National Institute for Health and Care Excellence

Draft for consultation

Post-traumatic stress disorder: management (update)

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

NICE guideline <number>

Evidence reviews

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

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Psychological, psychosocial and other non-pharmacological interventions for the treatment of PTSD in adults

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

- Review question 2.2 For adults with clinically important post-traumatic stress symptoms, what are the relative benefits and harms of psychological, psychosocial or other non-pharmacological interventions targeted at PTSD symptoms?

Review question 2.2 For adults with clinically important post-traumatic stress symptoms, what are the relative benefits and harms of psychological, psychosocial or other non-pharmacological interventions targeted at PTSD symptoms?

Introduction

This review is focused on people who have persistent traumatic stress symptoms. It covers both those with PTSD, as defined by a diagnosis according to DSM or ICD criteria, and those with clinically significant PTSD symptoms as indicated by baseline scores above a threshold on a validated scale. People with such symptoms experience significant distress and interference in functioning and quality of life. They may be seen in primary, secondary and tertiary mental health settings, and also social care settings. There may be specific treatment needs for people from particular groups, such as people who are refugees or seeking asylum, or due to the nature of their traumatic events, such as multiple abusive experiences, or due to particular comorbidities, such as common mental health problems, and drug and alcohol misuse. There are many psychological and psychosocial models that have developed to help understand the persistence of PTSD symptoms. These have led to the development of psychological and psychosocial treatments of PTSD.

There are two aims of this review. One, to identify the relative benefits and harms of psychological or psychosocial interventions targeted at PTSD symptoms. Two, to identify the most effective psychological or psychosocial interventions for the treatment of PTSD in adults.

Summary of the protocol (PICO table)

See Table 1 for a summary of the population, intervention, comparison and outcome (PICO) characteristics of this review.

Table 1: Summary of the protocol (PICO table)

Population	Adults with PTSD (as defined by a diagnosis of PTSD according to DSM, ICD or similar criteria, or clinically-significant PTSD symptoms as indicated by baseline scores above threshold on a validated scale more than one month after the traumatic event)

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

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

For full details see review protocol in Appendix A.

Methods and processes

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

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

Psychological interventions for the treatment of PTSD in adults

Introduction to the clinical evidence

A range of psychological interventions are currently used to treat PTSD, ranging from generic psychological therapies (for example, supportive counselling) to PTSD-specific approaches (for example, eye movement desensitisation and reprocessing [EMDR]).

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

Evidence for interventions in the following classes was also searched for but none was found: psychologically-focused debriefing; human givens therapy.

Although the specific interventions that make up a class do not all include exactly the same content or follow the same manual, they are using the same broad approach and the efficacy of interventions within that class is considered to be equivalent. For instance, interventions in the trauma-focused CBT class differ in whether the emphasis is on exposure or on cognitive techniques. However, although some programmes place their main emphasis on exposure, and others on cognitive techniques, most use a combination and there is considerable overlap in the proposed mechanisms underlying the effectiveness of the various versions of trauma-focused CBT.

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

Included studies

Three hundred and sixty two studies of trauma-focused CBT for the treatment of PTSD in adults were identified for full-text review. Of these 362 studies, 88 RCTs (N=8450) were included. Many of these 88 RCTs were three- or four-armed trials and as such were included in more than one comparison. There were 17 comparisons for trauma-focused CBT.

For early treatment (intervention initiated 1-3 months post-trauma) of PTSD symptoms, there was evidence for one relevant comparison: 2 RCTs (N=295) compared trauma-focused CBT with waitlist or no treatment (Bisson et al. 2004; Sijbrandij 2007).

For delayed treatment (intervention initiated more than 3 months post-trauma) of PTSD symptoms, 28 RCTs (N=2424) compared trauma-focused CBT with waitlist (Alghamdi et al. 2015; Blanchard 2002/Blanchard et al. 2003/Blanchard et al. 2003 [one study reported across three publications]; Bolton et al. 2014a; Buhmann et al. 2016; Chard, 2005; Cloitre et al. 2002; Difede et al. 2007b; Dunne et al. 2012; Ehlers et al. 2003; Ehlers et al. 2005; Ehlers et al. 2014; Falsetti et al. 2008; Fecteau & Nicki, 1999; Gersons et al. 2000; Hijazi et al. 2014; Hollifield et al. 2007; Jacob et al. 2014; Jung & Steil, 2013; Lindauer et al. 2005; Lindauer et al. 2008; McDonagh et al. 2005; Neuner et al. 2008; Pacella et al. 2012; Ruglass et al. 2017/ Hien 2011[one study reported across two publications]; van Emmerik et al. 2008; Weiss et al. 2015 (study 1); Weiss et al. 2015 (study 2); Zang et al. 2014). 36 RCTs (N=3257) compared trauma-focused CBT in addition to treatment as usual and/or medication, with treatment as usual or medication only (Akbarian et al. 2015; Asukai et al. 2010; Bass et al. 2013; Beck et al. 2009; Bohus et al. 2013; Brom et al. 1989; Buhmann et al. 2016; Coffey et al. 2016; Dorrepaal et al. 2012; Duffy et al. 2007; Foa et al. 2005; Foa et al. 2013b; Forbes et al. 2012; Hermenau et al. 2013; Hinton et al. 2005; Hinton et al. 2009; Kubany et al. 2003; Kubany et al. 2004; Maguen et al. 2017; Mills et al. 2012; Monson et al. 2006; Morath et al. 2014; Mueser et al. 2008; Neuner et al. 2004; Neuner et al. 2010; Pabst et al. 2014; Paunović, 2011; Popiel et al. 2015; Power et al. 2002; Resick et al. 2002; Rothbaum et al. 2005; Rothbaum et al. 2006; Ruglass et al. 2017/ Hien 2011[one study reported across two publications]; Sannibale et al. 2013; Stenmark et al. 2013; Wells et al. 2015). 6 RCTs (N=420) compared trauma-focused CBT (with or without additional treatment as usual) with eye movement desensitisation and reprocessing (EMDR; with or without additional treatment as usual) (Capezzani et al. 2013; Laugharne et al. 2016; Nijdam et al. 2012; Power et al. 2002; Rothbaum et al. 2005; Taylor et al. 2003). 4 RCTs (N=239) compared trauma-focused CBT (with or without additional treatment as usual) with non-trauma-focused CBT (with or without additional treatment as usual) (Cook et al. 2010; Foa et al. 1991; Hensel-Dittmann et al. 2011; Wells et al. 2015). 11 RCTs (N=903) compared trauma-focused CBT (with or without additional treatment as

usual) with counselling (with or without additional treatment as usual) (Blanchard 2002/Blanchard et al. 2003/Blanchard et al. 2003 [one study reported across three publications]; Bryant et al. 2003a; Castillo et al. 2016; Cloitre et al. 2010; Cottraux et al. 2008; Ehlers et al. 2014; Foa et al. 1991; Katz et al. 2014; Nacasch et al. 2011; Neuner et al. 2004; Neuner et al. 2008). 7 RCTs (N=1152) compared trauma-focused CBT (with or without additional treatment as usual) with present-centered therapy (with or without additional treatment as usual) (Ghafoori et al. 2017; McDonagh et al. 2005; Rauch et al. 2015; Schnurr et al. 2003; Schnurr et al. 2007/Haug et al. 2004 [one study reported across two publications]; Sloan et al. 2016b/Sloan et al. unpublished [one study reported across two papers]; Surís et al. 2013). 1 RCT (N=110) compared trauma-focused CBT with interpersonal psychotherapy (IPT) (Markowitz et al. 2015a). 1 RCT (N=112) compared trauma-focused CBT (in addition to treatment as usual) with psychodynamic therapy (in addition to treatment as usual) (Brom et al. 1989). 2 RCTs (N=211) compared trauma-focused CBT (with or without additional treatment as usual) with self-help (without support; with or without additional treatment as usual) (Ehlers et al. 2003; Sloan et al. 2016a/2018 [one study reported across two publications]). 1 RCT (N=125) compared trauma-focused CBT with self-help with support (van Emmerik et al. 2008). 1 RCT (N=112) compared trauma-focused CBT (in addition to treatment as usual) with hypnotherapy (in addition to treatment as usual) (Brom et al. 1989). 1 RCT (N=690) compared trauma-focused CBT with a psychoeducational session (Chambers et al. 2014). 3 RCTs (N=194) compared trauma-focused CBT (with or without additional treatment as usual) with relaxation (with or without additional treatment as usual) (Hinton et al. 2011; Markowitz et al. 2015a; Taylor et al. 2003). 1 RCT (N=84) compared trauma-focused CBT with acupuncture (Hollifield et al. 2007). 3 RCTs (N=557) compared trauma-focused CBT with SSRIs (Buhmann et al. 2016; Echiverri-Cohen et al. 2016; Popiel et al. 2015). 1 RCT (N=280) compared combined trauma-focused CBT and SSRIs with waitlist (Buhmann et al. 2016).

Sub-analyses were possible for the delayed treatment trauma-focused CBT versus waitlist, trauma-focused CBT in addition to treatment as usual or medication versus treatment as usual or medication only, and trauma-focused CBT (with or without additional treatment as usual) versus EMDR (with or without additional treatment as usual) comparisons, comparing effects by multiplicity of trauma, specific intervention, diagnostic status at baseline, and trauma type.

Excluded studies

Two hundred and seventy four studies were reviewed at full text and excluded from this review. The most common reasons for exclusion were non-randomised group assignment, small sample size (less than 10 participants per arm), efficacy or safety data could not be extracted, comparison outside protocol (within-class comparison), subgroup or secondary analysis of an RCT already included and/or that is not relevant, and systematic review with no new useable data and any meta-analysis results not appropriate to extract.

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

Summary of clinical studies included in the evidence review

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

Table 13, Table 14, Table 15, Table 16, Table 17, Table 18, Table 19, Table 20, Table 21, Table 22, Table 23, Table 24, Table 25, Table 26, Table 27 and Table 28).

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

Table 2: Summary of included studies: Trauma-focused CBT (TF-CBT) for early treatment (1-3 months)

Comparison	TF-CBT versus waitlist or no treatment
Total no. of studies (N randomised)	2 (295)
Study ID	Bisson 2004[1] Sijbrandij 2007[2]
Country	UK[1] Netherlands[2]
Diagnostic status	Clinically important PTSD symptoms (scoring above a threshold on validated scale) [1] PTSD diagnosis according to ICD/DSM criteria[2]
Mean months since onset of PTSD	NR (randomised 1-3 weeks post-injury and intervention delivered 5-10 weeks post-trauma) [1] NR ('acute') [2]
Mean age (range)	NR[1] 37.6 (range NR) [2]
Sex (% female)	57[1] 60[2]
Ethnicity (% BME)	NR
Coexisting conditions	NR[1] 44% major depression; 11% anxiety disorder other than PTSD[2]
Mean months since traumatic event	NR (randomised 1-3 weeks post-injury and intervention delivered 5-10 weeks post-trauma) [1] Baseline assessment at 1.3 (0.5) [2]
Type of traumatic event	Motor Vehicle Collisions: Physical injury (56% were injured from a motor vehicle accident, 35% from assault, 9% other injuries [included an electrocution, partial amputation of fingertips, falls and a variety of industrial injuries]) [1] Mixed: Assault (66%); accidental injury (13%); sexual assault (6%); sudden death of a loved one (5%); witnessing assault (2%); other (7%) [2]
Single or multiple incident index trauma	Single
Lifetime experience of trauma	36% had previous trauma history[1] 59% prior trauma[2]
Intervention details	Brief individual CBT (following unpublished manual)[1] Brief individual CBT: Cognitive therapy was based on the model developed by Foa et al. (1995) for female victims of rape adapted by the authors (Drs. Carlier and Gersons) for victims of all kinds of traumatic events[2]
Intervention format	Individual
Intervention intensity	4 x 1-hour weekly sessions (4 hours). Mean 3.3 sessions attended (SD=1.24); 71% completed all four sessions[1]

Comparison	TF-CBT versus waitlist or no treatment
	4x weekly 2-hour sessions (8 hours). Mean number of sessions attended 3.3. 79% completed all 4 sessions[2]
Comparator	No treatment: Standard care only (no formal psychosocial intervention). None of the control group received alternative treatment[1] Waitlist[2]
Intervention length (weeks)	4

Note.CBT, Cognitive nehaviour therapy; NR, Not reported; PTSD, Post-traumatic stress disorder; TF-CBT, Trauma-focused cognitive behaviour therapy.
[1]Bisson 2004; [2]Sijbrandij 2007

Table 3: Summary of included studies: Trauma-focused CBT (TF-CBT) for delayed treatment (>3 months)-part 1

Comparison	TF-CBT versus waitlist
Total no. of studies (N randomised)	28 (2424)
Study ID	Alghamdi 2015[1] Blanchard 2002/2003/2004[2] Bolton 2014a[3] Buhmann 2016[4] Chard 2005[5] Cloitre 2002[6] Difede 2007b[7] Dunne 2012[8] Ehlers 2003[9] Ehlers 2005[10] Ehlers 2014[11] Falsetti 2008[12] Fecteau 1999[13] Gersons 2000[14] Hijazi 2014[15] Hollifield 2007[16] Jacob 2014[17] Jung 2013[18] Lindauer 2005[19] Lindauer 2008[20] McDonagh 2005[21] Neuner 2008[22] Pacella 2012[23] Ruglass 2017/Hien 2011[24] van Emmerik 2008[25] Weiss 2015 (study 1)[26] Weiss 2015 (study 2)[27] Zang 2014[28]
Country	Saudi Arabia[1] US[2,5,6,7,12,15,16,21,23,24] Iraq[3,26,27] Denmark[4] Australia[8] UK[9,10,11]

Comparison	TF-CBT versus waitlist
	Canada[13] Netherlands[14,19,20,25] Rwanda[17] Germany[18] Uganda[22] China[28]
Diagnostic status	PTSD diagnosis according to ICD/DSM criteria [K=21][1,2,4,5,6,8,9,10,11,12,13,14,16,17,18,19,20,21,22,25,28] Clinically important PTSD symptoms (scoring above a threshold on validated scale) [K=7][3,7,15,23,24,26,27]
Mean months since onset of PTSD	NR[1,3,5,6,7,8,9,10,12,13,14,15,16,17,18,19,22,23,24,26,27,28] NR ('chronic [6-24 months]')[2] 176.4[4] NR ('chronic')[11,21] 55.2[20] NR (50% acute; 46% chronic)[25]
Mean age (range)	30.4 (22-41)[1] 39.7 (range NR)[2,20] 41.8 (range NR)[3] 45 (range NR)[4] 32.8 (18-56)[5] 34 (range NR)[6] 45.77 (range NR)[7] 32.5 (20-49)[8] Mean NR (18-65)[9] 36.6 (range NR)[10] 38.7 (range NR)[11] 35 (range NR)[12,22] 41.3 (25-63)[13] 36.4 (range NR)[14] 48.2 (range NR)[15] 42.2 (range NR)[16] 37.6 (range NR)[17] 37.2 (19-61)[18] 39 (range NR)[19] 40.4 (range NR)[21] 46.4(31-61)[23] 44.6 (range NR)[24] 40.2 (range NR)[25] 42.8 (range NR)[26] 40.3 (range NR)[27] 53.6 (28-80)[28]
Sex (% female)	0[1] 73[2] 59[3] 41[4] 100[5,6,12,18,21] 3[7] 50[8,20]

Comparison	TF-CBT versus waitlist
	NR[9] 54[10,19] 58[11] 70[13] 12[14] 56[15] 66[16] 84[17] 51[22] 37[23] 36[24] 67[25] 31[26] 34[27] 90[28]
Ethnicity (% BME)	NR[1,3,4,9,13,15,19,20,22,25,26,27,28] 10[2] 19[5] 54[6] 23[7] 27[8] 4[10] 31[11,12] 0[14] 36[16] 100[17] 11[18] 7[21] 61[23] 82[24]
Coexisting conditions	NR[1,7,9,15,16,17,22,23,25,26,27,28] 49% major depressive disorder (MDD); 35% generalized anxiety disorder (GAD) [2] Significant depression symptomatology was an inclusion criterion[3] Patients were not excluded solely based on psychotic symptoms (9% psychotic during treatment). 94% depression according to ICD-10. 27% Personality change after catastrophic events (ICD-10 code F62.0). 25% report traumatic brain injury[4] 40% of the participants met criteria for current major depression[5] 45% current major depression; 79% anxiety disorder (generalized anxiety disorder [GAD] the most common [48%])[6] 54% met the DSM-IV criteria for comorbid depression and 31% met the criteria for current alcohol use disorder[8] 39% current major depression; 21% comorbid anxiety disorders[10] Depressive disorder (35%); anxiety disorder (30%); substance abuse (15%); Axis II disorder (19%)[11]

Comparison	TF-CBT versus waitlist
	100% panic attacks (inclusion criterion). 89% met DSM-IV criteria for panic disorder (based on ADIS-R) [12] 85% had ongoing pain and physical complaints from their Motor Vehicle Collision (MVC)[13] 86% any other comorbid psychiatric disorder (DSM-III-R): 40% Major Depression; 12% Dysthymia; 26% Alcohol Dependence; 10% Generalized Anxiety; 9% Agoraphobia; 7% Social Phobia; 7% Phobic Disorder; 7% OCD; 5% Panic Disorder[14] Mean 3.4 (SD=1.06) DSM-IV Axis-I or Axis-II diagnoses: 57% major depressive disorder; 32% eating disorders; 32% borderline personality disorder; 25% social anxiety disorder[18] 13% had mild major depression (those with moderate or severe depression were excluded) [19] 15% had mild major depression (those with moderate or severe depression were excluded) [20] 11% met criteria for borderline personality disorder[21] 77% alcohol dependent, 66% drug dependent, 45% alcohol and drug dependent. Primary substance: alcohol (45%); cannabis (8%); cocaine (16%); alcohol and stimulants (25%); other polysubstance (6%). 37% anxiety, 28% major depressive disorder[24]
Mean months since traumatic event	NR[1,3,4,6,17,20,22,26,27] 13.7[2] 312[5] 21.2[7] 28.5[8] 6[9] Medians: 11.5 months (7-120) in intervention group; 10.8 (6-216) in control group[10] Mean NR (40% 3 months-1 year; 20% 1-2 years; 24% 2-4 years; 15% >4 years) [11] NR (inclusion criteria >3 months) [12] 18.8[13] 47.4[14] NR (participants had been in the US an average of 2.3 years) [15] NR (traumatic experience occurred before age 12 for 62%; between age 12 and 17 for 21%; 17% of participants experienced trauma only as an adult) [16] 268[18] 53[19] NR (mean age of onset 6.6 years [SD=2.6]) [21] 159 months (SD=63) since diagnosis[23] 181.1[24] 8[25] Mean NR (30-34 months) [28]
Type of traumatic event	Being an emergency responder in a traumatic event[1,14] Motor Vehicle Collisions[2,8,9,13] Witnessing war as a civilian: 'Survivor of systematic violence' [3,26,27]; Iraqi and Syrian refugees[15]; widowed or orphaned survivors of Rwandan (1994) genocide[17]; Rwandan and Somalian refugees settled in a refugee camp in Uganda[22]

