**A Systematic Review of Interventions to Promote Growth Following Adversity**

Karen Howells

Cardiff Metropolitan University

Cardiff, United Kingdom

Ross Wadey

St Mary’s University

London, United Kingdom

Kylie Roy-Davis

University of Roehampton

London, United Kingdom

Lynne Evans

Cardiff Metropolitan University

Cardiff, United Kingdom

Correspondence concerning this article should be addressed to Karen Howells, Cardiff Metropolitan University, Cyncoed Campus, Cyncoed Road, Cardiff, CF23 6XD. Tel. 029 2041 7153. Email: KLHowells@Cardiffmet.ac.uk

**Abstract**

**Background**: Athletes experience adversity across many aspects of their lives. Challenging the dominant idea that adversity is just a negative experience, a significant body of research in sport has demonstrated that these adverse events can also act as catalysts for positive change (Howells, Fletcher, & Sarkar, 2017). Yet, a limited number of researchers have focused on *how* to promote growth following adversity in sport. To support this line of inquiry our aim in this study was to facilitate knowledge transfer from other psychology disciplines by systematically reviewing intervention studies that aim to foster growth following adversity. **Methods**: We conducted the systematic review using PRISMA guidelines. Following inclusion and exclusion criteria, we appraised the studies using the Mixed Methods Appraisal Tool (Pluye & Hong, 2014). **Results**: Thirty-six studies were included in the review. We synthesized the studies in relation to participant characteristics (i.e., sample size, age, gender, ethnicity, adversity), study characteristics (i.e., design, content, duration, delivery, outcome measures), intervention outcomes (i.e., statistical significance, effect size, qualitative indicators of growth), antecedents (viz. mediators, moderators), and quality appraisal. **Conclusion**: In the discussion we critically consider the lessons sport and exercise psychology researchers can learn from published intervention studies from other fields of research (e.g., the use of meaningful metrics, that there are different trajectories of growth, growth is a multidimensional phenomenon). Future researchers should seek to build on findings to advance knowledge and understanding in the most significant and meaningful ways.

*Keywords*: Benefit-Finding, Injury, Sport, Stress, Synthesis, Trauma

**A Systematic Review of Interventions to Promote Growth Following Adversity**

Athletes encounter a wide range of negative events and experiences throughout their sporting careers. These events have been variously labelled *stressors* (e.g., time demands), *adversities* (e.g., coach bullying), and *traumas* (e.g., injury) (cf. Howells, Sarkar, & Fletcher, 2017). However, one of the challenges with researching adversity is that the meaning of these terms (e.g., what constitutes a ‘traumatic’ event?) vary within and across fields of research and cultures (Tedeschi, Shakespeare-Finch, Taku, & Calhoun, 2018); therefore, it is important that researchers define their terms of reference from the outset. Although some researchers are more interested in the objective qualities of the events, we agree with Tedeschi et al. (2018) that, “whether or not an event is traumatic, is in the eye of the beholder” (p. 4). Therefore, accounting for both the objective qualities, and the subjective meaning to the individual is important. Accordingly, herein we employ the term *adversity* to represent a more inclusive term than *stressor*. We define adversity as a relational state between an individual and their environment (cf. Howells & Fletcher, 2015) that includes the event (e.g., injury) and the individual’s cognitive (e.g., appraisal, rumination) and affective (e.g., distress) responses to it.

Despite the dominant conceptualization of adversity in sport as an undesirable occurrence with predominantly negative consequences (e.g., depression, post-traumatic stress disorder), researchers in the sporting domain have suggested that adverse events can also act as catalysts for positive change (e.g., Collins & MacNamara, 2012), particularly in elite cohorts (e.g., Hardy, Barlow, Evans, Rees, Woodman et al., 2017). This premise of positive change following adversity has been labelled in the sport and exercise psychology literature as *growth* (Howells et al., 2017). According to Tedeschi et al. (2018), growth is defined as, “positive changes in cognitive and emotional life that are likely to have behavioral implications; the changes can be profound and may be truly transformative” (p. 5). Researchers who have explored this concept in the context of sport and exercise have identified several indicators of growth, including increased spiritual awareness, better emotional regulation, more prosocial behavior, improved social relationships, and enhanced sport performance (cf. Howells et al., 2017). Although some researchers might suggest these positive changes are analogous to normative development, Tedeschi et al. (2018) suggested growth can be distinguished from normative maturation processes as only growth is the direct result of the struggle with the aftermath of adversity. It could, however, be argued that growth following adversity may indeed help to ‘accelerate’ normative development or that adversities themselves may impact on developmental pathways (cf. Tedeschi et al., 2018) but these are conceptual issues that warrant future research attention. Furthermore, despite seemingly overwhelming evidence that adversity-related experiences are associated with subsequent positive change, there are differential findings suggesting that growth in sport may be overstated. To elaborate, in a study that examined what factors associated with trauma experiences discriminate between super-champions, champions and those who did not succeed at the highest level of performance, Collins, MacNamara, and McCarthy (2016) reported a lack of universal trauma in the development pathways of performers across all levels.

Despite these differential findings (e.g., Collins et al., 2016), the evidence to support growth in sport and exercise is compelling. However, the focus thus far has been how we should conceptualize growth, the methodological processes involved in studying growth, testing and developing theory, exploring growth experiences, and identifying its antecedents and consequences (cf. Howells et al., 2017). Despite making significant strides conceptually, theoretically, and methodologically *how* to promote growth following adversity has received limited research attention.

One methodological approach that has been increasingly used in sport and exercise psychology to enhance knowledge and understanding in under-researched and/or emerging areas of empirical enquiry is a systematic review. This methodological approach was utilized by Howells et al., 2017) to understand how growth has been conceptualized in competitive sport, but their review focused on how growth has been researched rather than how growth may be facilitated. Given the paucity of intervention research on growth following adversity in sport, our aim in this study was to facilitate knowledge transfer from other psychology disciplines to guide sport and exercise psychology researchers by systematically reviewing intervention studies that aim to foster growth following adversity. Our rationale for this was twofold. First, we strongly believe that addressing the lessons that sport and exercise psychology researchers can learn from existing published intervention studies in other fields of research (e.g., cognitive psychology, developmental psychology, existential and humanistic psychology, health psychology) will help inform the design of intervention studies with athletes who have experienced adversity. Our intention here is not to identify the ‘best’ approach, rather to encourage diverse and innovative approaches to promote growth. Second, we believe that identifying what Hardy (2015) termed the “genuine unknowns” (p. 258), specifically, those issues that may not have been addressed by the reviewed literature, will help guide the direction of future research, such that it reduces the likelihood of needless replication. Hardy suggested that too often sport and exercise psychologists replicate studies from other fields and call them ‘new’, when we should be focusing on the genuine unknowns. Although our aim with this study was to facilitate knowledge transfer from other psychology disciplines, we seek to identify genuine unknowns to reciprocate knowledge transfer. Some might argue that there is limited transferability between disciplines, however, the evidence thus far on growth following adversity suggests that many of the findings ‘ring true’ across disciplines (cf. Tedeschi et al., 2018).

**Methods**

**Search Strategy**

The protocol we used for this systematic review was the Preferred Reporting Items for Systematic Reviews and Meta Analyses guidelines (PRISMA; Moher, Liberati, Altman, & PRISMA Group, 2009). The search strategy was threefold. First, in April 2018, the first author carried out an online search of the following electronic databases: PsycINFO, PsycARTICLES, SPORTDiscus, Web of Science Core Collection, and the Cochrane Library, to include all identifiable published studies up to 3rd April 2018. We did not identify an earliest publication boundary but as growth came to fruition with the advent of Tedeschi and Calhoun’s development of the PTGI in 1995, perhaps not surprisingly, the earliest study we identified was from 2001 (viz. Antoni et al., 2001). The keywords we used in the search were deductively informed by the terms utilized by researchers who have explored adversarial growth in sport and exercise participants in systematic reviews (Hefferon, Grealy, & Mutrie, 2009; Howells et al., 2017). They were: “post-traumatic growth”, “posttraumatic growth”, “stress-related growth”, “adversarial growth”, “benefit finding”, “perceived benefits”, “positive outcomes”, “thriving, “well-being” and “wellbeing”. We combined these terms with the following keywords related to interventions: “intervention”, “program”, “programme”, “therapy”, “counseling”, “counselling”, and “treatment”. We conducted the primary search using the following combination of search strings: String 1: Post-traumatic growth\* OR Posttraumatic growth\* OR Stress-related growth\* OR Adversarial Growth\* OR Benefit finding\* OR Perceived benefits\* OR Positive outcomes\* OR Thriving\* OR Well-being/Wellbeing. String 2: Interventions\* OR Program/Programme\* OR Therapy\* OR Counseling/Counselling\* OR Treatment. Our second strategy involved us manually exploring germane journals in the trauma, psychology, and sport performance literature.

**Criteria**

We used the following inclusion criteria to include studies that: (a) involved an intervention that focused on inducing change; (b) were directed at those who had experienced adversity first-hand rather than vicariously; (c) aimed to promote growth; (d) were published in peer-reviewed journals; and (e) were available in the English language. We excluded studies if they were book chapters, unpublished, dissertations, conference abstracts, or not written in the English language.

**Sifting of Research Papers**

Data were extracted by the first author and evaluated by title, abstract, and full text (see Figure 1). At each stage we appraised papers and excluded them from the sifting process if they did not meet the inclusion criteria. To illustrate, we excluded papers if they did not comprise an intervention (e.g., Collins et al., 2016), involved vicarious trauma or growth (e.g., Shoji et al., 2014), did not explicitly aim to promote growth (e.g., Gray et al., 2012), or were an unpublished dissertation (e.g., Averill, 2007). The second author independently assessed a random selection of 15 titles, 15 abstracts, and 15 texts using the inclusion and exclusion criteria to ensure the accuracy of the study selection procedure.

