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THÈSE

pour le

DIPLÔME D'ÉTAT DE DOCTEUR EN MÉDECINE

Qualification en Psychiatrie

Psychoeducation for Posttraumatic Stress Disorder in Adults: A Systematic Review of Delivery Formats and Modalities

Psychoéducation du trouble de stress post-traumatique chez l'adulte : une revue systématique des formats et modalités d'intervention

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Sous la direction du Docteur MADIETA Lou et du Docteur DECOUVELAERE Antoine

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« Au moment d'être admis à exercer la médecine, je promets et je jure d'être fidèle aux lois de l'honneur et de la probité. Mon premier souci sera de rétablir, de préserver ou de promouvoir la santé dans tous ses éléments, physiques et mentaux, individuels et sociaux. Je respecterai toutes les personnes, leur autonomie et leur volonté, sans aucune discrimination selon leur état ou leurs convictions. J'interviendrai pour les protéger si elles sont affaiblies, vulnérables ou menacées dans leur intégrité ou leur dignité. Même sous la contrainte, je ne ferai pas usage de mes connaissances contre les lois de l'humanité. J'informerai les patients des décisions envisagées, de leurs raisons et de leurs conséquences. Je ne tromperai jamais leur confiance et n'exploiterai pas le pouvoir hérité des circonstances pour forcer les consciences. Je donnerai mes soins à l'indigent et à quiconque me les demandera. Je ne me laisserai pas influencer par la soif du gain ou la recherche de la gloire.

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SERMENT D'HIPPOCRATE

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Psychoeducation for Posttraumatic Stress Disorder in Adults: A Systematic Review of Delivery Formats and Modalities

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Abstract

Introduction:

Posttraumatic stress disorder (PTSD) is a common mental health condition that may develop after direct or indirect exposure to traumatic events. Identifying risk factors is essential for guiding targeted early interventions. Psychoeducation, in particular, may serve as a low-cost and accessible gateway to care, especially in primary care settings.

Methods:

We conducted a systematic review of randomized controlled trials (RCTs) evaluating psychoeducational interventions for PTSD in adults. Systematic searches were carried out in PubMed, ScienceDirect, Web of Science, PTSDpubs, and Cochrane databases from January 1, 2000, to April 30, 2024. Eligible studies were RCTs including adult participants, with psychoeducation delivered as a stand-alone or primary component.

Results:

Seventeen RCTs, involving 2,204 participants, met the inclusion criteria. Psychoeducational interventions showed high variability in format, duration, and delivery.

Discussion:

Six studies reported a statistically significant reduction in PTSD symptoms attributable to psychoeducation (one preventive intervention and five post-diagnosis). All effective interventions were delivered digitally (websites or mobile applications), underscoring the scalability, adaptability, and cost-effectiveness of digital formats. However, overall clinical effectiveness remains inconsistent across studies. Several trials also reported benefits on secondary outcomes such as perceived stress, anxiety, stigma, and help-seeking intentions.

Conclusion:

This review confirms that psychoeducation, while insufficient as a stand-alone treatment for

PTSD, remains a valuable component of stepped-care strategies. Future studies should systematically evaluate outcomes such as stigma reduction and help-seeking behaviors, which are critical for initiating engagement in more intensive therapies. Preventive interventions would benefit from targeting high-risk populations based on known risk factors, thereby improving trial design and reducing the inclusion of individuals likely to experience spontaneous remission.

INTRODUCTION

1. Epidemiology

The posttraumatic stress disorder (PTSD) is a common and disabling condition that can occur following exposure to a traumatic event or to prolonged exposure to trauma (Bisson et al., 2015). It significantly impacts physical health and psychiatric comorbidity (Bisson et al., 2015), quality of life (C. Miller et al., 2025; Rapaport et al., 2005), and the social and professional functioning of affected individuals (Carmassi et al., 2021).

The prevalence of PTSD varies widely across contexts and methodologies. Data from the WHO World Mental Health survey indicate that 70.4% of the population report lifetime exposure to at least one traumatic event, with an average of 3.2 traumatic events among those exposed (Kessler et al., 2017). A recent umbrella review reported an overall prevalence of PTSD between 2.5% to 74% according to the nature of the traumatic event, with a pooled global prevalence of 23.95% (Schincariol et al., 2024). Furthermore, these figures may be underestimated in certain contexts due to self-stigmatization or the presence of other psychiatric disorders with more prominent clinical manifestations (Hofman & Slotema, 2024; Lewis et al., 2022).

2. Risk factors

The risk of developing PTSD is particularly high when the trauma involves the unexpected death of a loved one, rape, or sexual assault (Kessler et al., 2017). Intentional traumas, especially sexual violence, tend on average to cause more severe and disabling psychological effects than unintentional traumas (Rowland et al., 2022; Santiago et al., 2013), although this difference remains debated in the literature and may be primarily due to population characteristics and contextual issues (Schincariol et al., 2024). Individuals with prior trauma

exposure are also at increased risk of experiencing subsequent traumatic event and future PTSD risk (Schincariol et al., 2024).

Other risk factors have been identified in the literature, with varying levels of evidence, and can be grouped into three main categories:

- Pre-traumatic: female sex, belonging to an ethnic minority, low socioeconomic status and low educational level, history of chronic or severe illness, family history of psychiatric disorders, personal history of psychiatric disorders, neurobiological factors childhood adversity, and prior exposure to traumatic events (Pearl et al., 2023; Tortella-Feliu et al., 2019).
- Peritraumatic: intensity and severity of the trauma, perception of life threat, sense of loss of control, cumulative exposure to potentially traumatic experiences within the same context, dissociation, physical injury, witnessing injuries or deaths, and bereavement related to the event (Sayed et al., 2015; Tortella-Feliu et al., 2019).
- Post-traumatic: psychiatric comorbidity, lack of social support, poor cognitive flexibility, and low levels of physical activity (Sayed et al., 2015; Tortella-Feliu et al., 2019).

3. The need for early intervention

Only a minority of PTSD cases remit spontaneously within months of symptom onset (Kessler et al., 2017), and the median delay between PTSD onset and first therapeutic contact is several years (Wang et al., 2005). Evidence-based therapies for PTSD are, however, still difficult to access due to logistical barriers (Barnett et al., 2014), as well as a lack of knowledge about the disorder and confidence in the effectiveness of therapy (Hundt et al., 2015). This reality underscores the need for early and accessible intervention strategies following a traumatic event. It also highlights the importance of improving access to care, providing basic intervention as simple self-help strategies that are easy to implement, and encouraging more

complex help-seeking when needed. Psychoeducation, due to its simplicity, low cost, and capacity for large-scale dissemination, could be offered as such an early and accessible intervention strategies to all individuals exposed to a potentially traumatic event (Colom, 2011). Moreover, self-identification of specific risk factors makes it possible to identify the most vulnerable individuals and to target early interventions toward them, with the aim of preventing or limiting the chronicity of the disorder.

4. Definition of psychoeducation

Therapeutic education is a well-established and systematic component of care in many chronic conditions, such as diabetes and cardiovascular diseases (Correia et al., 2022; Labrunée et al., 2012). Psychoeducation is defined as the structured, relevant, and up-to-date provision of information about a disease or disorder, with the aim of improving the ability of affected individuals and their relatives to adapt to it (Motlova et al., 2017). This may include disorder-specific elements such as screening, symptom and relapse management, and available treatments, as well as more general information on maintaining a healthy lifestyle, developing problem-solving and communication skills, or managing stressors (Motlova et al., 2017). The overarching aim is to enable patients to respond in an appropriate and autonomous way to the demands of ongoing care (Whitworth, 2016). Psychoeducational interventions take multiple forms and can be delivered by trained professionals or by peers. They may target individuals with psychiatric conditions or their relatives, and can be conducted individually, in groups, or autonomously through written materials or online platforms (Bonsack et al., 2015).