Comparison	TF-CBT versus waitlist
	Mixed[5,6,10,11,12,19,23,24] Terrorist attacks: Disaster workers exposed to World Trade Centre attack and/or aftermath[7] Unclear: 38% reported experiencing ≥3 events; 33% identified ≥5 years of ongoing childhood abuse[16] Childhood sexual abuse[18,21] Domestic violence (67%) [20] Exposure to non-sexual violence (50%) [25] Natural disasters: Sichuan earthquake (2008) [28]
Single or multiple incident index trauma	Multiple [K=16][1,3,4,5,6,12,14,15,17,18,20,21,22,24,26,27] Single [K=9][2,7,8,9,10,13,19,25,28] Unclear [K=3][11,16,23]
Lifetime experience of trauma	NR[1,2,3,4,5,6,8,9,12,13,15,16,18,20,24,25,26,27] 67% had trauma history[7] Half of the participants reported an earlier trauma meeting the A criterion of DSM-IV (but these events were not addressed in treatment) [10] 70% history of other trauma; 10% reported history of childhood abuse[11] Mean number of traumas outside police work 3.5 (SD=2.5) [14] Mean number of traumatic event types ever experienced: 14.4 (SD=3.8) [17] Mean number of prior traumas 3.7 (SD=3.4) [19] Mean number of trauma types 3.3 (SD=1.1). Trauma history: 80% childhood physical abuse; 62% adult physical abuse; 50% adult sexual trauma[21] Mean number of trauma event types 14.1 (SD=5.2) [22] Mean 4.91 (SD=1.78) different types of prior trauma[23] 20% prior trauma (7% 1 prior trauma; 13% 2-3) [28]
Intervention details	Narrative exposure therapy (NET)[1,17,22,28] Cognitive behavioural intervention following protocol of Hickling and Blanchard (1997) [2] Cognitive Processing Therapy (CPT) [3,4,5,27] Skills Training in Affective and Interpersonal Regulation Followed by Exposure (STAIR–modified PE) [6] Cognitive-behavioral exposure treatment following modified protocol of Bryant et al. (1998, 1999) [7,25] Trauma-focused cognitive-behavioral therapy (TF-CBT) adapted from a detailed manual of an individual TF-CBT for acute stress disorder (Bryant 2000) [8] Cognitive therapy programme is based on Ehlers and Clark's (2000) model of persistent post-traumatic stress disorder[9,10,11] Multiple channel exposure therapy (M-CET; Falsetti & Resnick, 2000) [12] Brief individual CBT[13] Brief eclectic psychotherapy (BEP, following manual by Gerson & Carlier 1994/Gersons et al. 2004) [14,19,20] Brief narrative exposure therapy (NET), following a manual (Schauer et al. 2005) adapted to three sessions[15] CBT group[16]

Comparison	TF-CBT versus waitlist
	[Brief 2-session] Cognitive Restructuring and Imagery Modification (CRIM) [18] Prolonged exposure (PE) following protocol of Foa et al. (1999)/Foa (1991) [21,23] Concurrent treatment of PTSD and Substance Use Disorder (SUD) using Prolonged Exposure PE (COPE), integrates PE for PTSD (Foa et al. 2007) and relapse prevention treatment (RPT) for SUD (Marlatt & Donovan 2007; Carroll 1998) [24] Common Elements Treatment Approach (CETA), a transdiagnostic intervention developed by authors[26]
Intervention format	Individual [K=25][1,2,3,4,6,7,8,9,10,11,13,14,15,17,18,19,20,21,22,23,24,25,26,27,28] Individual & group [K=1][5] Group [K=2][12,16]
Intervention intensity	4x 60-90 min sessions (4-6 hours) [1] 8-12x weekly sessions (length of session not reported). Mean sessions attended 9.8 (1.2) [2] 12 sessions (length of session not reported) [3,27] 16 sessions (length of session not reported). Mean attended 12 sessions over 5.2 months[4] 17 x weekly group (1.5 hours) and 10 x weekly individual (1 hour) sessions (25.5 hours group, 10 hours individual) [5] 16 sessions (20 hours) in total composed of 8x weekly 1-hour sessions of Skills Training in Affect and Interpersnal Regulation (STAIR) (8 hours) and 8x twice-weekly 90-min sessions of modified PE (12 hours) [6] 12 x weekly 75-min sessions (15 hours) [7] 10x weekly 1-hour sessions (10 hours). 85% of participants attended all 10 sessions[8] 12 x weekly 90-min sessions (15 hours; followed by 3x monthly 60-min booster sessions) [9,10]. Mean received 9 weekly sessions (+ 2.4 booster sessions in follow-up period) [9]; Mean received 10 weekly sessions (SD=2.9; + mean 2.4 [SD=1.1] booster sessions in follow-up period) [10] 12x weekly sessions (up to 20 hours in total). Mean attended sessions 10.1 (SD=3.26) [11] 12 x weekly 90-min sessions (18 hours) [12,24]. Mean sessions attended 6.08 (SD = 4.75) [24] 4x weekly 2-2.5 hour sessions (8-10 hours) [13] 16x weekly 1-hour sessions (16 hours) [14] 3x weekly 60-90 min sessions (3-4.5 hours). 95% completed 3 sessions of NET[15] 12x weekly 2-hour sessions (24 hours) [16] 8 x weekly 1.5-2.5 hour sessions (12-20 hours) [17] 2x sessions, 1x 90-min + 1x 50-min (2.3 hours) [18] 16x weekly 45-60 min sessions (12-16 hours) [19,20] 14x 1.5-2 hour sessions (24.5 hours; first 7 sessions 2 hours and final 7 1.5 hours) [21] 6x twice-weekly 1-2 hour sessions (6-12 hours) [22] 10x twice-weekly 1.5-2 hour sessions (15-20 hours) [23] 5-10x 90-min sessions (7.5 hours for those with ASD or acute PTSD; 15 hours for those with chronic PTSD) [25] 8-12x weekly 50-60 min sessions (6.7-12 hours) [26]

Comparison	TF-CBT versus waitlist
	4x twice-weekly 60-90 min sessions (4-6 hours)/3x 1-2 hour sessions in 1 week (3-6 hours) [28]
Comparator	Waitlist
Intervention length (weeks)	3[1,15,22] 12[2,6,7,9,12,16,24,26,27] NR[3] 26[4] 17[5,19] 10[8] 13[10] 14[11] 4[13] 16[14,20] 8[17] 2[18] 18[21] 5[23] 5-10[25] 1-2[28]
Note. BME, Black and minorit ethnic; DSM, Diagnostic and Statistical Manual of Mental Disorders; GAD, Generalised anxiety disorder; ICD, International Classification of Disease; MDD, Major depressive disorder; NR, Not relevant; PE, Prolonged exposure; PTSD, Post-traumatic stress disorder; SUD, Substance use disorder; STAIR, Skills training in affect and interpersonal regulations; TF-CBT, Trauma-focused cognitive behaviour. *[1]Alghamdi 2015; [2]Blanchard 2002/2003/2004; [3]Bolton 2014a; [4]Buhmann 2016; [5]Chard 2005; [6]Cloitre 2002; [7]Difede 2007b; [8]Dunne 2012; [9]Ehlers 2003; [10]Ehlers 2005; [11]Ehlers 2014; [12]Falsetti 2008; [13]Fecteau 1999; [14]Gersons 2000; [15]Hijazi 2014; [16]Hollifield 2007; [17]Jacob 2014; [18]Jung 2013; [19]Lindauer 2005; [20]Lindauer 2008; [21]McDonagh 2005; [22]Neuner 2008; [23]Pacella 2012; [24]Ruglass 2017/Hien 2011; [25]van Emmerik 2008; [26]Weiss 2015 (study 1); [27]Weiss 2015 (study 2); [28]Zang 2014*	

Table 4: Summary of included studies: Trauma-focused CBT for delayed treatment (>3 months)-part 2

Comparison	TF-CBT + medication/TAU versus medication/TAU-only (or + attention-placebo)
Total no. of studies (N randomised)	36 (3257)
Study ID	Akbarian 2015[1] Asukai 2010[2] Bass 2013[3] Beck 2009[4] Bohus 2013[5] Brom 1989[6] Buhmann 2016[7] Coffey 2016[8] Dorrepaal 2012[9] Duffy 2007[10] Foa 2005[11] Foa 2013b[12] Forbes 2012[13] Hermenau 2013[14] Hinton 2005[15] Hinton 2009[16]

Comparison	TF-CBT + medication/TAU versus medication/TAU-only (or + attention-placebo)
	Kubany 2003[17] Kubany 2004[18] Maguen 2017[19] Mills 2012[20] Monson 2006[21] Morath 2014[22] Mueser 2008[23] Neuner 2004[24] Neuner 2010[25] Pabst 2014[26] Paunovic 2011[27] Popiel 2015[28] Power 2002[29] Resick 2002[30] Rothbaum 2005[31] Rothbaum 2006[32] Ruglass 2017/Hien 2011[33] Sannibale 2013[34] Stenmark 2013[35] Wells 2015[36]
Country	Iran[1] Japan[2] Democratic Republic of Congo (DRC) [3,14] US[4,8,11,12,15,16,17,18,19,21,23,30,31,32,33] Germany[5,22,25,26] Netherlands[6,9] Denmark[7] UK[10,29,36] Australia[13,20,34] Uganda[24] Sweden[27] Poland[28] Norway[35]
Diagnostic status	PTSD diagnosis according to ICD/DSM criteria [K=32][1,2,4,5,6,7,8,9,10,11,12,15,16,17,18,19,20,21,22,23,24,25,26,27,28,29,30,31,32,34,35,36] Clinically important PTSD symptoms (scoring above a threshold on validated scale) [K=4] [3,13,14,33]
Mean months since onset of PTSD	NR[1,2,3,6,12,13,14,17,18,19,22,23,24,25,26,28,29,30,33,34,35] NR ('chronic') [4,8,11,21,27,31,32] NR (treatment-resistant) [5,15,16] 176.4[7] NR (51% duration of symptoms >10 years) [9] Median 5.2 years (range 3 months-32 years) [10] NR (second-line treatment)[19] 1 month since diagnosis. Median duration of trauma symptoms 10 years (0.08-40) [20] Median 23.5 months[36]
Mean age (range)	31.6 (range NR)[1] 29.3 (range NR) [2]

Comparison	TF-CBT + medication/TAU versus medication/TAU-only (or + attention-placebo)
	35 (range NR) [3,35] 43.3 (22-69) [4] 36 (range NR) [5] 42 (18-73) [6] 45 (range NR) [7] 34 (range NR) [8] 38.8 (range NR) [9] 43.9 (range NR) [10] 31.3 (range NR) [11] 42.7 (36-47) [12] 53.4 (range NR) [13] 19 (16-25) [14] 51.8 (range NR) [15] 49.5 (range NR) [16] 36.4 (22-62) [17] 42.2 (18-70) [18] 61.2 (range NR) [19] 33.7 (range NR) [20] 54 (range NR) [21] 28 (16-47) [22] 44.2 (range NR) [23] 33.2 (range NR) [24] 31.4 (range NR) [25] 29.9 (19-54) [26] 37.2 (range NR) [27] 37.7 (range NR) [28] 39.2 (range NR) [29] 32 (range NR) [30] 33.8 (range NR) [31] 39.3 (range NR) [32] 44.6 (range NR) [33] 41.2 (range NR) [34,36]
Sex (% female)	79[1,6,23] 88[2] 100[3,5,11,17,18,26,30,31] 82[4] 41[7,22] 46[8] NR[9,28] 40[10] 35[12] 3[13] 0[14,19] 60[15,16,24] 62[20] 10[21] 31[25,35] 59[27] 42[29]

Comparison	TF-CBT + medication/TAU versus medication/TAU-only (or + attention-placebo)
	65[32] 36[33] 53[34] 38[36]
Ethnicity (% BME)	NR[1,2,3,5,6,7,9,10,14,15,16,20,22,24,25,26,27,28,29,34,35,36] 11[4] 21[8] 51[11,17] 66[12] 0[13] 47[18] 29[19,30] 7[21] 16[23] 32[31] 20[32] 82[33]
Coexisting conditions	NR[1,3,6,14,17,18,19,22,24,27,29,30,32] 88% MDD; 38% panic disorder; 13% GAD; 4% social anxiety disorder[2] 80% ongoing pain complaints from MVA[4] Mean number of current Axis I disorders: 3 (1.1). 80% MDD; 45% met DSM-IV criteria for borderline personality disorder[5] 94% ICD-10 depression; 27% Personality change after catastrophic events; 25% report traumatic brain injury[7] 100% co-occurring PTSD and substance dependence (inclusion criterion): 100% current alcohol dependence; 98% any current drug dependence. 80% current major depressive disorder, 69% additional anxiety disorder(s) [8] Mean number of current comorbidity DSM-IV axis I: 2.8 (1.9). MDD (55%). Mean number of anxiety disorders: 1.6 (1.2); social phobia (43%); panic disorder (42%). 19% substance abuse and/or dependence. Mean number of current comorbidity SIDP-IV axis II disorders: 1.4 (1.2); borderline personality disorder (53%); avoidant personality disorder (25%)[9] 72% any axis I comorbidity: 64% MDD; 21% panic disorder; 10% specific phobias; 14% alcohol or substance use disorder; 5% GAD; 3% social phobia; 3% other anxiety disorder; 2% bulimia nervosa[10] 67% had coexisting Axis I condition: 41% MDD; 20% social anxiety disorder; 20% specific phobias; 14% GAD; 12% panic disorder[11] 100% alcohol dependence (inclusion criterion) [12] 80% current mood disorder; 73% other anxiety disorder; 44% substance abuse or dependence[13] 100% met criteria for GAD[15] 100% had comorbid orthostatic panic[16] 100% DSM-IV-TR diagnosis of substance dependence (inclusion criterion); participants using median of 4.0 different drug classes in the preceding month; most commonly reported main drug of concern was heroin (21%), cannabis (19%), amphetamines (18%), benzodiazepines (16%), alcohol (12%), cocaine (7%),

Comparison	TF-CBT + medication/TAU versus medication/TAU-only (or + attention-placebo)
	other opiates (5%), and hallucinogens (1%). 73% screened positive for borderline personality disorder[20] 73% current comorbid diagnosis: 55% mood disorder; 48% other anxiety disorder; 2% substance abuse or dependence[21] 100% severe mental illness: 61% MDD; 23% bipolar disorder; 8% schizoaffective disorder; 7% schizophrenia. 25% borderline personality disorder; 41% substance use disorder[23] 19% drug abuse[25] 100% DSM-IV-TR criteria for borderline personality disorder[26] 49% Comorbid Axis I disorder; 41% Comorbid personality disorder; 21% traumatic brain injury in MVA; 39% had no comorbid mental disorders; 48% still had ongoing medical sequelae (including chronic pain) related to the accident[28] 40% had one comorbid diagnosis, 25% had two or more diagnoses in addition to PTSD[31] 77% alcohol dependent, 66% drug dependent, 45% alcohol and drug dependent. Primary substance: alcohol (45%); cannabis (8%); cocaine (16%); alcohol and stimulants (25%); other polysubstance (6%). 37% anxiety, 28% MDD[33] 100% DSM-IV alcohol use disorder. 95% alcohol dependent, 15% had other substance dependency[34] 40% with current major depressive episode[35] 56% coexisting psychiatric diagnosis: 28% MDD; 22% panic disorder; 6% MDD and panic disorder[36]
Mean months since traumatic event	NR[1,3,7,8,9,13,14,17,19,20,21,22,23,26,36] 18.8[2] 52.9[4] 340.5[5] NR (<5 years) [6] Medians: 8 years (0.3-33) in intervention group; 5.4 years (0.2-32) in control group[10] 108[11] 147[12] NR (mean 17.2 years in the US) [15] NR (mean 15.9 years in US) [16] 60[18] 90[24] NR (56 months living in exile) [25] 116.1[27] 17.8[28] 45.7[29] 102[30] 143.2[31] 97.2[32] 181.1[33] 222.4[34] NR (mean 56.0 months in exile) [35]
Type of traumatic event	Mixed: Accident related injury, cancer, domestic violence (% for each not reported) [1] Exposure to sexual abuse or assault: Sexual assault (54%); physical assault (17%); accidents (29%)[2]

Comparison	TF-CBT + medication/TAU versus medication/TAU-only (or + attention-placebo)
	Women who had experienced or witnessed sexual violence[3] Motor Vehicle Collisions[4] Childhood sexual abuse: Sexual abuse may have been a singular event (13%) lasted up to 5 years (39%) or longer than 5 years (46%). Mean reported age at the time of the first sexual abuse was 7.6 years (range 2–17 years) [5] Mixed: Loss of a loved one as a result of murder/suicide, traffic accidents, acute or chronic illness (74%); violent crime (17%); traffic accident (4%); other (5%)[6] Mixed: 43% torture; 28% refugee camp; 63% Danish asylum centre; 24% ex-combatant[7] Mixed: Any sexual assault occurring in adulthood or childhood (58%), attacked with a weapon (63%), attacked without a weapon (56%), accident (60%), childhood physical abuse (41%), natural disaster (35%)[8] Childhood abuse (100%) including sexual (94%) or physical (63%) abuse[9] Terrorist attacks: Multiple traumas (81% experienced multiple traumatic events; median=3) mostly linked to terrorism and other civil conflict in Northern Ireland (60% civilian; 40% police, soldier, or other profession with active involvement). Characteristics of index trauma event: Related to Northern Ireland "troubles" (84%); terrorist events outside Northern Ireland (5%); bombings (40%); shootings and killings (22%); taken hostage (14%); physical assault (14%); road injuries (9%); riots (1%). 74% experienced event (19% injured in event); 26% witnessed event[10] Exposure to sexual abuse or assault: Sexual assault (69%); nonsexual assault (14%); childhood sexual abuse (17%)[11] Mixed: Physical assault (41%); sexual assault (28%); combat (10%); other (21%)[12] Military combat: Service (of index trauma): 66% Vietnam; 14% Timor; 3% Iraq; 2% Afghanistan; 15% other[13] Male former combatants and child soldiers in Democratic Republic of Congo[14] Witnessing war as a civilian: Cambodian genocide (1975-1979) [15,16] Domestic violence[17,18] Military combat: 79% Vietnam; Operation Iraqi Freedom (OIF) (15%); Operation Enduring Freedome (OEF) (6%); Gulf war (3%); Other (9%). 67% single service tour and 33% mutliple[19] Mixed: Physical assault (93%); threatened or held captive (89%); witnessed death/injury (79%); sexual assault (78%); childhood sexual abuse (55%); accident/disaster (66%); torture (24%); military combat (2%); other (68%)[20] Military combat: 83% served in war zone. Index trauma: 78% combat, 17% sexual and 5% noncombat physical assault. 80% Vietnam War; 7% Post-Vietnam; 10% Gulf War I; 3% Korean War[21] Witnessing war as a civilian: Refugees with a history of war and torture experiences (38% from Africa; 62% from Middle East). Mean 9 war/torture events[22] Mixed: 34% childhood sexual abuse; 17% childhood physical abuse; 15% sudden unexpected death of a loved one; 13% adult