**Methodological Appraisal**

Thirty-seven studies (see Table 1) met the inclusion criteria which the first two authors assessed for methodological quality using the Mixed Methods Appraisal Tool (MMAT; Pluye & Hong, 2014). The MMAT has been identified as a valid and reliable tool that comprises of 19 quality criteria for appraising qualitative, quantitative randomized controlled trials, quantitative non-randomized controlled, quantitative (descriptive), and mixed methods studies (Souto et al., 2015). Nevertheless, we were aware that using this tool meant we were potentially appraising studies (particularly the qualitative research), regardless of their intent and purpose, in preordained and set ways (cf. McGannon & Smith, 2018). Therefore, the quality assessment provided detail as a starting point for us to appraise the methodological quality of the studies rather than the quality of the writing, or the effectiveness of a trial, and we acknowledge the role that our own interpretation may have had in this process. We categorized studies according to the MMAT criteria whereby quasi-experimental studies were classified as *quantitative nonrandomized controlled*, single subject-design as *quantitative descriptive*, and studies that used interviews, participant observation, or written narratives were classified as *qualitative*. Further explanation on the criteria we utilized is included in Table 3. We added up scores for each methodological design; mixed method studies only scored as high as their lowest score for each study design (cf. Smith, Sestak, Forster, Partridge, Side, et al., 2016).

**Data Extraction and Analysis**

Once we had selected and quality appraised the studies, we extracted the following data: participant characteristics (i.e., sample size, age, gender, ethnicity, adversity), study characteristics (i.e., design, content, duration, delivery, outcome measures), intervention outcomes (i.e., statistical significance and effect size, their meaning or qualitative indicators of growth), antecedents (viz. mediators, moderators), and quality appraisal (see Table 1). Abbreviations are detailed in Table 2. At this juncture it is important to explain what was meant by an ‘effective’ intervention. Recent systematic reviews have involved the authors assessing intervention effectiveness by examining whether the test statistic reaches the desired level of *p* < .05 (viz. Jaarsma & Smith, 2018). However, this focus on the existence or non-existence of an effect has been heavily criticized for its narrow-focus and incomplete reporting (Ivarsson, Andersen, Stenling, Johnson, & Lindwall, 2015). To elaborate, Cohen (1990) reported that a common misconception is that *p* < .05 is a dichotomous breaking point: the point upon which a *yes-no* decision is made. However, “*significant* does not mean *important* or *meaningful*” (Higgs, 2013, p. 458). The *p* value does not inform us about the magnitude or the meaningfulness of differences or associations; therefore, it is not a good indicator of intervention effectiveness. To illustrate, one standard method of assessing growth is the use of self-report measures, such as the Posttraumatic Growth Inventory (PTGI; Tedeschi & Calhoun, 1996). Yet questions about how to interpret the scores include: What cut off values researchers should use to determine whether (or not) growth has occurred because of an intervention. How much is enough? What does an increase in growth mean in terms of real-world behavior? Tedeschi et al. (2018) suggested:

Even the endorsement of a great deal of growth on only one item of the PTGI can indicate significant change for an individual, even if the total score is low. In addition, a moderate total score that is the result of a sum of many relatively low scores on individual items may not indicate much significant growth (p. 34).

With this knowledge in mind, we needed to address how to assess the effectiveness of the growth interventions included in this study. Regarding quantitative studies, Ivarsson et al. (2015) recommended a more meaningful interpretation of statistics. That is, they suggested moving away from just reporting *p* values to also including effect sizes *and* interpret what they might mean. Andersen et al. (2007) reported, “Not only do consumers of sport and exercise psychology research need to have information regarding effect sizes, but we also need to read what researchers have to say about what those effect sizes actually mean” (p. 670). In relation to qualitative studies, we examined participants’ accounts of their experiences of the intervention. Not all participants had to report positive changes for the intervention for it to be deemed effective, as meaningful outcomes might differ between participants and over time.

**Results**

**Study Selection and Quality Assessment**

Of the 938 papers that we originally identified for potential inclusion, 37 studies met the eligibility criteria. One paper by Taku, Cann, Tedeschi, and Calhoun (2017) comprised two studies with distinct samples, accordingly, it was reported as two separate studies (i.e., Taku et al., 2017a; Taku et al., 2017b). All studies were appraised using the MMAT numerical scoring (see Tables 3 and 4). We removed one study (Gregory & Prana, 2013) from the review as we interpreted the research question could not be addressed with the data collected. The quality of the 36 final studies ranged from two (low) to six (high) (see Table 4).

**Participant Characteristics**

 **Sample Size.** Collectively across the 36 studies included, there were 2970 participants with a mean sample size of 82.44 (*SD =* 61.64). Collectively the quantitative studies comprised 2907 participants with a mean sample size of 90.84 (*SD =* 60.26). The qualitative studies ranged in sample size from seven to 27 participants (*M* = 15.25, *SD* = 7.69). Studies were categorized into those that sampled between 1 to 50 participants (*n* = 13), 51 to 100 participants (*n* = 13), 101 to 200 participants (*n* = 7), and 201 participants or more (*n* = 3).

 **Age and Gender.** Two studies provided age ranges (Hefferon, Grealy, & Mutrie, 2008; Singer et al., 2012) and 34 studies provided mean values, with an overall mean of 40.58 years (*SD* = 14.65) across studies. One study (Chaves, Vázquez, & Hervás, 2016) involved children. Eight hundred and twenty-six (28%) participants were male and 2144 (72%) were female.

 **Ethnicity.** Most of the studies (*n* = 24) provided information about participant ethnicity or national identity. Of these, the majority reported diversity in the study cohort despite a dominant group that reflected the country of study origin. Eight studies focused on one ethnicity (see Table 1). A more in-depth analysis was hindered by a lack of coherence in terminology used in respect of ethnicity, with some studies reporting on non-mutually exclusive groupings involving both ethnicity and national identity. For example, Lo et al. (2014) reported percentages of Caucasian and Canadian participants.

**Adversity.** The majority of the interventions (*n* = 28) targeted a specific type of adversity.(Table 1). One study (Roepke, Benson, Tsukayama, & Yaden, 2017) addressed a range of adversities that conformed to the criteria established through completion of the Life Events Checklist (LEC; Weathers, Blake, Schnurr, Kaloupek, Marx et al., 2013), and the remainder (*n* = 7) addressed a range of adversities that participants self-reported as traumatic (see Table 1). The majority (*n* = 29) of studies detailed the length of time since the adversity occurred.

**Study Characteristics**

**Study Design.** Twenty-two studies used a randomized controlled trial, whereby participants were randomly allocated to either the intervention or control conditions. Three studies used a quasi-experimental design with two experimental groups and one control group, whereas three studies used a quasi-experimental design that involved one intervention and control condition. Four studies adopted a single subject design where there was no control condition. Four studies used a retrospective or concurrent qualitative methodology to assess the intervention effects (see Table 1). Data was collected either through quantitative (i.e., questionnaires) and/or qualitative methods (i.e., interviews, participant observation) at various time points (see Table 1). Where the design included a follow-up assessment the follow-up data collection point ranged from three to 78 weeks (*M* = 21.73, *SD* = 19.56) post intervention. Thirty-two studies used standardized quantitative instruments; data was collected at two time points (i.e., pre-intervention, post-intervention; *n* = 13), three time points (i.e., pre-intervention, post-intervention, follow-up; *n* = 10), four time points (i.e., pre-intervention, post-intervention, two follow-up points; *n =* 8), and at five time points (i.e., pre-intervention, post-intervention, three follow-up points; *n* = 1). Qualitative studies collected data at one point (*n* = 1), two points (i.e., pre-intervention, post-event *n* = 2) and at five points (*n* = 1).

**Content.** The studies used different intervention strategies categorized as (see Table 5): cognitive-behavioral (*n* = 6), mindfulness (*n* = 3), psychoeducation (*n* = 6), disclosure (*n* = 8), social support (*n* = 4), sport and leisure (*n* = 5), and other (*n* = 5). Three studies were allocated to multiple categories as the interventions involved a comparison between different approaches. We allocated one study (Nijdam et al., 2018) to the same category twice as the study involved a comparison between different approaches.

**Duration and Delivery.** The duration of the interventions ranged from one day to 19 months, with an average of 9.79 weeks (*SD =* 16.12). Where a study presented a range in length (e.g., 8-12 weeks), the median of that intervention was used.Thirty-two studies were delivered face-to-face and four were online. Eleven studies reported on the training and/or competencies of the intervention facilitators (see Table 1).

**Outcome Measures.** Of the 25 studies (including Kallay and Baban [2008] which referred to multiple constructs) that referred to PTG, 22 (88%) measured growth using the PTGI (Tedeschi & Calhoun, 1996) or the PTGI-SF (Cann et al., 2010). One study (Stockton et al., 2014) used the PTGI-SF and the psychological well-being post-traumatic change questionnaire (PWB-PTCQ; Joseph et al., 2012), three studies utilized interviews, and two studies used the Stress-Related Growth Scale (SRGS; Park, Cohen, & Murch, 1996). Of the seven studies that referred to benefit finding, there was a lack of coherence about how the construct was measured (see Table 1). One study (Dolbier et al., 2010) referred to stress-related growth (SRG; Park et al., 1996), but used the PTGI. One study that referred to a context-specific form of growth (i.e., sport injury-related growth; Salim & Wadey, 2018), in the absence of a measurement tool for the concept, used the SRGS.