5. Psychoeducation for PTSD

Psychoeducation is a simple, low-cost, accessible intervention (Colom, 2011) that can be integrated into diverse therapeutic formats (Krupnick & Green, 2008; Whitworth, 2016). It can

be used in two main contexts : as a preventive intervention before or after trauma exposure, or as a component of PTSD treatment (Whitworth, 2016).

Psychoeducation occupies a strategic role in the management of PTSD because it addresses several barriers to recovery that are frequently observed in trauma-exposed populations. First, it helps normalize post-traumatic reactions by providing clear, evidence-based explanations about trauma mechanisms and the range of possible psychological and physiological responses, thereby reducing stigma and self-blame (Krupnick & Green, 2008; Phoenix, 2007). Second, it empowers individuals to actively engage in their recovery by enhancing their understanding of the disorder, increasing awareness of available resources, and developing coping skills such as emotional regulation (Bryant et al., 2013; McLean & Foa, 2017), stress management, and problem-solving (Whitworth, 2016). To this end, It can target therapy-related aspects including treatment satisfaction, available resources and knowledge about the condition, as well as psychological disturbances following a traumatic event including self-esteem, quality of life, and overall well-being (Lukens & McFarlane, 2004).

Awareness of the disorder and understanding its mechanisms are major drivers of treatment adherence, they help patients better recognize their symptoms, reduce stigma, understand the relevance of proposed interventions, and actively engage in care (Ferrajão & Oliveira, 2015). Such understanding also strengthens their perceived control over the disorder, contributing to reduced distress and improved overall treatment effectiveness (Ferrajão & Oliveira, 2015). Psychoeducation further provides a space to revisit and recontextualize cognitions and behaviors perceived as maladaptive, facilitating their reconsideration and the adoption of more functional strategies (Morabito & Schmidt, 2023). Psychoeducation for relatives is also essential, as it improves their understanding of the disorder, fostering social support that is better aligned with the patient's needs. Such support is a recognized protective

factor that can enhance adherence and persistence in treatment (Ferrajão & Oliveira, 2015; Sherman et al., 2012).

Finally, comorbidities are more the rule than the exception in PTSD (Ginzburg et al., 2010; Petrakis et al., 2011) and patients with comorbid depressive disorders tend to report more severe PTSD-specific symptoms both before and after treatment, highlighting a less favorable clinical outcome compared to those with PTSD alone (Klein Breteler et al., 2021). Psychoeducation may allow an earlier screening and care of such comorbidities frequently associated with PTSD, including anxiety disorder, substance use disorder and major depressive disorder.

6. Recommendations

International guidelines, such as those from the World Health Organization (WHO, 2013), the National Institute for Health and Care Excellence (NICE, 2018), and the U.S. Department of Veterans Affairs/Department of Defense (VA/DoD, 2023), acknowledge the potential value of psychoeducation in association with recommended psychotherapy, but data on its specific efficacy remain mixed. Many studies highlight its acceptability, its association with improved attitudes towards mental health care which can lead to increased help-seeking behaviors and its function as a gateway to care (Brooks et al., 2021). However, its direct effect on PTSD symptoms remains debated and there is a lack of evidence regarding the most effective delivery methods and the optimal timing for implementing psychoeducation in relation to trauma exposure.

7. Objectives of the systematic review

Psychoeducation for PTSD can be delivered through individual, group, digital, or self-help formats, each with distinct advantages and limitations. Individual sessions allow personalization and strengthen therapeutic alliance but require substantial resources (Howard

et al., 2022; Karatzias, 2025). Group formats facilitate peer support and normalization while being cost-effective, though some participants may be reluctant to share in a group setting (Hundt, Robinson, et al., 2015; Stenberg et al., 2016). Digital interventions improve accessibility and scalability but may be less effective without guidance and depend on user engagement (Akdemir et al., 2024; Stefanopoulou et al., 2020). Printed self-help materials are inexpensive and easily disseminated, yet often lack interactivity and have limited impact when used alone (Harris et al., 2005; Turpin et al., 2005). Blended approaches, combining scalable formats with professional follow-up, appear promising in optimizing adherence and clinical benefit.

A wide range of psychoeducational formats are now available, particularly with the advent of digital tools. The general aim is to provide sufficient psychoeducation to promote patients' understanding of their condition and foster autonomy in its management, especially in a healthcare context where access to specialized care is often restricted by logistical and financial constraints.

This systematic literature review aims to explore the various formats and modalities of psychoeducation for PTSD in adults, whether used for preventive or therapeutic purposes. The objective is to better understand its effects, the conditions under which it is effective, and its potential for integration into stepped, personalized, and accessible care pathways, as well as to develop a guidance tool to help select the most appropriate modality according to clinical and organizational constraints.

METHOD

1. Aim of the study

The main objective of our study was to evaluate merit and demerit of each specific psychoeducation to provide an algorithm of psychoeducation intervention according to care

context and objectives. To this extent we performed a systematic review of the literature evaluating the effect of psychoeducation on the variation of PTSD symptoms, evaluated using validated standardized instruments.

2. Studied intervention description

This review defines psychoeducation as an intervention aimed at providing information about any aspect of post-traumatic stress disorder (PTSD) and fostering the acquisition of skills to better manage its symptoms with the primary aim of enhancing understanding, self-management, and help-seeking, rather than engaging in in-depth therapeutic processing of the traumatic event. To be included, psychoeducation had to be the primary intervention under investigation and explicitly described as psychoeducational by the study authors.

Interventions involving structured exposure, trauma-focused cognitive restructuring, or other core components of evidence-based psychotherapies for PTSD were excluded, unless the psychoeducational component was delivered and assessed independently.

3. Study design

We included randomized controlled trials (RCTs) involving adults aged 18 and over, comparing a psychoeducational intervention to a control group receiving either treatment as usual (TAU) or being placed on a waitlist.

4. Eligibility and exclusion criteria

We applied the following eligibility criteria: they had to be published in English or French; the study had to be a randomized controlled trial (RCT) evaluating efficacy of psychoeducation as the sole intervention; participants were aged 18 years or older; they had experienced a potentially traumatic event; the intervention was explicitly described as psychoeducational; and the study assessed PTSD symptom severity using a standardized scale. A formal PTSD diagnosis was not required in order to include studies evaluating preventive psychoeducation.

5. Literature search

We conducted a systematic search of the literature in PubMed, Science direct, Web of Science, PTSDpubs and Cochrane. The search was conducted on septembre 2024 and covered studies published from January 1st, 2000 to April 30th, 2024. We used a search strategy that included the following keywords: « psychoeducation », « patient education », « post-traumatic stress », « psychological trauma », « PTSD » and « randomized controlled trial ».

6. Study selection and data extraction

One reviewer screened titles and abstracts for relevance. Three reviewers followed by full-text assessment for eligibility. Discrepancies were resolved through discussion and consensus. Data were extracted using a standardized form in Microsoft Excel, including study characteristics, sample size, intervention details, outcome measures, and results.

7. Risk of bias assessment

Risk of bias was assessed using the Cochrane Risk of Bias tool version 2 (RoB 2), considering five domains: randomization process, deviations from intended interventions, missing outcome data, measurement of the outcome, and selection of the reported result. Each domain was rated as **“low risk of bias”**, **“some concerns”**, or **“high risk of bias”** according to the RoB 2 criteria. One reviewer performed the assessment and discussed judgments with two others reviewers (Higgins et al., 2011).

8. Data synthesis

A narrative synthesis was conducted due to the heterogeneity of interventions, populations, and outcomes. No meta-analysis was performed. This review was conducted in accordance with PRISMA 2020 guidelines.

