0.75$ ) Depression: $-0.35$ ( $d = -0.47$ ) PTSD: $-0.46$ ( $d = -0.49$ ) Anxiety: $-0.27$ ( $d = -0.41$ ) Significant unstandardized regression coefficients ( $p < 0.05$ ) from $T_0$ to 3–4-month FU in functional impairment: $-0.35$ ( $d = 0.29$ ) which disappeared at 7–8-month FU Highly significant unstandardized regression coefficients ( $p < 0.001$ ) from 3–4-month FU to 7–8-month FU in disaster preparedness: 2.90 ( $d = 0.52$ ) |

Table A2. Cont.

| Study                    | Intervention Name and Description  | Study Design                | Timepoint of Intervention after Stressor Exposure | No. of Sessions              | Type of Stressor | Target Population                                       | Delivery Format | Assessed Outcomes   | Results                         |
|--------------------------|--|-----------------------------|---|------------------------------|------------------|---|-----------------|---|---------------------------------|
| Keyan et al. (2021) [39] | Problem Management Plus (PM+) [34]: Brief psychosocial intervention<br>Adaption to be delivered in a group setting (Group PM+)<br>Four strategies: managing stress, managing problems, behavioral activation, strengthening social support<br>Delivered by trained nonspecialist lay providers | RCT (Intervention vs. ETAU) | During COVID-19                                   | A total of 6 for 60 min each | COVID-19         | N = 240 adults with a score $\geq 3$ on the GHQ-12 [98] | Online          | Primary outcome: Anxiety and depressive symptoms: Hospital Anxiety and Depression Scales, HADS [99]<br>Secondary outcomes: Generalized Anxiety: Generalized Anxiety Disorder Scale, GAD-7 [69]<br>Sleep Impairment: Insomnia Severity Index, ISI [100]<br>Mood: Positive and Negative Affect Schedule, PANAS [101]<br>Anhedonia: Pleasure Scale [102]<br>COVID stress: COVID Stress Scales, CSS [103] | Not applicable (study protocol) |

Table A2. Cont.

| Study                        | Intervention Name and Description  | Study Design                | Timepoint of Intervention after Stressor Exposure | No. of Sessions               | Type of Stressor                          | Target Population   | Delivery Format | Assessed Outcomes   | Results  |
|------------------------------|--|-----------------------------|---|-------------------------------|---|---|-----------------|---|--|
| Sangraula et al. (2020) [35] | Problem Management Plus (PM+) [34]: Brief psychosocial intervention<br>Adaption to be delivered in a group setting (Group PM+)<br>Four strategies: managing stress, managing problems, behavioral activation, strengthening social support<br>Delivered by trained nonspecialist lay providers | cRCT (Intervention vs. EUC) | Not reported                                      | A total of 5 for 2.5–3 h each | Earthquake-affected region of rural Nepal | <i>N</i> = 121 participants<br>83% female<br>Group PM+ ( <i>n</i> = 61): Age ( <i>M</i> = 46.7; <i>SD</i> = 14)<br>EUC ( <i>n</i> = 60): Age ( <i>M</i> = 49.3; <i>SD</i> = 13.6) | Face-to-face    | Primary outcome:<br>Depressive symptoms: Primary Health Questionnaire, PHQ-9 [70]<br>Secondary outcomes:<br>Psychological distress: General Health Questionnaire, GHQ-12 [98];<br>Heart–mind screener [104]<br>Daily functioning: WHO Disability Assessment Scale, WHODAS [105]<br>PTSD symptoms: Post-traumatic stress disorder Check List, PCL-5 [84]<br>Psychosocial problems: Psychosocial Mental Health Problems, PMHP [106]<br>Social Support: Multidimensional Scale of Perceived Social Support, MSPSS [93]<br>Coping strategies: Reducing Tension Checklist, RTC [107]<br>Traumatic events: Traumatic Events Inventory, TEI [108]<br>Personally identified problems: Psychological Outcome Profiles, PSYCHLOPS [109] | Feasibility and acceptability for nonspecialists to deliver Group PM+<br><br>PHQ-9:<br>T <sub>0</sub> PM(PM+; [34]): <i>M</i> = 9.7 ( <i>SD</i> = 4.8);<br>T <sub>0</sub> EUC: <i>M</i> = 10.9 ( <i>SD</i> = 4.3)<br>Post PM(PM+; [34]): <i>M</i> = 6.2 ( <i>SD</i> = 3.7);<br>Post EUC: <i>M</i> = 9.3 ( <i>SD</i> = 4.3)<br>WHODAS:<br>T <sub>0</sub> PM(PM+; [34]): <i>M</i> = 21.5 ( <i>SD</i> = 4.9);<br>T <sub>0</sub> EUC: <i>M</i> = 20.9 ( <i>SD</i> = 4.2)<br>Post PM(PM+; [34]): <i>M</i> = 12.1 ( <i>SD</i> = 8.0); Post EUC: <i>M</i> = 15.7 ( <i>SD</i> = 6.4)<br>GHQ-12: T <sub>0</sub> PM(PM+; [34]): <i>M</i> = 24.2 ( <i>SD</i> = 4.8); T <sub>0</sub> EUC: <i>M</i> = 21.4 ( <i>SD</i> = 4.8)<br>Post PM(PM+; [34]): <i>M</i> = 11.9 ( <i>SD</i> = 6.6); Post EUC: <i>M</i> = 17.6 ( <i>SD</i> = 6.0)<br>PMH(PM+; [34]):<br>T <sub>0</sub> PM(PM+; [34]): <i>M</i> = 10.1 ( <i>SD</i> = 3.3);<br>T <sub>0</sub> EUC: <i>M</i> = 11.2, ( <i>SD</i> = 2.7)<br>Post PM(PM+; [34]): <i>M</i> = 9.1, ( <i>SD</i> = 3.0); Post EUC: <i>M</i> = 11.2, ( <i>SD</i> = 2.9)<br>PCL-5:<br>T <sub>0</sub> PM(PM+; [34]): <i>M</i> = 17.5 ( <i>SD</i> = 7.2);<br>T <sub>0</sub> EUC: <i>M</i> = 21.8 ( <i>SD</i> = 5.7)<br>Post PM(PM+; [34]): <i>M</i> = 14.8 ( <i>SD</i> = 8.1); Post EUC: <i>M</i> = 20.5 ( <i>SD</i> = 5.6)<br>RTC:<br>T <sub>0</sub> PM(PM+; [34]): <i>M</i> = 15.6 ( <i>SD</i> = 4.8);<br>T <sub>0</sub> EUC: <i>M</i> = 10.2 ( <i>SD</i> = 5.1)<br>Post PM(PM+; [34]): <i>M</i> = 20.6 ( <i>SD</i> = 5.8); Post EUC: <i>M</i> = 9.4 ( <i>SD</i> = 4.2)<br>MSPSS:<br>T <sub>0</sub> PM(PM+; [34]): <i>M</i> = 33.3 ( <i>SD</i> = 8.0);<br>T <sub>0</sub> EUC: <i>M</i> = 29.6 ( <i>SD</i> = 8.7)<br>Post PM(PM+; [34]): <i>M</i> = 34.2 ( <i>SD</i> = 7.0), Post EUC: <i>M</i> = 29.4 ( <i>SD</i> = 8.7) |