Comparison	TF-CBT + medication/TAU versus medication/TAU-only (or + attention-placebo)
	sexual assault; 11% adult physical assault; 4% other traumatic event; 2% sexual and physical assault; 2% witnessing violence; 1% motor vehicle accident; 1% combat[23] Witnessing war as a civilian: Sudanese civil war[24] Witnessing war as a civilian: Asylum-seekers with a history of victimization by organized violence[25] Mixed: Physical and sexual abuse occurred repeatedly and/or over a longer period. The most common traumatic event types reported by the women in the both groups were assault by a family member or an acquaintance (82%) and sexual abuse or assault by a family member or an acquaintance (77%)[26] Unclear: Details of index trauma not reported (only lifetime experience of trauma) [27] Motor Vehicle Collisions (MVC): Status during MVC: Driver (38%); Passenger (30%); Cyclist (5%); Pedestrian (14%); Found out about death (7%); Other (5%). Patient considered MVA perpetrator (11%)[28] Mixed: Motor vehicle collision (31%; 24% passenger, 7% pedestrian); occupational accident (22%); physical assault (18%); sexual assault (4%); traumatic death (4%); real/implied physical threat (13%); other (7%)[29] Exposure to sexual abuse or assault: Women who had experienced a discrete incident of completed rape (oral, anal or vaginal) in childhood (41%) or adulthood[30] Exposure to sexual abuse or assault: Rape in adulthood (12 or older) or a single incident of rape in childhood by either a family member or non-family member[31] Mixed: Sexual assault (37%); non-sexual assault (25%); death of another (22%); motor vehicle accident (9%); other (8%)[32] Mixed: 70% multiple trauma: Physical assault (59%); sexual assault (38%); sudden injury or death of other (42%); accident or disaster (8%); other (10%)[33] Mixed: Violent crime (31%); child physical/sexual abuse (23%); witnessed injury/killing/mutilation (15%); news of someone close (11%); adult abusive relationship (7%); accident/fire/explosion (7%); danger of losing life/other (8%)[34] Witnessing war as a civilian: Refugees and asylum seekers. Region of origin: Afghanistan (15%); Iraq (27%); Middle East (remaining countries; 16%); Africa (26%); Other (15%)[35] Mixed: Actual assault (28%); threatened assault (3%); sexual assault (9%); assaulted another (3%); road traffic accident (25%); witness (9%); fire (13%); war/combat (6%); armed robberry (3%)[36]
Single or multiple incident index trauma	Multiple[3,5,7,8,9,10,13,14,15,16,17,18,19,20,21,22,23,24,25,26,33,35] Single[2,4,6,28,29,30,31,32,34,36] Unclear[1,11,12,27]
Lifetime experience of trauma	NR[1,2,3,5,6,7,8,10,12,13,14,15,16,19,21,23,25,29,32,33,34] 45% of the participants had also previously experienced other traumas including natural disasters, non-motor accident trauma, sexual assault, witnessing a violent death[4] Experience of adult abuse (63%): physical (43%) or sexual (49%)[9]

Comparison	TF-CBT + medication/TAU versus medication/TAU-only (or + attention-placebo)
	97% witnessed or experienced other (nonindex) traumatic event; 83% experienced other interpersonal violence[11] Mean 8.3 (SD=3.2) types of traumatic events. Most common (reported by >40%) types of trauma exposure: Natural disaster (49%); Sudden death friendlloved one (57%); Threatened with death/serious harm (78%); Growing up: witnessed family violence (46%); Growing up: physically punished (49%); As an adult: unwanted sexual contact (49%); Stalked (70%)[17] Mean 9.0 (SD=4.2) types of traumatic events. Most common (reported by >40%) types of trauma exposure: Sudden death of friend or loved one (59%); Life-threatening/disabling event to loved one (44%); Threatened with death or serious harm (80%); Growing up: witnessed family violence (44%); Growing up: physically abused (59%); Before age 13: sexual contact—someone at least 5 years older (48%); As an adult: unwanted sexual contact (56%); Stalked (66%)[18] Trauma types experienced median 6.0 (2-10); 77% experienced trauma during childhood[20] Trauma types experienced mean 7.0 (SD=2.0) [22] Mean number of traumatic event types 10.1 (SD=6.5) [24] Mean types of trauma 5[26] Traumatic events experienced, and/or witnessed (reported by >10%): Severe assault (62%); rape (38%); childhood traumatic events (28%); manslaughter attempt (21%); assault (17%); sexual assault (14%)[27] Number of previous traumatic events (before current MVA): 2.1 (sd=1.3). 5% childhood trauma[28] Mean 6.4 adult crime incidents (SD=4.9) in addition to the index rape. 86% had experienced ≥1 other major crime victimization in addition to the index rape: 48% ≥1 additional rape; 14% serious physical assaults; 54% physical assaults with minor injuries; 22% kidnapped as part of a crime; 18% robbery victims; 36% attempted rapes; 26% criminal or vehicular homicide involving a friend or family member; 14% victim of attempted murder[30] Including the index assault, participants experienced a mean of 6.0 traumas (SD = 4.1) prior to study entry[31] Mean number of traumatic event types: 8.2 (2.5) [35] Total number of traumas median 2.0 (IQR 1.0-3.0) [36]
Intervention details	Cognitive therapy + medication (including antidepressants and benzodiazepines) [1,10]/sertraline[7] Prolonged exposure (PE) following manual by Foa et al. 1991/1998/2007 + TAU[2,31]/paroxetine[28]/sertraline[32]/naltrexone[12] Cognitive Processing Therapy (CPT) based on manual by Chard et al. (2008) + TAU[3] Group CBT (GCBT) following Beck & Coffey 2005 protocol + TAU [4] Dialectical behaviour therapy for PTSD (DBT-PTSD; following protocol by Steil et al. 2011), residential programme + TAU[5] Trauma desensitization + TAU[6] Prolonged exposure + standard substance misuse treatment[8]/Concurrent Treatment of PTSD and Substance Use Disorders Using Prolonged Exposure (COPE) [20,33]/Integrated CBT for PTSD and alcohol use disorders (AUD) [34]

Comparison	TF-CBT + medication/TAU versus medication/TAU-only (or + attention-placebo)
	Stabilizing treatment group based on the manual by Zlotnick et al. (1997) + TAU[9] Two arms combined: Prolonged exposure alone (PE) and prolonged exposure + cognitive restructuring (PE/CR) + TAU[11] Cognitive Processing Therapy (CPT; following manual by Resick et al. 2001/2007) + medication[13,21] Narrative Exposure Therapy for Forensic Offender Rehabilitation (FORNET) + TAU[14] CBT based on the protocol of Hinton et al. (2004) + supportive psychotherapy and medication (SSRI + clonazepam) [15,16] Cognitive Trauma Therapy for Battered Women (CTT-BW) + TAU[17,18] Impact of Killing (IOK), novel CBT intervention + TAU[19] Narrative exposure therapy (NET) following protocol of Schauer et al. + TAU[22,24,26,35]/medication[25] CBT for PTSD program + TAU[23] Exposure inhibition therapy (EIT) + TAU[27] Exposure + Cognitive Restructuring (E+CR) following protocol used by Marks et al. (1998) + medication[29] Two arms combined: Cognitive processing therapy (CPT) and prolonged exposure (PE) + TAU[30] Prolonged exposure therapy, following protocol used in Marks et al. 1998 + TAU[36]
Intervention format	Group[1,4,9] Individual [2,6,7,8,10,11,12,13,15,16,17,18,19,20,21,22,23,24,25,26,27,28,29,30,31,32,33,34,35,36] Individual & group[3,5,14]
Intervention intensity	<8 sessions[14,19,24] 8-12 sessions[1,2,3,8,10,11,13,15,16,17,18,21,22,25,27,28,29,30,31,32,33,34,35,36] >12 sessions[4,5,6,7,9,12,20,23,26]
Comparator	Medication[1,7,10,12,21,28,29,32] TAU: Psych and pharm[2,5,9,13,15,16,19,23,25] TAU: Psych[3,14,24,35] TAU (no further details)[4,6,11,17,18,22,27,30,31,36] Standard substance misuse treatment[20,33,34] + attention-placebo (healthy lifestyle sessions)[8] Treatment by Experts for Borderline Personality Disorder (TBE) [26]
Intervention length (weeks)	10[1,2,29,35] 17[3,25] 14[4,26] 12[5,10,11,15,16,22,28,33,34] 16[6] 26[7,23] 5-8[8] 20[9] 24[12] 6[13,17,18,19,21,30,31] 2[14] 13[20]

Comparison	TF-CBT + medication/TAU versus medication/TAU-only (or + attention-placebo)
	3[24] 9[27] 5[32] 8[36]

Note. BME, Black and minorit ethnic; DSM, Diagnostic and Statistical Manual of Mental Disorders; GAD, Generalised anxiety disorder; ICD, International Classification of Disease; MDD, Major depressive disorder; MVA, motor vehicle accident NR, Not relevant; OIF, Operation Iraqi Freedom; OEF, Operation Enduring Freedom; PTSD, Post-traumatic stress disorder; TAU, Treatment as usual; TF-CBT, Trauma-focused cognitive behaviour
[1]Akbarian 2015; [2]Asukai 2010; [3]Bass 2013; [4]Beck 2009; [5]Bohus 2013; [6]Brom 1989; [7]Buhmann 2016; [8]Coffey 2016; [9]Dorrepaal 2012; [10]Duffy 2007; [11]Foa 2005; [12]Foa 2013b; [13]Forbes 2012; [14]Hermenau 2013; [15]Hinton 2005; [16]Hinton 2009; [17]Kubany 2003; [18]Kubany 2004; [19]Maguen 2017; [20]Mills 2012; [21]Monson 2006; [22]Morath 2014; [23]Mueser 2008; [24]Neuner 2004; [25]Neuner 2010; [26]Pabst 2014; [27]Paunovic 2011; [28]Popiel 2015; [29]Power 2002; [30]Resick 2002; [31]Rothbaum 2005; [32]Rothbaum 2006; [33]Ruglass 2017/Hien 2011; [34]Sannibale 2013; [35]Stenmark 2013; [36]Wells 2015

Table 5: Summary of included studies: Trauma-focused CBT for delayed treatment (>3 months)-part 3

Comparison	TF- CBT (+/- TAU) versus EMDR (+/- TAU)	TF- CBT (+/- TAU) versus non-TF-CBT (+/- TAU)
Total no. of studies (N randomised)	6 (420)	3 (207)
Study ID	Capezzani 2013[1] Laugharne 2016[2] Nijdam 2012[3] Power 2002 Rothbaum 2005[5] Taylor 2003[6]	Cook 2010[7] Foa 1991[8] Hensel-Dittmann 2011[9]
Country	Italy[1] Australia[2] Netherlands[3] UK[4] US[5] Canada[6]	US[7,8] Germany[9]
Diagnostic status	PTSD diagnosis according to ICD/DSM criteria[1,3,4,5,6] Clinically important PTSD symptoms (scoring above a threshold on validated scale) [2]	PTSD diagnosis according to ICD/DSM criteria
Mean months since onset of PTSD	NR[1,3,4] NR (90% had symptoms ≥3 months) [2] NR ('chronic') [5] 104.4[6]	NR ('chronic') [7] NR[8,9]
Mean age (range)	51.7 (range NR)[1] 40.1 (range NR)[2] 37.8 (range NR)[3] 39.2 (range NR)[4] 33.8 (range NR)[5] 37 (range NR)[6]	59.4 (range NR)[7] 31.8 (range NR)[8] NR[9]

Comparison	TF- CBT (+/- TAU) versus EMDR (+/- TAU)	TF- CBT (+/- TAU) versus non-TF-CBT (+/- TAU)
Sex (% female)	90[1] 70[2] 56[3] 42[4] 100[5] 75[6]	0[7] 100[8] NR[9]
Ethnicity (% BME)	NR[1,2,3,4] 32[5] 23[6]	58[7] 26[8] NR[9]
Coexisting conditions	NR[1,2,4] 60% major depressive disorder; 16% anxiety disorder other than PTSD[3] 40% had one comorbid diagnosis, 25% had two or more diagnoses in addition to PTSD[5] 42% major depression, 31% panic disorder, 12% social anxiety disorder[6]	All participants had regular nightmares (≥1 a week for ≥6 months) and global sleep disturbance (as rated by the Pittsburg Sleep Quality Addendum for PTSD (PSQI). 56% depressive disorder and 53% anxiety disorder (assessed with the Structured Clinical Interview (SCID)[7] NR[8] 82% major depression, 18% dysthymia, 54% anxiety disorder/Obessive Compulssive Disorder (OCD), 11% substance abuse, and 4% psychotic disorder[9]
Mean months since traumatic event	NR[1,6] NR (50% had delayed-onset PTSD [≥6 months])[2] 30.3[3] 45.7[4] 143.2[5]	NR[7,9] 72.7[8]
Type of traumatic event	Diagnosis of life-threatening condition: Participants in follow-up treatment for cancer (breast, colon, uterus, thyroid, melanoma, lung, stomach)[1] Mixed: Adult sexual assault (20%); witnessing death or injury (25%); serious injury to self (10%); motor vehicle accident (10%); threat to physical safety (10%); sudden death of a loved one (10%); child sexual assault (5%); physical assault (5%); natural disaster (5%)[2] Exposure to non-sexual violence. Civilian trauma: Assault (53%); sexual assault (11%); accident (19%); disaster (7%); war-related (5%); other (5%). 19% complex trauma[3] Mixed: Motor vehicle collision (31%; 24% passenger, 7% pedestrian); occupational accident	Military combat: Vietnam war veterans[7] Exposure to sexual abuse or assault: Rape or attempted rape. 54% perpetrator was a stranger; 46% perpetrator was an acquaintance. 60% weapon used[8] Witnessing war as a civilian: 93% asylum seekers who had fled from their countries of origin after experiencing organized violence. 76% reported experiences of torture and >70% had been in detention[9]

Comparison	TF- CBT (+/- TAU) versus EMDR (+/- TAU)	TF- CBT (+/- TAU) versus non-TF-CBT (+/- TAU)
	(22%); physical assault (18%); sexual assault (4%); traumatic death (4%); real/implied physical threat (13%); other (7%)[4] Exposure to sexual abuse or assault: Rape in adulthood (12 or older) or a single incident of rape in childhood by either a family member or non-family member[5] Mixed: The most common forms of traumatic event reported were sexual assault (45%), transportation accidents (43%), physical assault (43%), and being exposed to a sudden death (e.g., witnessing a homicide, 22%)[6]	
Single or multiple incident index trauma	Single[1,2,3,4,5] Unclear[6]	Multiple[7,9] Single[8]
Lifetime experience of trauma	NR[1,2,4] 54% had earlier traumatic experiences[3] Including the index assault, participants experienced a mean of 6.0 traumas (SD = 4.1) prior to study entry[5] Most participants (65%) had experienced more than one type of traumatic event[6]	NR
Intervention details	Cognitive behavioural therapy techniques[1] Prolonged Exposure (PE) was structured according to Prolonged Exposure Therapy for PTSD: Emotional Processing of Traumatic Experiences-Therapist Guide. 60% of participants in this arm taking an antidepressant and 10% prescribed a benzodiazepine[2] Brief Eclectic psychotherapy (following manual by Gersons et al. 2004) + TAU[3] Exposure + Cognitive Restructuring (E+CR) following protocol used by Marks et al. (1998). 81% were taking psychotropic medication[4] Prolonged exposure (PE) followed protocol used in Foa et al. (1991) and Foa & Rothbaum (1998) + TAU[5] Exposure therapy based on Marks et al. (1998) manual (essentially same as Foa & Rothbaum 1998	Imagery rehearsal therapy + 78% were receiving concurrent psychotherapy (primarily supportive) and 93% were receiving treatment from a psychiatrist[7] Prolonged exposure (PE) [8] Narrative exposure therapy (NET) following manual by Schauer et al. (2005) [9]

Comparison	TF- CBT (+/- TAU) versus EMDR (+/- TAU)	TF- CBT (+/- TAU) versus non-TF-CBT (+/- TAU)
	but no breathing retraining). 48% were taking some form of psychotropic medication. Concomitant psychological therapy was not allowed[6]	
Intervention format	Individual	Group[7] Individual[8,9]
Intervention intensity	8 x weekly sessions (length of sessions not reported) [1] 12x twice-weekly sessions (length of sessions not reported) [2] 16x weekly 45-60 min sessions (12-16 hours). Mean sessions attended 14.7 (SD= 4.5) [3] 10x weekly 90-min sessions (15 hours) [4] 9x twice-weekly 90-min sessions (13.5 hours) [5] 8x 90-min sessions (12 hours) [6]	6x weekly 90-min sessions (9 hours). Mean attended sessions 4.1 (SD=2.29). 64% completed at least 5 sessions[7] 9x twice-weekly 90-min sessions (13.5 hours) [8] 10x 90-min sessions (15 hours) [9]
Comparator	Eye movement desensitisation and reprocessing (EMDR) following standard Shapiro protocol[1] + 48%[6]/70%[4] were taking psychotropic medication at the time of the study/+ TAU[5] Eye movement desensitisation and reprocessing (EMDR) therapy was based on Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols, and Procedures. 60% of participants in this arm were prescribed antidepressants and 30% were prescribed an antipsychotic agent (for treatment of PTSD symptoms) [2] Eye movement desensitisation and reprocessing (EMDR) following manual by De Jongh & Broeke (2004) + TAU[3]	Sleep and Nightmare Management Treatment + 78% were receiving concurrent psychotherapy (primarily supportive) and 93% were receiving treatment from a psychiatrist[7] Stress inoculation training (SIT) adapted from Veronen and Kilpatrick (1983) protocol[8] Stress inoculation training (SIT) based on adapted version for the treatment of rape victims (Foa, unpublished) and modified for the needs of survivors of organised violence[9]
Intervention length (weeks)	8[1] 6[2,5] 16[3] 10[4] NR[6]	6[7] 4.5[8] 13[9]
Note. [1]Capezzani 2013; [2]Laugharne 2016; [3]Nijdam 2012; [4]Power 2002; [5]Rothbaum 2005; [6]Taylor 2003; [7]Cook 2010; [8]Foa 1991; [9]Hensel-Dittmann 2011		

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Table 6: Summary of included studies: Trauma-focused CBT for delayed treatment (>3 months)-part 4