**Intervention Outcomes**

Of the 36 studies, 29 (80.5%) reported growth as an outcome of the intervention (i.e., significant statistical difference between groups, significant statistical difference between pre- and post-intervention scores, perceived growth from qualitative methods). They comprised all of the mindfulness studies (Carlson et al., 2016; Garland, Carlson, Cook, Lansdell & Speca, 2007; Victorson et al., 2017; Zhang et al., 2017), 83% of the cognitive-behavioral studies (Antoni et al., 2001; Knaevelsrud et al., 2010; McGregor et al., 2014; Penedo et al., 2006; Ye et al., 2017), 86% of the bespoke psychoeducation programs (Dolbier, Jaggars, & Steinhardt, 2010; Karagiorgou, et al., 2018; Ramos, Leal, & Tedeschi, 2016; Taku et al., 2017 a, b; Wagner et al., 2007), 75% of the social support studies (Carlson et al., 2016; Chiba et al., 2016; Morris et al., 2011), 78% of the disclosure studies (Hagenaars & van Minnen, 2010; Hijazi et al., 2014; Kallay & Baban, 2008; Roepke et al., 2017; Salim & Wadey, 2018; Slavin‐Spenny et al., 2011, Stockton et al., 2014), 60% of those studies that utilized sport or leisure (Garland et al., 2007; Hefferon et al., 2008; McDonough et al., 2011), and 100% of studies that could not be categorized that comprised wish-granting, brief eclectic psychotherapy (BEP), eye movement desensitization and reprocessing theory (EMDR), and individual therapy, narrative group psychotherapy (Chaves et al., 2016; Nijdam et al., 2018; Ruini et al., 2014; Salo et al., 2008).

Twenty quantitative studies presented significant differences (*p* < .05) between the experimental and control groups (cf. Jaarsma & Smith, 2018). However, their effect sizes, where reported, were variable (see Table 1) and none reported on how these effect sizes related to real world application. To elucidate, the studies either did not report the measure of effect size used (Salo et al., 2008), did not report effect sizes (Kallay & Baban, 2008; Karagiorgou et al., 2018; Penedo et al., 2006; Ramos et al., 2017; Stockton et al., 2014; Taku et al., 2017b), used omnibus effect sizes with scores ranging from .03 to .21 (i.e., η2 or η2p; Antoni et al., 2001; Chaves et al., 2016; Dolbier et al., 2010; Hagenaars & van Minnen, 2010; McGregor et al., 2014; Ruini, Masoni, Ottolini, & Ferrari, 2014; Salim & Wadey, 2018; Slavin‐Spenny et al., 2011; Taku et al., 2017a; Ye et al., 2017; Zhang et al., 2017) or Cohen’s *d* with scores ranging from 0.03 to 1.16 (Carlson et al., 2016; Garland et al., 2007; Hijazi et al., 2014; Nijdam et al., 2018; Roepke et al., 2017; Wagner et al., 2007). Given the positive directions of the effect sizes, the findings correspond with an effective intervention (i.e., increased growth in the treatment condition compared to the control condition). However, the size of the effects varied greatly between studies, thereby suggesting differences in the magnitude (i.e., how much) of growth experienced. That said, the findings are challenging to interpret because they correspond to self-report scales (e.g., what does an increase in scores from 10 and 15 on a PTGI subscale mean?) rather than actual behaviors or action-oriented growth (cf. Ivarsson et al., 2015). Furthermore, none of the authors interpreted the meaningfulness or practical significance of the effect size to help the reader understand them in terms of their real-world meaning (for our interpretations, see the discussion).

All four of the qualitative studies reported growth with Hefferon et al. (2008) reporting that: “the women [who were cancer survivors engaged in the physical activity intervention] regarded the class as a sort of ‘saviour’ and there was evidence to suggest that this type of group therapy facilitated PTG” (p. 38). Karagiorgou et al. (2018) interviewed four individuals who participated in a brief positive psychotherapy trial (PPT) and three who took part in a treatment as usual (TAU) condition. Although both groups reported positive changes, only those who took part in the PPT reported intent to adopt healthier behaviors; this was categorized as reflecting lifestyle improvements and new possibilities. In McDonough et al.’s (2011) study, PTG was identifiable in all domains but the number of participants who reported growth in each domain varied from 15 out of 17 participants (viz. appreciation of life; new possibilities) to only three (viz. spiritual growth). Morris et al. (2011) reported that “all participants reported positive life changes, or PTG . . . since being diagnosed with cancer and taking part in [the intervention]” (p. 670). These changes were reported across the five domains of PTG.

Contrary to hypotheses, some participants in the control groups also experienced growth. Zhang et al. (2017) identified that the Chinese breast cancer patients undergoing the usual care condition showed significant increases in PTG, whereas, Taku et al. (2017b), Gallagher et al. (2018), and Karagiorgou et al. (2018) identified higher levels of PTG in the control group than in the experimental condition. In the latter study, the authors acknowledged that it is possible that some of the positive themes discussed in their study (in both groups) may have reflected premorbid traits rather than growth per se. Seven studies did not report significant differences between groups in respect of growth (Bennett, Lundberg, Zabriskie, & Eggett, 2014; Gallagher et al., 2018; Liu & Kia-Keating, 2017; Lo et al., 2014; Salo et al., 2008; Singer et al., 2012; Zoellner et al., 2011) but collectively the studies provide further insight into the facilitation of growth. Bennett et al. (2014) speculated that growth was not observed in the cohort of PTSD sufferers as the recreation experience was sufficient to reduce PTSD in some participants but was not enough to facilitate PTG. Gallagher et al. (2018) reported that although PTG was not observed in an expressive writing condition, in fact there was a reduction in PTG from baseline with a small effect size. Interestingly, the cancer facts condition (established as a control comparison) was associated with higher levels of PTG lending some support for an education intervention. Despite reporting that there were no significant differences between two different writing groups (affirmation and expressive), qualitative open questions in Liu and Kia-Keating’s (2017) study suggested that participants’ perceptions about positive outcomes can be incoherent with PTG outcomes measured by standardized instruments. For example, despite the study reporting that the intervention did not appear to have significant effects on participants’ perceived levels of PTG (measured by the PTGI), one participant was reported as saying: “The questions have helped me to see meaning in what happened” (p. 12) suggesting that the participant was able to identify a positive impact of the intervention. Lo et al. (2014) reported on participants’ spiritual wellbeing in a CALM intervention and suggested that the effect was not robust (*p* = .06). Salo et al. (2008) reported no growth in individual therapy. Singer et al. (2012) found no difference in PTG between an art therapy intervention and control group after 22 weeks. They suggested their results may reflect shortcomings of the measurement approach that they employed, specifically, that the SRGS may not have been sensitive enough to measure positive changes in their participants. However, they argued that the SRGS, as a unidimensional instrument, is conceptually and empirically more valid than the PTGI (Joseph & Linley, 2006). The unidimensional aspect of the SRGS resonates with the inconsistent findings in Zoellner et al.’s (2011) study that identified PTG in specific domains.

**Antecedents and Durability of Growth.** Nine studies identified mechanisms that accounted for growth or were able to isolate moderators of growth. However, many studies speculated why growth may (or may not) have occurred. The need to speculate rather than be able to confidently identify why growth had occurred was often reported as a limitation of the studies. To illustrate, Hefferon et al. (2008) stated: “There is the challenge of determining whether it was the class or simply the activity that influenced experience of growth” (p. 38), and in discussing their findings, McDonough et al. (2011) stated their findings from breast cancer survivors engaging in dragon boating “reinforce the roles of social relationships and support as possible mechanisms in the development of posttraumatic growth” (p. 645). Of those studies that were able to isolate the mechanisms and/or moderators that contributed to growth, two studies (Antoni et al., 2001; Hijazi et al., 2014) provided evidence that emotional processing directly promoted growth and two studies (Kallay & Baban, 2008; Salim & Wadey, 2018) attributed growth to emotional disclosure and cognitive processing. Specifically, Salim and Wadey (2018) suggested that verbal disclosure, measured by: (a) an increase in cognitive mechanism words, (b) an increase in positive emotions, and (c) a decrease in negative emotions, was the mechanism through which growth occurred in injured athletes who were low in hardiness. Stockton et al. (2014), who found increased levels of PTG when measured by the PWB-PTCQ but not the PTGI-SF, suggested that increased insight words demonstrating a coherent narrative, were instrumental in the realization of PTG. One study (Ramos et al., 2017) identified that challenge to core beliefs and subsequent intrusive rumination moderated the development of PTG, and Ye et al. (2018) identified that problem-focused (adaptive) coping mediated the development of PTG (but were only able to speculate on why this was the case). Finally, Knaevelsrud et al. (2010) found a significant positive relationship between optimism and growth, and Dolbier et al. (2010) identified personal characteristics of self-esteem and self-leadership and the coping category of hopeful coping as being related to greater growth.

Of the studies that reported growth, and included a follow-up assessment, most identified that the differences between the conditions were maintained over time. However, several suggested significant changes over time that were contradictory. Specifically, Antoni et al. (2011) reported that Cognitive Behavioral Stress Management (CBSM) intervention participants had higher benefit scores than controls at the post treatment assessment, but that the difference had faded by the 9-month follow-up. Conversely, Victorson et al. (2017) found their mindfulness group demonstrated significant within group improvements in PTG, which increased longitudinally (see Table 1).

