

# Online post-traumatic stress disorder treatment for young people and their carers

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		<input checked="" type="checkbox"/> Protocol
<b>Registration date</b> 06/07/2020	<b>Overall study status</b> Completed	<input checked="" type="checkbox"/> Statistical analysis plan
		<input checked="" type="checkbox"/> Results
<b>Last Edited</b> 05/08/2025	<b>Condition category</b> Mental and Behavioural Disorders	<input type="checkbox"/> Individual participant data

## Plain English summary of protocol

### Background and study aims

Many teenagers will be exposed to a potentially traumatic event at some point before they are 18 years old, and many of them will develop post-traumatic stress disorder (PTSD). PTSD is distressing and often causes problems at home and at school. Cognitive therapy for PTSD is very effective when young people can go to regular weekly face-to-face appointments to see a trained therapist. However, face-to-face therapy is sometimes not offered to young people due to a shortage of trained therapists, and some young people cannot attend the clinic for many reasons. This means that many young people with PTSD miss out on effective treatments. Researchers have developed a progressive web app to deliver cognitive therapy to young people with PTSD with a smartphone, tablet or computer. They want to find out what young people and their carers or parents think of this way of delivering therapy. They want to find out how easy it is to recruit young people and to engage them in the treatment to inform a larger trial in the future. They also want to see whether symptoms of PTSD and other problems such as depression and anxiety reduce after doing the therapy and how this compares to natural recovery.

### Who can participate?

Young people (aged 12-17 years) whose main presenting problem is PTSD following a single-event trauma (e.g. serious accidents or assaults)

### What does the study involve?

Participants are randomly allocated to either receive online therapy to receive delayed treatment, where they will wait 16 weeks before receiving the online treatment. Face-to-face therapy will be offered to young people allocated to the waitlist condition if clinics are running as usual and offering face-to-face appointments following the COVID-19 pandemic. The online treatment involves therapist-supported online delivery of all components from a face-to-face CT manual, including psycho-education, reclaiming life, developing a narrative of the trauma, re-appraisal of trauma-related cognitions, updating the trauma memory, stimulus discrimination training, developing a relapse-prevention blueprint. Work with parents is via a parallel parent App. Young people are supported to complete their treatment via a weekly phone call from their therapist. The researchers will carry out detailed assessments before and after treatment to see if symptoms are reduced after doing the therapy, and how symptom improvement compares

across the two groups. These will be repeated at 38 weeks (follow-up) for the active treatment group only to see if any treatment effects are long-lasting.

What are the possible benefits and risks of participating?

Sometimes this therapy, whether delivered face-to-face or online, may be upsetting. However, a therapist will be available throughout treatment to support young people if this happens. In addition, the online therapy has already been used by some young people. They did not experience any disadvantages or risks in using the online therapy. There is a 50% chance young people will be allocated to the delayed treatment group. This means that they will be asked to wait for 16 weeks before receiving the online therapy. The researchers may also be able to offer young people face-to-face treatment after the 16-week wait, if preferred, and if clinics are running normally at the time. Young people can seek support from their GP if they feel they need support while waiting for treatment to begin. The evidence so far shows that young people are likely to be helped by receiving treatment through this study. Young people will have a 50% chance of being allocated to online therapy without having to wait. The researchers think that the online therapy will be effective in treating PTSD. Face-to-face cognitive therapy for PTSD has been shown to be very effective, and the researchers have designed the new online therapy using the same treatment components as this treatment.

Where is the study run from?

King's College London (UK)

When is the study starting and how long is it expected to run for?

June 2020 to July 2022

Who is funding the study?

Medical Research Council (UK)

Who is the main contact?

Dr Patrick Smith

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## Contact information

### Type(s)

Scientific

### Contact name

Dr Patrick Smith

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## **Additional identifiers**

**Integrated Research Application System (IRAS)**  
262807

**Central Portfolio Management System (CPMS)**  
42768

## **Study information**

### **Scientific Title**

Internet-delivered cognitive therapy (iCT) for young people with post-traumatic stress disorder (PTSD) - early-stage randomized controlled trial

### **Acronym**

OPTYC

### **Study objectives**

This is an early stage trial with two arms: a newly developed internet-delivered Cognitive Therapy (iCT) programme to treat PTSD in adolescents, and a Wait List condition. The objectives of the RCT are to: provide feasibility data on acceptability, compliance, retention, and delivery; and to provide initial estimates of the effect of iCT on symptoms of PTSD, anxiety and depression relative to a wait-list condition.