Comparison	TF- CBT (+/- TAU) versus counselling (+/- TAU)	TF-CBT (+/- TAU) versus present-centered therapy (+/- TAU)
Total no. of studies (N randomised)	11 (903)	7 (1152)
Study ID	Blanchard 2002/2003/2004[1] Bryant 2003a[2] Castillo 2016[3] Cloitre 2010[4] Cottraux 2008[5] Ehlers 2014[6] Foa 1991[7] Katz 2014[8] Nacasch 2011[9] Neuner 2004[10] Neuner 2008[11]	Ghafoori 2017[12] McDonagh 2005[13] Rauch 2015[14] Schnurr 2003[15] Schnurr 2007/Haug 2004[16] Sloan 2016b/unpublished[17] Suris 2013[18]
Country	US[1,3,4,7,8] Australia[2] France[5] UK[6] Israel[9] Uganda[10,11]	US
Diagnostic status	PTSD diagnosis according to ICD/DSM criteria[1,2,3,4,5,6,7,9,10,11] Clinically important PTSD symptoms (scoring above a threshold on validated scale) [8]	PTSD diagnosis according to ICD/DSM criteria[12,13,15,16,17,18] Clinically important PTSD symptoms (scoring above a threshold on validated scale) [14]
Mean months since onset of PTSD	NR ('chronic [6-24 months]') [1] NR (inclusion criteria ≥ 3 months) [2] NR[3,4,7,8,9,10,11] 84 (120) [5] NR ('chronic') [6]	NR[12,15,16,17,18] NR ('chronic') [13] NR (>3 months inclusion criterion) [14]
Mean age (range)	39.7 (range NR) [1] 35.2 (range NR) [2] 35.9 (range NR) [3] 35.3 (range NR) [4] 39 (range NR) [5] 38.7 (range NR) [6] 31.8 (range NR) [7] 42 (22-66) [8] 34.3 (range NR) [9] 33.2 (range NR) [10] 35 (range NR) [11]	35.2 (18-71)[12] 40.4 (range NR)[13] 31.9 (range NR)[14] 50.7 (range NR)[15] 44.8 (range NR)[16] 55.8 (range NR)[17] 46.1 (range NR)[18]
Sex (% female)	73[1] 52[2] 100[3,4,7,8] 70[5] 58[6]	83[12] 100[13,16] 8[14] 0[15,17] 85[18]

Comparison	TF- CBT (+/- TAU) versus counselling (+/- TAU)	TF-CBT (+/- TAU) versus present-centered therapy (+/- TAU)
	NR[9] 60[10] 51[11]	
Ethnicity (% BME)	10[1] NR[2,5,9,10,11] 69[3] 63[4] 31[6] 26[7] 56[8]	72[12] 7[13] 17[14] 34[15] 45[16] 26[17] 56[18]
Coexisting conditions	49% major depressive disorder (MDD); 35% generalized anxiety disorder (GAD) [1] NR[2,5,7,8,10,11] 62% mood disorder; 60% anxiety disorder; 3% substance use/abuse[3] Current Axis I comorbidity: 89% ≥1; 62% ≥2; 30% ≥3; 20% ≥4[4] Depressive disorder (35%); anxiety disorder (30%); substance abuse (15%); Axis II disorder (19%) [6] 67% mood disorders; 43% anxiety disorders[9]	NR[12,18] 11% met criteria for borderline personality disorder[13] 47% major depressive episode; 14% panic disorder; 8% agoraphobia; 8% social phobia; 6% alcohol abuse; 6% generalized anxiety disorder[14] 67% had any current psychiatric disorder: 56% had mood disorder; 32% anxiety disorder; 5% substance abuse[15] 78% any current comorbid psychiatric disorder: 64% mood disorder; 48% anxiety disorder; 2% substance abuse[16] 55% major depressive disorder, 21% generalized anxiety disorder, 12% panic disorder, 9% binge eating disorder, 7% social anxiety disorder, 5% specific phobia, 3% obsessive compulsive disorder, 3% cannabis abuse, 1% alcohol abuse[17]
Mean months since traumatic event	13.7[1] 9.4[2] NR[3,4,5,8,11] Mean NR (40% 3 months-1 year; 20% 1-2 years; 24% 2-4 years; 15% >4 years) [6] 72.7[7] 115.8[9] 90[10]	NR[12,14,15,17] NR (mean age of onset 6.6 years [SD=2.6]) [13] 270[16] NR (≥3 months) [18]
Type of traumatic event	Motor Vehicle Collisions[1] Exposure to non-sexual violence: Non-sexual assault (53%); motor vehicle accident (47%)[2] Military combat: Operation Enduring Freedom (OEF) (Afganistan)/Operation Iraqi Freedome (OIF) (Iraq) service	Mixed[12] Childhood sexual abuse[13] Military combat: 86% Iraq deployment and 22% Afghanistan[14]; Vietnam veterans[15]; combat (70%) [17] Exposure to sexual abuse or assault (in adulthood) [16,18]

Comparison	TF- CBT (+/- TAU) versus counselling (+/- TAU)	TF-CBT (+/- TAU) versus present-centered therapy (+/- TAU)
	members (served active duty after September 11th 2001) [3] Childhood sexual abuse: Childhood sexual abuse (90%), childhood physical abuse (79%), emotional abuse or neglect (82%)[4] Mixed: Car accidents (33%); physical assault victims (26%); rape (8%); miscellaneous experiences (8%); family violence (7%); witnessed extreme violence (7%); incest (5%); witnessed the death of a close relative (3%); painful and complicated surgery (2%)[5] Mixed: Interpersonal violence (36%); Accidents/disaster (38%); Death/harm to others (8%); Other (18%)[6] Exposure to sexual abuse or assault: Rape or attempted rape. 54% perpetrator was a stranger; 46% perpetrator was an acquaintance. 60% weapon used[7] Exposure to sexual abuse or assault: Female veterans who had a history of sexual trauma, including: military sexual trauma (88%); childhood sexual abuse (71%); adult sexual assault (44%); domestic violence (68%)[8] Military combat: Combat (63%); terror (37%)[9] Witnessing war as a civilian: Sudanese civil war[10], Rwandan and Somalian refugees settled in a refugee camp in Uganda[11]	
Single or multiple incident index trauma	Single[1,2,5,7] Multiple[3,4,8,9,10,11] Unclear[6]	Single[12] Multiple[13,14,15,16,17] Unclear[18]
Lifetime experience of trauma	NR[1,2,7,8,9] 70% 8–17 trauma types; 66% ≥25 trauma incidents[3] Mean number of lifetime traumas: 6.57 (SD=1.17). Experience of trauma as an adult: Domestic violence (63%); sexual assault (49%); physical assault (24%); other interpersonal victimization (61%) [4] Mean number of traumatic episodes: 1.78 (0.9) [5]	Mean number of traumas experienced 6.49 (SD=3.45) [12] Mean number of trauma types 3.3 (SD=1.1). Trauma history: 80% childhood physical abuse; 62% adult physical abuse; 50% adult sexual trauma[13] NR[14,15,17,18] Lifetime trauma exposure mean event types 9.7: any sexual trauma (92%); military sexual trauma (73%); physical assault (88%); combat exposure (25%); disaster

Comparison	TF- CBT (+/- TAU) versus counselling (+/- TAU)	TF-CBT (+/- TAU) versus present-centered therapy (+/- TAU)
	70% history of other trauma; 10% reported history of childhood abuse[6] Mean number of traumatic event types 10.1 (SD=6.5) [10] Mean number of trauma event types 14.1 (SD=5.2) [11]	exposure (72%); serious accident (82%); life-threatening illness or injury (43%); other traumatic event (89%) [16]
Intervention details	Cognitive behavioural intervention following protocol of Hickling and Blanchard (1997)[1] Two arms combined: cognitive restructuring with prolonged imaginal exposure (CR/IE) and imaginal exposure alone (IE) [2] Imaginal exposure[3] Skills Training in Affective and Interpersonal Regulation Followed by Exposure (STAIR–modified PE) [4] CBT included exposure in imagination or in vivo and cognitive therapy[5] Cognitive therapy based on Ehlers and Clark's (2000) PTSD model[6] Prolonged exposure (PE) [7,8] (+ TAU) [9] Narrative exposure therapy (NET) following protocol of Schauer et al[10,11]	Prolonged exposure (PE)[12,13] + TAU[14,16] Trauma-focused group therapy (TFCT) + TAU[15,17] Cognitive processing therapy (CPT) followed manual by Resick and Schnicke (1993) for the treatment of rape-related PTSD and further adapted for the treatment of PTSD in veterans and military personnel (Resick et al. 2007) + TAU[18]
Intervention format	Individual[1,2,4,5,6,7,8,9,10,11] Group[3]	Individual[12,13,14,16,18] Group[15,17]
Intervention intensity	8-12 x weekly sessions. Mean sessions attended 9.8 (1.2) [1] 8 x weekly 90-min sessions (12 hours) [2] 16x weekly 90-min sessions (24 hours). 4% of sessions were missed[3] 16 x weekly sessions (length of session not reported) composed of 8 sessions of skills training and 8 sessions of exposure[4] 10-16x 1-2 hour sessions (16 hours). 97% attendance[5] 12x weekly sessions (up to 20 hours in total) + 3 booster sessions during 3-month follow-up if necessary. Mean attended sessions 10.1 (SD=3.26; + mean 2.07 [SD=1.46] booster sessions during follow-up) [6]	12x weekly 60-90 min sessions (12-18 hours). Mean number of sessions attended 6.8 (SD=4.3) [12] 14x 1.5-2 hour sessions (24.5 hours; first 7 sessions 2 hours and final 7 1.5 hours) [13] 10-12 80-min sessions (13-16 hours) [14] 30x weekly 1.5-2 hour sessions (all sessions 1.5 hours except the exposure sessions which were 2 hours). Mean 21.8 sessions attended[15] 10x weekly 90-min sessions (15 hours). Mean sessions attended 8.0[16] 14x 2-hour sessions (28 hours). 38% 'inadequate dose' (no further detail reported) [17] 12x weekly or bi-weekly sessions (length of session not reported).

Comparison	TF- CBT (+/- TAU) versus counselling (+/- TAU)	TF-CBT (+/- TAU) versus present-centered therapy (+/- TAU)
	9x twice-weekly 90-min sessions (13.5 hours) [7] 10 sessions[8] 9-15x weekly 1.5-2 hour sessions (13.5-30 hours). Mean sessions attended 11 (SD=2.9) [9] 4x 1.5-2 hour sessions (6-8 hours) [10] 6x twice-weekly 1-2 hour sessions (6-12 hours) [11]	Mean sessions attended 9.7 (SD=3.5). 65% completed all 12 sessions[18]
Comparator	Supportive psychotherapy (SUPPORT) intervention[1] Supportive counselling[2,3,7] + TAU[10]/Supportive Rogerian counselling[5,8] Skills training followed by supportive counselling (STAIR/Support) [4] Emotion-focused supportive therapy[6] Nondirective, psychodynamically oriented therapy + TAU[9] Trauma counselling (TC) [11]	Present-centered therapy (PCT) individual, included psychoeducation, breathing retraining, and reviewing daily difficulties[12,13] Present centered therapy (PCT) individual + TAU[14,16,18] Present Centered Group Therapy (PCGT) [15]/Present-centered therapy group (GPCT) + TAU[17]
Intervention length (weeks)	12[1] 8[2] 16[3,4,5] 14[6] 4.5[7] NR[8] 15[9] 3[10,11]	12[12] 18[13] NR[14,18] 30[15] 10[16] 16[17]

Note. BME, Black and minorit ethnic; CPT, Cognitive processing therapy; DSM, Diagnostic and Statistical Manual of Mental Disorders; NR, Not relevant; OIF, Operation Iraqi Freedom; OEF, Operation Enduring Freedom; PCT, Present-centered therapy; PSQI, Pittsburg Sleep Quality Addendum for PTSD; PTSD, Post-traumatic stress disorder; STAIR, Skills training in affect and interpersonal regulations; TAU, Treatment as usual; TF-CBT, Trauma-focused cognitive behaviour; TFCT, Trauma-focused group therapy;

[1]Blanchard 2002/2003/2004; [2]Bryant 2003a; [3]Castillo 2016; [4]Cloitre 2010; [5]Cottraux 2008; [6]Ehlers 2014; [7]Foa 1991; [8]Katz 2014; [9]Nacasch 2011; [10]Neuner 2004; [11]Neuner 2008; Ghafoori 2017[12]; McDonagh 2005[13]; Rauch 2015[14]; Schnurr 2003[15]; Schnurr 2007/Haug 2004[16]; Sloan 2016b/unpublished[17]; Suris 2013[18]

Table 7: Summary of included studies: Trauma-focused CBT for delayed treatment (>3 months)-part 5

Comparison	TF- CBT (+ TAU) versus metacognitive therapy (+ TAU)	TF- CBT versus interpersonal psychotherapy (IPT)	TF- CBT (+ TAU) versus psychodynamic therapy (+ TAU)
Total no. of studies (N randomised)	1 (32)	1 (110)	1 (112)

Comparison	TF- CBT (+ TAU) versus metacognitive therapy (+ TAU)	TF- CBT versus interpersonal psychotherapy (IPT)	TF- CBT (+ TAU) versus psychodynamic therapy (+ TAU)
Study ID	Wells 2015	Markowitz 2015a	Brom 1989
Country	UK	US	Netherlands
Diagnostic status	PTSD diagnosis according to ICD/DSM criteria	PTSD diagnosis according to ICD/DSM criteria	PTSD diagnosis according to ICD/DSM criteria
Mean months since onset of PTSD	Median 23.5 months	NR ('chronic')	NR
Mean age (range)	41.2 (range NR)	40.1 (range NR)	42 (18-73)
Sex (% female)	38	70	79
Ethnicity (% BME)	NR	35	NR
Coexisting conditions	56% coexisting psychiatric diagnosis: 28% major depressive disorder; 22% panic disorder; 6% major depressive disorder and panic disorder	Current major depressive disorder (50%); recurrent major depressive disorder (34%); current generalised anxiety disorder (13%). Any axis II diagnosis (49%): 25% paranoid; 14% narcissistic; 5% borderline; 21% avoidant; 3% dependent; 25% obsessive-compulsive; 25% depressive; 15% passive-aggressive	NR
Mean months since traumatic event	NR	169.2	NR (<5 years)
Type of traumatic event	Mixed: Actual assault (28%); threatened assault (3%); sexual assault (9%); assaulted another (3%); road traffic accident (25%); witness (9%); fire (13%); war/combat (6%); armed robbery (3%)	Domestic violence: 93% reported interpersonal trauma (42% acute; 58% chronic)	Mixed: Loss of a loved one as a result of murder/suicide, traffic accidents, acute or chronic illness (74%); violent crime (17%); traffic accident (4%); other (5%)
Single or multiple incident index trauma	Single	Multiple	Single

Comparison	TF- CBT (+ TAU) versus metacognitive therapy (+ TAU)	TF- CBT versus interpersonal psychotherapy (IPT)	TF- CBT (+ TAU) versus psychodynamic therapy (+ TAU)
Lifetime experience of trauma	Total number of traumas median 2.0 (IQR 1.0-3.0)	Mean number of traumas 2.8 (SD=1.8). 36% reported trauma in childhood or adolescence	NR
Intervention details	Prolonged exposure therapy, following protocol used in Marks et al. (1998) + TAU (concurrent pharmacological treatment permitted)	Prolonged exposure included narrating an increasingly detailed trauma narrative (imaginal exposure) and confronting trauma reminders (in vivo exposure) to extinguish fear responses	Trauma desensitization, a behavioral therapeutic technique derived from the systematic desensitization method (Wolpe, 1958), based on both the two-factor approach of conditioning (Mowrer, 1960) and cognitive learning theories (particularly that of Abramson, Seligman, & Teasdale, 1978) + TAU
Intervention format	Individual	Individual	Individual
Intervention intensity	8x weekly 1-hour sessions (8 hours)	10x 90-min sessions (15 hours; 7x weekly and 3 remaining sessions over next 7 weeks)	Planned intensity NR. Mean number of sessions attended 15.0 (SD=2.9)
Comparator	Metacognitive Therapy, following manual by Wells and Sembi (2004) + TAU	International Psychotherapy (IPT) addressed not trauma but its interpersonal aftermath, and no homework was assigned. The first half of IPT emphasized affective attunement, recognizing, naming, and expressing one's feelings in non-trauma-related interpersonal situations; the remainder addressed typical IPT problem areas (e.g., role disputes, role transitions)	Brief psychodynamic therapy (Horowitz, 1976) + TAU
Intervention length (weeks)	8	14	16

Note. BME, Black and minorit ethnic; CPT, Cognitive processing therapy; DSM, Diagnostic and Statistical Manual of Mental Disorders; IPT, Interpersonal Psychotherapy; NR, Not relevant; TAU, Treatment as usual; TF-CBT, Trauma-focused cognitive behaviour; TFCT, Trauma-focused group therapy;

Table 8: Summary of included studies: Trauma-focused CBT for delayed treatment (>3 months)-part 6

Comparison	TF-CBT (+/- TAU) versus self-help (without support; +/- TAU)	TF-CBT versus self-help with support	TF-CBT (+ TAU) versus hypnotherapy (+ TAU)
Total no. of studies (N randomised)	2 (211)	1 (125)	1 (112)
Study ID	Ehlers 2003[1] Sloan 2016a/2018[2]	van Emmerik 2008	Brom 1989
Country	UK[1] US[2]	Netherlands	Netherlands
Diagnostic status	PTSD diagnosis according to ICD/DSM criteria	PTSD diagnosis according to ICD/DSM criteria	PTSD diagnosis according to ICD/DSM criteria
Mean months since onset of PTSD	NR	NR (50% acute; 46% chronic)	NR
Mean age (range)	Mean NR (18-65) [1] 43.9 (range NR) [2]	40.2 (range NR)	42 (18-73)
Sex (% female)	NR[1] 48[2]	67	79
Ethnicity (% BME)	NR[1] 45[2]	NR	NR
Coexisting conditions	NR	NR	NR
Mean months since traumatic event	6[1] NR[2]	8	NR (<5 years)
Type of traumatic event	Motor Vehicle Collisions (MVC): Involvement in a MVC that required A & E attendance[1] Mixed: Adult non-sexual assault (19%); child sexual assault (16%); adult sexual assault (15%); combat related (13%); sudden death (noncombat) or violence to a friend or loved one (10%); child non-sexual assault (9%); motor vehicle accident (8%); injury from other accidental causes (10%)[2]	Exposure to non-sexual violence: Nonsexual violence (50%); Traffic accident (23%); Sexual violence (11%); Other (16%)	Mixed: Loss of a loved one as a result of murder/suicide, traffic accidents, acute or chronic illness (74%); violent crime (17%); traffic accident (4%); other (5%)
Single or multiple	Single	Single	Single