**Discussion**

The aim of this study was to facilitate knowledge transfer from other psychology disciplines by systematically reviewing intervention studies that aim to foster growth following adversity. Given the current landscape of research in sport and exercise psychology (cf. Howells et al., 2017), minimal interventions to facilitate growth in athletes (Salim & Wadey, 2018), and the repeated calls for intervention studies, this study is timely as the findings from the review address two critical issues. The first involves identifying what sport and exercise psychology researchers can learn from existing published interventions in growth following adversity to help inform future growth intervention research in sport. The second relates to identifying the genuine unknowns that can inform future research in both our discipline and the wider psychology disciplines.

**What Lessons can we Learn?**

We identified several lessons as a result of the systematic review that can help to inform future research in sport and exercise psychology: (a) growth can be facilitated through a range of different interventions, (b) growth can have different trajectories, and (c) growth is a multidimensional phenomenon. The first lesson from this systematic review is that growth following adversity can be facilitated. Preliminary support is offered from the studies reviewed for several intervention strategies (i.e., mindfulness, psychoeducation, emotional disclosure, social support, sport and exercise, eye movement desensitization and reprocessing therapy; see Table 1). This is encouraging as it provides a “persuasive narrative of hope” (Howells et al., 2017, p. 151) for athletes who experience adversity. Further, this finding provides the basis for future research in this area to inform professional practice (cf. Wadey et al., 2018). However, two caveats to this lesson are that many of the studies reviewed did not report the practical significance and meaning of an increase in growth and the studies also had several methodological shortcomings. Therefore, researchers and practitioners should interpret this lesson with caution.

 To expand, the outcome measures used were self-report scales such as the PTGI; therefore, does a change in the numbers on a questionnaire pre-to-post-intervention translate into meaningful change? One of the reasons why many of the studies in this review were not able to address this issue was because they did not report effect sizes or reported “empty effect sizes” (Ivarsson et al., 2015, p. 453). Future research, therefore, should aim to use meaningful metrics in intervention studies. Ivarsson et al. (2015) suggested that reporting an effect size without interpretation adds, in principle, little to the results and encouraged future researchers to interpret effect sizes in terms of their real-world meaning. Tedeschi et al. (2018) argued that: “there are various ways of approaching the interpretation of responses to the PTGI and associated measures depending on the purposes of the research” (p. 95). Researchers could interpret effect sizes in respect of the magnitude of change; that is some changes may be transformative suggesting evidence of constructive growth, whereas others may represent small changes that may be representative of illusory growth (cf. Zoellner & Maercker, 2006). In this review some studies reported low effect sizes, which may indicate less transformative growth (e.g., SRG) involving individuals regressing to old habits. Those studies that reported high effect sizes, could indicate more radical and veridical positive transformation that is enduring and is representative of Tedeschi and Calhoun’s (2004) conceptualization of PTG.

 The studies that we reviewed also had several other methodological shortcomings. First, many of the intervention studies employed analyses that compared growth scores between the experimental and control groups. One problem with between-person analyses is the omission of within-person variation. To detect such variation, future research could use analyses such as latent growth modelling (Wang, Shen, & Boye, 2012). Second, the studies relied on one method of assessment of growth (e.g., self-report questionnaires). Future research should aim to adopt several methods of assessment (e.g., questionnaires, surveys, interviews, observations, experience sampling, neurological indicators, biological markers) to provide a more nuanced understanding of growth. This might involve extending the sample to include significant others (e.g., friends, family, teammates) who could provide additional insights. Finally, future quantitative intervention studies could improve on the validity and reliability of previous research by using randomization, blinded trials (or providing more information on these processes), and meaningful metrics, as well as ensure congruence between the conceptualization and operationalization of growth (e.g., using the PTGI for PTG). Qualitative studies could safeguard rigor by engaging in reflexivity and employing methods such as member reflections (Smith, 2018).

The second lesson is that there are different trajectories of growth. The studies in this systematic review that conducted follow-up assessments using validated instruments (e.g., PTGI) showed that growth remained stable, declined, or increased over time. One interpretation of this finding is that the studies that identified growth remained stable over time promoted transformative, enduring change, for example, in how the participants related to others (e.g., Hagenaars & van Minnen, 2010). Those that increased over time reflect the ongoing temporal process of growth. In contrast, those that declined promoted less transformative and more fleeting positive change (cf. Tedeschi et al., 2018) and may be indicative of illusory growth (cf. Zoellner & Maercker, 2006). To account for this finding, it is important that sport and exercise psychology researchers use longitudinal, repeated measures designs to examine interventions designed to promote adversarial growth in athletes. The third lesson is that it is also important that future research accounts for the multidimensional nature of growth in their measurement. Some of the interventions did not result in an increase in all the dimensions of growth (see Table 1); therefore, future research should be clear from the outset what dimensions of growth the intervention aims to foster.

**What are the Genuine Unknowns?**

Rather than sport and exercise psychologists replicating the studies identified in this review with athletes to answer ‘safe’ research questions that are limited in their scope and contribution beyond existing research from other disciplines, this review identifies genuine unknowns that could enable researchers to make a more substantive contribution to our knowledge and understanding. To this end, the identified genuine unknowns are the: (a) establishment of the extent to which the findings are transferable to the sport and exercise population; (b) exploration of novel types of growth; (c) identification of mediators and moderators of growth; (d) movement beyond the individual (i.e., an intrapersonal level of analysis); and (e) accounting for cultural variations. One of the first unknowns is that we cannot be certain that the findings from the wider literature will be transferable to sport and exercise participants. The participants in the reviewed studies encountered traumatic experiences such as cancer, however, we argue that athletes and exercise participants are not exempt from the misfortunes and hardships of life; they are human beings first and foremost. Beyond the adversities, we cannot be sure what strategies (e.g., mindfulness, cognitive behavioral therapy) will be of most value to athletes. Thus, we encourage researchers to design interventions that comprise multiple strategies to identify those that are most suited to an athletic population.

The reviewed studies did not address novel growth dimensions. To expand, the interventions took a cerebral approach rather than, for example, an embodied perspective, and over-relied on the PTGI. In a qualitative meta-synthesis of the growth literature on life-threatening physical illnesses, Hefferon et al. (2009) suggested a new domain of growth: new awareness of the body. This focus on the physical has also been addressed in respect to the measurement of growth. Walsh, Groarke, Morrison, Durkan, Rogers, et al. (2018) recently developed a new measure of growth: Physical Post Traumatic Growth Inventory (P-PTGI). In light of research that indicated that athletes have reported physical indicators of growth following adversity (e.g., physically stronger, increased fitness; Howells et al., 2017), future sport and exercise psychology researchers could design interventions to foster this dimension of growth. Another unknown is that many of the interventions did not address *when* or *for whom* (i.e., moderators) nor *how* or *why* (i.e., mediators) the interventions led to increased growth. This focus warrants further exploration. Researchers should also be cognizant of what level(s) the theory operates at (e.g., intra, inter, group, organizational, national, international). Research on growth and specifically, the intervention studies reviewed, was focused primarily at an individual (psychological) level and has targeted intraindividual dimensions measured by the PTGI (e.g., personal strength, appreciation of life). Future researchers in sport and exercise psychology should consider whether the concept of growth can operate at other levels. These avenues represent exciting and unchartered waters for future intervention research in sport and exercise.

A final unknown is how the meaning and understanding of growth may vary across cultures. A limitation of many of the studies in this review was that they did not report the ethnicity of the study population. Although it was encouraging that many of the studies emanated from different countries, what was also not clear was how the interventions were culturally defined. Given that many researchers have pointed to the importance of taking culture into consideration when describing and explaining growth (Weiss & Berger, 2010) and that cultural diversity is an important challenge faced by sport and exercise psychologists (Ryba, Stambulova, Si, & Schinke, 2013), it is critical that future research moves beyond the “universal” athlete. For example, Americans have been shown to report higher levels of growth compared to Japanese, Australian, and Spanish samples. Furthermore, the indicators of growth might be different between cultures. Furthermore, engagement in competitive sport requires socialization into a micro-culture of sport and the internalization of specific norms, values, and behaviors (Hanrahan, 2010). Athletes who experience adversity and challenges are culturally expected to narrate their experiences in certain ways and this can impact on their perceptions of adversity and the development of growth. That said, these cultural variations have not been accounted for in interventions studies thus far and represent an important area of future research in sport and exercise psychology.

**Limitations**

This systematic review had a specific focus on interventions designed to facilitate growth. Its scope meant that studies with an alternative aim, such as those involving healing trauma through EDMR, or those that tangentially identified growth were excluded. This exclusion could have potentially discounted strategies that could facilitate growth. For those studies that did meet the inclusion criteria we went beyond an erroneous identification of intervention effectiveness as constituting a significant difference between the experimental and control group. Although we identified effect sizes reported in the studies, we found that many did not sufficiently “interpret what they mean in the real world” (Ivarsson et al., 2015, p. 449). Furthermore, we are cognizant of a publication bias that means that potentially non-significant and ineffective interventions may not have been published and therefore excluded from this review. In respect of the transferability of the findings, the participants in this review were diverse both in their characteristics and in the adversities that they experienced; accordingly, the findings have relevance to an athletic population. Nevertheless, although athletes are susceptible to the same adversities experienced by the wider population, athletes may experience other adversities that are contextually unique (e.g., a career ending injury), and elite athletes in particular, have different motivations for participation, different psychological responses to competition (e.g., Collins et al., 2016; Hardy et al., 2017), and may experience adversity in different ways to non-elite athletes (e.g., Anderson, Hanrahan, & Mallet, 2014). Accordingly, we should be cautious about the extent to which the findings can inform interventions in sport and exercise psychology.