Table A2. Cont.

| Study                      | Intervention Name and Description  | Study Design                | Timepoint of Intervention after Stressor Exposure | No. of Sessions             | Type of Stressor                | Target Population  | Delivery Format | Assessed Outcomes  | Results   |
|----------------------------|--|-----------------------------|---|-----------------------------|---------------------------------|--|-----------------|--|---|
| Jordans et al. (2021) [36] | Problem Management Plus (PM+) [34]: Brief psychosocial intervention<br>Adaption to be delivered in a group setting (Group PM+)<br>Four strategies: managing stress, managing problems, behavioral activation, strengthening social support<br>Delivered by trained nonspecialist lay providers | cRCT (Intervention vs. EUC) | Not reported                                      | A total of 5 for 2.5 h each | Disaster-prone regions in Nepal | <i>N</i> = 611 adults screened for psychological distress and functional impairment in 72 eligible wards<br>82.2% female<br>Age ( <i>M</i> = 44.8; <i>SD</i> = 14.4) | Face-to-face    | Primary outcome: General psychological distress: General Health Questionnaire, GHQ-12 [98]<br>Secondary outcomes: Depressive symptoms: Primary Health Questionnaire, PHQ-9 [70]<br>Daily functioning: WHO Disability Assessment Scale, WHODAS [105]<br>PTSD symptoms: Post-traumatic stress disorder Check List, PCL-5 [84]<br>Perceived social support: Multi-dimensional Scale of Perceived Social Support, MSPSS [93]<br>Somatic symptoms: Somatic Symptom Scale 8, SSS-8 [110]<br>General psychological distress: Heart–mind screener (Community Informant Detection Tool, CIDT [111]) | Group-PM+ > EUC#breakLower distress in the PM+ Group at both midline (SMD = −0.4 (95% CI: −0.5, 0.0.2); <i>p</i> < 0.001) and endline (SMD = −0.2 (95% CI: −0.4, −0.0); <i>p</i> = 0.014) compared to the control arm#breakLower depression symptoms of the Group-PM+ arm at endline (PHQ-9 mean difference = −1.0, 95% CI: −1.8, −0.1, |

mboxemph  
=  
0.028)#breakGroup-  
PM+ arm  
had fewer  
“heart-  
mind”  
problems  
at endline  
(risk ratio  
= 0.8 (95%  
CI: 0.7,  
1.0,  
*p* = 0.042))#breakGroup-  
PM+

Table A2. Cont.

| Study                     | Intervention Name and Description  | Study Design                | Timepoint of Intervention after Stressor Exposure | No. of Sessions | Type of Stressor                       | Target Population  | Delivery Format | Assessed Outcomes  | Results  |
|---------------------------|--|-----------------------------|---|-----------------|--|--|-----------------|--|--|
| Rahman et al. (2016) [37] | Problem Management Plus (PM+) [34]: Brief psychosocial intervention<br>Adaption to be delivered in a group setting (Group PM+)<br>Four strategies: managing stress, managing problems, behavioral activation, strengthening social support<br>Delivered by trained nonspecialist lay providers | RCT (Intervention vs. ETAU) | Not reported                                      | Five            | Conflict-affected Peshawar in Pakistan | N = 60 participants with both marked distress and impairment | Face-to-face    | Primary outcome: Psychological distress: General Health Questionnaire, GHQ-12 [98]<br>Secondary outcomes: Daily functioning: WHO Disability Assessment Scale, WHODAS [105]<br>PTSD symptoms: Post-traumatic stress disorder Check List, PCL-5 [84] | PM+ > ETAU<br>The intervention arm showed improvement in functioning (mean WHODAS 2.0 scores reduced from $17.7 \pm 9.2$ to $6.6 \pm 6.1$ vs. $17.0 \pm 10.5$ to $11.3 \pm 10.4$ in controls) and in post-traumatic stress symptoms (mean PCL-5 scores reduced from $34.2 \pm 20.1$ to $9.8 \pm 9.1$ vs. $32.3 \pm 17.1$ to $19.5 \pm 18.5$ in controls)<br>PM+ = ETAU<br>No significant change in GHQ-12 scores |