RESULTS

1. Flow chart and inclusions

We screened the abstracts of 1,731 articles, and 17 studies met the eligibility criteria and were included in the review. These studies collectively involved a total of 2204 participants. A flow diagram (Figure 1) illustrates the inclusion and exclusion process used in this review.

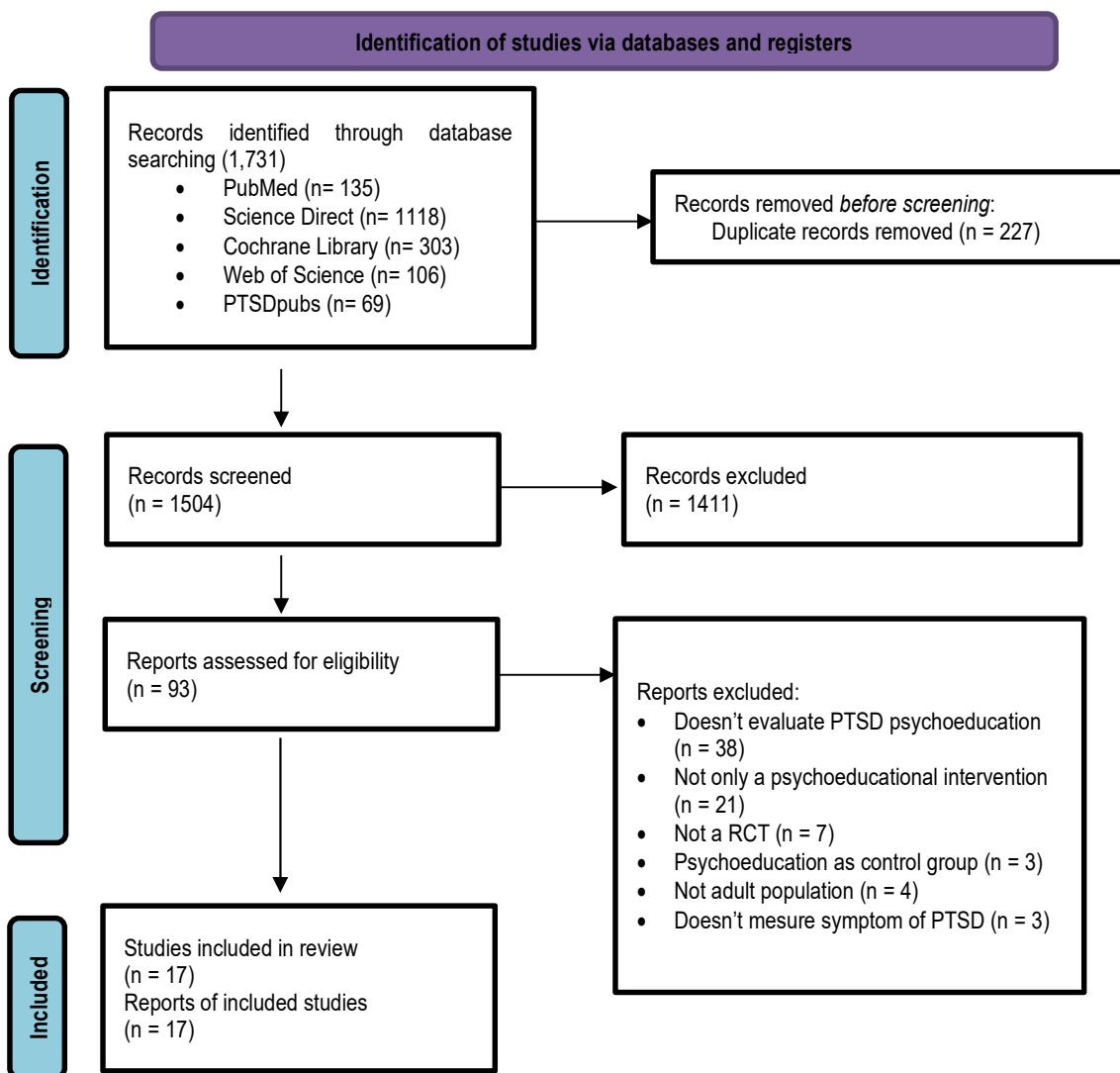


Figure 1 : Flow diagram of the selection process

2. Description of the studies

Seventeen randomized controlled trials published between 2006 and 2023 were included in this review. The studies were conducted across a wide range of countries, including the United States, Australia, Ireland, the Netherlands, Germany, the United Kingdom, Sweden, Switzerland, and Burundi. The total number of participants was 2204 adults, with sample sizes ranging from 46 to 300. Study characteristics are summarized in Table 1.

Populations varied across studies: some trials targeted trauma-exposed civilians (e.g., Hensler et al., 2022; Nickerson et al., 2020), while others focused on specific subgroups such as military personnel (Engel et al., 2015; Roy et al., 2017), incarcerated women (Mahoney et al., 2020), or partners of individuals with PTSD (Hendrikx & Murphy, 2021; Roy et al., 2017), parents of children with cancer or severe injuries (Cernvall et al., 2017; Sveen et al., 2017), forcibly displaced persons and refugees (eg., Nickerson et al., 2020), vulnerable person (Ghafoori et al., 2016) or firefighters and emergency responders (Tuckey & Scott, 2014). The gender distribution varied, with some trials including exclusively female or male participants. PTSD symptoms were assessed using validated instruments such as the PTSD Checklist (PCL), the Harvard Trauma Questionnaire partie IV (HTQ and HTQ-b), the Posttraumatic Diagnostic Scale (PDS), the Secondary Traumatic Stress Scale (STSS), the PTSD Symptom Scale - Self Report (PSS-SR), the Structured Interview for PTSD (SI-PTSD), the Clinician-Administered PTSD Scale (CAPS), and the Impact of Event Scale-Revised (IES-R). Some studies evaluated psychoeducation as a primary treatment component, while others assessed it in a preventive or early-intervention context.

3. Primary outcome

Among the seventeen randomized controlled trials included, six reported a statistically significant reduction in PTSD symptoms attributable to the psychoeducational intervention

(Cernvall et al., 2017; Engel et al., 2015; Hendrikx & Murphy, 2021; Hensler et al., 2022; Morabito & Schmidt, 2023; Röhr et al., 2021; Roy et al., 2017; Sveen et al., 2017). Furthermore, two studies reported significant symptom reductions over time in both groups with no between-group differences. One compared an app with and without encouragement to use it and one compared app versus psychoeducational reading material (Röhr et al., 2021; Roy et al., 2017).

4. Secondary outcomes

In addition to PTSD symptoms, most studies assessed other outcomes, providing insight into the broader relevance and potential benefits of psychoeducation for trauma-exposed individuals even in the absence of significant PTSD symptom reduction. Depression and anxiety symptoms was measured in 14 studies (e.g., Mahoney et al., 2020). Other outcomes measured included perceived stress and psychological distress (von Känel et al., 2018), mental health stigma and help-seeking intentions (Nickerson et al., 2020); functional impairment (Ghafoori et al., 2016), parenting stress in trials targeting parents of injured or ill children (e.g., (Cernvall et al., 2017; Sveen et al., 2017), knowledge acquisition and coping strategies (e.g., Miller et al., 2015).

5. Psychoeducation timing and modalities

Six studies implemented psychoeducation as a preventive intervention, shortly after trauma exposure and before a formal PTSD diagnosis (at 1 month). Among these, one used a group format (Tuckey & Scott, 2014), two involved a single and individual sessions lasting between 45 minutes and 2 hours (Sijbrandij et al., 2006; von Känel et al., 2018a), one used a 9-minute video (K. E. Miller et al., 2015), and two delivered the intervention via a website (Mouthaan et al., 2013; Sveen et al., 2017).