**Conclusion**

To conclude, it is hoped that in synthesizing existing empirical intervention research this systematic review provides a springboard to enhance the quality of future intervention research and professional practice to help foster growth in athletes who have experienced adversity. That said, we end this systematic review on a cautionary note. Some studies in this systematic review did identify that participants may experience re-traumatization during interventions (although no authors explicitly identified this as having been the case in their studies). Future researchers should aim to put appropriate safeguards in place to ensure that the well-being of participants is at the forefront of research and practice.

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Potentially relevant papers gathered from initial searches (*N =* 938)

Abstracts reviewed

(*n =* 180))

Papers rejected at full paper (*n =* 56)

Rationale for exclusion:

Intervention not aimed at promoting growth (*n =* 32)

The sample population did not focus on those who have experienced trauma (*n* *=* 13)

Not an intervention-based study (*n =* 11)

Abstract from conference proceeding (*N =* 1)

Article was not available in English (*N =* 1)

The article was a reply to another paper, not an intervention (*N =* 1)

Papers rejected at title (*n =* 758)

Papers rejected at abstract (*n =* 86)

Rationale for exclusion:

Article was a discussion of theories and not an intervention (*n =* 41)

Intervention not aimed at promoting growth (*n =* 38)

Not an intervention-based study (*n* = 8)

The sample population did not focus on those who have experienced trauma (*N =* 8)

Not an intervention-based study (*N =* 8)

Book (*N =* 1)

Duplicate study (*N =* 2)

Full papers reviewed

(*n =* 93)

)

Paper rejected at MMAT quality assessment (*n =* 1)

Full papers included

(*n =* 37)

Full papers analysed

(*n =* 36)