Table A2. Cont.

| Study                     | Intervention Name and Description  | Study Design               | Timepoint of Intervention after Stressor Exposure | No. of Sessions              | Type of Stressor                     | Target Population                                     | Delivery Format | Assessed Outcomes  | Results   |
|---------------------------|--|----------------------------|---|------------------------------|--------------------------------------|---|-----------------|--|---|
| Bryant et al. (2017) [38] | Problem Management Plus (PM+) [34]: Brief psychosocial intervention<br>Adaption to be delivered in a group setting (Group PM+)<br>Four strategies: managing stress, managing problems, behavioral activation, strengthening social support<br>Delivered by trained nonspecialist lay providers | RCT (Intervention vs. EUC) | Not reported                                      | A total of 5 for 90 min each | Gender-based violence (GBV) in Kenya | $N = 421$ women<br>Age ( $M = 35.56$ ; $SD = 13.39$ ) | Face-to-face    | Primary outcome: Psychological distress: General Health Questionnaire, GHQ-12 [98]<br>Secondary outcomes: Daily functioning: WHO Disability Assessment Scale, WHODAS [105]<br>PTSD symptoms: Post-traumatic stress disorder Check List, PCL-5 [84]<br>Personally identified problems: Psychological Outcome Profiles, PSYCHLOPS [109]<br>Stressful life events: Life Events Checklist, LEC [112] | PM+ > EUC<br>Greater reduction in distress from baseline to 3 months (95% CI $1.86 \pm 4.79$ , $p = 0.001$ ) in the PM+ Group<br>For WHODAS the difference between PM+ and EUC in the change from baseline to 3-month follow-up was 1.96 (95% CI $0.21 \pm 3.71$ , $p = 0.03$ ), for PCL it was 3.95 (95% CI $0.06 \pm 7.83$ , $p = 0.05$ ), and for PSYCHLOPS it was 2.15 (95% CI $0.98 \pm 3.32$ , $p = 0.001$ ), all in favour of PM+. Moderate effect sizes in favour of PM+ for GHQ-12 score (0.57, 95% CI $0.32 \pm 0.83$ ) and PSYCHLOPS (0.67, 95% CI $0.31 \pm 1.03$ ), and small effect sizes for WHODAS (0.26, 95% CI $0.02 \pm 0.50$ ) and PCL (0.21, 95% CI $0.00 \pm 0.41$ ).<br>PM+ = EUC<br>For the LEC the between-group difference at 3-month follow-up was 0.31 (95% CI $0.02 \pm 1.23$ , $p = 0.51$ ), indicating no difference in exposure to stressful life events between the groups. There was a very small between-group effect size (0.03, 95% CI $-0.23$ to 0.15). |



Table A2. Cont.

| Study                       | Intervention Name and Description   | Study Design                | Timepoint of Intervention after Stressor Exposure | No. of Sessions                                    | Type of Stressor     | Target Population  | Delivery Format | Assessed Outcomes   | Results   |
|-----------------------------|---|-----------------------------|---|--|----------------------|--|-----------------|---|---|
| O'Donnell et al. (2020) [6] | Skills fOr Life Adjustment and Resilience program (SOLAR) [6]: Brief disaster-focused psychosocial intervention#breakSix modules: healthy living, managing strong emotions, getting back into life, coming to terms with the disaster, managing worry and rumination, maintaining healthy relationships#breakDelivered by trained coaches | Uncontrolled pre–post study | 1 year after stressor exposure                    | A total of 4 for 50 min each. The first for 80 min | Australian Bushfires | N = 15 adults impacted by bushfires with subclinical anxiety, post-traumatic stress, or depression symptoms, and distress<br>53.3% female<br>Age (M = 58.68, SD = 11.53) | Face-to-face    | Primary outcomes:<br>Psychological distress: Kessler Psychological Distress Scale, K10 [113]<br>PTSD symptoms: PTSD Checklist for DSM-5, PCL-5 [84]<br>Secondary outcomes: Single impairment item [6]<br>Psychological Outcome Profiles instrument, PSYCHLOPS [109] | Pre–post quantitative analysis demonstrated reductions in psychological distress, post-traumatic stress symptoms, and impairment ( $p < 0.05$ )<br>K10: T <sub>0</sub> : M = 18.40 (SD = 5.01); Post: M = 13.08 (SD = 2.36); 3-Month FU: M = 13.73 (SD = 2.81)<br>PCL-5: T <sub>0</sub> : M = 17.87 (SD = 8.29); Post: M = 5.07 (SD = 5.65); 3-Month FU M = 6.93 (SD = 6.51)<br>PSYCHLOPS: T <sub>0</sub> : M = 11.79 (SD = 4.39); Post: M = 5.25 (SD = 2.30); 3-Month FU M = 5.67 (SD = 2.84)<br>Impairment: T <sub>0</sub> : M = 4.64 (SD = 1.95); Post: M = 1.07 (SD = 1.54); 3-Month FU M = 2.2 (SD = 2.27) |

Table A2. Cont.