Comparison	TF-CBT (+/- TAU) versus self-help (without support; +/- TAU)	TF-CBT versus self-help with support	TF-CBT (+ TAU) versus hypnotherapy (+ TAU)
incident index trauma			
Lifetime experience of trauma	NR	NR	NR
Intervention details	Cognitive therapy programme is based on Ehlers and Clark's (2000) model of persistent post-traumatic stress disorder[1] Cognitive Processing Therapy (CPT) plus written account + TAU (concurrent psychotropic medication permitted)[2]	CBT followed the prototypical format (for example, Bryant et al. 1998,1999)	Trauma desensitization, a behavioral therapeutic technique derived from the systematic desensitization method (Wolpe, 1958), based on both the two-factor approach of conditioning (Mowrer, 1960) and cognitive learning theories (particularly that of Abramson, Seligman, & Teasdale, 1978) + TAU
Intervention format	Individual	Individual	Individual
Intervention intensity	12 x weekly 90-min sessions (15 hours; followed by 3x monthly 60-min booster sessions). Mean received 9 weekly sessions (+ 2.4 booster sessions in follow-up period)[1] 12x weekly 1-hour sessions (12 hours)[2]	5-10x 90-min sessions (7.5 hours for those with Acute Stress Syndrome (ASD) or acute PTSD; 15 hours for those with chronic PTSD)	Planned intensity NR. Mean number of sessions attended 15.0 (SD=2.9)
Comparator	Cognitive bibliotherapy, 64-page booklet (approximately 18000 words) entitled 'Understanding Your Reactions to Trauma' (Herbert, 1996)[1] Written Exposure Therapy (WET) + TAU[2]	Structured writing therapy (SWT)	Hypnotherapy + TAU. The emphasis of the hypnotherapists in this study was on behavioral therapy
Intervention length (weeks)	12	5-10	16

Note. [1]Ehlers 2003; [2]Sloan 2016a/2018

Table 9: Summary of included studies: Trauma-focused CBT for delayed treatment (>3 months)-part 7

Comparison	TF-CBT versus psychoeducational session	TF-CBT (+/- TAU) versus relaxation (+/- TAU)
Total no. of studies (N randomised)	1 (690)	3 (194)
Study ID	Chambers 2014	Hinton 2011[1] Markowitz 2015a[2] Taylor 2003[3]
Country	Australia	US[1,2] Canada[3]
Diagnostic status	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	PTSD diagnosis according to ICD/DSM criteria
Mean months since onset of PTSD	NR	NR ('chronic') [1,2] 104.4[3]
Mean age (range)	52.5 (range NR)	49.5 (range NR) [1] 40.1 (range NR) [2] 37 (range NR) [3]
Sex (% female)	88	100[1] 70[2] 75[3]
Ethnicity (% BME)	NR	100[1] 35[2] 23[3]
Coexisting conditions	NR	NR[1] Current major depressive disorder (50%); recurrent major depressive disorder (34%); current generalised anxiety disorder (13%). Any axis II diagnosis (49%): 25% paranoid; 14% narcissistic; 5% borderline; 21% avoidant; 3% dependent; 25% obsessive-compulsive; 25% depressive; 15% passive-aggressive[2] 42% major depression, 31% panic disorder, 12% social anxiety disorder[3]
Mean months since traumatic event	NR	NR[1,3] 169.2[2]
Type of traumatic event	Unintentional injury/illness/medical emergency: Caregivers of patients with cancer (breast (31%), colorectal (9%), prostate (9%), hematologic (8%), lung (8%), and gynecologic (7%))	Unclear: No details given[1] Domestic violence: 93% reported interpersonal trauma (42% acute; 58% chronic) [2] Mixed: The most common forms of traumatic event reported were sexual assault (45%), transportation accidents (43%), physical assault (43%), and

Comparison	TF-CBT versus psychoeducational session	TF-CBT (+/- TAU) versus relaxation (+/- TAU)
		being exposed to a sudden death (e.g., witnessing a homicide, 22%)[3]
Single or multiple incident index trauma	Single	Unclear[1,3] Multiple[2]
Lifetime experience of trauma	NR	NR[1] Mean number of traumas 2.8 (SD=1.8). 36% reported trauma in childhood or adolescence[2] Most participants (65%) had experienced more than one type of traumatic event[3]
Intervention details	Cognitive behavioural intervention (following unpublished manual) including psychoeducation about the psychological impact of cancer, coping and stress management skills, problem solving, cognitive therapy, and enhancing support networks	Culturally-adapted CBT group based on protocol of Hinton et al. (2004, 2005) + TAU (SSRI at maximally tolerated dose and supportive therapy) [1] Prolonged exposure included narrating an increasingly detailed trauma narrative (imaginal exposure) and confronting trauma reminders (in vivo exposure) to extinguish fear responses[2] Exposure therapy based on Marks et al. (1998) manual (essentially same as Foa & Rothbaum 1998 but no breathing retraining) + TAU (48% were taking some form of psychotropic medication) [3]
Intervention format	Individual	Group[1] Individual[2,3]
Intervention intensity	5x sessions. Median 4 attended sessions	14x weekly 1-hour sessions (14 hours) [1] 10x 90-min sessions (15 hours; 7x weekly and 3 remaining sessions over next 7 weeks). Mean attended sessions 8.3 (SD=3.1) [2] 8x 90-min sessions (12 hours) [3]
Comparator	Single psychoeducational phone call with an oncology nurse; feedback to the participant about his or her levels of distress and brief instruction in evidence-based strategies to reduce stress	Applied muscle relaxation (AMR) following manual by Hinton and Safren (2009) + TAU[1] Relaxation therapy, highly scripted, induces progressive muscle and mental relaxation[2] Relaxation training based on manual by Marks et al. (1998) + TAU (48% were taking some form of psychotropic medication) [3]

Comparison	TF-CBT versus psychoeducational session	TF-CBT (+/- TAU) versus relaxation (+/- TAU)
Intervention length (weeks)	13	14[1,2] NR[3]
Note. [1]Hinton 2011; [2]Markowitz 2015a; [3]Taylor 2003		

Table 10: Summary of included studies: Trauma-focused CBT for delayed treatment (>3 months)-part 8

Comparison	TF-CBT versus acupuncture	TF-CBT versus SSRIs	TF-CBT + SSRIs versus waitlist
Total no. of studies (N randomised)	1 (84)	3 (557)	1 (280)
Study ID	Hollifield 2007	Buhmann 2016[1] Echiverri-Cohen 2016[2] Popiel 2015[3]	Buhmann 2016
Country	US	Denmark[1] US[2] Poland[3]	Denmark
Diagnostic status	PTSD diagnosis according to ICD/DSM criteria	PTSD diagnosis according to ICD/DSM criteria	PTSD diagnosis according to ICD/DSM criteria
Mean months since onset of PTSD	NR	176.4[1] NR ('chronic') [2] NR[3]	176.4
Mean age (range)	42.2 (range NR)	45 (range NR) [1] 37.7 (range NR) [2,3]	45 (range NR)
Sex (% female)	66	41[1] 75[2] NR[3]	41
Ethnicity (% BME)	36	NR[1,3] 33[2]	NR
Coexisting conditions	NR	94% depression according to ICD-10. 27% Personality change after catastrophic events (ICD-10 code F62.0). 25% report traumatic brain injury[1] NR[2] 49% Comorbid Axis I disorder; 41% Comorbid personality disorder; 21% traumatic brain injury in MVA; 39% had no comorbid mental disorders; 48% still had ongoing medical sequelae (including	94% depression according to ICD-10. 27% Personality change after catastrophic events (ICD-10 code F62.0). 25% report traumatic brain injury

Comparison	TF-CBT versus acupuncture	TF-CBT versus SSRIs	TF-CBT + SSRIs versus waitlist
		chronic pain) related to the accident[3]	
Mean months since traumatic event	NR (traumatic experience occurred before age 12 for 62%; between age 12 and 17 for 21%; 17% of participants experienced trauma only as an adult)	NR[1] 150[2] 17.8[3]	NR
Type of traumatic event	Unclear: 38% reported experiencing ≥3 events; 33% identified ≥5 years of ongoing childhood abuse	Mixed: 43% torture; 28% refugee camp; 63% Danish asylum centre; 24% ex-combatant[1] Mixed: Sexual assault (31%); physical assault (27%); child sexual assault (22%); child physical assault (8%); motor vehicle accident (6%); natural disaster (4%); death of loved one (2%)[2] Motor Vehicle Collision (MVC). Status during MVC: Driver (38%); Passenger (30%); Cyclist (5%); Pedestrian (14%); Found out about death (7%); Other (5%). Patient considered Motor Vehicle Accidents (MVA) perpetrator (11%)[3]	Mixed: 43% torture; 28% refugee camp; 63% Danish asylum centre; 24% ex-combatant
Single or multiple incident index trauma	Unclear	Multiple[1] Unclear[2] Single[3]	Multiple
Lifetime experience of trauma	NR	NR[1,2] Number of previous traumatic events (before current MVA): 2.1 (sd=1.3). 5% childhood trauma[3]	NR
Intervention details	CBT group	CBT, following an unpublished manual, included core CBT methods, psychoeducation, methods from acceptance and commitment therapy, mindfulness exercises,	CBT (following an unpublished manual) + sertraline (titrated up to 200mg/day)

Comparison	TF-CBT versus acupuncture	TF-CBT versus SSRIs	TF-CBT + SSRIs versus waitlist
		and in vivo and visualised exposure[1] Prolonged exposure (Foa et al. 2002) [2] Prolonged exposure (PE; following manual by Foa et al. 2007) [3]	
Intervention format	Group	Individual	Individual
Intervention intensity	12x weekly 2-hour sessions (24 hours)	16 sessions (length of session not reported). Mean attended 12 sessions over 5.2 months[1] 10x weekly 90-120 min sessions (15-20 hours) [2] 10-12x weekly 90-min sessions (15-18 hours). Mean attended sessions 8.6 (SD=3.5) [3]	16 sessions of CBT (length of session not reported) + 200mg/day serrtaline (+ 10 clinical management sessions). Mean attended CBT sessions was 12. Mean final dose was 119.3 mg sertraline (+/– 66 mg) and 15.7 mg (+/– 12 mg) mianserin.Mean number of attended clinical management sessions was 9
Comparator	Manual acupuncture (needles without electrical stimulation)	Sertraline[1,2] Paroxetine[3]	Waitlist
Intervention length (weeks)	12	26 10 12	26
Note. [1]Buhmann 2016; [2]Echiverri-Cohen 2016; [3]Popiel 2015			

1 See appendix G for full evidence tables.

2 Quality assessment of clinical studies included in the evidence review

3 The clinical evidence profiles for this review (trauma-focused CBT for the treatment
4 of PTSD in adults) are presented in Table 11, Table 12 and Table 13, Table 14,
5 Table 15, Table 16, Table 17, Table 18, Table 19, Table 20, Table 21, Table 22,
6 Table 23, Table 24, Table 25, Table 26, Table 27 and Table 28.

7 **Table 11: Summary clinical evidence profile: Trauma-focused CBT versus**
8 **waitlist or no treatment for early treatment (1-3 months)**

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist or no treatment	Corresponding risk Trauma-focused CBT			
PTSD symptomatology self-rated -		The mean PTSD symptomatology self-rated -		152 (1 study)	very low[1,2,3]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist or no treatment	Corresponding risk Trauma-focused CBT			
Endpoint IES change score Follow-up: mean 4 weeks		endpoint in the intervention groups was 0.27 standard deviations lower (0.59 lower to 0.05 higher)			
PTSD symptomatology self-rated - 10-month follow-up IES change score Follow-up: mean 43 months		The mean PTSD symptomatology self-rated - 10-month follow-up in the intervention groups was 0.47 standard deviations lower (0.79 to 0.14 lower)		152 (1 study)	very low[1,3,4]
PTSD symptomatology clinician-rated - Endpoint CAPS endpoint/change score Follow-up: mean 4 weeks		The mean PTSD symptomatology clinician-rated - endpoint in the intervention groups was 0.43 standard deviations lower (0.98 lower to 0.12 higher)		265 (2 studies)	very low[1,2,3,5]
PTSD symptomatology clinician-rated - 4-month follow-up CAPS change score Follow-up: mean 17 weeks		The mean PTSD symptomatology clinician-rated - 4-month follow-up in the intervention groups was 0.3 standard deviations lower (0.7 lower to 0.09 higher)		98 (1 study)	very low[1,2]
PTSD symptomatology clinician-rated - 10-month follow-up CAPS endpoint Follow-up: mean 43 weeks		The mean PTSD symptomatology clinician-rated - 10-month follow-up in the intervention groups was 0.32 standard deviations lower (0.64 lower to 0 higher)		152 (1 study)	low[3,4]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist or no treatment	Corresponding risk Trauma-focused CBT			
Remission - Endpoint Number of people no longer meeting diagnostic criteria for PTSD Follow-up: mean 4 weeks	328 per 1000	492 per 1000 (325 to 748)	RR 1.5 (0.99 to 2.28)	143 (1 study)	very low[1,2]
Remission - 4-month follow-up Number of people no longer meeting diagnostic criteria for PTSD Follow-up: mean 17 weeks	422 per 1000	494 per 1000 (342 to 709)	RR 1.17 (0.81 to 1.68)	143 (1 study)	very low[1,2]
Response self-rated - Endpoint Number of participants showing at least 50% improvement from baseline on IES Follow-up: mean 4 weeks	197 per 1000	251 per 1000 (138 to 454)	RR 1.27 (0.7 to 2.3)	152 (1 study)	very low[1,3,6]
Response self-rated - 10-month follow-up Number of participants showing at least 50% improvement from baseline on IES Follow-up: mean 43 months	276 per 1000	448 per 1000 (287 to 696)	RR 1.62 (1.04 to 2.52)	152 (1 study)	very low[1,3,7]
Anxiety symptoms - Endpoint HADS-A change score Follow-up: mean 4 weeks		The mean anxiety symptoms - endpoint in the intervention groups was 0.32 standard deviations lower (0.83 lower to 0.18 higher)		266 (2 studies)	very low[1,2,3,5]
Anxiety symptoms - 4-month follow-up HADS-A change		The mean anxiety symptoms - 4-month follow-up in the intervention		102 (1 study)	very low[1,2]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist or no treatment	Corresponding risk Trauma-focused CBT			
score Follow-up: mean 17 weeks		groups was 0.34 standard deviations lower (0.73 lower to 0.05 higher)			
Anxiety symptoms - 10-month follow-up HADS-A change score Follow-up: mean 43 weeks		The mean anxiety symptoms - 10-month follow-up in the intervention groups was 0.09 standard deviations lower (0.41 lower to 0.23 higher)		152 (1 study)	very low[1,3,4]
Depression symptoms - Endpoint HADS-D change score Follow-up: mean 4 weeks		The mean depression symptoms - endpoint in the intervention groups was 0.35 standard deviations lower (0.96 lower to 0.25 higher)		266 (2 studies)	very low[1,2,3,8]
Depression symptoms - 4-month follow-up HADS-D change score Follow-up: mean 17 weeks		The mean depression symptoms - 4-month follow-up in the intervention groups was 0.44 standard deviations lower (0.83 to 0.04 lower)		102 (1 study)	very low[1,4]
Depression symptoms - 10-month follow-up HADS-D change score Follow-up: mean 43 weeks		The mean depression symptoms - 10-month follow-up in the intervention groups was 0.09 standard deviations lower (0.41 lower to 0.23 higher)		152 (1 study)	very low[1,3,4]
Discontinuation (loss to follow-up) Number of participants lost to follow-up (for any reason)	179 per 1000	159 per 1000 (75 to 339)	RR 0.89 (0.42 to 1.9)	295 (2 studies)	very low[1,5,6]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist or no treatment	Corresponding risk Trauma-focused CBT			
Follow-up: mean 4 weeks					

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

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

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

[3] Data is not reported/cannot be extracted for all outcomes

[4] OIS not met (N<400)

[5] Substantial heterogeneity (I2=50-80%)

[6] 95% CI crosses line of no effect and thresholds for both clinically important harm and clinically important benefit

[7] OIS not met (events<300)

[8] Considerable heterogeneity (I2>80%)