Eleven studies delivered the psychoeducational intervention after a confirmed PTSD diagnosis. Among these, one were in a single and individual session (Ghafoori et al., 2016), two used group-based formats (Mahoney et al., 2020; Yeomans et al., 2010), five used websites (e.g., Engel et al., 2015), and three used mobile applications (e.g., Roy et al., 2017).

The included interventions varied in their degree of therapeutic support. Some were entirely self-guided, while others involved some level of professional guidance or interaction. Six studies provided no therapeutic support beyond the digital or written content. These were fully self-administered interventions, such as mobile apps (e.g., Hensler et al., 2022; Röhr et al., 2021), websites (Morabito & Schmidt, 2023; Mouthaan et al., 2013; Nickerson et al., 2020), or video-based content (e.g., Miller et al., 2015). Five studies included some form of guided support, either via therapist feedback, email or text reminders, live chat functions, or structured webinars (e.g., Cernvall et al., 2017). Six studies involved in-person interventions delivered by trained facilitators, usually in a group or individual format (e.g., (Ghafoori et al., 2016).

Ten were grounded in cognitive-behavioral principles (Cernvall et al., 2017) ; and focused on increasing knowledge of PTSD, developing coping strategies, and reducing distress or stigma. The duration of interventions varied widely, from brief audiovisual content to structured programs spanning several weeks.

6. Specific Considerations for PTSD Coach Trials

The initial database search identified three trials evaluating the PTSD Coach mobile application. Only one of these met the predefined inclusion criteria and was retained (Hensler et al., 2022). A second manual search later retrieved additional RCTs on PTSD Coach. However, as the aim of this review was to explore a diversity of psychoeducational formats, we maintained our initial selection and included only one trial on PTSD Coach to avoid overrepresenting a single

intervention model. The discussion will draw on the conclusions of a recent systematic review and meta-analysis on PTSD Coach to contextualize our findings (Bröcker et al., 2023).

Title	First author (year)	Country	Participants	Type of trauma	PTSD measures	Sample size	Intervention participant's age and gender	Type of intervention	Primary outcomes	Results
A randomized, controlled, pilot study of a single session psychoeducation treatment for urban, culturally diverse, trauma-exposed adults	Ghafoori (2016)	USA	Vulnerable (immigrant, individual with history of mental illness or victim of violence) trauma survivors	All type of trauma	PTSD Checklist Civilian Version (PCL-C),	N = 86 PE = 38 WL = 48	Age = Unknown Gender = 55.2% Male	Individual unique session with CBT based psychoeducation, possible reactions, prolonged exposure, treatment and referral to community providers of mental health treatment	The severity of posttraumatic stress symptoms (PLC-C) At 1 month	No significant reduction in PTSD symptoms severity, anxiety, disability, or on improving attitudes towards seeking professional psychological help
A Randomizes Trial of a Reconciliation Workshop with and Without PTSD Psychoeducation in Burundian Sample	Yeomans (2010)	Burundi	War-displaced rural Burundians.	War events (to harm or kill others, witness the murder of relatives, or be victims of rape)	Harvard Trauma Questionnaire partie IV (HTQ and HTQ-b)	N = 124 PE = 41 Without PE = 41 WL = 42	Age = 38.6 Gender = 55.6% Male	Group based psychoeducation intervention with teaching relaxation skills vs a Group intervention without psychoeducation vs waiting list	The severity of posttraumatic stress symptoms (HTQ) at 2 weeks after the intervention	Both interventions (with and without PE) reduced posttraumatic stress symptoms
How important are Phase 1 interventions for complex interpersonal trauma? A pilot randomized control trial of a group psychoeducational intervention	Mahoney (2020)	United Kingdom	Incarcerated women	Complex interpersonal trauma	PTSD Checklist civilian version for DSM-IV (PCL-C)	N = 86 PE = 44 WL/TAU = 42	Age = 33.35 Gender = 100% female	Group-based psychoeducation intervention of 8 at 10 sessions with coping strategies	The severity of posttraumatic stress symptoms (PLC-C) after 5 weeks of treatment and at 1 month following treatment	No significant reduction in severity of PTSD symptoms

Delivery of self-training and education for stressful situations (DESTRESS-PC): a randomized trial of nurse-assisted online self-management for PTSD in primary care	Engel (2015)	USA	Recently deployed military service members and veterans	War-related trauma, including military sexual trauma	PTSD Checklist Civilian Version for DSM-IV (PCL), Clinician-Administered PTSD Scale (CAPS)	N = 80 PE = 43 TAU = 37	Age = 36.5 Gender = 81,27% male	internet-based, guided by nurse, psychoeducation and self-management program grounded in CBT, delivered over 6 weeks	The severity of posttraumatic stress symptoms (PCL) at 6-, 12- and 18-weeks post-randomization	Significant but moderate reduction in PTSD symptoms at 12 weeks in the intervention group; not maintained at 18 weeks.
'Tell Your Story': a randomized controlled trial of an online intervention to reduce mental health stigma and increase help-seeking in refugee men with posttraumatic stress	Nickerson (2020)	Australia	Refugee men (Arabic, Farsi, Tamil-speaking)	All type of trauma (principally of dying, torture, witnessing murder, lack of food/water)	Primary Care PTSD Screen (PC-PTSD-5), Posttraumatic Diagnostic Scale (PDS)	N = 103 PE = 54 WL = 49	Age = 39.4 Gender = 100% male	Internet-based unguided program with psychoeducation, social contact, and cognitive reappraisal of negative beliefs about mental health and help-seeking	self-stigma related to PTSD (adaptation of SSDS), self-stigma related to help-seeking (SSOSH) and help-seeking intentions (adapted version of the GHSQ) at 4 and 8 weeks after baseline	No significant effects for self-stigma for PTSD. Significant reduction in self-stigma for help-seeking and increased help-seeking; no effect on PTSD symptoms
Twelve-Month Follow-Up of a Randomized Controlled Trial of Internet-Based Guided Self-Help for Parents of Children on Cancer Treatment	Cernvall (2017)	Sweden	Parents of children on treatment for a cancer	Parental stress related to child's cancer diagnosis and treatment	PTSD-Checklist-Civilian version (PCL-C)	N = 58 PE = 31 WL/TAU = 27	Age = 38 Gender = 91% female 91%	Internet-based guided self-help program based on CBT, 10-week duration	Severity of posttraumatic stress symptoms (PLC-C) after the intervention and at 12 months	Significant reduction in PTSD symptoms maintained at 12 months in the intervention group

Supporting the Mental Health Needs of Military Partners Through the Together Webinar Program: Pilot Randomized Controlled Trial	Hendrikx (2021)	United Kingdom	Partners of UK veterans with PTSD or mental health difficulties	Secondary trauma from living with a partner with PTSD	Secondary Traumatic Stress Scale (STSS)	N = 196 PE = 97 WL = 99	Age = 48.6 Gender = 100% female	Internet-based guided psychoeducational group intervention based on CBT delivered via webinar over six weeks	secondary traumatic stress (STSS), General psychological distress (GHQ-12) at 1 month after the intervention	Significant reductions in psychological distress and secondary trauma symptoms
Efficacy of a brief web-based tonic immobility psychoeducation intervention among trauma-exposed adults: A randomized clinical trial	Morabito (2023)	USA	Trauma-exposed adults with prior tonic immobility	All type of trauma (principally sexual, physical assault)	PTSD Checklist for DSM-5 (PCL-5)	N = 51 PE = 26 Control (HET) = 25	Age = 21.57 Gender = 84.8% female	Internet-based unguided psychoeducation on tonic immobility vs a web-based health-focused psychoeducation intervention (HET)	Severity of posttraumatic stress symptoms (PCL-5), Posttraumatic cognitions (PTCI) at 1-week and 1-month follow-up	Significant reductions in PTSD symptoms and posttraumatic cognitions in EP group
An App a Day Keeps the Doctor Away: Guided Education and Training via Smartphones in Subthreshold Post Traumatic Stress Disorder	Roy (2017)	USA	Active or retired military, or dependent spouse	Deployment-related or other significant stressful life events	PTSD Checklist (PCL)	N = 144 PE = 72 control = 72	Age = 33.55 Gender = 53.5% male	App-based CBT psychoeducation, social engagement, and yoga program. The evaluated group was encouraged to use the apps, unlike the control group.	Severity of posttraumatic stress symptoms (PCL) weekly throughout the 6-week intervention and at 3, 6 and 12 months followups	Both groups improved; no significant difference between groups overall, but greater reduction in avoidance symptoms observed in the intervention group