| Study                     | Intervention Name and Description   | Study Design  | Timepoint of Intervention after Stressor Exposure | No. of Sessions | Type of Stressor           | Target Population  | Delivery Format | Assessed Outcomes  | Results   |
|---------------------------|---|---|---|-----------------|----------------------------|--|-----------------|--|---|
| Gibson et al. (2021) [40] | Skills fOr Life Adjustment and Resilience program (SOLAR) [6]: Brief disaster-focused psychosocial intervention#breakSix modules: healthy living, managing strong emotions, getting back into life, coming to terms with the disaster, managing worry and rumination, maintaining healthy relationships#breakDelivered by trained coaches | Controlled pre–post pilot study (Intervention vs. UC) | 3 years and 7 months after stressor exposure      | Five            | Tropical Cyclone Pam, 2015 | N = 99 residents of Tuvalu exposed to Tropical Cyclone Pam across Nui (n = 49)<br>76% female Age (M = 34.12; range: 18–71) and Funafuti (n = 50)<br>57% female Age (M = 50.02; range: 20–74) | Face-to-face    | Primary outcome: Psychological distress: Hopkins symptom checklist-25 (HSCL-25) Tuvalu, HSCL-25 [114]<br>Secondary outcomes: PTSD symptoms: PTSD Checklist for DSM-5, PCL-5) [84]<br>Impairment: Tuvalu impairment checklist, TIC [114]<br>Participant-identified difficulties: Psychological outcomes profiles, PSYCHLOPS [109] | Acceptability: High degree of session attendance of 4 sessions (SD = 1.25) on average; program was found to be useful and/or important; participants would recommend the program<br>Feasibility: Pre–Post training analyses: Significant improvements in coaches' knowledge of program content, $t(10) = 4.36, p = 0.001, d_{RM} = 1.76, 95\% \text{ CI: } [0.41, 3.11]$ ; their ability to apply that knowledge in response to example vignettes, $t(10) = 19.10, p < 0.001, d_{RM} = 6.83, 95\% \text{ CI: } [3.15, 10.51]$ ; and their confidence delivering the program, $t(9) = 2.98, p = 0.015, d_{RM} = 1.26, 95\% \text{ CI: } [0.07, 2.45]$<br>Efficacy:<br>Distress: SOLAR > UC<br>Mean difference of 0.520 [95% CI: 0.646, 0.395], with the intervention group adjusted mean statistically significantly lower than that of the control group (Glass' delta = 1.106 [0.839, 1.373])<br>PTSD symptoms:<br>SOLAR > UC<br>Large significant difference between groups (Glass' delta = 1.575 [1.341, 1.810]), with significantly greater declines in PTSD symptoms in the intervention group<br>Impairment: SOLAR > UC<br>Greater reductions in impairment in the intervention group (Glass' delta = 1.316 [1.117, 1.516]) |

Table A2. Cont.

| Study  | Intervention Name and Description   | Study Design                             | Timepoint of Intervention after Stressor Exposure | No. of Sessions | Type of Stressor | Target Population   | Delivery Format | Assessed Outcomes  | Results   |
|--|---|--|---|-----------------|------------------|---|-----------------|--|---|
| Lotzin, Hinrichsen, Kenntemich, Freyberg, Lau, & O'Donnell (2021) [41] | Skills fOr Life Adjustment and Resilience program (SOLAR) [6]: Brief disaster-focused psychosocial intervention#breakSix modules: healthy living, managing strong emotions, getting back into life, coming to terms with the disaster, managing worry and rumination, maintaining healthy relationships#breakDelivered by trained coaches | RCT (Intervention vs. Wait list control) | Not reported                                      | Five            | Traumatic events | N = 30 German trauma survivors with subclinical symptoms of depression, anxiety, or post-traumatic stress disorder or functional impairment<br>Age (M = 42)<br>SOLAR group program (n = 15): 73.3% female<br>Wait list control group (n = 15): 53.3% female | Face-to-face    | Primary outcome: Feasibility: Client Satisfaction Questionnaire, CSQ-8 [115,116]<br>Secondary outcomes: Psychological distress: Kessler Psychological Distress Scale-10, K10 [113]<br>Symptoms of insomnia: Insomnia Severity Index, ISI [100]<br>PTSD symptoms: PTSD Checklist for DSM-5, PCL-5 [84]<br>Patient-centered outcomes: Psychological Outcome Profiles Scale, PSYCHLOPS [109]<br>Quality of life: Assessment of Quality of Life-6D, AQoL-6D [117]<br>Perceived social support: Interpersonal Support Evaluation List-12, ISEL-12 [118] | Feasibility: Among the 14 participants that started the SOLAR program, 13 (92.9%) completed 4 out of 5 sessions, 3 (10.0%) of the 30 randomized participants dropped out of the study, on average, participants were “very satisfied” (M = 3.85, SD = 0.44) with the program<br>SOLAR > Wait list control Distress decreased in the intervention group but remained in the moderate/severe range in the control group (d = 0.195).<br>Symptoms of insomnia decreased in the intervention group and marginally decreased in the control group (d = 0.596)<br>Large effect sizes (d = 1.667) for patient-cenered outcomes: Severity of the problem causing the most distress declined in the intervention group but not in the control group<br>Greater reduction in impairment in the intervention group relative to the control group (d = 0.362)<br>Intervention group showed a greater improvement in quality of life including mental health (d = 0.642), relationships (d = 0.541), and problem coping (d = 0.548)<br>Perceived social support increased more greatly in the intervention group relative to the control group (d = 0.560)<br>SOLAR = Wait list control<br>PTSD symptoms did not more greatly decrease in the intervention group relative to the control group (d = 0.032) |

Table A2. Cont.