*Figure 1.*

*PRISMA Diagram of the Stages of the Systematic Review*

Table 1

*Summary of Studies Included in the Review*

| **Author(s) and Year** | **Sample size (M/F)** | **Age****(SD)****[Range]** | **Adversity** | **Design** | **Duration****(Time points)** | **Measures** | **Data Analysis** | **Growth Findings** | **Significance and effect size** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Antoni et al. (2001) | 100 (0/100) | 50.23(9.15)[29-79] | Early Stage Breast Cancer | RCT | 10 weeks(4) | POMS; CES-D;IES;LOT-R; BF (author designed) Emotional processing Trained facilitators | Factor analysis; Mixed effect ordinal regression analysis; MIXOR analysis | Increased participants’ BF. Remained significantly elevated at 3 months follow-up. Greatest impact on those women who were lowest in optimism at baseline | Intervention *F* (3, 138) = 12.36, *p* < .001, η2 = .21Intervention vs ControlInitial → Post: *F*(l, 99) = 4.69, *p* < .04, η2 = .053 months follow-up: *F*(l, 99) = 3.28, *p* = .07, η2 = .039 months: (*F* = 1.58, ns). |
| Bennett et al. (2014) | 34 (17/17) | 36.59-- | Varied | Quasi-experimental | 5 days(2) | RDAS; PCL-M/C; PTGITrained facilitators | Statistical Analysis Systems (SAS); Descriptive statistics; ANOVA; ANCOVA (using pretest scores as a covariate) | No significant outcomes for growth | No significant changes were observed on the pretest and posttest scores using thePTGI for Group A (M = -.37, *SE =* 3.76, í(15) = -.10, *p* = .922), Group B (M =-2.64, *SE =* 3.43, f(15) = -.77, *p* = 453), or the Control Group (M = -4.63, *SE* = 3.43, i(15) = -1.35, *p =* .197) |
| Carlson et al. (2016) | 252 (0/252) | 54.66(10.02)- | Breast cancer | RCT | 12 weeks(4) | Mindfulness:POMS, SOSI, FACT-B, MOS-SSS, FACIT-Sp, PTGI-RSET: POMS, SOSI, FACT-B, MOS-SSS, FACIT-Sp, PTGI-R | Descriptive statistics (demographics); SAS; Two-level piecewise hierarchical linear modelling with random intercepts | PTGI-R scores improved during the intervention period in both groups. The full impact of MBCR on the ability to appreciate life, find meaning and purpose and see new possibilities developed slowly over time. SET had less benefit to breast cancer survivors  | PTGI-R InterventionGroup x Time*p* = .02*d* = .26Follow-up Group x Time*p* = .03 |
| Chaves et al. (2016) | 78(45/33) | 11.68(3.39)[5-18] | Severe Physical Illness | RCT | 1 session(2) | PNES, SLSS, BMSLSS, PedsQoL, BFSC, BBWS, YLOT, VIA-Y, PedsQoL, CESD-7, Medical status | Chi-squared and t-tests; repeated measures mixed between-within subject ANOVAs; repeated measures ANCOVAs; univariate *F* tests | Higher levels of BF in those children in the wish-making condition | BFSC *F* = 1.54 η2p = .03 |
| Chiba et al. (2015)  | 31 (21/10)[[1]](#footnote-1) | 41.17-[23-64] | Chronic mental illness | RCT | 8 weeks(2) | SISR-A, Kessler 6Trained facilitators | Content analysis | Of the 31 participants, 23 responded that they realized some sort of BF through the intervention. | Testing for statistical significance between the results for the two groups was not completed due to the small sample size. |
| Dolbier et al.(2010) | 64(10/74) | 21 (median)-[18-53] | Most stressful event | RCT | 4 weeks(2) | PTGI, CD-RISC, Rosenberg Self-Esteem Scale, Self-Leadership Scale, CES-D, Social Provisions Scale | Multiple regression, 2 x 2 repeated measures ANOVA | A significant group by time interaction for total growth: the intervention group showed greater increases in PTG pre- to post-intervention compared with the control group. | Group x Time interaction for the total growth scale (η2 = .09; growth subscales, appreciation of life (η2 = .10), personal strength(η2 = .08), new possibilities (η2 = .06); relating to others and spiritual change (each η2 = .01). |
| Gallagher et al. (2018) | 96 (0/96) | 54.54(7.91)- | Breast cancer | RCT | 3 weeks(5) | PTGI, PSS-SR | Latent growth curve modelling | Breast cancer survivors did not experience a clinically significant improvement in PTG. The cancer facts condition resulted in superior outcomes for PTG. | The effect size magnitude of the decrease in PTG was small (ESsg = −.16;95% CI −.03: −.28), but statistically significant based on the confidence interval of the effect size. |
| Garland et al.(2007) | 104(9/95) | 52.45-[26-79] | Cancer | Quasi-experimental | 6-8 weeks(2) | PTGI-R, FACIT-Sp12 SOSI, POMS | T-tests, chi-squared test, repeated measures ANOVA, Pearson product-moment correlations | Both MBSR and creative arts (HA) programs improved significantly over time on PTG. Increased PTG was positively related to increased spirituality in the MBSR program, but not the HA program. | Pre →post PTGI-R (total)HA (Cohen’s *d* = .09); MBSR (Cohen’s *d* = .28) Increased spirituality (*r* = .285, *p* =.028) in MBSR. |
| Hagenaars & van Minnen (2010) | 80 (18/62) | 35.7(11.7)- | PTSD from mixed traumas | Single subject | 8-12 weeks(2) | SCID-I, SCID-II, PSS-SR, PTGITrained facilitators | ANOVAs, bivariate correlations, hierarchical regression analyses | Increases in PTG (but not Appreciation for Life). | Pre → post*F* (1, 64) = 8.39, *p* < .01, η2p = .14. Significant for: Relating to Others, *F* (1, 64) = 6.35, *p* < .05, η2p = .12New Possibilities, *F* (1, 64) = 8.84, *p* < .01, η2p = .16Personal Strength*, F* (1, 64) = 8.37, *p* < .01, η2p = .15 |
| Hefferon et al. (2008) | 10 (0/10) | [43-63] | Breast cancer | Qualitative (IPA) | 12 weeks(1) | Individual open-ended interview | Interpretative Phenomenological Analysis | Increases in PTG (especially Appreciation for Life). | N/A |
| Hijazi et al. (2014) | 63 (28/35) | 48.2(8.9)- | Refugees suffering from post-traumatic stress | RCT | 3 weeks(4) | PTGI, WHO-5, HTQ, BDI, PHQ-15 | Mixed design(between-within) repeated measures analyses of variance (RM-ANOVA) | Compared to waitlist controls, NET increased PTG 2 and 4 months later, with medium to large effects. | PTG effect at 2 months *d* = 0.234 months *d* = .52Interaction (Condition x Time) between condition at 2 months *ES* = .48 and at 4 months *ES* = .83(*ES* was calculated as ((Brief NET follow-up *M* − baseline *M*) − (control follow-up *M* − baseline *M*)) / *SD* of the pooled changeScores). |
| Kallay & Baban (2008) | 82 (0/82) | 50.09-[41-55] | Cancer | Single subject | 4 days(3) | BDI, POMS, LRI, SRGS | Paired samples t-test  | Participants experienced at the follow-up assessment significantly higher levels BF. | Intervention (meaning in life) *t* = - 3.60 at *p*  < .01, BF *t* = - 2.60 at *p* < .01. |
| Karagiorgou et al. (2018) | 7(5/2) | 60.57(7.96)- | Acquired Brain Injury | Qualitative (Thematic Analysis) | 8 sessions(1) | PTGI | Thematic Analysis | Growth in both but lifestyle improvements and new possibilities were only evident in the PPT group | N/A |
| Knaevelsrud et al. (2010) | 96 (9/87) | 35-[18-68] | PTSD  | RCT | 5 weeks(3) | IES-R, BSI, PTGI, LOT-R, NEO-PI-R | ANOVAs, Regression analysis | Significant changes in PTG in the treatment group.  | Difference between groups*F* = 11.34, *p* < .001. |
| Liu & Kia-Keating (2017) | 39 (9/30) | 20.7-- | Exposed to Isla Vista Tragedy  | RCT | 4 days(3) | CSE, PTGI-SF, PCL-C, BTQ | ANOVAs, pairwise comparisons with Bonferroni adjustment, bivariate correlations | No significant effects on participants’ perceived levels of PTG | There was no significantchange in PTG across time in either group: PTG × Group *F =* 0.07, *η2p* = < .01 |
| Lo et al. (2014) | 41 (10/31) | 52(12)- | Advanced Cancer | Single subject | 6 months(4) | PHQ-9, FACIT-Sp-12, DADDS, ECR-M16, PTGITrained facilitators | Multilevel modelling | Spiritual wellbeing was found to increase. No significant changes in growth | Regression estimates of the effect of time on PTG, *p = .*57 |
| McDonough et al. (2011) | 17 (0/17) | 51.4(11.09)- | Breast cancer survivors | Qualitative (IPA) | 19 months(5) | Multiple semi-structured interviews | IPA | Progressive improvements in social relationships, support, and PTG | N/A |
| McGregor et al. (2014) | 29 (0/29) | 47.52(6.39)- | Breast cancer | RCT | 10 weeks(3) | Immune measures, perceived benefits, distress | ANCOVAs and hierarchical regression analysis | Women who took part in the CBSM intervention reported increases in BF from having been diagnosed with breast cancer. | Group x Time T1 to T2 [*F* (1,26) = 4.69, *p* < .05, η2 = .15]. T1 to T2 CBSM group *t* (17) = 2.95, *p*  < .01, 95% CI = 0.13–1.07.  |
| Morris et al. (2011) | 27 (0/27) | 49.82(7.04)- | Breast cancer | Qualitative (IPA and Thematic Analysis) | 10 days(2) | Participant observation, Semi-structured interviews, written narratives | IPA, Thematic Analysis | PTG was reported by all participants. | N/A |
| Nijdam et al. (2018) | 116 (55/61) | 38.53(11.33)- | Diagnosis of PTSD from a single traumatic event | RCT | *M =* 6.65 weeks (*SD =* 4.24)(3) | PTGI, SCID-I/P, IES-R | Independent sample t-tests, Mann-Whitney U tests; Chi-square tests and Fisher's. Pearson's r correlations Spearman's rho correlations  | Significant increases in PTG with medium to large effect sizes.  | Baseline →2nd post assessmentPTGI *F* (1, 77) = .06, *p* = .809, *d* = .056PTGI relating to others *F* (1, 77) = .37, *p* = .547, *d* = .138PTGI new possibilities*F* (1, 77) = .63, *p* = .432, *d* = .18PTGI personal strength *F* (1, 77) = .05, *p* = .818, *d* = .051PTGI spiritual change *F* (1, 77) = 2.23, *p* = .139, *d* = .339PTGI appreciation of life *F* (1, 77) = .02, *p* = .883, *d* = .032 |
| Penedo et al. (2006) | 191 (191/0) | 65.1(7.7)- | Localized prostate cancer | RCT | 10 weeks(3) | Measure of Current Status, FACT-G, PCSTrained facilitators | Bivariate correlations and ANOVAs | The CBSM condition led to increases in BF. | CBSM was a significant predictor of post intervention BF (*F* for ΔR2 = 5.52, *p* < .05)Pre→post (experimental) Increases in BF (*t* = 2.65, *p* < .01), PSMS (*t* = 3.35, *p* < .01)  |
| Ramos et al. (2017) | 205 (0/205) | 54.31(9.98)- | Breast cancer | RCT | 8 weeks(4) | PTGI, CBI, ERRI | Descriptive statistics and Pearson correlations, Latent Growth Modelling (LGM), ANCOVA | The intervention group had higher levels of PTG when compared with the control group. There was inter-individual variability in the rate of growth. | PTG over timeThe mean of the slope (v) = .15, (z = 1.79, *p* = .073). PTG T1 to T3. (*v* = .39, SE = .14, *z* = 2.72, *p* = .006)  |
| Roepke et al. (2017) | 188 (22/146) | 42.79(12.71)- | Adversity that conformed to LEC within last 6 months  | RCT | 4 weeks(4) | LEC, S-PCL-C, PTGI, C-PTGI, DOQ, CES-D, SWLS | Hierarchical linear modeling and response profile analysis, Latent Growth Curve Modeling  | Those who engaged in prospective writing experienced greater current-standing PTG over time compared to both control groups.  | Effect sizes (Cohen’s *d*) were 0.03 and 0.16 at posttest and 0.28 and 0.46 at follow-up |
| Ruini et al.(2014) | 21(0/21) | 39.33(11.51)- | Adjustment disorder following various stress and difficulties | Single subject (with qualitative social validation) | 7 weeks(2) | PTGI, PWB, SQ, Focus groups for social validation | General linear model | Participants reported increased personal growth, an enhanced sense of appreciation of life and personal strength. | Significant effect of intervention (*F*(12, 9) = 8.406, *p* = .002, *η*2p = .918 |
| Salim & Wadey (2018) | 45 (28/17) | 23.3 (5.22)- | Sport related injury  | Quasi-experimental (with qualitative social validation) | 4 weeks(3) | SRGS, Social validation interviews | Mixed deign ANOVAs, Bonferroni-corrected pairwise comparison tests, Linguistic Inquiry and word count | Findings support the efficacy of VD to promote growth in athletes’ low in hardiness. The VD group reported significantly more growth than both the WD and control groups | Group × Time interaction (Wilks’s *λ =* .34, *F* [4, 82] = 14.51, *p =* .00, *η*2p = .41). T2 and T3 increased growth (*ps <* .05)Between groups (F [1, 42] = 3.38, *p =* .04, *η*2p = .14). Between the VD Group and control group (*p* = .04) |
| Salo et al. (2008) | 115 (115/0) | 30.99(6.25)- | Ex political prisoners | Quasi-experimental | 12 months(2) | HTQ, somatic symptoms survey, PTGI, traumatic experiences, self and other representations, and the contents of representationsTrained facilitators | Descriptive statistics, within-subject MANOVAs | Only individual treatment was effective in increasing PTG. | PTGI change (*F* = 1.70, *ES* = .03) |
| Singer et al. (2012) | 165 (88/77) | --[18- > 55] | Hematological malignancy patients | Quasi-experimental | 22 weeks(2) | SRGS, German Questionnaire for Social Support | Descriptive statistics, ANCOVAs | No evidence of PTG. | Intervention x control group *F* = 1.61, *p = .*21 |
| Slavin‐Spenny et al. (2011) | 193(35/158) | 22(5.5)- | Unresolved stressful experiences | RCT | 1 day(2) | PTGI, IES-R, BSI, Physical Health Symptoms Questionnaire  | ANOVA, chi-squares, ANCOVAs | Disclosure leads to PTG but different types of disclosure have similar effects  | Disclosure led to significantly higher PTGI total score*F* (1, 190) = 8.69, *p* = .004, pη2 = .04Disclosure led to significantly higher scores on 4 sub-scales:New possibilities: *F* (1, 190) = 10.84, *p* = .001, pη2 = .05Relating to Others: *F* (1, 190) = 7.70, *p* = .006, pη2 = .04Personal Strength: *F* (1, 190) = 5.58, *p* = .019, pη2 = .03Appreciation of life: *F* (1, 190) = 7.25, *p* = .008, pη2 = .04Spiritual change unaffected by disclosure: *F* (1, 190) = 0.53, *p* = .47, pη2 = .00 |
| Stockton et al. (2014) | 24(1/23) | 33.18(12.31)[19-36] | Traumatic events | RCT | -(3) | IES-R, PTGI-SF, PWB-PTCQ, EEM | Independent samples t-tests, chi-squared tests | PTG significantly increased from baseline to 8-week follow-up in the expressive writing group but not in the control group. | No significant difference between groups on PTGI-SF:*t* = -0.065, *p* = .949Significant differences between groups on PWB—PTCQ:*t* = -2.490, *p* =.022 |
| Taku et al. (2017) – Study 1 | 67 (0/67) | 17.12 (1.25)- | A traumatic event in the last 3 years (unspecified) | Quasi-experimental | -(2) | PTGI | 2-way mixed ANOVA | Participating in the intervention fostered adolescents’ PTG perceptions and knowledge. | A main effect of Time *F* (1, 65) = 11.84, *p* = .001, *η*2p = .15. T2 (*M* = 2.28, SE = .11, 95% CI = [2.07, 2.49]) vs T1 (*M* = 2.02, SE = .10, 95% CI = [1.81, 2.23])*F* (1, 65) = 6.24, *p* = .015, *η*2p = .09.  |
| Taku et al. (2017) – Study 2 | 136 (53/83) | 16.18(.40)- | A traumatic event in the last 3 years (unspecified | RCT | -(2) | PTGI | 2-way mixed ANOVA | Participating in the PTG intervention program fostered PTG perceptions three weeks later, compared to participation in a program focusing on negative changes or PTSD. Those who were in the control group showed a higher level of PTG at Time 2. | ExperimentalGroup 1 (*M =* 2.32, SE = .13, 95% CI = [2.06, 2.58]) and the Control Group (*M =* 2.21, SE = .13, 95% CI = [1.96, 2.46]) showed higher PTG than Experimental Group 2 (*M =* 1.83, SE = .13, 95% CI = [1.58, 2.08]) at Time 2 |
| Victorson et al. (2017) | 43 (43/0) | 70.19(6.84)[57-83] | Men diagnosed with low-risk localized prostate cancer | RCT | 8 weeks(4) | MAX-PC, PTGI, IUS, MAAS, PGH-10, | Chi-squared and t-tests, regression analysis | PTG was the only outcome to demonstrate significant and robust increases over the 12-month period for participants in the mindfulness arm, compared with those in the control arm. | Mindfulness (increased) between baseline and 8 week (*p* = .01; *ES* = .43), baseline and 6 months (*p* < .05; ES = .41), and baseline and 12 months *p* < .01; *ES* = .72).Between groups (*p* = .01; *ES* = .73). PTGI subscales: relating to others (*p* = .03; *d* = .55) and personal strength (*p* < .01; *d* = .80). |
| Wagner et al. (2007) | 51 (4/47) | 37.59(10.42)- | Individuals with complicated grief. | RCT | 5 weeks(4) | PTGI-SF, LOT-R, IES, SCL-90, SF-12, measures of complicated grief and psychopathological outcomesTrained facilitators | Repeated measures ANOVAs | PTG increased with the treatment group. | Group x Time interaction for PTG (PTGI), *F* (1, 47) = 13.23, *p* < .001, *d* = 1.16. |
| Ye et al. (2017) | 60 (0/60) | 27.45(3.25)- | Young HIV-infected Chinese MSM | RCT | 4 weeks(2) | WCC, PTGI, IES, interviews (in preparation phase)Trained facilitators | Chi-squared, ANOVAs, Mediation analysis | Enhanced the level of PTG. | Significant Group × Time interaction effects occurred for PTG (*F* [1, 58] = 4.28,*p* < .05, η2 = .07). |
| Zhang et al. (2017) | 60 (0/60) | 47.34(7.01)- | Breast cancer | RCT(3) | 8 weeks(3) | CPTGI, STAI, CPSSTrained facilitators | ANOVA | Significantly improved level of PTG but both groups showed improvements in PTG.  | Group x Time interaction of the PTGI total score (*F* = 34.73, *p* = .00, η2 = .38) |
| Zoellner et al. (2011) | 40 (10/30) | 41.2(10.7)- | Severe motor vehicle accident survivors with PTSD | RCT(3) | 8-12 weeks(3) | ISS, trauma severity survey, CAPS, PTGI, LOT-R, NEO-PI-RTrained facilitators | Two-way repeated measures ANOVAs | There was no evidence of a significant treatment effect on overall PTG and only a small effect size. | Effect sizes: The CBT group, medium size increase in new possibilities (*d* = .42) and personal strength (*d* = .69). The WLC group, medium size increase in spiritual change (*d* = .53). Small decrease in appreciation of life for both groups (*d* = .19 and −.26). |