A Self-Help App for Syrian Refugees with Posttraumatic Stress (Sanadak): Randomized Controlled Trial	Röhr (2021)	Germany	Syrian refugees with mild to moderate posttraumatic stress	War-related and migration-related trauma	Posttraumatic Diagnostic Scale for DSM-5 (PDS-5)	N = 133 PE (with app) = 65 PE (with reading material) = 68	Age = 33.32 Gender = 61% male	App-based Arabic CBT with unguided psychoeducation and self-help exercise during 4 weeks vs psychoeducational reading material	Severity of posttraumatic stress symptoms (PDS-5) immediately after the intervention, at 1 and 4 months	Both groups improved; no significant difference between groups overall; significant reduction in self-stigma in intervention group
Efficacy, Benefits, and Harms of a Self-management App in a Swedish Trauma-Exposed Community Sample (PTSD Coach): Randomized Controlled Trial	Hensler (2022)	Sweden	Adults exposed to a potentially traumatic event within the last 2 years	All type of trauma	PTSD Checklist for DSM-5 (PCL-5)	N = 179 PE = 89 WL = 90	Age = 42.78; Gender = 91.6% female	App-based CBT (PTSD Coach) with unguided psychoeducation and coping tools	Severity of posttraumatic stress symptoms (PCL-5) at 3 months	Small but significant reduction in PTSD and depressive symptoms compared to waitlist;
Emotional or educational debriefing after psychological trauma: randomised controlled trial	Sijbrandij (2006)	Netherlands	Adults exposed to a recent traumatic event (≤ 2 weeks)	All type of trauma	Structured Interview for PTSD (SI-PTSD), HADS	N = 236 Educational debriefing = 79, Emotional debriefing = 76, Control = 81	Age = 40.4 Gender = 59.6% female	Individual unique session debriefing (emotional or educational) based on CISD protocol lasted 45min to 1 h	Severity of posttraumatic stress symptoms (SI-PTSD) at 2 weeks, 6 weeks and 6 months	Severity of PTSD decreased over time in all three groups without significant difference between groups; emotional debriefing was associated with higher PTSD symptoms in participants with high hyperarousal

Early Psychological Counseling for the Prevention of Posttraumatic Stress Induced by Acute Coronary Syndrome: The MI-SPRINT Randomized Controlled Trial	von Känel (2018)	Switzerland	patients with verified acute STEMI or non-STEMI, referred for acute coronary care intervention	Acute coronary syndrome (myocardial infarction)	Clinician-Administered PTSD Scale (CAPS), Posttraumatic Diagnostic Scale (PDS)	N = 190 PE = 97 stress counseling active control = 93	Age = 59.91; Gender = 82% male	Individual unique session trauma-focused counseling vs. active control (stress counseling), both 45 min, plus psychoeducational booklet	Severity of posttraumatic stress symptoms (CAPS, PDS) at 3 months	No significant difference in CAPS scores. Self-rated PTSS (PDS) and psychological distress were higher in the trauma-focused group
Group critical incident stress debriefing with emergency services personnel: a randomized controlled trial	Tuckey (2014)	Australia	Fire-fighters	Single work-related incidents	Impact of Event Scale-Revised (IES-R), GHQ-12	N = 122 PE = 48 CISD = 36 control = 38	Age unknown Gender = 91% male	Group-based CISD session (1.5-2 hours) based on Mitchell model vs stress management education vs control without intervention at 72 hours post-incident	Severity of posttraumatic stress symptoms (IES-R) at 4 weeks	No significant effect on severity of PTSD symptoms
Psychological Outcomes After a Sexual Assault Video Intervention: A Randomized Trial	Miller (2015)	USA	Female sexual assault survivors undergoing forensic examination within 72 hours	Recent sexual assault	PTSD Symptom Scale - Self Report (PSS-SR) based on the DSM-IV	N = 179 PE = 94 Standard care = 85	Age = 28.8 Gender = 100% female	Video-based (9 minutes) psychoeducational show post forensic examinations, focused on education and instruction of empirically effective coping strategies	Severity of posttraumatic stress symptoms (PSS-SR) at 2 weeks and 2 months	No significant effect on PTSD symptoms between the two groups. Women without prior sexual assault had lower PTSD symptoms at 2-week follow-up. Video group had lower anxiety scores (STAI).

Internet-based information and support program for parents of children with burns: A randomized controlled trial	Sveen (2017)	Sweden	Parents of children hospitalized for burns	Child's burn injury	Impact of Event Scale-Revised (IES-R)	N = 104 PE = 52 control = 52	Age = 37.35 Gender = 68% female	Internet-based guided CBT psychoeducational and self-help program in 6 modules over 6 weeks	Severity of posttraumatic stress symptoms (IES-R) and general perceived stress among the parents (PSS) post assessment, at 3 and 12 months	Significant reduction in posttraumatic stress (IES-R) post assessment but not after 12 months
Internet-Based Early Intervention to Prevent Posttraumatic Stress Disorder in Injury Patients: Randomized Controlled Trial	Mouthaan (2013)	Netherlands	Adult injury patients admitted to trauma centers within 72 hours post-injury	Severe physical injury (traffic accidents, falls, violence)	Clinician-Administered PTSD Scale (CAPS), Impact of Event Scale-Revised (IES-R)	N = 300 PE = 151 Control = 149	Age = 43.84 Gender = 60% male	Internet-based unguided CBT program in 30 minutes with psychoeducation, self-exposure, and stress management	Severity of posttraumatic stress symptoms (CAPS, IES-R) at 1, 3, 6 and 12 months	No significant difference between groups; PTSD list of symptoms decreased over time in both arms. Subgroup with high initial symptoms improved more in intervention arm

CAPS: Clinician-Administered PTSD Scale ; CBT: Cognitive Behavioral Therapy ; CISD: critical incident stress debriefing ; GHSQ: General Help-Seeking Questionnaire ; HADS: Hospital Anxiety and Depression Scale ; HTQ: Harvard Trauma Questionnaire ; IES-R: Impact of Event Scale-Revised ; PE: psychoeducation ; PDS: Posttraumatic Diagnostic Scale ; PLC: PTCI : Posttraumatic cognitions inventory ; PSS: Perceived Stress Scale ; SI-PTSD: Structured Interview for PTSD ; SSDS: Self Stigma of Depression Scale ; SSOSH: Self-Stigma of Seeking Help ; STEMI: ST elevation myocardial infarction ; STSS: Secondary Traumatic Stress Scale ; TAU: Treatment As Usual ; WL: waiting list

Table I: Characteristics of randomized controlled trials included in the systematic review

7. Risk of bias

The risk of bias for the 17 included studies was assessed using the Cochrane RoB 2.0 tool and is presented in Table 2. Of these studies, 3 (17.6%) were rated as low risk of bias, 4 (23.5%) as raising some concerns, and 10 (58.8%) as high risk of bias.