### **Ethics approval required**

Old ethics approval format

### **Ethics approval(s)**

Approved 30/06/2020, London Bridge Research Ethics Committee (Skipton House, 80 London Road London SE1 6LH, UK; +44 (0)207 104 8019; londonbridge.rec@hra.nhs.uk), REC ref: 19/LO/1354

### **Study design**

Two-arm parallel-group single-blind (outcome assessor) early-stage randomized controlled trial

### **Primary study design**

Interventional

### **Study type(s)**

Treatment

### **Health condition(s) or problem(s) studied**

Post-traumatic stress disorder (PTSD)

### **Interventions**

Randomisation will be carried out by an independent clinical trials unit. Individual patient-level randomisation, with allocation in a 1:1 ratio, using minimisation methods employing two factors (gender and symptom severity), will be used to randomise into one of two arms:

**1. Internet-delivered Cognitive Therapy (iCT; n = 17)**

This comprises therapist-supported online delivery of all components from our face-to-face Cognitive Therapy (CT) manual (Smith et al., 2010), including: psycho-education, reclaiming life, developing a narrative of the trauma, re-appraisal of trauma-related cognitions, updating the trauma memory, stimulus discrimination training, developing a relapse-prevention blueprint. Young people are supported to complete treatment via a weekly phone call from their therapist. There is a separate online programme for parents and carers.

**2. Wait List (WL; n = 17)**

Patients allocated to WL will be asked to wait for 16 weeks before being offered iCT. If preferred, and if clinics are open and functioning as usual at the time, patients will be able to opt for face-to-face CT-PTSD after the 16-week wait.

Assessments will take place at pre-treatment (0 weeks), mid-treatment (6 weeks post-randomisation), post-treatment (16 weeks post-randomisation), and at follow-up (38 weeks post-randomisation). Follow up assessments at 38 weeks will be conducted for the iCT arm only.

**Intervention Type**

Behavioural

**Primary outcome(s)**

As this is an early-stage trial, the primary outcomes are feasibility outcomes and adherence metrics. Feasibility data on acceptability, compliance, retention, and delivery will be collected to enable an estimation of key parameters to inform a larger trial. This is in line with MRC guidance.

The following feasibility data on acceptability will be collected during the trial recruitment phase at the pre-intervention assessment and during the randomisation phase (June 2020- August 2021):

1. The total number of young people referred to the trial by (i) schools, (ii) Child and Adolescent Mental Health Services (CAMHS), or (iii) GP or self-referral
2. Number of young people screened in schools, and of these, the proportion who are considered to be eligible at school and proceed to a phone call with family
3. Number and proportion of young people in schools scoring above cut-off on a validated screening questionnaire (a score of  $\geq 17$  on the Children's Revised Impact of Event Scale, CRIES-8); relative to the number of young people screened in schools
4. The number and proportion of young people in schools who score above cut-off on the CRIES-8 but decline further participation with the trial (relative to those scoring above cut-off)
5. The number and proportion of young people in schools who score above cut-off on CRIES-8 and consent to further assessment but are deemed ineligible at baseline assessment (relative to those deemed eligible at baseline assessment)
6. Number of assessment appointments offered to participants (via any referral route)
7. Number and proportion of assessment appointments attended by participants, relative to the number of appointments offered, reported by referral source (schools, CAMHS, GP referral, and self-referral)
8. Reasons for not attending assessment appointments (count and percentages) reported by referral source (schools, CAMHS, GP referral, and self-referral)
9. Number and proportion of young people who, at the baseline assessment, consent to

participation in the trial (number consented / number attended assessment). Reasons for not consenting if known (count and percent)

10. Number and proportion of young people eligible for the trial after baseline assessment (number eligible at baseline interview/number assessed for eligibility at baseline interview)

11. Number of young people who are randomised, and proportion of consented young people who are randomised (number randomised / number consented)

12. Reasons for withdrawing from the trial if known

13. Number retained in study at 16 weeks (post-treatment) and at 38 weeks (follow-up), and proportions of those who start treatment that are retained (number retained / number started, and number retained/number randomised), by arm

Acceptability will also be gauged by carrying out qualitative interviews with young people about the acceptability of the research procedures, the assessment measures and views of randomisation at 16 weeks (post-treatment).