Table 2

*Abbreviations and Measures used in the Interventions*

|  |  |
| --- | --- |
| Abbreviation  | Measure |
| BBWS  | Beliefs in the Benevolence of the World Scale |
| BDI  | Beck Depression Inventory |
| BFSC  | Benefit Finding Scale for Children |
| BMSLSS  | Brief Multidimensional Students’ Life Satisfaction Scale |
| BSI  | Brief Symptom Inventory |
| BTQ  | Brief Trauma Questionnaire  |
| CAPS  | Clinician-Administered PTSD Scale |
| CBI  | The Brief Cancer Behavior Inventory |
| CD-RISCCES-DCPSSCPTGIC-PTGI  | Connor-Davidson Resilience ScaleCenter for Epidemiologic Studies-Depression ScaleChinese Version of the Perceived Stress ScaleChinese version of the Post-Traumatic Growth InventoryCurrent Standing Post-Traumatic Growth Inventory |
| CSE  | Coping Self Efficacy |
| DADDSDOQ  | Death and Dying Distress ScaleDoors Opening Questionnaire  |
| ECR-M16EEMERRI  | Modified Experiences in Close RelationshipsEssay Evaluation MeasureEvent Related Rumination Inventory |
| FACIT-Sp-12  | Functional Assessment of Chronic Illness Therapy- Spiritual Well-Being Scale |
| FACT-B/G  | The Functional Analysis of Cancer Therapy |
| HTQ  | Harvard Trauma Questionnaire |
| IES (-R) | Impact of Events Scale (-Revised) |
| ISSIUS  | Injury Severity ScoreIntolerance of Uncertainty Short Form |
| LEC  | Life Events Checklist |
| LOT-R  | Life-Orientation Test-Revised |
| LRIMAASMAX-PC  | Life Regard IndexMindful Attention Awareness ScaleMemorial Anxiety Scale for Prostate Cancer |
| NEO-PI-R  | Openness to Experience Scale of the NEO Personality Inventory Revised |
| PCL-M/CPCS  | PTSD Checklist, Military/Civilian VersionPositive Contributions Scale |
| PedsQoL PGH-10  | Pediatric Quality of Life ScalePROMIS Global Health-10 |
| PHQ-15 / 9  | Patient Health Questionnaire |
| PNES  | Positive and Negative Emotional Style Scale |
| POMS  | Profile of Mood States |
| PROMIS  | Patient-Reported Outcomes Measurement Information System |
| PSS-SR  | Posttraumatic Stress Symptom Scale, Self-Report |
| PTGI (-SF)PWB-PTCQ | Post-Traumatic Growth Inventory (-Short Form)Psychological Well-Being Post-Traumatic Changes Questionnaire  |
| RDAS SCID-I/P/IISCL-90  | Revised Dyadic Adjustment ScaleStructured Clinical Interview for DSM-IV DisordersBrief Symptom Inventory |
| SF-12  | Health Survey Short Form- 12 version 2 |
| SISR-A  | Self-Identified Stage of Recovery- Part A |
| SLSS  | Student Life Satisfaction Scale |
| SOSI SQ  | Symptoms of Stress InventorySymptom Questionnaire |
| SRGS  | Stress-Related Growth Scale |
| STAI SWLS  | State-Trait Anxiety InventorySatisfaction with Life Scale |
| VIA-Y  | Values in Action Inventory of Character Strengths for Youth |
| WCC  | Ways of Coping Checklist-Revised |
| WHO-5  | World Health Organization Well-Being Index-Arabic translation |
| YLOT  | Youth Life Orientation Test |

Table 3

*Mixed Methods Appraisal Tool (MMAT) Criteria for Assessing Studies*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| MMAT - Screening questions (for all types) | Qualitative | Quantitative (randomized controlled trials) | Quantitative nonrandomized | Quantitative descriptive | Mixed methods |
| 1. Are there clear qualitative and quantitative research questions (or objectives\*), or a clear mixed methods question (or objective\*)?
 | 1.1. Are the sources of qualitative data (archives, documents, informants, observations) relevant to address the research question (objective)? | 2.1. Is there a clear description of the randomization (or an appropriate sequence generation)? | 3.1. Are participants (organizations) recruited in a way that minimizes selection bias?  | 4.1. Is the sampling strategy relevant to address the quantitative research question (quantitative aspect of the mixed methods question)? | 5.1. Is the mixed methods research design relevant to address the qualitative and quantitative research questions (or objectives), or the qualitative and quantitative aspects of the mixed methods question (or objective)? |
| 1. Do the collected data allow address the research question (objective)? E.g., consider whether the follow-up period is long enough for the outcome to occur (for longitudinal studies or study components)
 | 1.2. Is the process for analyzing qualitative data relevant to address the research question (objective)? | 2.2. Is there a clear description of the allocation concealment (or blinding when applicable)? | 3.2. Are measurements appropriate (clear origin, or validity known, or standard instrument; and absence of contamination between groups when appropriate) regarding the exposure/ intervention and outcomes? | 4.2. Is the sample representative of the population under study? | 5.2. Is the integration of qualitative and quantitative data (or results\*) relevant to address the research question (objective)? |
| -- | 1.3. Is appropriate consideration given to how findings relate to the context, e.g., the setting, in which the data were collected? | 2.3. Are there complete outcome data (80% or above)? | 3.3. In the groups being compared (exposed vs. non-exposed; with intervention vs. without; cases vs. controls), are the participants comparable, or do researchers take into account (control for) the difference between these groups? | 4.3. Are measurements appropriate (clear origin, or validity known, or standard instrument)? | 5.3. Is appropriate consideration given to the limitations associated with this integration, e.g., the divergence of qualitative and quantitative data (or results\*) in a triangulation design? |
| -- | 1.4. Is appropriate consideration given to how findings relate to researchers’ influence, e.g., through their interactions with participants? | 2.4. Is there low withdrawal/drop-out (below 20%)? | 3.4. Are there complete outcome data (80% or above), and, when applicable, an acceptable response rate (60% or above), or an acceptable follow-up rate for cohort studies (depending on the duration of follow-up)? | 4.4. Is there an acceptable response rate (60% or above)? | -- |