Study (Author, Year)	Randomization Process	Deviations from Intended Interventions	Missing Outcome Data	Measurement of the Outcome	Selection of the Reported Result
Ghafoori et al., 2016	Low	Some concerns	High	Low	Some concerns
Yeomans et al., 2010	Low	Low	Low	Low	Some concerns
Mahoney et al., 2020	Low	Some concerns	Some concerns	Low	Low
Engel et al., 2015	Low	Low	Low	Low	Some concerns
Nickerson et al., 2020	Low	Low	Low	Low	Low
Cernvall et al., 2017	Low	Low	Some concerns	Low	Some concerns
Hendrikx & Murphy, 2021	Some concerns	High	High	Low	Some concerns
Morabito & Schmidt, 2023	Low	Low	Some concerns	Low	Low
Roy et al., 2017	Some concerns	Low	Low	Low	Some concerns
Röhr et al., 2021	Low	Low	Low	Low	Low
Hensler et al., 2022	Low	Some concerns	Low	Low	Low
Tuckey & Scott, 2014	Some concerns	Low	Some concerns	Low	Some concerns
Sijbrandij et al., 2006	Some concerns	Low	Low	Low	Some concerns
Von Känel et al., 2018	Low	Low	Low	Low	Low
Miller et al., 2015	Some concerns	Some concerns	High	Low	Some concerns
Sveen et al., 2017	Low	Some concerns	Some concerns	Low	Low
Mouthaan et al., 2013	Low	Some concerns	Some concerns	Low	Low

Table II: Risk of bias (RoB 2) assessment for the five RoB domains

DISCUSSION

This systematic review focuses on psychoeducational interventions for post-traumatic stress disorder in adults, with a specific emphasis on the diversity of delivery formats (e.g., group vs individual, face-to-face vs digital, guided vs self-directed). This is, to our knowledge, the first systematic review to examine and compare the varied formats of psychoeducation as stand-alone or primary interventions for PTSD.

1. Summary of main findings

Among the seventeen randomized controlled trials included in this review, psychoeducational interventions showed high variability in format, duration, content, and level of therapeutic support. Six studies reported a statistically significant reduction in PTSD symptoms attributable to the psychoeducational intervention (Cernvall et al., 2017; Engel et al., 2015; Hendrikx & Murphy, 2021; Hensler et al., 2022; Morabito & Schmidt, 2023; Sveen et al., 2017). These positive results were consistently observed in digital interventions, although other digital formats did not show significant effects. Digital interventions associated with clinical improvement were generally therapist-guided (e.g. Engel et al., 2015), which is consistent with other work in the literature (Akdemir et al., 2024) and may be explained in particular by a higher attrition rate in the unguided intervention (Lakhtakia & Torous, 2022). Several studies nonetheless reported benefits on secondary outcomes, such as perceived stress (e.g. Sveen et al., 2017), anxiety (e.g. von Känel et al., 2018), posttraumatic cognitions (Morabito & Schmidt, 2023), stigma (e.g. Nickerson et al., 2020), and help-seeking intentions (e.g. Röhr et al., 2021).

The findings of this study align with previous reviews on psychoeducation for post-traumatic stress, which emphasize the inconsistency of results across different studies (Whitworth, 2016; Brouzos et al., 2022; Wessely et al., 2008). As in these earlier works, our findings indicate

that while some psychoeducational interventions may be associated with an improvement in symptoms, the effects remain uncertain across studies. Our findings indicate that digital intervention seems to be a particularly useful form of psycho-education, this effect needs to be further documented. These results therefore reinforce the idea that the effectiveness of psychoeducation largely depends on its format, the context in which it is implemented, and its integration with other therapeutic modalities.

2. Effect of Post-Diagnostic vs. Preventive Interventions

A distinction in this review concerns the timing of psychoeducation in relation to PTSD onset. Ten studies implemented the intervention after a confirmed diagnosis, while six delivered it as a preventive measure shortly after trauma exposure. The findings suggest that post-diagnostic interventions are more likely to reduce PTSD symptoms. In contrast, only one preventive intervention demonstrates a significant effect on symptom severity (Sveen et al., 2017) which is in line with previous reviews (Brooks et al., 2021). These results are also consistent with previous evidence questioning the benefit of early psychological debriefing (McNally et al., 2003; Rose et al., 2002) or psychoeducation (Wessely et al., 2008)

As stated previously, the median delay between PTSD onset and first treatment contact could be very long, estimated at 12 years in Wang et al., 2005, underlining the need for early, accessible, and help-oriented interventions, especially in primary care settings. With this goal in mind, several studies included in this review emphasized the importance of delivering psychoeducational content that supports self-care and engagement (Nickerson et al., 2020; Röhr et al., 2021), rather than merely presenting a list of symptoms which could potentially exacerbate post-traumatic stress symptoms (Mayou et al., 2000).

It may be feasible to provide systematic psychoeducation in primary care, combining clear information on the main symptoms of PTSD with self-management techniques. Such an

approach could help reduce stigma, promote communication within the social network, and improve patients' understanding of the disorder. Information on access to more intensive treatments, when needed, should also be included.

In addition, combining psychoeducation with a screening of patients according to known risk factors, like dissociation or distress (Bunnell et al., 2018; van der Mei et al., 2020) could help identify high risk profile and allow for systematic re-evaluation of symptoms after a few weeks, or referral to a more comprehensive therapeutic program integrating psychoeducation within a more intensive approach. This strategy would also improve the selection of at-risk participants in future preventive psychoeducation trials. The predominance, in several studies, of participants with a relatively low baseline risk of developing PTSD may limit the ability to detect the true preventive effect of psychoeducation. Actually, the broader literature highlights the relevance of preventive psychoeducational interventions, both for facilitating access to care and for potentially reducing PTSD incidence. In the absence of effective PTSD prevention with psychoeducation, studies aiming to develop strategies for the prevention of PTSD should systematically include an assessment of stigma as well as the ability to seek formal help (from healthcare professionals) and informal help (from one's social network), as these two closely related dimensions (Murphy & Busuttil, 2015) are recognized risk factors for the development of PTSD (Sayed et al., 2015).

3. Format and therapeutic support

The delivery format of psychoeducational interventions emerged as a potentially influential factor in this review. Interventions were provided through various channels, including in-person groups, individual sessions, websites, mobile apps, videos, and webinars. A general trend suggests that interventions that include therapeutic guidance, even minimal, are more likely to show positive effects, both in terms of PTSD symptom reduction and participant

engagement which is a strength in a condition where avoidance is common. This trend is consistent with findings in other clinical areas, particularly in depression and anxiety, where several meta-analyses have shown that self-help programs are significantly more effective when guided by a professional (Akdemir et al., 2024; Baumeister et al., 2014; Saddichha et al., 2014) particularly in people with more severe symptoms (Werntz et al., 2023)

Our review highlights the effectiveness of digital interventions like Internet-based platforms and mobile applications, which have the advantage of being widely disseminated, simple, low-cost, scalable, available through multiple delivery formats and adaptable to each individual's pace and timing including refugees or people with daily obligations (Hendrikx & Murphy, 2021; Nickerson et al., 2020). Several studies suggest that, digital intervention may offer comparable effectiveness to face-to-face interventions (Hedman-Lagerlöf et al., 2023). However, the use of exclusively online formats does not always ensure strong participant engagement (Mouthaan et al., 2013) and may lead to high rates of refusal or non-participation. Although Roy's study did not show a significant difference between the two groups, those receiving incentive messages reported significantly greater use of the apps (Roy et al., 2017). These findings support the use of the association of a digital intervention with the minimal presence of a professional, as to enhance adherence, engagement, and the overall acceptability of psychoeducational programs.