Table 12: Summary clinical evidence profile: Trauma-focused CBT versus waitlist for delayed treatment (>3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist	Corresponding risk Trauma-focused CBT			
PTSD symptomatology self-rated at endpoint PCL/SPTSS/HTQ/MPSS/PDS/PSS-SR/IES-R change score Follow-up: 1-26 weeks		The mean PTSD symptomatology self-rated at endpoint in the intervention groups was 1.64 standard deviations lower (2.29 to 1 lower)		618 (14 studies)	very low1
PTSD symptomatology self-rated at 6-7 week follow-up IES/HTQ change score Follow-up: 6-7 weeks		The mean PTSD symptomatology self-rated at 6-7 week follow-up in the intervention groups was 0.7 standard deviations lower (1.12 to 0.28 lower)		145 (2 studies)	very low[1,2,3]
PTSD symptomatology self-rated at 3-month follow-up HTQ change score Follow-up: mean 13 weeks		The mean PTSD symptomatology self-rated at 3-month follow-up in the intervention groups was 0.31 standard deviations lower		63 (1 study)	very low[1,3,4]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist	Corresponding risk Trauma-focused CBT			
		(0.84 lower to 0.21 higher)			
PTSD symptomatology self-rated at 8-month follow-up PDS change score Follow-up: mean 35 weeks		The mean PTSD symptomatology self-rated at 8-month follow-up in the intervention groups was 1 standard deviations lower (1.34 to 0.66 lower)		166 (1 study)	very low[1,2,3]
PTSD symptomatology self-rated at 1-year follow-up IES change score Follow-up: mean 52 weeks		The mean PTSD symptomatology self-rated at 1-year follow-up in the intervention groups was 0.78 standard deviations lower (1.23 to 0.33 lower)		82 (1 study)	very low[1,2,3]
PTSD symptomatology clinician-rated at endpoint CAPS/HTQ/SI–PTSD/PSS-I change score Follow-up: 2-20 weeks		The mean PTSD symptomatology clinician-rated at endpoint in the intervention groups was 1.35 standard deviations lower (1.81 to 0.89 lower)		632 (12 studies)	very low[1,3,5]
PTSD symptomatology clinician-rated at 3-5 month follow-up CAPS/PSS-I/HTQ change score Follow-up: 13-22 weeks		The mean PTSDsymptomatology clinician-rated at 3-5 month follow-up in the intervention groups was 0.58 standard deviations lower (0.9 to 0.25 lower)		507 (4 studies)	very low[1,3,6]
Remission at endpoint Number of people no longer meeting diagnostic criteria for PTSD or no longer above clinical threshold on scale Follow-up: 2-20 weeks	182 per 1000	516 per 1000 (401 to 664)	RR 2.83 (2.2 to 3.64)	628 (14 studies)	very low[1,3,6,7]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist	Corresponding risk Trauma-focused CBT			
Remission at 3-6 month follow-up Number of people no longer meeting diagnostic criteria for PTSD or no longer above clinical threshold on scale Follow-up: 13-26 weeks	241 per 1000	579 per 1000 (406 to 826)	RR 2.4 (1.68 to 3.42)	175 (3 studies)	very low[1,3,7]
Remission at 8-month follow-up Number of people no longer meeting diagnostic criteria for PTSD Follow-up: mean 35 weeks	127 per 1000	270 per 1000 (127 to 577)	RR 2.12 (1 to 4.53)	166 (1 study)	very low[1,2,3]
Response self-rated at endpoint Number of people showing clinically significant improvement (based on reliable change indices [RCI])/ ≥50% improvement on PDS) Follow-up: 10-13 weeks	107 per 1000	509 per 1000 (244 to 1000)	RR 4.75 (2.28 to 9.88)	111 (3 studies)	very low[1,3,7]
Response self-rated at 6-month follow-up Number of people showing ≥ 50% improvement on PDS Follow-up: mean 26 weeks	379 per 1000	891 per 1000 (550 to 1000)	RR 2.35 (1.45 to 3.82)	57 (1 study)	very low[1,3,7]
Response clinician-rated Number of people showing improvement of at least 10 points on CAPS/clinically significant improvement on CAPS based on reliable change indices (RCI) Follow-up: 2-12 weeks	159 per 1000	402 per 1000 (161 to 1000)	RR 2.53 (1.01 to 6.31)	89 (3 studies)	very low[1,3,7]
Anxiety symptoms at endpoint BAI/HADS-A/STAI State/HSCL-25 Anxiety/DASS Anxiety/HAM-A change score Follow-up: 1-26 weeks		The mean anxiety symptoms at endpoint in the intervention groups was 1.33 standard deviations lower (1.72 to 0.94 lower)		760 (15 studies)	very low[1,3,6]
Anxiety symptoms at 2-month follow-up STAI State change score Follow-up: 14 weeks		The mean anxiety symptoms at 2-month follow-up in the intervention groups was 0.65 standard		82 (1 study)	very low[1,2,3]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist	Corresponding risk Trauma-focused CBT			
		deviations lower (1.09 to 0.2 lower)			
Anxiety symptoms at 5-6 month follow-up BAI/HSCL-25 Anxiety change score Follow-up: 22-26 weeks		The mean anxiety symptoms at 5-6 month follow-up in the intervention groups was 0.8 standard deviations lower (1.43 to 0.17 lower)		422 (3 studies)	very low[1,3,5]
Anxiety symptoms at 1-year follow-up STAI State change score Follow-up: mean 52 weeks		The mean anxiety symptoms at 1-year follow-up in the intervention groups was 0.69 standard deviations lower (1.13 to 0.24 lower)		82 (1 study)	very low[1,2,3]
Depression symptoms at endpoint BDI/BDI-II/CES-D/HADS-D/HSCL-25 Depression/DASS Depression/HAMD change score Follow-up: 1-26 weeks		The mean depression symptoms at endpoint in the intervention groups was 0.94 standard deviations lower (1.23 to 0.64 lower)		972 (19 studies)	very low[1,6]
Depression symptoms at 6-7 week follow-up BDI/BDI-II change score Follow-up: 6-7 weeks		The mean depression symptoms at 6-7 week follow-up in the intervention groups was 0.6 standard deviations lower (0.94 to 0.26 lower)		145 (2 studies)	very low[1,2,3]
Depression symptoms at 3-6 month follow-up BDI-II/CES-D/HSCL-25 Depression change score Follow-up: 13-26 weeks		The mean depression symptoms at 3-6 month follow-up in the intervention groups was 0.53 standard deviations lower (0.87 to 0.18 lower)		550 (5 studies)	very low[1,3,6]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist	Corresponding risk Trauma-focused CBT			
Depression symptoms at 1-year follow-up BDI change score Follow-up: mean 52 weeks		The mean depression symptoms at 1-year follow-up in the intervention groups was 0.8 standard deviations lower (1.25 to 0.35 lower)		82 (1 study)	very low[1,2,3]
Dissociative symptoms at endpoint DES change score Follow-up: 12-20 weeks		The mean dissociative symptoms at endpoint in the intervention groups was 1.08 standard deviations lower (1.42 to 0.73 lower)		153 (3 studies)	low[1,2]
Dissociative symptoms at 2-month follow-up DES change score Follow-up: 8 weeks		The mean dissociative symptoms at 2-month follow-up in the intervention groups was 0.17 standard deviations higher (0.26 lower to 0.61 higher)		82 (1 study)	very low[1,3,4]
Dissociative symptoms at 1-year follow-up DES change score Follow-up: mean 52 weeks		The mean dissociative symptoms at 1-year follow-up in the intervention groups was 0.22 standard deviations higher (0.22 lower to 0.65 higher)		82 (1 study)	very low[1,3,4]
Emotional and behavioural problems: Anger STAXI change score Follow-up: mean 18 weeks		The mean emotional and behavioural problems: anger in the intervention groups was 0.43 standard deviations lower (0.98 lower to 0.12 higher)		52 (1 study)	very low[1,3,4]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist	Corresponding risk Trauma-focused CBT			
Substance use Number of days of primary substance use in past 30 days (ASI-Lite change score) Follow-up: mean 12 weeks		The mean substance use in the intervention groups was 0.2 standard deviations higher (0.43 lower to 0.83 higher)		39 (1 study)	very low[1,4]
Global functioning GAF change score Follow-up: mean 12 weeks Better indicated by higher values		The mean global functioning in the intervention groups was 2.02 standard deviations higher (1.34 to 2.71 higher)		51 (1 study)	very low[1,3,7]
Functional impairment at endpoint SDS/SAS-SR change score Follow-up: 12-26 weeks		The mean functional impairment at endpoint in the intervention groups was 1.23 standard deviations lower (1.89 to 0.58 lower)		339 (6 studies)	very low[1,2,5]
Functional impairment at 6-month follow-up SDS change score Follow-up: mean 26 weeks		The mean functional impairment at 6-month follow-up in the intervention groups was 0.95 standard deviations lower (1.51 to 0.39 lower)		55 (1 study)	very low[1,2,3]
Relationship difficulties IIP change score Follow-up: mean 12 weeks		The mean relationship difficulties in the intervention groups was 1.72 standard deviations lower (2.41 to 1.04 lower)		46 (1 study)	low[1,2]
Quality of life at endpoint WHO-5/SF-36 mental health/Q-LES-Q-SF/QOLI change score Follow-up: 10-26 weeks		The mean quality of life at endpoint in the intervention groups was 0.52 standard deviations higher		236 (4 studies)	very low[1,4,5]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist	Corresponding risk Trauma-focused CBT			
Better indicated by higher values		(0.26 lower to 1.3 higher)			
Quality of life at 6-week follow-up WHO-5 change score Follow-up: mean 6 weeks Better indicated by higher values		The mean quality of life at 6-week follow-up in the intervention groups was 0.83 standard deviations higher (0.29 to 1.37 higher)		63 (1 study)	very low[1,2,3]
Quality of life at 3-month follow-up WHO-5 change score Follow-up: mean 13 weeks Better indicated by higher values		The mean quality of life at 3-month follow-up in the intervention groups was 0.85 standard deviations higher (0.31 to 1.39 higher)		63 (1 study)	very low[1,2,3]
Discontinuation (loss to follow-up) Number of participants lost to follow-up (for any reason) Follow-up: 1-26 weeks	176 per 1000	264 per 1000 (183 to 382)	RR 1.5 (1.04 to 2.17)	1834 (26 studies)	low[1,6]

ASI=Addition severity index; BAI=Beck Anxiety Index; BDI=Beck Depression Inventory; CAPS=Clinician-administered PTSD symptom scale; CBT=cognitive behavioural therapy; CES-D=Centre of Epidemiological Studies-Depression; CI=confidence interval; DASS=Depression Anxiety Stress Scales; DES=Dissociative Experiences Scales; GAF=Global assessment of functioning; HADS-A/D=Hospital Anxiety and Depression Scale-Anxiety/Depression; HAMD=Hamilton Rating Scale for Depression; HSCL-25=Hopkins Symptom Checklist-25; HTQ=Harvard Trauma Questionnaire; IES-R=Impact of Event Scale-Revised; MPSS=Modified PTSD symptom scale; PCL=PTSD checklist; PDS=Post-traumatic Diagnositic Scale; PSS-I/SR=PTSD symptom scale-interview/self-report; PTSD=post-traumatic stress disorder; RR=risk ratio; SAS-SR=Social Adjustment Scale-Self-Report; SDS=Sheehan Disability Scale; SI-PTSD=Structured interview for PTSD; SMD=standardised mean difference; SPTSS=Screen for post-traumatic stress disorders; STAI=State-Trait Anxiety Inventory; STAXI=State-Trait Anger Experssion Inventory