The following feasibility data on adherence, compliance and delivery will be collected in the iCT arm throughout the treatment phase (0-12 weeks):

14. Number of times logged into the programme per week and in total

15. Time spent logged in per week and in total

16. Number of modules completed in total and according to device used (phone, tablet, computer)

17. Number of therapist phone calls attended per week and in total, and the number of missed phone appointments

18. Time spent on phone calls per week and in total

19. Number of messages to/from therapist per week and in total

20. Number and proportion of young people who start treatment (number starting treatment /number randomised)

21. Number of weeks of therapy completed

22. Reasons for dropping out of treatment if known

Feasibility data on retention will be collected, including the reasons for withdrawing from the trial, if known and the number retained in the study at 16 weeks (post-treatment) and at 38 weeks (follow-up), and proportions of those who start treatment that are retained (number retained / number started, and number retained/number randomised), by arm.

The primary clinical outcome is the presence or absence of a diagnosis of post-traumatic stress disorder (PTSD) according to the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) published by the American Psychiatric Association, determined using a gold-standard semi-structured clinical interview: the Clinician-Administered PTSD Scale for DSM-5 - child and adolescent version (CAPS-5-CA), administered at 0 and 16 weeks after randomisation. This is a clinician-administered interview and will be administered by trained, reliable raters who are blind to treatment allocation.

### **Key secondary outcome(s)**

Current secondary outcome measures as of 23/11/2021:

Young person completed outcome measures:

1. PTSD symptom severity measured using the CAPS-CA-5 at 0 (baseline) and 16 weeks post-randomisation (post intervention)

2. PTSD symptoms measured using the Child Post Traumatic Stress Scale (CPSS-5) and at 0, 16 and 38 weeks post randomisation (follow up)

3. Re-experiencing the traumatic event and avoidance measured using the Children's Revised

Impact of Event Scale - 8 item version (CRIES-8) at 0, 6, 16, and 38 weeks

4. Anxiety and depression measured using the Revised Children's Anxiety and Depression Scale (RCADS-C) at 0, 16 and 38 weeks

Parent/carer completed outcome measures:

5. Emotional and behavioural problems measured using the Strength & Difficulties Questionnaire (SDQ-P) at 0, 16 and 38 weeks

6. Depression and anxiety measured using the Revised Children's Anxiety and Depression Scale (RCADS-P) at 0, 16 and 38 weeks

Process measures

7. Negative trauma-related cognitions and appraisals measured using the Child Post Traumatic Cognitions Inventory (CPTCI) at 0, 6, 16 and 38 weeks

8. Memory quality measured using the Trauma Memory Quality Questionnaire (TMQQ) at 0, 6, 16 and 38 weeks

9. Rumination measured using the Trauma Related Rumination Questionnaire items at 0, 6, 16 and 38 weeks

Health economic measures

10. Health economics measured using the Child & Adolescent Service Use Schedule (CA-SUS) at 0, 16 and 38 weeks

11. Health-related quality of life using the Child Health Utility Index 9D (CHU-9D) measured at 0, 16 and 38 weeks

These outcomes will only be repeated at 38 weeks post-randomisation (follow-up) in the RCT for the active treatment arm

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Previous secondary outcome measures:

Young person completed outcome measures:

1. PTSD symptom severity measured using the CAPS-CA-5 at 0 (baseline) and 16 weeks post-randomisation (post intervention)

2. PTSD symptoms measured using the Child Post Traumatic Stress Scale (CPSS-5) and at 0, 16 and 38 weeks post randomisation (follow up)

3. Re-experiencing the traumatic event and avoidance measured using the Children's Revised Impact of Event Scale - 8 item version (CRIES-8) at 0, 6, 16, and 38 weeks

4. Anxiety and depression measured using the Revised Children's Anxiety and Depression Scale (RCADS-C) at 0, 16 and 38 weeks

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9. Health economics measured using the Child & Adolescent Service Use Schedule (CA-SUS) at 0, 16 and 38 weeks

These outcomes will only be repeated at 38 weeks post-randomisation (follow-up) in the RCT for the active treatment arm

**Completion date**

19/07/2022

## Eligibility

**Key inclusion criteria**

Young people:

1. Aged 12-17 years old
2. Main presenting problem is PTSD (diagnosed using CAPS-5-CA) and there is not a co-morbid problem that would preclude treatment of PTSD
3. PTSD symptoms relate to a single trauma
4. Participant has access to compatible smartphone or larger computing device (e.g. laptop, desktop computer, iPad) with internet access and to a safe and confidential space in which to engage in iCT
5. Participant speaks English to a level that allows therapy without the need for an interpreter, and reads English to a level that allows independent use of iCT