One app study (Roy et al., 2017) found that participants who received explicit usage instructions reported significantly higher levels of use than those who received unguided access. In this regard, mobile apps offer a specific advantage over websites: they allow for push notifications, which can help maintain user engagement. This feature could provide a cost-effective and scalable compromise between fully self-guided and therapist-led interventions. These findings are consistent with the other systematic review (Bröcker et al., 2023), which highlights the overall acceptability of the PTSD Coach app while noting that user

engagement varies and appears to be enhanced by push notifications or minimal guidance. Their comparative analysis suggests higher adherence in mobile formats than in web-based versions, supporting the use of interactive and flexible tools. Looking forward, the integration of artificial intelligence may provide an additional layer of personalized support, dynamically tailored to each user's characteristics and evolving needs (Isa, 2024; Lenton-Brym et al., 2025).

4. Target populations and contextual adaptation

The reviewed studies involved a wide variety of populations, including refugees, military personnel and their partners, incarcerated individuals, emergency responders, and parents of children with severe illnesses or injuries. This diversity illustrates the versatility of psychoeducational interventions, which should be adapted to distinct sociocultural and clinical contexts. It also highlights the need for context-sensitive designs, as the nature of trauma and barriers to care differ substantially between populations.

Some groups, such as refugees or incarcerated women (e.g. Miller et al., 2015; Nickerson et al., 2020), may face significant obstacles in accessing conventional mental health services. In these vulnerable contexts, psychoeducation can serve as an entry point to care by increasing awareness, reducing stigma, and improving help-seeking attitudes. Other studies have targeted individuals indirectly affected by trauma, such as spouses or parents of military personnel (e.g. Roy et al., 2017).

With the aim of fostering social contact and the sharing of experiences and their consequences, psychoeducation may also play a role in enhancing the understanding of the disorder among relatives, as well as in supporting those affected by secondary or vicarious trauma, particularly among military personnel, emergency responders, and victims of physical or sexual assault. For example, a study of a brief psychoeducational intervention for relatives of veterans with

PTSD showed very positive results in terms of improved understanding of the disorder, increased sense of support, and greater willingness to apply the knowledge acquired (Campbell & Caska Wallace, 2023). Future studies could specifically explore psychoeducation for relatives, in order to better understand their role in the recovery process and to support the social and professional reintegration of individuals with PTSD.

However, the diversity of target populations also introduces challenges in terms of standardizing intervention content, ensuring cultural sensitivity, and measuring comparable outcomes. Tailoring content to the specific needs and expectations of each group remains essential to ensure relevance, engagement, and effectiveness.

5. Decision algorithm

Based on the literature review we conducted, we propose a decision algorithm presented in figure 2 to guide psychoeducation intervention in PTSD.

5.1. Post-event follow-up (decision framework)

Implement psychological first aid, then assess risk factors, especially peritraumatic distress and dissociation, with or without standardized tools that have predictive value for PTSD: the Peritraumatic Distress Inventory (PDI) (Bunnell et al., 2018) and the Peritraumatic Dissociative Experiences Questionnaire (PDEQ) (van der Mei et al., 2020).

- Absence of risk factors: depending on resources, favor a group-based or digital intervention (often more feasible than individual care). Normalize potential reactions (reduce stigma, encourage communication with relatives), offer some simple stress-management techniques (e.g., breathing, grounding, sleep hygiene), and provide a clear contact point/re-consultation instructions if key symptoms persist (re-experiencing, avoidance, negative alterations in mood, hyperarousal).

- Presence of risk factors: depending on resources, favor a group-based or digital intervention (often more feasible than individual care) including the above elements, more structured psychoeducation and CBT components (coping, behavioral activation, principles of graded exposure) while explaining the rationale for validated therapies (trauma-focused CBT, EMDR).

5.2. For established PTSD

Access to specific evidence-based PTSD therapies is commonly limited or subject to lengthy delays (Stein et al., 2023).

5.2.1. General population

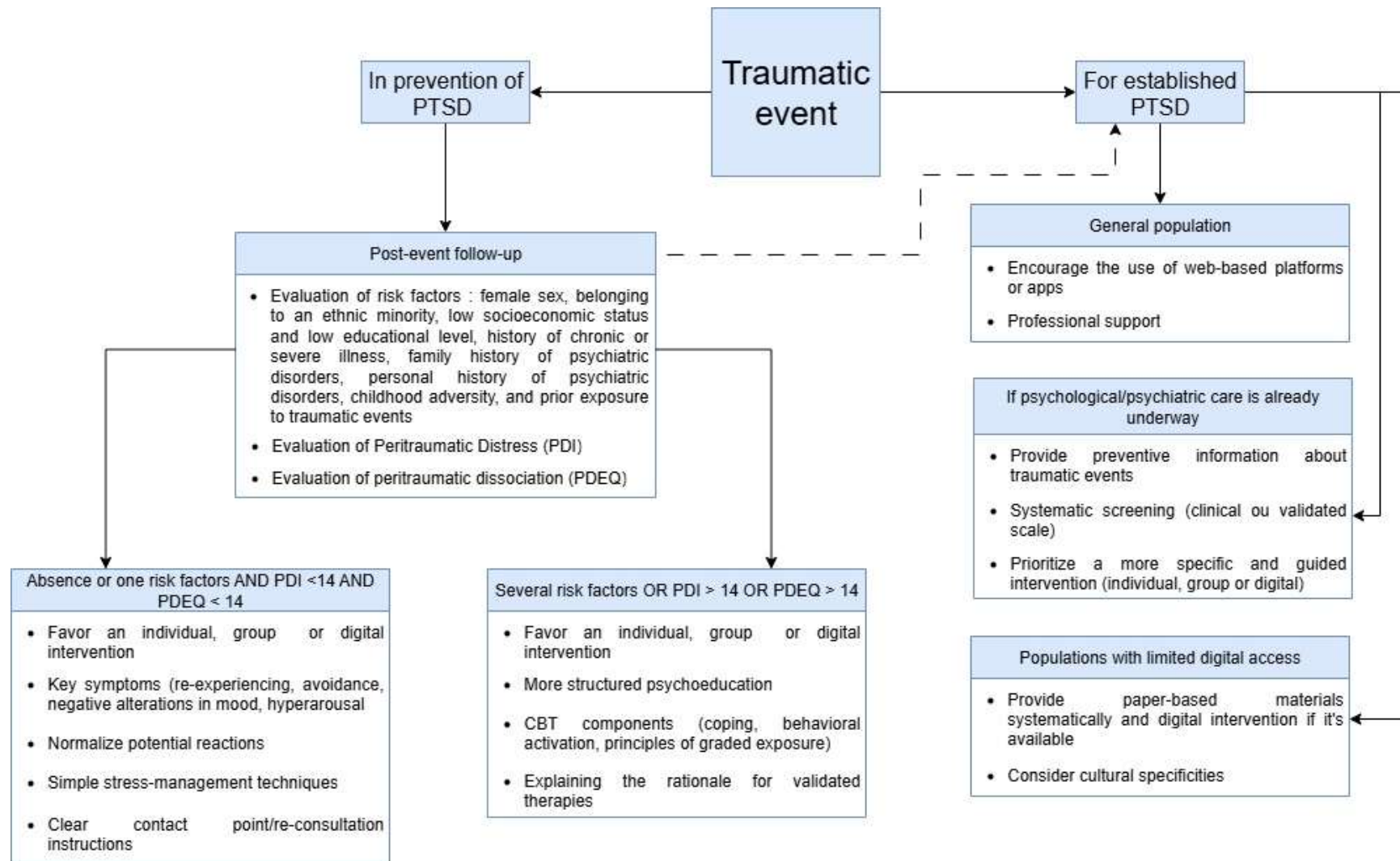
- Encourage and support the use of web-based valid platforms or apps (e.g., PTSD Coach, PE Coach), to reduce attrition and enhance treatment engagement.