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

[2] *OIS not met (N<400)*

[3] *Data is not reported/cannot be extracted for all outcomes*

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

[5] *Considerable heterogeneity (I2>80%)*

[6] *Substantial heterogeneity (I2=50-80%)*

[7] *OIS not met (events<300)*

Table 13: Summary clinical evidence profile: Trauma-focused CBT + medication/TAU versus medication/TAU-only (or + attention-placebo) for delayed treatment (>3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Medication/TAU-only (or + attention-placebo)	Corresponding risk Trauma-focused CBT + medication/TAU			
PTSD symptomatology self-rated at endpoint IES/IES-R/PDS/PSS-SR/HTQ/DTS/PCL/MPSS change score Follow-up: 3-26 weeks		The mean PTSD symptomatology self-rated at endpoint in the intervention groups was 1.18 standard deviations lower (1.55 to 0.82 lower)		1179 (21 studies)	very low[1,2]
PTSD symptomatology self-rated at 1-month follow-up PCL/PDS change score Follow-up: 4 weeks		The mean PTSD symptomatology self-rated at 1-month follow-up in the intervention groups was 1.56 standard deviations lower (2.16 to 0.95 lower)		134 (2 studies)	very low[1,3,4,5]
PTSD symptomatology self-rated at 3-4 month follow-up PCL/PDS/IES-R change score Follow-up: 13-17 weeks		The mean PTSD symptomatology self-rated at 3-4 month follow-up in the intervention groups was 1.22 standard deviations lower (1.65 to 0.79 lower)		286 (4 studies)	very low[1,3,4,5]
PTSD symptomatology self-rated at 5-6 month follow-up IES-R/PDS change score Follow-up: 22-26 weeks		The mean PTSD symptomatology self-rated at 5-6 month follow-up in the intervention groups was 0.88 standard deviations lower (1.45 to 0.31 lower)		201 (3 studies)	very low[1,3,4,5]
PTSD symptomatology self-rated at 9-12 month follow-up PDS change score Follow-up: 39-52 weeks		The mean PTSD symptomatology self-rated at 9-12 month follow-up in the intervention groups was 0.77 standard deviations lower		121 (3 studies)	very low[1,2,5,6]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Medication/TAU-only (or + attention-placebo)	Corresponding risk Trauma-focused CBT + medication/TAU			
		(1.98 lower to 0.44 higher)			
PTSD symptomatology clinician-rated at endpoint CAPS/HTQ/PSS-I/SI-PTSD change score Follow-up: 2-26 weeks		The mean PTSD symptomatology clinician-rated at endpoint in the intervention groups was 1.35 standard deviations lower (1.69 to 1.02 lower)		1640 (22 studies)	very low[1,2]
PTSD symptomatology clinician-rated at 1-month follow-up CAPS change score Follow-up: 4 weeks		The mean PTSD symptomatology clinician-rated at 1-month follow-up in the intervention groups was 0.81 standard deviations lower (1.54 to 0.08 lower)		243 (4 studies)	very low[1,2,4,5]
PTSD symptomatology clinician-rated at 3-4 month follow-up CAPS change score Follow-up: 13-17 weeks		The mean PTSD symptomatology clinician-rated at 3-4 month follow-up in the intervention groups was 1.01 standard deviations lower (1.76 to 0.27 lower)		280 (5 studies)	very low[1,2,4,5]
PTSD symptomatology clinician-rated at 5-6 month follow-up CAPS/HTQ/PSS-I/PDS change score Follow-up: 22-26 weeks		The mean PTSD symptomatology clinician-rated at 5-6 month follow-up in the intervention groups was 0.78 standard deviations lower (1.06 to 0.51 lower)		648 (7 studies)	very low[1,3,5]
PTSD symptomatology clinician-rated at 9-12 month follow-up CAPS/PDS-I/CIDI-PTSD change score Follow-up: 39-52 weeks		The mean PTSD symptomatology clinician-rated at 9-12 month follow-up in the intervention groups was 0.6 standard deviations lower (1.67 lower to 0.47 higher)		94 (3 studies)	very low[1,2,5,6]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Medication/TAU-only (or + attention-placebo)	Corresponding risk Trauma-focused CBT + medication/TAU			
Remission at endpoint Number of people no longer meeting diagnostic criteria/above threshold on a scale for PTSD Follow-up: 6-26 weeks	143 per 1000	478 per 1000 (279 to 821)	RR 3.34 (1.95 to 5.73)	917 (12 studies)	very low[1,2,7]
Remission at 1-3 month follow-up Number of people no longer meeting diagnostic criteria for PTSD Follow-up: 4-13 weeks	140 per 1000	234 per 1000 (102 to 535)	RR 1.67 (0.73 to 3.81)	249 (3 studies)	very low[5,8]
Remission at 6-month follow-up Number of people no longer meeting diagnostic criteria for PTSD Follow-up: mean 26 weeks	115 per 1000	260 per 1000 (160 to 420)	RR 2.26 (1.39 to 3.66)	324 (4 studies)	low[1,7]
Remission at 1-year follow-up Number of people no longer meeting diagnostic criteria for PTSD Follow-up: mean 52 weeks	167 per 1000	588 per 1000 (157 to 1000)	RR 3.53 (0.94 to 13.29)	29 (1 study)	low[5,6]
Response self-rated at endpoint Number of people showing clinically significant improvement based on reliable change indices [RCI] on IES/IES-R/DTS	252 per 1000	461 per 1000 (272 to 781)	RR 1.83 (1.08 to 3.1)	328 (5 studies)	very low[1,5,7]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Medication/TAU-only (or + attention-placebo)	Corresponding risk Trauma-focused CBT + medication/TAU			
Follow-up: 5-20 weeks					
Response self-rated at 6-month follow-up Number of people showing clinically significant improvement (based on reliable change indices [RCI]) on PDS Follow-up: mean 26 weeks	188 per 1000	624 per 1000 (210 to 1000)	RR 3.33 (1.12 to 9.9)	32 (1 study)	very low[1,5,7]
Response clinician-rated at endpoint Number of people showing clinically significant improvement based on reliable change indices [RCI]/improvement of at least 12/30 points on CAPS Follow-up: 6-14 weeks	164 per 1000	468 per 1000 (236 to 932)	RR 2.86 (1.44 to 5.69)	245 (4 studies)	very low[1,3,5,7]
Response clinician-rated at 1-month follow-up Number of people showing clinically significant improvement based on reliable change indices [RCI]/improvement of at least 12 points on CAPS Follow-up: mean 4 weeks	167 per 1000	608 per 1000 (62 to 1000)	RR 3.65 (0.37 to 36.42)	141 (2 studies)	very low[1,3,5,8]
Dissociative symptoms at endpoint DES change score		The mean dissociative symptoms at endpoint in the intervention groups was		114 (2 studies)	low[1,4]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Medication/TAU-only (or + attention-placebo)	Corresponding risk Trauma-focused CBT + medication/TAU			
Follow-up: 6-12 weeks		0.9 standard deviations lower (1.29 to 0.52 lower)			
Dissociative symptoms at 1-month follow-up DES change score Follow-up: mean 4 weeks		The mean dissociative symptoms at 1-month follow-up in the intervention groups was 0.85 standard deviations lower (1.33 to 0.37 lower)		74 (1 study)	very low[1,4,5]
Dissociative symptoms at 3-month follow-up DES change score Follow-up: mean 13 weeks		The mean dissociative symptoms at 3-month follow-up in the intervention groups was 0.69 standard deviations lower (1.16 to 0.22 lower)		74 (1 study)	very low[1,4,5]
Dissociative symptoms at 6-month follow-up DES change score Follow-up: mean 26 weeks		The mean dissociative symptoms at 6-month follow-up in the intervention groups was 0.45 standard deviations lower (1.3 lower to 0.39 higher)		22 (1 study)	very low[1,5,6]
Dissociative symptoms at 1-year follow-up DES change score Follow-up: mean 52 weeks		The mean dissociative symptoms at 1-year follow-up in the intervention groups was 0.25 standard deviations lower (1.09 lower to 0.59 higher)		22 (1 study)	very low[1,5,8]
Anxiety symptoms at endpoint BAI/HAM-A/STAI State change score Follow-up: 5-26 weeks		The mean anxiety symptoms at endpoint in the intervention groups was 0.74 standard deviations lower (1.12 to 0.35 lower)		647 (13 studies)	very low[1,2]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Medication/TAU-only (or + attention-placebo)	Corresponding risk Trauma-focused CBT + medication/TAU			
Anxiety symptoms at 1-month follow-up STAI State change score Follow-up: mean 4 weeks		The mean anxiety symptoms at 1-month follow-up in the intervention groups was 0.94 standard deviations lower (1.48 to 0.41 lower)		60 (1 study)	very low[1,4,5]
Anxiety symptoms at 3-month follow-up BAI/STAI State change score Follow-up: mean 13 weeks		The mean anxiety symptoms at 3-month follow-up in the intervention groups was 0.72 standard deviations lower (1.09 to 0.35 lower)		124 (2 studies)	low[1,4]
Anxiety symptoms at 5-6 month follow-up BAI/STAI State change score Follow-up: 22-26 weeks		The mean anxiety symptoms at 5-6 month follow-up in the intervention groups was 0.23 standard deviations lower (0.64 lower to 0.17 higher)		98 (2 studies)	low[1,6]
Anxiety symptoms at 9-12 month follow-up STAI State change score Follow-up: 39-52 weeks		The mean anxiety symptoms at 9-12 month follow-up in the intervention groups was 0.18 standard deviations higher (0.22 lower to 0.58 higher)		96 (2 studies)	very low[1,6]
Depression symptoms at endpoint BDI/BDI-II/CES-D/HAMD/MADRS change score Follow-up: 5-26 weeks		The mean depression symptoms at endpoint in the intervention groups was 1.04 standard deviations lower (1.33 to 0.74 lower)		1536 (22 studies)	very low[1,2]
Depression symptoms at 1-month follow-up BDI/BDI-II/HAMD change score		The mean depression symptoms at 1-month follow-up in the intervention groups was		194 (3 studies)	very low[1,2,5,6]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Medication/TAU-only (or + attention-placebo)	Corresponding risk Trauma-focused CBT + medication/TAU			
Follow-up: mean 4 weeks		0.55 standard deviations lower (1.37 lower to 0.26 higher)			
Depression symptoms at 3-4 month follow-up BDI-II/HAMD change score Follow-up: 13-17 weeks		The mean depression symptoms at 3-4 month follow-up in the intervention groups was 0.72 standard deviations lower (0.94 to 0.5 lower)		358 (5 studies)	very low[1,4,5]
Depression symptoms at 5-6 month follow-up BDI-II/HSCL-25 Depression/HAMD change score Follow-up: 22-26 weeks		The mean depression symptoms at 5-6 month follow-up in the intervention groups was 0.41 standard deviations lower (0.62 to 0.2 lower)		379 (6 studies)	low[1,4]
Depression symptoms at 9-12 month follow-up HAMD/BDI-II change score Follow-up: 39-52 weeks		The mean depression symptoms at 9-12 month follow-up in the intervention groups was 0.33 standard deviations lower (0.7 lower to 0.04 higher)		118 (3 studies)	very low[1,5,6]
Personality disorder symptoms - Endpoint BSL change score Follow-up: mean 12 weeks		The mean personality disorder symptoms - endpoint in the intervention groups was 1.01 standard deviations lower (1.5 to 0.53 lower)		74 (1 study)	very low[1,4,5]
Personality disorder symptoms - 1-month follow-up BSL change score Follow-up: mean 4 weeks		The mean personality disorder symptoms - 1-month follow-up in the intervention groups was 0.63 standard		74 (1 study)	very low[1,4,5]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Medication/TAU-only (or + attention-placebo)	Corresponding risk Trauma-focused CBT + medication/TAU			
		deviations lower (1.09 to 0.16 lower)			
Personality disorder symptoms - 3-month follow-up BSL change score Follow-up: mean 13 weeks		The mean personality disorder symptoms - 3-month follow-up in the intervention groups was 0.62 standard deviations lower (1.09 to 0.15 lower)		74 (1 study)	very low[1,4,5]
Personality disorder symptoms - 6-month follow-up BSL change score Follow-up: mean 26 weeks		The mean personality disorder symptoms - 6-month follow-up in the intervention groups was 0.6 standard deviations higher (0.26 lower to 1.46 higher)		22 (1 study)	very low[1,5,6]
Personality disorder symptoms - 1-year follow-up BSL change score Follow-up: mean 52 weeks		The mean personality disorder symptoms - 1-year follow-up in the intervention groups was 0.27 standard deviations higher (0.57 lower to 1.11 higher)		22 (1 study)	very low[1,5,8]
Alcohol use disorder symptoms at endpoint AUDIT/SADQ change score Follow-up: 6-12 weeks		The mean alcohol use disorder symptoms at endpoint in the intervention groups was 0.07 standard deviations lower (0.53 lower to 0.38 higher)		105 (2 studies)	very low[1,5,6]
Alcohol use disorder symptoms at 3-5 month follow-up AUDIT/SADQ change score Follow-up: 13-22 weeks		The mean alcohol use disorder symptoms at 3-5 month follow-up in the intervention groups was 0.01 standard deviations higher		104 (2 studies)	very low[1,2,5,8]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Medication/TAU-only (or + attention-placebo)	Corresponding risk Trauma-focused CBT + medication/TAU			
		(1.07 lower to 1.09 higher)			
Alcohol use disorder symptoms at 9 month follow-up SADQ change score Follow-up: mean 39 weeks		The mean alcohol use disorder symptoms at 9 month follow-up in the intervention groups was 0.1 standard deviations higher (0.48 lower to 0.67 higher)		47 (1 study)	very low[1,5,6]
Alcohol use: Percent days abstinent from alcohol (change score) - 3-month follow-up TLFB Follow-up: mean 13 weeks Better indicated by higher values		The mean alcohol use: percent days abstinent from alcohol (change score) - 3-month follow-up in the intervention groups was 0.18 standard deviations higher (0.19 lower to 0.56 higher)		126 (1 study)	low[1,6]
Alcohol use: Percent days abstinent from alcohol (change score) - 6-month follow-up TLFB Follow-up: mean 26 weeks Better indicated by higher values		The mean alcohol use: percent days abstinent from alcohol (change score) - 6-month follow-up in the intervention groups was 0.11 standard deviations higher (0.26 lower to 0.48 higher)		126 (1 study)	low[1,4]
Alcohol use: Percent drinking days (change score) - Endpoint TLFB Follow-up: mean 24 weeks		The mean alcohol use: percent drinking days (change score) - endpoint in the intervention groups was 0.2 standard deviations higher (0.23 lower to 0.64 higher)		82 (1 study)	very low[1,5,6]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Medication/TAU-only (or + attention-placebo)	Corresponding risk Trauma-focused CBT + medication/TAU			
Alcohol use: Percent drinking days (change score) - 6-month follow-up TLFB Follow-up: mean 26 weeks		The mean alcohol use: percent drinking days (change score) - 6-month follow-up in the intervention groups was 0.4 standard deviations lower (0.84 lower to 0.03 higher)		82 (1 study)	very low[1,5,6]
Alcohol use: Drinks per drinking day (change score) - Endpoint TLFB Follow-up: mean 12 weeks		The mean alcohol use: drinks per drinking day (change score) - endpoint in the intervention groups was 0.23 standard deviations higher (0.35 lower to 0.81 higher)		46 (1 study)	very low[1,5,6]
Alcohol use: Drinks per drinking day (change score) - 5-month follow-up TLFB Follow-up: mean 22 weeks		The mean alcohol use: drinks per drinking day (change score) - 5-month follow-up in the intervention groups was 0.92 standard deviations higher (0.3 to 1.54 higher)		45 (1 study)	very low[1,4,5]
Alcohol use: Drinks per drinking day (change score) - 9-month follow-up TLFB Follow-up: mean 39 weeks		The mean alcohol use: drinks per drinking day (change score) - 9-month follow-up in the intervention groups was 0.33 standard deviations higher (0.25 lower to 0.91 higher)		47 (1 study)	very low[1,5,6]
Drug use: Percent days abstinent from drugs (change score) - 3-month follow-up		The mean drug use: percent days abstinent from drugs (change score) - 3-month follow-up in the		126 (1 study)	low[1,4]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Medication/TAU-only (or + attention-placebo)	Corresponding risk Trauma-focused CBT + medication/TAU			
TLFB Follow-up: mean 13 weeks Better indicated by higher values		intervention groups was 0.48 standard deviations higher (0.11 to 0.86 higher)			
Drug use: Percent days abstinent from drugs (change score) - 6-month follow-up TLFB Follow-up: mean 26 weeks Better indicated by higher values		The mean drug use: percent days abstinent from drugs (change score) - 6-month follow-up in the intervention groups was 0.82 standard deviations higher (0.43 to 1.21 higher)		126 (1 study)	low[1,4]
Substance use: Number of days of primary substance use in past 30 days - Endpoint ASI-Lite change score Follow-up: mean 12 weeks		The mean substance use: number of days of primary substance use in past 30 days - endpoint in the intervention groups was 1.01 standard deviations higher (0.37 to 1.64 higher)		44 (1 study)	very low[1,4]
Substance use: Number of days of primary substance use in past 30 days - 1-month follow-up ASI-Lite change score Follow-up: mean 4 weeks		The mean substance use: number of days of primary substance use in past 30 days - 1-month follow-up in the intervention groups was 0.68 standard deviations higher (0.1 to 1.27 higher)		49 (1 study)	very low[1,7]
Substance use: Number of days of primary substance use in past 30 days - 2-month follow-up ASI-Lite change score		The mean substance use: number of days of primary substance use in past 30 days - 2-month follow-up in the intervention groups was		46 (1 study)	very low[1,4]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Medication/TAU-only (or + attention-placebo)	Corresponding risk Trauma-focused CBT + medication/TAU			
Follow-up: mean 8 weeks		0.87 standard deviations higher (0.26 to 1.47 higher)			
Substance use: Number of days of primary substance use in past 30 days - 3-month follow-up ASI-Lite change score Follow-up: mean 13 weeks		The mean substance use: number of days of primary substance use in past 30 days - 3-month follow-up in the intervention groups was 0.58 standard deviations higher (0.01 to 1.14 higher)		50 (1 study)	very low[1,4]
Substance dependence remission at endpoint Number of people no longer meeting diagnostic criteria for substance dependence Follow-up: 12-13 weeks	390 per 1000	405 per 1000 (234 to 701)	RR 1.04 (0.6 to 1.8)	165 (2 studies)	very low[1,8]
Substance dependence remission at 5-6 month follow-up Number of people no longer meeting diagnostic criteria for substance dependence Follow-up: 22-26 weeks	455 per 1000	500 per 1000 (359 to 695)	RR 1.1 (0.79 to 1.53)	165 (2 studies)	very low[1,8]
Substance dependence remission at 9-month follow-up Number of people no longer meeting diagnostic criteria for substance	414 per 1000	364 per 1000 (194 to 679)	RR 0.88 (0.47 to 1.64)	62 (1 study)	very low[5,6]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Medication/TAU-only (or + attention-placebo)	Corresponding risk Trauma-focused CBT + medication/TAU			
dependence Follow-up: mean 39 weeks					
Global functioning - Endpoint GAF change score Follow-up: mean 12 weeks Better indicated by higher values		The mean global functioning - endpoint in the intervention groups was 1.25 standard deviations higher (0.75 to 1.75 higher)		74 (1 study)	very low[1,4,5]
Global functioning - 1-month follow-up GAF change score Follow-up: mean 4 weeks Better indicated by higher values		The mean global functioning - 1-month follow-up in the intervention groups was 1.77 standard deviations higher (1.23 to 2.32 higher)		74 (1 study)	very low[1,4,5]
Global functioning - 3-month follow-up GAF change score Follow-up: mean 13 weeks Better indicated by higher values		The mean global functioning - 3-month follow-up in the intervention groups was 1.48 standard deviations higher (0.96 to 2 higher)		74 (1 study)	very low[1,4,5]
Functional impairment SDS/M2C change score/SAS endpoint Follow-up: 6-26 weeks		The mean functional impairment in the intervention groups was 0.53 standard deviations lower (0.87 to 0.18 lower)		295 (5 studies)	low[1,4]
Emotional and behavioural problems: Aggression/Anger - Endpoint AAS/DARS-7 change score Follow-up: 2-6 weeks		The mean emotional and behavioural problems: aggression/anger - endpoint in the intervention groups was 0.42 standard deviations lower		89 (2 studies)	very low[1,4,5]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Medication/TAU-only (or + attention-placebo)	Corresponding risk Trauma-focused CBT + medication/TAU			
		(0.84 lower to 0 higher)			
Emotional and behavioural problems: Aggression/Anger - 3-6 month follow-up AAS/DARS-7 change score Follow-up: 13-26 weeks		The mean emotional and behavioural problems: aggression/anger - 3-6 month follow-up in the intervention groups was 0.58 standard deviations lower (1 to 0.15 lower)		89 (2 studies)	very low[1,4,5]
Quality of life - Endpoint WHO-5/SF-12 change score Follow-up: 3-26 weeks Better indicated by higher values		The mean quality of life - endpoint in the intervention groups was 0.06 standard deviations lower (0.34 lower to 0.21 higher)		203 (3 studies)	low[1,4]
Quality of life - 3-4 month follow-up WHO-5/SF-12 change score Follow-up: 13-17 weeks Better indicated by higher values		The mean quality of life - 3-4 month follow-up in the intervention groups was 0.16 standard deviations higher (0.65 lower to 0.97 higher)		92 (2 studies)	very low[1,3,8]
Quality of life - 6-month follow-up SF-12 change score Follow-up: mean 26 weeks Better indicated by higher values		The mean quality of life - 6-month follow-up in the intervention groups was 0.67 standard deviations higher (0.1 to 1.24 higher)		53 (1 study)	very low[1,4,5]
Quality of life - 1-year follow-up SF-12 change score Follow-up: mean 52 weeks Better indicated by higher values		The mean quality of life - 1-year follow-up in the intervention groups was 0.4 standard deviations higher (0.4 lower to 1.19 higher)		25 (1 study)	very low[1,5,6]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Medication/TAU-only (or + attention-placebo)	Corresponding risk Trauma-focused CBT + medication/TAU			
Relationship difficulties - Endpoint ADAS change score Follow-up: mean 6 weeks		The mean relationship difficulties - endpoint in the intervention groups was 0.86 standard deviations higher (0.33 to 1.4 higher)		59 (1 study)	very low[1,4,5]
Relationship difficulties - 3-month follow-up ADAS change score Follow-up: mean 13 weeks		The mean relationship difficulties - 3-month follow-up in the intervention groups was 0.15 standard deviations higher (0.36 lower to 0.66 higher)		59 (1 study)	very low[1,5,6]
Discontinuation Number of participants lost to follow-up for any reason Follow-up: 2-26 weeks	254 per 1000	303 per 1000 (257 to 356)	RR 1.19 (1.01 to 1.4)	2764 (35 studies)	moderate[1]

AAS=Adult attachment scale; ADAS=Alxheimer's Disease Assesment Scale; ASI= Addition severity index; AUDIT=Alcohol use disorders identification test; BAI= Beck Anxiety Index; BSL=Borderline symptom list; CAPS= Clinician-administered PTSD symptom scale; CBT= cognitive behavioural therapy; CI= confidence interval; CES-D= Centre of Epidemiological Studies-Depression; CIDI-PTSD=; DARS=Drug and alcohol recovery service; DES= Dissociative Experiences Scales; DTS=Davidson Trauma Scale; GAF= Global assessment of functioning; HAM-A/D= Hamilton Rating Scale-Anxiety/Depression; HSCL-25= Hopkins Symptom Checklist-25; HTQ= Harvard Trauma Questionnaire; IES-R= Impact of Event Scale-Revised; MADRS=Montgomery-Asberg Depression Rating Scale; MPSS= Modified PTSD symptom scale; PSS-I/SR= PTSD symptom scale-interview/self-report; PCL= PTSD checklist; PDS= Post-traumatic Diagnositic Scale; PTSD= post-traumatic stress disorder; RR= risk ratio; SADQ=Severity of alcohol dependence questionnaire; SAS= Social Adjustment Scale; SF-12=Short form-12; SI-PTSD= Structured interview for PTSD; SMD= standardised mean difference; STAI= State-Trait Anxiety Inventory; TAU=Treatment as usual; TLFB=Alcohol timeline followback;

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

[2] Considerable heterogeneity (I2>80%)

[3] Substantial heterogeneity (I2=50-80%)

[4] OIS not met (N<400)

[5] Data is not reported/cannot be extracted for all outcomes

[6] 95% CI crosses both line of no effect and threshold for clinically important effect

[7] OIS not met (events<300)

[8] 95% CI crosses line of no effect and threshold for both clinically important benefit and clinically important harm

Table 14: Summary clinical evidence profile: Trauma-focused CBT (+/- TAU) versus eye movement desensitisation and reprocessing (EMDR; +/- TAU) for delayed treatment (>3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Eye movement desensitisation and reprocessing (EMDR; +/- TAU)	Corresponding risk Trauma-focused CBT (+/- TAU)			
PTSD symptomatology self-rated at endpoint IES/IES-R/PSS-SR change score Follow-up: 6-10 weeks		The mean PTSD symptomatology self-rated at endpoint in the intervention groups was 0.6 standard deviations higher (0.27 lower to 1.48 higher)		139 (4 studies)	very low[1,2,3]
PTSD symptomatology self-rated at 3-month follow-up PSS-SR change score Follow-up: mean 13 weeks		The mean PTSD symptomatology self-rated at 3-month follow-up in the intervention groups was 0.41 standard deviations lower (1.13 lower to 0.32 higher)		30 (1 study)	low[1,3]
PTSD symptomatology self-rated at 6-month follow-up PSS-SR change score Follow-up: mean 26 weeks		The mean PTSD symptomatology self-rated at 6-month follow-up in the intervention groups was 0.46 standard deviations lower (1.11 lower to 0.18 higher)		38 (1 study)	low[1,3]
PTSD symptomatology clinician-rated at endpoint CAPS/SI-PTSD change score Follow-up: 6-16 weeks		The mean PTSD symptomatology clinician-rated at endpoint in the intervention groups was 0.2 standard deviations higher (0.23 lower to 0.63 higher)		204 (5 studies)	very low[1,3,4]
PTSD symptomatology clinician-		The mean PTSD symptomatology clinician-rated at		30 (1 study)	low[1,3]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Eye movement desensitisation and reprocessing (EMDR; +/- TAU)	Corresponding risk Trauma-focused CBT (+/- TAU)			
rated at 3-month follow-up CAPS change score Follow-up: mean 13 weeks		3-month follow-up in the intervention groups was 0.25 standard deviations lower (0.97 lower to 0.47 higher)			
PTSD symptomatology clinician-rated at 6-month follow-up CAPS change score Follow-up: mean 26 weeks		The mean PTSD symptomatology clinician-rated at 6-month follow-up in the intervention groups was 0.07 standard deviations lower (0.7 lower to 0.57 higher)		38 (1 study)	very low[1,5]
Remission at endpoint Number of people no longer meeting diagnostic criteria or no longer above clinical threshold on scale for PTSD Follow-up: 6-8 weeks	695 per 1000	584 per 1000 (243 to 1000)	RR 0.84 (0.35 to 2.04)	230 (4 studies)	very low[1,2,5]
Remission at 3-month follow-up Number of people no longer above clinical threshold on scale for PTSD Follow-up: mean 13 weeks	211 per 1000	318 per 1000 (109 to 922)	RR 1.51 (0.52 to 4.38)	41 (1 study)	very low[1,5]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Eye movement desensitisation and reprocessing (EMDR; +/- TAU)	Corresponding risk Trauma-focused CBT (+/- TAU)			
Remission at 6-month follow-up Number of people no longer meeting diagnostic criteria for PTSD Follow-up: mean 26 weeks	600 per 1000	828 per 1000 (570 to 1000)	RR 1.38 (0.95 to 2)	48 (1 study)	low[1,3]
Response self-rated at endpoint Number of people showing clinically significant improvement based on reliable change indices (RCI) on IES Follow-up: mean 10 weeks	436 per 1000	244 per 1000 (126 to 475)	RR 0.56 (0.29 to 1.09)	76 (1 study)	very low[1,3,6]
Response self-rated at 15-month follow-up Number of people showing clinically significant improvement based on reliable change indices (RCI) on IES Follow-up: mean 65 weeks	256 per 1000	162 per 1000 (67 to 403)	RR 0.63 (0.26 to 1.57)	76 (1 study)	very low[1,5,6]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Eye movement desensitisation and reprocessing (EMDR; +/- TAU)	Corresponding risk Trauma-focused CBT (+/- TAU)			
Dissociative symptoms at endpoint DES/CAPS dissociation cluster change score Follow-up: mean 6 weeks		The mean dissociative symptoms at endpoint in the intervention groups was 0.41 standard deviations higher (0.36 lower to 1.18 higher)		70 (2 studies)	very low[1,3,4]
Dissociative symptoms at 3-month follow-up CAPS dissociation cluster change score Follow-up: mean 13 weeks		The mean dissociative symptoms at 3-month follow-up in the intervention groups was 0 standard deviations higher (0.72 lower to 0.72 higher)		30 (1 study)	very low[1,5]
Dissociative symptoms at 6-month follow-up DES change score Follow-up: mean 26 weeks		The mean dissociative symptoms at 6-month follow-up in the intervention groups was 0.47 standard deviations higher (0.17 lower to 1.12 higher)		38 (1 study)	low[1,3]
Anxiety symptoms at endpoint STAI State/HADS-A/HAM-A change score Follow-up: 6-16 weeks		The mean anxiety symptoms at endpoint in the intervention groups was 0.62 standard deviations higher (0.33 to 0.9 higher)		202 (4 studies)	very low[1,6,7]
Anxiety symptoms at 6-month follow-up STAI State change score		The mean anxiety symptoms at 6-month follow-up in the intervention groups was 0.21 standard		38 (1 study)	low[1,3]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Eye movement desensitisation and reprocessing (EMDR; +/- TAU)	Corresponding risk Trauma-focused CBT (+/- TAU)			
Follow-up: mean 26 weeks		deviations lower (0.85 lower to 0.43 higher)			
Depression symptoms at endpoint BDI/BDI-II/HADS-D/MADRS change score Follow-up: 6-16 weeks		The mean depression symptoms at endpoint in the intervention groups was 0.53 standard deviations higher (0.19 to 0.86 higher)		232 (5 studies)	very low[1,4,6,7]
Depression symptoms at 3-month follow-up BDI change score Follow-up: mean 13 weeks		The mean depression symptoms at 3-month follow-up in the intervention groups was 0.22 standard deviations higher (0.5 lower to 0.93 higher)		30 (1 study)	very low[1,5]
Depression symptoms at 6-month follow-up BDI change score Follow-up: mean 26 weeks		The mean depression symptoms at 6-month follow-up in the intervention groups was 0.48 standard deviations higher (0.17 lower to 1.13 higher)		38 (1 study)	low[1,3]
Functional impairment SDS change score Follow-up: mean 10 weeks		The mean functional impairment in the intervention groups was 0.66 standard deviations higher (0.07 to 1.25 higher)		48 (1 study)	very low[1,6,7]
Discontinuation Number of participants	230 per 1000	317 per 1000 (225 to 446)	RR 1.38 (0.98 to 1.94)	346 (6 studies)	low[1,3]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Eye movement desensitisation and reprocessing (EMDR; +/- TAU)	Corresponding risk Trauma-focused CBT (+/- TAU)			
lost to follow-up for any reason Follow-up: 6-16 weeks					