*Table 4*

*MMAT Quality Appraisal of Intervention Studies*

| Authors | ScreeningQuestions  | Qualitative | QuantitativeRandomizedControlled | QuantitativeNonrandomized | Quantitative Descriptive | Mixed Methods | Total |
| --- | --- | --- | --- | --- | --- | --- | --- |
| A | B | 1.1 | 1.2 | 1.3 | 1.4 | 2.1 | 2.2 | 2.3 | 2.4 | 3.1 | 3.2 | 3.3 | 3.4 | 4.1 | 4.2 | 4.3 | 4.4 | 5.1 | 5.2 | 5.3 |  |
| Antoni et al. (2001) | 1 | 1 | - | - | - | - | 0 | 0 | 1 | 0 | - | - | - | - | - | - | - | - | - | - | - | 3 |
| Bennett et al. (2014) | 1 | 1 | - | - | - | - | - | - | - | - | 0 | 1 | 1 | 1 | - | - | - | - | - | - | - | 5 |
| Carlson et al. (2016) | 1 | 1 | - | - | - | - | 1 | 1 | 0 | 0 | - | - | - | - | - | - | - | - | - | - | - | 4 |
| Chaves et al. (2016) | 1 | 1 | - | - | - | - | 0 | 0 | 1 | 1 | - | - | - | - | - | - | - | - | - | - | - | 4 |
| Chiba et al. (2015)  | 1 | 1 | - | - | - | - | 0 | 0 | 1 | 1 | - | - | - | - | - | - | - | - | - | - | - | 4 |
| Dolbier et al.(2010) | 1 | 1 | - | - | - | - | 0 | 0 | 1 | 1 | - | - | - | - | - | - | - | - | - | - | - | 4 |
| Gallagher et al. (2018) | 1 | 1 | - | - | - | - | 0 | 1 | X | 1 | - | - | - | - | - | - | - | - | - | - | - | 4 |
| Garland et al.(2007) | 1 | 1 | - | - | - | - | - | - | - | - | 0 | 1 | 1 | 1 | - | - | - | - | - | - | - | 3 |
| Gregory & Prana (2013) | 1 | 0 | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | 1 |
| Hagenaars & van Minnen (2010) | 1 | 1 | - | - | - | - | - | - | - | - | - | - | - | - | 1 | 1 | 1 | 1 | - | - | - | 6 |
| Hefferon et al. (2008) | 1 | 1 | 1 | 1 | 1 | 1 | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | 6 |
| Hijazi et al. (2014) | 1 | 1 | - | - | - | - | 1 | 1 | 1 | 1 | - | - | - | - | - | - | - | - | - | - | - | 6 |
| Kallay & Baban (2008) | 1 | 1 | - | - | - | - | - | - | - | - | - | - | - | - | X | 1 | 0 | 0 | - | - | - | 3 |
| Karagiorgou et al. (2018) | 1 | 1 | 1 | 1 | 1 | 0 | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | 5 |
| Knaevelsrud et al. (2010) | 1 | 1 | - | - | - | - | 0[[2]](#footnote-2) | 0 | 1 | 1 | - | - | - | - | - | - | - | - | - | - | - | 3 |
| Lo et al. (2014) | 1 | 1 | - | - | - | - | - | - | - | - | - | - | - | - | 1 | 1 | 1 | 0 | - | - | - | 5 |
| Liu & Kia-Keating (2017) | 1 | 1 | - | - | - | - | 0 | 0 | 1 | 1 | - | - | - | - | - | - | - | - | - | - | - | 4 |
| McDonough et al. (2011) | 1 | 1 | 1 | 1 | 1 | 1 | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | 6 |
| McGregor et al. (2014) | 1 | 1 | - | - | - | - | 0 | 0 | X | X | - | - | - | - | - | - | - | - | - | - | - | 2 |
| Morris et al. (2011) | 1 | 1 | 1 | 1 | 1 | 1 | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | 6 |
| Nijdam et al. (2018) | 1 | 1 | - | - | - | - | 0[[3]](#footnote-3) | 1 | 1 | 0 | - | - | - | - | - | - | - | - | - | - | - | 4 |
| Penedo et al. (2006) | 1 | 1 | - | - | - | - | 1 | 1 | 0 | X | - | - | - | - | - | - | - | - | - | - | - | 4 |
| Ramos et al. (2017) | 1 | 1 | - | - | - | - | 0[[4]](#footnote-4) | 0 | X | X | - | - | - | - | - | - | - | - | - | - | - | 2 |
| Roepke et al. (2017) | 1 | 1 | - | - | - | - | 1 | 0 | 0 | 0 | - | - | - | - | - | - | - | - | - | - | - | 3 |
| Ruini et al. (2014) | 1 | 1 | 1 | 0 | 0 | 0 | - | - | - | - | - | - | - | - | 1 | 1 | 1 | 1 | - | - | - | 3 |
| Salim & Wadey (2018) | 1 | 1 | 1 | 1 | 1 | 0 | - | - | - | - | 1 | 1 | 1 | X | - | - | - | - | 1 | 1 | 1 | 5 |
| Salo et al. (2008) | 1 | 1 | - | - | - | - | - | - | - | - | 1 | 1 | 1 | X | - | - | - | - | - | - | - | 5 |
| Slavin‐Spenny et al. (2011) | 1 | 1 | - | - | - | - | 0 | 0 | 1 | 1 | - | - | - | - | - | - | - | - | - | - | - | 4 |
| Singer et al. (2012) | 1 | 1 | - | - | - | - | - | - | - | - | 1 | 0 | 1 | 1 | - | - | - | - | - | - | - | 5 |
| Stockton et al. (2014) | 1 | 1 | - | - | - | - | 0 | 0 | 1 | 0 | - | - | - | - | - | - | - | - | - | - | - | 3 |
| Taku et al. (2017) – Study 1 | 1 | 1 | - | - | - | - | - | - | - | - | 0 | 1 | 0 | X | - | - | - | - | - | - | - | 3 |
| Taku et al. (2017) – Study 2 | 1 | 1 | - | - | - | - | 0 | 0 | X | X | - | - | - | - | - | - | - | - | - | - | - | 2 |
| Victorson et al. (2017) | 1 | 1 | - | - | - | - | 1 | 1 | 1 | 1 | - | - | - | - | - | - | - | - | - | - | - | 6 |
| Wagner et al. (2007) | 1 | 1 | - | - | - | - | 0[[5]](#footnote-5) | 0 | X | X | - | - | - | - | - | - | - | - | - | - | - | 2 |
| Ye et al. (2017) | 1 | 1 | - | - | - | - | 0 | 0 | X | 1 | - | - | - | - | - | - | - | - | - | - | - | 3 |
| Zhang et al. (2017) | 1 | 1 | - | - | - | - | 1 | 1 | X | 1 | - | - | - | - | - | - | - | - | - | - | - | 5 |
| Zoellner et al. (2011) | 1 | 1 | - | - | - | - | 0[[6]](#footnote-6) | 1 | 1 | 0 | - | - | - | - | - | - | - | - | - | - | - | 4 |

*Note.* 0 = Indicates a negative response to the question; 1 = Indicates a positive response to the question; X = Indicates that there is insufficient information to answer the question.

Table 5

*Thematic Categorization of Programs*

|  |  |  |
| --- | --- | --- |
| **Higher Order Categories** | **Programs** | **Studies** |
| Cognitive-Behavioral | Behavioral and cognitive strategies | Antoni et al., 2001 |
| Cognitive-behavioral therapy | Knaevelsrud et al., 2010; Zoellner et al., 2011 |
| Cognitive-behavioral stress management | McGregor et al., 2014; Penedo et al., 2006 |
| Coping enhancement program | Ye et al., 2017 |
| Mindfulness | Mindfulness based cancer recovery (MBCR) | Carlson et al., 2016; Garland et al., 2007 |
| Mindfulness based stress reduction | Victorson et al., 2017; Zhang et al., 2017 |
| Psychoeducation | Transforming lives through resilience educationPositive psychotherapy | Dolbier et al. 2010Karagiorgou, et al., 2018 |
| Managing Cancer and Living Meaningfully (CALM) (individual) | Lo et al., 2014 |
| Closed and structured group  | Ramos et al., 2017 |
| Learning about stress changes | Taku et al, 2017 a,b |
| Internet education program | Wagner et al., 2007 |
| Disclosure | Expressive writing | Gallagher et al., 2018; Kallay & Baban, 2008; Stockton et al., 2014  |
| Online narrative writing | Liu & Kia-Keating, 2017 |
| Narrative exposure therapy (NET)Exposure therapy | Hijazi et al., 2014Hagenaars & van Minnen, 2010 |
| Prospective writingDisclosure (written, private spoken, passive listening, active facilitation) | Roepke et al., 2017Slavin‐Spenny et al., 2011 |
| Emotional disclosure | Salim & Wadey, 2018 |
| Social Support | Supportive expressive therapy (group) | Carlson et al., 2016 |
| Role modelling and reflection (peer) | Chiba et al. |
| Peer support program – AHT | Morris et al., 2011 |
| Group therapy | Salo et al., 2008 |
| Sport and Leisure | Sport and recreation program | Bennett et al., 2014 |
| Physical activity intervention | Hefferon et al., 2008 |
| Dragon boating | McDonough et al., 2011 |
| Art therapyHealing through the creative arts (HA) | Singer et al., 2012Garland et al., 2007 |
| Other | Wish-granting | Chaves et al. 2016 |
| Brief Eclectic Psychotherapy (BEP) | Nijdam et al., 2018 |
| Eye movement desensitization and reprocessing theory (EMDR)Narrative group psychotherapy | Nijdam et al., 2018Ruini et al., 2014 |
| Individual therapy | Salo et al., 2017 |

1. Only intervention group demographics provided [↑](#footnote-ref-1)
2. The details including recruitment procedures are available in Knaevelsrud and Maercker (2007) [↑](#footnote-ref-2)
3. The details including recruitment procedures are available in Nijdam, Gersons, Reitsma, De Jongh, and Olff (2012) [↑](#footnote-ref-3)
4. The details including recruitment procedures are available in Ramos, Leal, and Tedeschi (2016) [↑](#footnote-ref-4)
5. The details including recruitment procedures are available in Wagner, Knaevelsrud, & Maercker (2005). [↑](#footnote-ref-5)
6. The details including recruitment procedures are available in Maercker (2006). [↑](#footnote-ref-6)