| Study                      | Intervention Name and Description  | Study Design                | Timepoint of Intervention after Stressor Exposure | No. of Sessions                    | Type of Stressor          | Target Population  | Delivery Format | Assessed Outcomes   | Results   |
|----------------------------|--|-----------------------------|---|------------------------------------|---------------------------|--|-----------------|---|---|
| Ramirez et al. (2013) [43] | Listen Protect Connect (LPC) [42]: School-based crisis response strategy of PFA<br>Five steps: Listen, Protect, Connect, Model, and Teach<br>Delivered by school staff | Uncontrolled pre–post study | 10 months after the stressor                      | A total of 1 for 25 min on average | Great Flood of Iowa, 2008 | N = 20 children with personal trauma or expressed distress<br>20% female<br>Age (range: 12–17 years) | Face-to-face    | Primary outcomes:<br>PTSD symptoms: Child PTSD Symptom Scale [119]<br>Depressive symptoms: Center for Epidemiologic Studies Depression Scale, CES-D [83]<br>Secondary outcomes:<br>Social support: Multidimensional Scale of Perceived Support, MSPSS [93]<br>School connectedness: Healthy Kids Resilience Measure of School Connectedness [120] | Marginally significant decrease in PTSD symptoms over time ( $p = 0.09$ )<br>3.7 points from $T_0$ to the 8-week FU<br>Significant decrease in depressive symptoms 2 weeks (adjusted $M = 14.3$ ; $p < 0.01$ ) and 4 weeks (adjusted $M = 13.2$ ; $p < 0.01$ ) after intervention and slightly increase 8 weeks (adjusted $M = 15.2$ ; $p < 0.01$ ) after intervention<br>Social support increased from $T_0$ to the 2-week FU (adjusted $M = 3.9$ ; $p = 0.08$ ), and increased significantly from $T_0$ through 8-weeks (adjusted $M = 4.0$ ; $p < 0.01$ )<br>School connectedness was higher at 2- ( $M = 63.8$ ; $p = 0.06$ ) and 4-weeks ( $M = 68.9$ , $p < 0.01$ ) than at $T_0$ ( $M = 58.6$ ), but this relationship diminished by 8-weeks |

Table A2. Cont.

| Study                                   | Intervention Name and Description   | Study Design                | Timepoint of Intervention after Stressor Exposure | No. of Sessions             | Type of Stressor                  | Target Population  | Delivery Format | Assessed Outcomes   | Results  |
|---|---|-----------------------------|---|-----------------------------|-----------------------------------|--|-----------------|---|--|
| <b>Brief psychotherapeutic programs</b> |   |                             |   |                             |                                   |  |                 |   |  |
| Ito et al. (2016) [44]                  | Brief School-Based Cognitive Behavioral Intervention [44]: School-based cognitive behavioral intervention<br>Four steps: identification of problems, psychoeducation, decreasing negative appraisal, and practice of relaxation breathing<br>Delivered by clinical psychologists trained in CBT | Uncontrolled pre–post study | 3 years after the stressor                        | A total of 1 90 min session | Great East Japan Earthquake, 2011 | <i>N</i> = 22 adolescents with severe post-traumatic stress symptoms<br>15 female, 7 male<br>Age ( <i>M</i> = 15.4; <i>SD</i> = 0.5) | Face-to-face    | Primary outcome: PTSD symptoms: Impact of Event Scale-Revised, IES-R [121]<br>Secondary outcome: Depressive symptoms: Center for Epidemiologic Studies Depression Scale, CES-D [83] | Significant improvements in all post-traumatic stress symptoms at postintervention ( <i>d</i> = 0.81, <i>p</i> = 0.01).<br>IES-R Total: <i>T</i> <sub>0</sub> : <i>M</i> = 35.39 ( <i>SD</i> = 10.19);<br>Post: <i>M</i> = 24.95 ( <i>SD</i> = 15.19)<br>Effects were maintained throughout the 4-month FU period ( <i>d</i> = 1.10, <i>p</i> < 0.001)<br>IES-R Total: 4-month FU <i>M</i> = 19.32 ( <i>SD</i> = 17.83)<br>No significant reduction in depressive symptoms |

Table A2. Cont.

| Study               | Intervention Name and Description  | Study Design                | Timepoint of Intervention after Stressor Exposure | No. of Sessions            | Type of Stressor        | Target Population   | Delivery Format | Assessed Outcomes  | Results  |
|---------------------|--|-----------------------------|---|----------------------------|-------------------------|---|-----------------|--|--|
| Taylor & Weems [47] | Strength after Trauma (StArT) [46]: Manual-based hurricane trauma-focused CBT intervention<br>Five modules: psychoeducation, cognitive restructuring, exposure, problem solving, and relapse prevention<br>Delivered by a person experienced in psychotherapeutic treatment of adolescents | Uncontrolled pre–post study | 4 years after the stressor                        | A total of 10 for 1 h each | Hurricane Katrina, 2005 | <i>N</i> = 6 children exposed to Hurricane Katrina and/or its aftermath who met diagnostic criteria for PTSD<br>4 female, 2 male<br>Age (range: 8–13 years) | Face-to-face    | Primary outcomes:<br>PTSD symptoms: Reaction Index for Children, PTSD-RI [122]<br>Diagnostic Interview Schedule for Children-Predictive Scales, DISC-PS [123]<br>Secondary outcomes:<br>Negative cognitions: Children’s Negative Cognitive Error Questionnaire, CNCEQ [124]<br>Anxiety sensitivity: Administration of the Childhood Anxiety Sensitivity Index, CASI [125]<br>Control beliefs: Short form Anxiety Control Questionnaire for Children, ACQ-C [126] | Significant decline in PTSD symptoms ( $d = 2.00$ ; $p < 0.05$ ) between pre- and posttreatment<br>PTSD-RI: $T_0$ : $M = 45.0$ ( $SD = 11.6$ ); Post: $M = 15.0$ ( $SD = 17.5$ )<br>Significant decline in cognitive errors between pre- and post-treatment ( $d = 0.826$ ; $p < 0.05$ )<br>CNCEQ: $T_0$ $M = 47.0$ ( $SD = 25.1$ ); Post $M = 31.7$ ( $SD = 7.39$ )<br>No statistically significant differences in CASI, ACQ-C, and DISC-PS total and anxiety scores from $T_0$ to Post |