5.2.2. If psychological/psychiatric care is already underway

- Provide preventive information about traumatic events and conduct systematic screening, as patients may conceal symptoms due to shame or competing symptomatology.
- Systematic screening of patients during a clinical examination or using a validated scale (e.g. Life Events Checklist for DSM-5, LEC-5)
- In the presence of psychiatric history (higher PTSD risk), prioritize a more specific and guided intervention (as above).

5.2.3. Populations with limited digital access (e.g., migrants, incarcerated persons)

- Provide paper-based materials systematically (ideally multilingual) or digital intervention if it's available and consider cultural specificities



PDEQ: Peritraumatic Dissociative Experiences Questionnaire ; PDI: Peritraumatic Distress Inventory ; PTSD: Post Traumatic Stress Disorder

Figure 2 : Proposal of a decision algorithm after a traumatic event

6. Limitations

Several methodological limitations must be considered when interpreting the findings of this review. Although all included studies were randomized controlled trials, their methodological quality varied considerably. Some showed moderate to high risk of bias, due to issues such as lack of participant blinding (often unavoidable in psychoeducational interventions), absence of preregistered protocols, or substantial loss to follow-up.

In addition, many studies had small sample sizes, which limits statistical power and generalizability. Some trials did not clearly report adherence or initial participation rates, making it difficult to assess the real-world acceptability of the interventions. Few studies included long-term follow-up, despite the possibility that the benefits of psychoeducation might evolve over time.

Finally, this review includes a limited number of studies and the substantial heterogeneity in populations, intervention formats, and outcome measures limits comparability across studies. While this diversity provides valuable exploratory insight, it also complicates any attempt at rigorous quantitative synthesis but provide information to guide the future development of more targeted, accessible, and patient-centered psychoeducational interventions.

CONCLUSION

This review confirms that psychoeducation, while insufficient as a stand-alone treatment for PTSD, remains a valuable component of care strategies, particularly in primary care settings. Even when it does not prevent the onset of the disorder, it can help encourage help-seeking behaviors and reduce barriers to mental health services. Concerning the content of the psychoeducation, the most promising interventions combine symptom normalization with

active coping strategies, helping individuals manage the emotional, social, or functional challenges related to trauma.

Concerning the format of psychoeducation, digital formats, whether websites or mobile apps appear to be the most promising way to disseminate psychoeducation on a large scale while minimizing human and financial costs. However, their effectiveness and user engagement appear to be enhanced when supported by professional guidance, or at least by personalized prompts built into the tools. Finally, these interventions must be tailored to diverse populations, taking into account their specific constraints and cultural representations of psychological care.

With regard to interventions delivered during an established posttraumatic stress state, digital strategies are becoming increasingly widespread and offer numerous advantages, including accessibility, cost-effectiveness, and flexibility. However, it is essential to more precisely assess user adherence and to better identify the symptom profiles for which these interventions are most effective.

In the future, we propose to more rigorously evaluate the effectiveness of preventive interventions in improving stigma as well as individuals' ability to seek help and engage in appropriate therapeutic care when needed. Moreover, this should also be emphasized in interventions targeting individuals with an established PTSD diagnosis. It would also be relevant to develop care models based on risks factors, symptom evolution and patient demand, allowing for stepped-care approaches aimed at reducing the risk of chronicity.

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Psychoéducation du trouble de stress post-traumatique chez l'adulte : une revue systématique des formats et modalités d'intervention

RÉSUMÉ

Introduction : Le trouble de stress post-traumatique (TSPT) est une affection psychiatrique fréquente pouvant se développer après une exposition directe ou indirecte à des événements traumatiques. L'identification des facteurs de risque est essentielle pour orienter des interventions précoces ciblées. La psychoéducation, en particulier, peut constituer une porte d'entrée vers les soins à faible coût et accessible, notamment en soins primaires.

Méthodes : Nous avons réalisé une revue systématique des essais contrôlés randomisés (ECR) évaluant les interventions psychoéducatives pour le TSPT chez l'adulte. Les recherches systématiques ont été menées dans les bases de données PubMed, ScienceDirect, Web of Science, PTSDpubs et Cochrane, du 1er janvier 2000 au 30 avril 2024. Les études éligibles étaient des ECR incluant des participants adultes, avec une psychoéducation délivrée comme intervention autonome ou composante principale.

Résultats : Dix-sept ECR, impliquant 2 204 participants, ont satisfait aux critères d'inclusion. Les interventions psychoéducatives présentaient une forte variabilité en termes de format, de durée et de modalité de délivrance.

Discussion : Six études ont rapporté une réduction statistiquement significative des symptômes de TSPT attribuable à la psychoéducation (une intervention préventive et cinq après diagnostic). Toutes les interventions efficaces étaient délivrées par voie numérique (sites web ou applications mobiles), soulignant l'évolutivité, l'adaptabilité et le caractère économique des formats digitaux. Cependant, l'efficacité clinique globale reste inconstante selon les études. Plusieurs essais ont également montré des bénéfices sur des critères secondaires tels que le stress perçu, l'anxiété, la stigmatisation et les intentions de recours aux soins.

Conclusion : Cette revue confirme que la psychoéducation, bien qu'insuffisante en tant que traitement autonome du TSPT, demeure un élément précieux des stratégies de soins par paliers. Les futures études devraient évaluer de manière systématique des critères tels que la réduction de la stigmatisation et les comportements de recours aux soins, qui sont essentiels pour initier l'engagement dans des thérapies plus intensives. Les interventions préventives gagneraient à cibler des populations à haut risque sur la base de facteurs de risque connus, ce qui permettrait d'améliorer la conception des essais et de réduire l'inclusion de personnes susceptibles de connaître une rémission spontanée.

Mots-clés : Trouble de stress post-traumatique, Psychoéducation, Soins primaires

Psychoeducation for Posttraumatic Stress Disorder in Adults: A Systematic Review of Delivery Formats and Modalities

ABSTRACT

Introduction: Posttraumatic stress disorder (PTSD) is a common mental health condition that may develop after direct or indirect exposure to traumatic events. Identifying risk factors is essential for guiding targeted early interventions. Psychoeducation, in particular, may serve as a low-cost and accessible gateway to care, especially in primary care settings.

Methods: We conducted a systematic review of randomized controlled trials (RCTs) evaluating psychoeducational interventions for PTSD in adults. Systematic searches were carried out in PubMed, ScienceDirect, Web of Science, PTSDpubs, and Cochrane databases from January 1, 2000, to April 30, 2024. Eligible studies were RCTs including adult participants, with psychoeducation delivered as a stand-alone or primary component.

Results: Seventeen RCTs, involving 2,204 participants, met the inclusion criteria. Psychoeducational interventions showed high variability in format, duration, and delivery.

Discussion: Six studies reported a statistically significant reduction in PTSD symptoms attributable to psychoeducation (one preventive intervention and five post-diagnosis). All effective interventions were delivered digitally (websites or mobile applications), underscoring the scalability, adaptability, and cost-effectiveness of digital formats. However, overall clinical effectiveness remains inconsistent across studies. Several trials also reported benefits on secondary outcomes such as perceived stress, anxiety, stigma, and help-seeking intentions.

Conclusion: This review confirms that psychoeducation, while insufficient as a stand-alone treatment for PTSD, remains a valuable component of stepped-care strategies. Future studies should systematically evaluate outcomes such as stigma reduction and help-seeking behaviors, which are critical for initiating engagement in more intensive therapies. Preventive interventions would benefit from targeting high-risk populations based on known risk factors, thereby improving trial design and reducing the inclusion of individuals likely to experience spontaneous remission.

Keywords : Posttraumatic Stress Disorder, Psychoeducation, Primary care