Parents or carers:

1. Parent or carer of a young person who meets all of the inclusion criteria above and none of the exclusion criteria below
2. Parent or carer speaks English to a level that allows participation in therapy without the need for an interpreter, and reads English to a level that allows independent use of iCT
3. Parent or carer has access to compatible smartphone or larger computing device (e.g. laptop, desktop computer, iPad) with internet access

**Participant type(s)**

Patient, Carer

**Healthy volunteers allowed**

No

**Age group**

Mixed

**Sex**

All

**Total final enrolment**

31

**Key exclusion criteria**

Young people:

1. Brain damage
2. Intellectual disability
3. Pervasive developmental disorder or neurodevelopmental disorder
4. Other psychiatric diagnosis that requires treatment before PTSD
5. Moderate to high risk to self

6. Ongoing trauma-related threat
7. Started treatment with psychotropic medication, or changed medication, within the last 2 months
8. Currently receiving another psychological treatment
9. Has already received trauma-focused CBT in relation to the same traumatic event that they are currently seeking treatment for

Parents or carers:

Parents or carers are not eligible if their son or daughter meets the exclusion criteria above. There are no additional exclusion criteria for parents or carers

**Date of first enrolment**

14/07/2020

**Date of final enrolment**

01/11/2021

## **Locations**

**Countries of recruitment**

United Kingdom

England

**Study participating centre**

**Maudsley Hospital**

South London and Maudsley NHS Foundation Trust

Denmark Hill

London

United Kingdom

SE5 8AZ

**Study participating centre**

**Hellesdon Hospital**

Norfolk and Suffolk NHS Foundation Trust

Drayton High Road

Norwich

United Kingdom

NR6 5BE

**Study participating centre**

**Erleigh House**

Berkshire Health NHS Foundation Trust

University of Reading

Reading

United Kingdom  
RG6 6BZ

**Study participating centre**

**Warneford Hospital**

Oxford Health NHS Foundation Trust  
Warneford Lane  
Headington  
Oxford  
United Kingdom  
OX3 7JX

**Study participating centre**

**NELFT NHS Foundation Trust**

651 The Crescent  
Colchester Business Park  
Colchester  
United Kingdom  
CO4 9YQ

**Study participating centre**

**Northern Health Centre**

Whittington Health NHS Foundation Trust  
580 Holloway Road  
London  
United Kingdom  
N7 6LB

**Study participating centre**

**Fulbourn Hospital**

Cambridge and Peterborough NHS Foundation Trust  
Elizabeth House  
Cambridge Road  
Cambridgeshire  
United Kingdom  
CB21 5EF

**Study participating centre**

**Memorial Hospital**

OXLEAS NHS Foundation Trust  
Highpoint House

Shooters Hill  
London  
United Kingdom  
SE18 3RZ

## Sponsor information

### Organisation

Joint Institute of Psychiatry, Psychology & Neuroscience and the South London and Maudsley NHS Foundation Trust.

### ROR

<https://ror.org/015803449>

## Funder(s)

### Funder type

Government

### Funder Name

Medical Research Council Developmental pathway Funding Scheme (DPFS) MRC reference: MR/P017355/1

### Alternative Name(s)

Medical Research Council (United Kingdom), UK Medical Research Council, Medical Research Committee and Advisory Council, MRC

### Funding Body Type

Government organisation

### Funding Body Subtype

National government

### Location

United Kingdom

## Results and Publications

### Individual participant data (IPD) sharing plan

All investigators will have access to the final trial dataset. Our intentions are to maximise the availability and sharing of our data for the benefit of the wider research community, while providing for its long-term preservation and making due allowance for the potential commercial

value of findings. The project management group will make the decision on whether to supply research data to a potential new researcher. Independent oversight of data access and sharing will be provided by the TSC. Data released to the wider community after publication will be fully anonymised.

## IPD sharing plan summary

Other

### Study outputs

Output type	Details	Date created	Date added	Peer reviewed?	Patient-facing?
<a href="#">Results article</a>		06/02/2025	05/08/2025	Yes	No
<a href="#">Protocol article</a>		21/03/2022	09/08/2022	Yes	No
<a href="#">HRA research summary</a>			28/06/2023	No	No
<a href="#">Statistical Analysis Plan</a>	version 1.0	24/09/2021	11/08/2022	No	No
<a href="#">Study website</a>	Study website	11/11/2025	11/11/2025	No	Yes