Table A2. Cont.

| Study                      | Intervention Name and Description  | Study Design                | Timepoint of Intervention after Stressor Exposure | No. of Sessions | Type of Stressor      | Target Population  | Delivery Format | Assessed Outcomes  | Results  |
|----------------------------|--|-----------------------------|---|-----------------|-----------------------|--|-----------------|--|--|
| Hamblen et al. (2017) [49] | Cognitive behavioral therapy for post-disaster distress (CBT-PD) [48]: CBT intervention for post-disaster distress. Three main sections: psychoeducation, coping skills, and cognitive restructuring. Delivered by trained therapists. | Uncontrolled pre-post study | 10–15 months or 21–26 months after the stressor   | A total of 10   | Hurricane Sandy, 2012 | <i>N</i> = 342 adults with disaster-related symptoms exposed to Hurricane Sandy. 80% female. Age ( <i>M</i> = 57; <i>SD</i> = 13). | Face-to-face    | Primary outcome: PTSD symptoms: Short Post-Traumatic Stress Disorder Rating Interview–Expanded, Sprint-E [127] | 2 × 3 × 4 (Severity × Timing × Session) mixed ANOVA: Large improvements in reduction in distress symptoms between pretreatment and intermediate ( <i>M</i> diff = 6.47, <i>d</i> = 0.70) treatments and between intermediate and posttreatment ( <i>M</i> diff = 6.90, <i>d</i> = 0.71). No effect of timing, but severity had a strong main effect on distress: Less severe group improved between referral and pretreatment ( <i>M</i> diff = 2.96, <i>d</i> = 0.33), more severe group worsened over that time ( <i>M</i> diff = 2.28, <i>d</i> = 0.31); more severe group improved between pretreatment and intermediate treatment ( <i>M</i> diff = 9.42, <i>d</i> = 1.16, compared with <i>M</i> diff = 0.78, <i>d</i> = 0.09, in the less severe group). Improvements between intermediate treatment and posttreatment (for severe group, <i>M</i> diff = 6.96, <i>d</i> = 0.68; for moderate group, <i>M</i> diff = 6.79, <i>d</i> = 0.79) in both groups. 5-Month FU: Slightly decrease in Sprint-E total scores in the moderate distress group ( <i>M</i> diff = 1.30, <i>d</i> = 0.14), but increased slightly in the severe distress group ( <i>M</i> diff = 2.64, <i>d</i> = 0.24). |



Table A2. Cont.

| Study                      | Intervention Name and Description  | Study Design                      | Timepoint of Intervention after Stressor Exposure | No. of Sessions     | Type of Stressor | Target Population   | Delivery Format | Assessed Outcomes   | Results   |
|----------------------------|--|-----------------------------------|---|---------------------|------------------|---|-----------------|---|---|
| de Roos et al. (2011) [52] | Exposure-based Cognitive Behavioral Therapy (CBT) [50]: CBT-based trauma treatment Elements: psychoeducation, repeated exposure to the trauma memory, cognitive restructuring, exploring, and correcting undesired or unhelpful coping behavior, and relapse prevention Eye Movement Desensitization and Reprocessing (EMDR) [51]: Intervention focusing on disaster-related trauma memory Eight-phase approach: Phase 1: History-taking, Phase 2: Preparing the client, Phase (PM+; [34]): Assessing the target memory, Phases 4–7: Processing the memory to adaptive resolution, Phase 8: Evaluating treatment results Delivered by a clinical therapist | RCT (Exposure-based CBT vs. EMDR) | 6 months after fireworks factory explosion        | Up to 4 for 60 min. | Explosion        | <i>N</i> = 52 children with firework disaster-related symptoms CBT ( <i>n</i> = 26): 10 female, 16 male Age ( <i>M</i> = 10; <i>SD</i> = 4.1) EMDR ( <i>n</i> = 26): 13 female, 13 male | Face-to-face    | Primary outcomes: PTSD symptoms: UCLA PTSD Reaction Index for DSM IV, PTSD-RI [128], Child Report of Post-traumatic Symptoms, CROPS [129], Parent Report of Post-traumatic Symptoms, PROPS [129] Secondary outcomes: Depressive symptoms: Birleson Depression Scale, BDS [130] Anxiety symptoms: Multidimensional Anxiety Scale for Children, MASC [131] Behavioral problems: Child Behavior Check List, CBCL [132] | EMDR = CBT (no significant differences between the treatments) Significant reductions on all measures ( <i>p</i> -values < 0.001) in both treatment groups PTSD symptoms UCLA EMDR: <i>T</i> <sub>0</sub> : <i>M</i> = 31.4 ( <i>SD</i> = 12.3); Post: <i>M</i> = 16.1 ( <i>SD</i> = 9.0); 3-Month FU: <i>M</i> = 14.2 ( <i>SD</i> = 9.0) CBT: <i>T</i> <sub>0</sub> : <i>M</i> = 30.5 ( <i>SD</i> = 10.4); Post: <i>M</i> = 16.9 ( <i>SD</i> = 9.6); 3-Month FU: <i>M</i> = 16.7 ( <i>SD</i> = 9.3) PTSD symptoms CROPS EMDR: <i>T</i> <sub>0</sub> : <i>M</i> = 23.3 ( <i>SD</i> = 9.9); Post: <i>M</i> = 12.0 ( <i>SD</i> = 9.1); 3-Month FU: <i>M</i> = 11.2 ( <i>SD</i> = 8.0) CBT: <i>T</i> <sub>0</sub> : <i>M</i> = 22.7 ( <i>SD</i> = 9.6); Post: <i>M</i> = 12.3 ( <i>SD</i> = 8.1); 3-Month FU: <i>M</i> = 11.9 ( <i>SD</i> = 8.3) PTSD symptoms PROBS EMDR: <i>T</i> <sub>0</sub> : <i>M</i> = 30.5 ( <i>SD</i> = 11.5); Post: <i>M</i> = 17.7 ( <i>SD</i> = 9.6); 3-Month FU: <i>M</i> = 19.2 ( <i>SD</i> = 13.1) CBT: <i>T</i> <sub>0</sub> : <i>M</i> = 34.7 ( <i>SD</i> = 12.8); Post: <i>M</i> = 19.5 ( <i>SD</i> = 11.7); 3-Month FU: <i>M</i> = 21.3 ( <i>SD</i> = 13.3) |

Table A2. Cont.

| Study                       | Intervention Name and Description  | Study Design                             | Timepoint of Intervention after Stressor Exposure | No. of Sessions              | Type of Stressor | Target Population   | Delivery Format | Assessed Outcomes  | Results   |
|-----------------------------|--|--|---|------------------------------|------------------|---|-----------------|--|---|
| Scheiber et al. (2019) [53] | Preventive Resilience Training for Unaccompanied Refugee Minors [53]: Short-term CBT-based resilience training Covers the topics of psychoeducation, development of personal and cultural resources, and emotion regulation strategies Delivered by clinical psychologists or social workers with training in trauma therapy | RCT (Intervention vs. Wait list control) | Not reported                                      | A total of 6 for 90 min each | Migration        | Adolescents $N = 55$ male refugees Intervention ( $n = 15$ ): Age ( $M = 16.67$ ; $SD = 0.72$ ) Control ( $n = 32$ ): Age ( $M = 16.19$ ; $SD = 0.78$ ) | Face-to-face    | Primary outcomes: Symptoms of PTSD and Depression: Process of Recognition and Orientation of Torture victims in European Countries Questionnaire, PROTECT [133] Symptoms of PTSD, depression, and anxiety: Refugee Health Screener, RHS-15 [134] Secondary outcome: Well-being: Questions based on Demir et al. (2016) [135] | $2 \times 2$ (Group $\times$ Time) ANOVA: No significant main or interaction effects No significant differences in PROTECT and RHS-15 scores Well-being: Significant differences between intervention and control group at postintervention ( $U(15, 2) = 137.5$ , $p = 0.01$ , $Z = -2.50$ , $r = -0.36$ ) |

Table A2. Cont.

| Study                       | Intervention Name and Description   | Study Design                | Timepoint of Intervention after Stressor Exposure | No. of Sessions               | Type of Stressor | Target Population   | Delivery Format | Assessed Outcomes  | Results  |
|-----------------------------|---|-----------------------------|---|-------------------------------|------------------|---|-----------------|--|--|
| Gallegos et al. (2015) [56] | Mindfulness-Based Stress Reduction (MBSR) [54]: Transdiagnostic intervention to improve mindfulness<br>Includes four practices: sitting meditation, walking meditation, mindful movement, and body scan<br>Delivered by an experienced MBSR teacher | Uncontrolled pre-post study | Not reported                                      | A total of 8 for 120 min each | Childhood trauma | $N = 50$ trauma-exposed women<br>Age ( $M = 44.1$ ; $SD = 11.2$ ) | Face-to-face    | Primary outcomes:<br>Perceived stress:<br>Perceived Stress Scale, PSS-10 [136]<br>Trait and state anxiety:<br>Spielberger State-Trait Anxiety Inventory, STAI [137]<br>Difficulties in Emotion Regulation Scale, DERS [138]<br>PTSD symptoms:<br>Modified PTSD Symptom Scale Self-Report, MPSS-SR [94]<br>Depression: Center for Epidemiologic Studies Depression Scale, CES-D [83]<br>Mindfulness: Five Facet Mindfulness Questionnaire, FFMQ [139]<br>Immunological outcome variables: IL-6, TNF- $\alpha$ , and CRP | Linear Mixed Models with repeated measures:<br>PSS-10: Significant reduction at Post ( $\beta = -6.6$ ; $p < 0.001$ ) and at 1-month FU ( $\beta = -7.2$ ; $p < 0.001$ ) compared to $T_0$<br>CES-D: Significant reduction at Post ( $\beta = -10.3$ ; $p < 0.001$ ) and at 1-month FU ( $\beta = -14.5$ ; $p < 0.001$ ) compared to $T_0$<br>STAI-T: Significant reduction at Post ( $\beta = -8.9$ ; $p < 0.001$ ) and at 1-month FU ( $\beta = -13.1$ ; $p < 0.001$ ) compared to $T_0$<br>STAI-S: Significant reduction at Post ( $\beta = -8.6$ ; $p < 0.001$ ) and at 1-month FU ( $\beta = -14.0$ ; $p < 0.05$ ) compared to $T_0$<br>DERS: Significant reduction at Post ( $\beta = -15.1$ ; $p < 0.05$ ) and at 1-month FU ( $\beta = -25.8$ ; $p < 0.001$ )<br>Significant increase on all FFMQ facets ( $p < 0.05$ or $p < 0.001$ ) at Post and 1-month FU compared to $T_0$<br>No significant effects of the intervention for time on the pro-inflammatory cytokines IL-6, TNF- $\alpha$ , and CRP, but IL-6 decreased with increased attendance ( $\beta = -0.0$ ; $p < 0.05$ ) |

Table A2. Cont.

| Study                     | Intervention Name and Description   | Study Design                             | Timepoint of Intervention after Stressor Exposure | No. of Sessions              | Type of Stressor                      | Target Population  | Delivery Format | Assessed Outcomes   | Results  |
|---------------------------|---|--|---|------------------------------|---------------------------------------|--|-----------------|---|--|
| Tehrani (2019) [57]       | Trauma Therapy Program [57]: Psychotherapeutic intervention which involves EMDR or TF-CBT elements Delivered by therapists trained in either TF-CBT or EMDR or both therapies   | Uncontrolled pre–post study              | Not reported                                      | A total of 6 for 90 min each | Traumatic events in emergency service | <i>N</i> = 429 emergency service professionals (235 female, 194 male) No age indication  | Face-to-face    | Primary outcomes: Symptoms of anxiety and depression: Goldberg Anxiety/Depression Scale, GADS [140] Arousal, avoidance, and re-experience: Impact of Events Scale-E, IES-E [141] Resilience: Sense of Coherence (SOC) Scale [142] | Mean clinical scores before and after the therapy: Anxiety: $T_0$ : $M = 7.5$ ( $SD = 1.6$ ); Post: $M = 4.0$ ( $SD = 2.8$ ); 95% CI: 3.3, 3.9, $p < 0.001$ Depression: $T_0$ : $M = 6.2$ ( $SD = 2.0$ ); Post: $M = 3.1$ ( $SD = 2.7$ ); 95% CI: 2.8, 3.4, $p < 0.001$ PTSD: $T_0$ : $M = 63.3$ ( $SD = 14.3$ ); Post: $M = 32.7$ ( $SD = 20.7$ ); 95% CI: 28.5, 32.9, $p < 0.001$ All the SOC scales (i.e., meaningfulness, comprehensibility, and manageability) showed a significant improvement between $T_0$ and Post  |
| Church et al. (2013) [60] | Emotional Freedom Techniques [59]: Brief psychotherapeutic intervention Includes trauma exposure, cognitive, and somatic therapeutic components and combines the exposure to traumatic memories with self-acceptance statements Delivered by EFT certified therapists | RCT (Intervention vs. Wait list control) | Not reported                                      | A total of 6 for 60 min each | War in Iraq and Afghanistan           | <i>N</i> = 55 war veterans returning from Iraq and Afghanistan meet the clinical criterion for PTSD 89.8 % male Age ( $M = 51.7$ ; $SD = 14$ ) | Face-to-face    | Primary Outcomes: PTSD symptoms: PTSD Checklist—Military, PCL-M [143] Symptom severity and breadth: Symptom Assessment-45 Questionnaire, SA-45 [144]  | Linear mixed-effects models with the factors group (EFT vs. control) and time ( $T_0$ vs. 30 days post-intervention (Control/6 sessions EFT) Significant group $\times$ time interaction ( $p < 0.05$ ) for the PCL-M total score, the SA-45 global scales (symptom severity and breadth), and all SA-45 symptom scales (anxiety, depression, hostility, etc.) PCL-(PM+; [34]): $F(1, 51) = 67.78$ ; $p < 0.0001$ Control: $T_0$ $M = 62.71$ , Post $M = 63.23$ EFT: $T_0$ $M = 62.01$ , Post $M = 39.41$ Symptom severity: $F(1, 51) = 46.56$ ; $p < 0.0001$ Control: $T_0$ $M = 72.39$ , Post $M = 69.98$ EFT: $T_0$ $M = 74.79$ , Post $M = 58.51$ Symptom breadth: $F(1, 51) = 34.48$ ; $p < 0.0001$ Control: $T_0$ $M = 72.72$ , Post $M = 70.42$ EFT: $T_0$ $M = 72.74$ , Post $M = 57.61$ |

Table A2. Cont.

| Study            | Intervention Name and Description  | Study Design                             | Timepoint of Intervention after Stressor Exposure | No. of Sessions | Type of Stressor | Target Population   | Delivery Format | Assessed Outcomes   | Results                         |
|------------------|--|--|---|-----------------|------------------|---|-----------------|---|---------------------------------|
| Chen (2020) [63] | Solution-Focused Brief Therapy (SFBT) [61]: Brief future-oriented and goal-oriented psychotherapeutic intervention exploring current resources and future hopes<br>Delivered by a clinical therapist | RCT (Intervention vs. Wait list control) | During COVID-19                                   | A total of 2–4  | COVID-19         | <i>N</i> = 76 adolescents with manifesting anxiety symptoms and GAD-7 $\geq 10$<br>Age (range: 11–18 years) | Online          | Primary outcome: Anxiety symptoms: Generalized Anxiety Disorder-7, GAD-7 [69], State-Trait Anxiety Inventory, STAI; [137], and Spence Children's Anxiety Scale-Parent report, SCAS-P [145]<br>Secondary outcomes: Depressive symptoms: Patient Health Questionnaire-9, PHQ-9 [70]<br>Coping: Coping Style Scale for Secondary School Students, CSS<br>General Satisfaction: Client Satisfaction Questionnaire-8, CSQ-8 [80] | Not applicable (study protocol) |

Note. *M* diff = mean difference; OR = odds ratio;  $T_0$  = baseline; Post = post-intervention; FU = follow-up; *d* = Cohen's measure of sample effect size for comparing two sample means; *U* = Mann–Whitney test statistic,  $d_{RM}$  = repeated measures effect size estimates; SMD = standardized mean difference; CI = confidence interval; RCT = randomized controlled trial; cRCT = cluster-randomized controlled trial; ANOVA = analysis of variance; UC = usual care; TAU = treatment as usual; EUC = enhanced usual care; ETAU = enhanced treatment as usual; CBT = cognitive behavioral therapy; PTSD = post-traumatic stress disorder; GAD = generalized anxiety disorder; MDD = major depressive disorder; PFA = psychological first aid; TF-CBT = trauma-focused cognitive behavioral therapy.

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