BDI=Beck Depression Inventory; CAPS= Clinician-administered PTSD symptom scale; CBT= cognitive behavioural therapy; CI= confidence interval; DES= Dissociative Experiences Scales; EMDR=Eye movement desensitisation and reprocessing; HADS-A/D=; HAM-A= Hamilton Rating Scale for Anxiety; IES-R=Impact of Event Scale-Revised; MADRS= Montgomery-Asberg Depression Rating Scale; PSS-SR= PTSD symptom scale-self-report; PTSD= post-traumatic stress disorder; RR= risk ratio; SDS=Self-rating Depression Scale; SI-PTSD=; STAI= Structured interview for PTSD; SMD=Standardised mean difference; TAU=Treatment as usual

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

[2] *Considerable heterogeneity (I2>80%)*

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

[4] *Substantial heterogeneity (I2=50-80%)*

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

[6] *Data is not reported/cannot be extracted for all outcomes*

[7] *OIS not met (N<400)*

Table 15: Summary clinical evidence profile: Trauma-focused CBT (+/-TAU) versus non-trauma-focused CBT (+/- TAU) for delayed treatment (>3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Non-trauma-focused CBT (+/- TAU)	Corresponding risk Trauma-focused CBT (+/-TAU)			
PTSD symptomatology self-rated at 1-month follow-up PCL change score Follow-up: mean 4 weeks		The mean PTSD symptomatology self-rated at 1-month follow-up in the intervention groups was 0.02 standard deviations higher (0.37 lower to 0.42 higher)		99 (1 study)	very low[1,2,3]
PTSD symptomatology self-rated at 3-month		The mean PTSD symptomatology self-rated at 3-month follow-up		98 (1 study)	very low[1,3,4]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Non-trauma-focused CBT (+/-TAU)	Corresponding risk Trauma-focused CBT (+/-TAU)			
follow-up PCL change score Follow-up: mean 13 weeks		in the intervention groups was 0.16 standard deviations higher (0.24 lower to 0.56 higher)			
PTSD symptomatology self-rated at 6-month follow-up PCL change score Follow-up: mean 26 weeks		The mean PTSD symptomatology self-rated at 6-month follow-up in the intervention groups was 0.21 standard deviations higher (0.2 lower to 0.62 higher)		93 (1 study)	very low[1,3,4]
PTSD symptomatology clinician-rated at endpoint PSS-I change score Follow-up: mean 5 weeks		The mean PTSD symptomatology clinician-rated at endpoint in the intervention groups was 0.47 standard deviations higher (0.35 lower to 1.3 higher)		24 (1 study)	very low[1,3,4]
PTSD symptomatology clinician-rated at 1-3 month follow-up CAPS change score Follow-up: 4-13 weeks		The mean PTSD symptomatology clinician-rated at 1-3 month follow-up in the intervention groups was 0.53 standard deviations lower (1.35 lower to 0.3 higher)		121 (2 studies)	very low[1,3,4,5]
PTSD symptomatology clinician-rated at 6-month follow-up CAPS change score Follow-up: mean 26 weeks		The mean PTSD symptomatology clinician-rated at 6-month follow-up in the intervention groups was 1.36 standard deviations lower (2.31 to 0.41 lower)		22 (1 study)	very low[1,2,3]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Non-trauma-focused CBT (+/-TAU)	Corresponding risk Trauma-focused CBT (+/-TAU)			
Remission at endpoint Number of people no longer meeting diagnostic criteria for PTSD Follow-up: mean 5 weeks	412 per 1000	284 per 1000 (103 to 778)	RR 0.69 (0.25 to 1.89)	31 (1 study)	very low[1,3,6]
Remission at 1-month follow-up Number of people no longer meeting diagnostic criteria for PTSD Follow-up: mean 4 weeks	0 per 1000	0 per 1000 (0 to 0)	RR 6.12 (0.35 to 108.58)	28 (1 study)	very low[1,3,6]
Remission at 6-month follow-up Number of people no longer meeting diagnostic criteria for PTSD Follow-up: mean 26 weeks	154 per 1000	134 per 1000 (22 to 818)	RR 0.87 (0.14 to 5.32)	28 (1 study)	very low[1,3,6]
Remission at 1-year follow-up Number of people no longer meeting diagnostic criteria for PTSD Follow-up: mean 52 weeks	154 per 1000	200 per 1000 (40 to 1000)	RR 1.3 (0.26 to 6.62)	28 (1 study)	very low[1,3,6]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Non-trauma-focused CBT (+/-TAU)	Corresponding risk Trauma-focused CBT (+/-TAU)			
Response clinician-rated at endpoint Number of people showing clinically significant improvement based on reliable change indices (RCI) on PSS-I Follow-up: mean 5 weeks	588 per 1000	288 per 1000 (112 to 718)	RR 0.49 (0.19 to 1.22)	31 (1 study)	very low[1,3,4]
Anxiety symptoms STAI State change score Follow-up: mean 5 weeks		The mean anxiety symptoms in the intervention groups was 0.09 standard deviations higher (0.72 lower to 0.9 higher)		24 (1 study)	very low[1,3,6]
Depression symptoms at endpoint BDI change score Follow-up: mean 5 weeks		The mean depression symptoms at endpoint in the intervention groups was 0.39 standard deviations higher (0.43 lower to 1.21 higher)		24 (1 study)	very low[1,3,4]
Depression symptoms at 1-month follow-up BDI/HAMD change score Follow-up: mean 4 weeks		The mean depression symptoms at 1-month follow-up in the intervention groups was 0.48 standard deviations lower (1.3 lower to 0.33 higher)		119 (2 studies)	very low[1,3,4,5]
Depression symptoms at 3-month follow-up		The mean depression symptoms at 3-month follow-up		98 (1 study)	very low[1,3,4]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Non-trauma-focused CBT (+/-TAU)	Corresponding risk Trauma-focused CBT (+/-TAU)			
BDI change score Follow-up: mean 13 weeks		in the intervention groups was 0.26 standard deviations lower (0.66 lower to 0.14 higher)			
Depression symptoms at 6-month follow-up BDI/HAMD change score Follow-up: mean 26 weeks		The mean depression symptoms at 6-month follow-up in the intervention groups was 0.7 standard deviations lower (1.84 lower to 0.45 higher)		114 (2 studies)	very low[1,3,4,5]
Sleeping difficulties - 1-month follow-up PSQI change score Follow-up: mean 4 weeks		The mean sleeping difficulties - 1-month follow-up in the intervention groups was 0.1 standard deviations lower (0.5 lower to 0.3 higher)		97 (1 study)	very low[1,3,4]
Sleeping difficulties - 3-month follow-up PSQI change score Follow-up: mean 13 weeks		The mean sleeping difficulties - 3-month follow-up in the intervention groups was 0.12 standard deviations higher (0.27 lower to 0.52 higher)		100 (1 study)	very low[1,3,4]
Sleeping difficulties - 6-month follow-up PSQI change score Follow-up: mean 26 weeks		The mean sleeping difficulties - 6-month follow-up in the intervention groups was 0.17 standard deviations lower (0.57 lower to 0.23 higher)		99 (1 study)	very low[1,3,4]
Quality of life - 1-month		The mean quality of life - 1-month		95 (1 study)	very low[1,2,3]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Non-trauma-focused CBT (+/-TAU)	Corresponding risk Trauma-focused CBT (+/-TAU)			
follow-up SF-36 MH change score Follow-up: mean 4 weeks Better indicated by higher values		follow-up in the intervention groups was 0.56 standard deviations higher (0.15 to 0.97 higher)			
Quality of life - 3-month follow-up SF-36 MH change score Follow-up: mean 13 weeks Better indicated by higher values		The mean quality of life - 3-month follow-up in the intervention groups was 0.24 standard deviations higher (0.16 lower to 0.64 higher)		97 (1 study)	very low[1,3,4]
Quality of life - 6-month follow-up SF-36 MH change score Follow-up: mean 26 weeks Better indicated by higher values		The mean quality of life - 6-month follow-up in the intervention groups was 0.29 standard deviations higher (0.13 lower to 0.71 higher)		91 (1 study)	very low[1,3,4]
Discontinuation Number of participants lost to follow-up for any reason Follow-up: 5-13 weeks	140 per 1000	260 per 1000 (141 to 479)	RR 1.86 (1.01 to 3.43)	183 (3 studies)	low[1,7]

BDI=Beck Depression Inventory; CAPS=Clinician-administered PTSD scale; CBT=cognitive behavioural therapy; CI=confidence interval; HAMD=Hamilton depression scale; PCL=PTSD checklist; PSS-I=PTSD Symptom Scale-Interview; PSQI=Pittsburgh Sleep Quality Index; PTSD=post-traumatic stress disorder; RR=risk ratio; SF-36=Short form 36; SMD=standardised mean difference; STAI=State-Trait Anxiety Inventory; TAU=treatment as usual

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

[2] OIS not met (N<400)

[3] Data is not reported/cannot be extracted for all outcomes

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

[5] Substantial heterogeneity (I2=50-80%)

[6] *95% CI crosses line of no effect and threshold for both clinically important benefit and clinically important harm*
[7] *OIS not met (events<300)*

Table 16: Summary clinical evidence profile: Trauma-focused CBT (+/- TAU) versus counselling (+/- TAU) for delayed treatment (>3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Counselling (+/- TAU)	Corresponding risk Trauma-focused CBT (+/- TAU)			
PTSD symptomatology self-rated at endpoint PCL/PDS/PSS-SR change score Follow-up: 3-16 weeks		The mean PTSD symptomatology self-rated at endpoint in the intervention groups was 0.58 standard deviations lower (1.11 to 0.05 lower)		277 (6 studies)	very low[1,2,3]
PTSD symptomatology self-rated at 2-4 month follow-up PCL/PDS/PSS-SR change score Follow-up: 8-17 weeks		The mean PTSD symptomatology self-rated at 2-4 month follow-up in the intervention groups was 0.38 standard deviations lower (0.81 lower to 0.05 higher)		434 (5 studies)	very low[1,2,4,5]
PTSD symptomatology self-rated at 6-8 month follow-up PCL/PDS/PSS-SR change score Follow-up: 26-34 weeks		The mean PTSD symptomatology self-rated at 6-8 month follow-up in the intervention groups was 0.3 standard deviations lower (0.83 lower to 0.24 higher)		392 (4 studies)	very low[1,4,6]
PTSD symptomatology self-rated at 1-year follow-up PCL/PDS change score Follow-up: mean 52 weeks		The mean PTSD symptomatology self-rated at 1-year follow-up in the intervention groups was 0.91 standard deviations lower (2.78 lower to 0.95 higher)		79 (2 studies)	very low[1,5,6,7]
PTSD symptomatology self-rated at 2-year follow-up PCL change		The mean PTSD symptomatology self-rated at 2-year follow-up in the intervention groups was		39 (1 study)	very low[1,4,5]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Counselling (+/- TAU)	Corresponding risk Trauma-focused CBT (+/- TAU)			
score Follow-up: mean 104 weeks		0.54 standard deviations lower (1.18 lower to 0.11 higher)			
PTSD symptomatology clinician-rated at endpoint CAPS/PSS-I change score Follow-up: 5-16 weeks		The mean PTSD symptomatology clinician-rated at endpoint in the intervention groups was 1.04 standard deviations lower (1.73 to 0.36 lower)		321 (6 studies)	very low[1,3,5,6]
PTSD symptomatology clinician-rated at 3-month follow-up CAPS change score Follow-up: mean 13 months		The mean PTSD symptomatology clinician-rated at 3-month follow-up in the intervention groups was 0.89 standard deviations lower (1.42 to 0.37 lower)		184 (3 studies)	very low[1,2,3]
PTSD symptomatology clinician-rated at 6-month follow-up CAPS change score Follow-up: mean 26 months		The mean PTSD symptomatology clinician-rated at 6-month follow-up in the intervention groups was 0.85 standard deviations lower (1.2 to 0.49 lower)		132 (2 studies)	low[1,3]
PTSD symptomatology clinician-rated at 1-year follow-up CAPS/PSS-I/CIDI-PTSD change score Follow-up: mean 52 weeks		The mean PTSD symptomatology clinician-rated at 1-year follow-up in the intervention groups was 1.62 standard deviations lower (2.87 to 0.38 lower)		109 (3 studies)	very low[1,3,5,6]
PTSD symptomatology clinician-rated at 2-year follow-up		The mean PTSD symptomatology clinician-rated at 2-year follow-up in the intervention		39 (1 study)	very low[1,4,5]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Counselling (+/- TAU)	Corresponding risk Trauma-focused CBT (+/- TAU)			
CAPS change score Follow-up: mean 104 weeks		groups was 0.53 standard deviations lower (1.17 lower to 0.12 higher)			
Remission at endpoint Number of people no longer meeting diagnostic criteria or no longer above threshold on a scale for PTSD Follow-up: 5-16 weeks	300 per 1000	489 per 1000 (375 to 639)	RR 1.63 (1.25 to 2.13)	320 (6 studies)	low[1,8]
Remission at 3-month follow-up Number of people no longer meeting diagnostic criteria or no longer above threshold on a scale for PTSD Follow-up: mean 13 weeks	250 per 1000	670 per 1000 (322 to 1000)	RR 2.68 (1.29 to 5.59)	100 (2 studies)	very low[1,2,5,8]
Remission at 6-8 month follow-up Number of people no longer meeting diagnostic criteria or no longer above threshold on a scale for PTSD Follow-up: 26-34 weeks	279 per 1000	457 per 1000 (307 to 680)	RR 1.64 (1.1 to 2.44)	472 (5 studies)	very low[1,2,8]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Counselling (+/- TAU)	Corresponding risk Trauma-focused CBT (+/- TAU)			
Remission at 1-year follow-up Number of people no longer meeting diagnostic criteria for PTSD Follow-up: mean 52 weeks	375 per 1000	698 per 1000 (446 to 1000)	RR 1.86 (1.19 to 2.91)	70 (2 studies)	very low[1,5,8]
Response clinician-rated Number of people showing clinically significant improvement on PSS-I based on reliable change indices (RCI) Follow-up: mean 5 weeks	143 per 1000	286 per 1000 (61 to 1000)	RR 2 (0.43 to 9.21)	28 (1 study)	very low[1,5,7]
Anxiety symptoms at endpoint BAI/STAI State/BSI Anxiety/HAM-A change score Follow-up: 5-16 weeks		The mean anxiety symptoms at endpoint in the intervention groups was 0.93 standard deviations lower (1.2 to 0.67 lower)		358 (8 studies)	low[1,3]
Anxiety symptoms at 3-month follow-up BAI/STAI State change score Follow-up: mean 13 weeks		The mean anxiety symptoms at 3-month follow-up in the intervention groups was 0.7 standard deviations lower (1 to 0.4 lower)		184 (3 studies)	low[1,3]
Anxiety symptoms at 6-8 month		The mean anxiety symptoms at 6-8 month follow-up in		228 (4 studies)	low[1,3]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Counselling (+/- TAU)	Corresponding risk Trauma-focused CBT (+/- TAU)			
follow-up BAI/STAI State/HAM-A change score Follow-up: 26-34 weeks		the intervention groups was 0.81 standard deviations lower (1.2 to 0.41 lower)			
Anxiety symptoms at 1-year follow-up STAI State change score Follow-up: mean 52 weeks		The mean anxiety symptoms at 1-year follow-up in the intervention groups was 0.88 standard deviations lower (1.45 to 0.3 lower)		52 (1 study)	very low[1,3,5]
Anxiety symptoms at 2-year follow-up STAI State change score Follow-up: mean 104 weeks		The mean anxiety symptoms at 2-year follow-up in the intervention groups was 0.72 standard deviations lower (1.38 to 0.07 lower)		39 (1 study)	very low[1,3,5]
Depression symptoms at endpoint BDI/BDI-II/BDI-13/BSI Depression change score Follow-up: 5-16 weeks		The mean depression symptoms at endpoint in the intervention groups was 0.42 standard deviations lower (0.68 to 0.17 lower)		358 (8 studies)	low[1,3]
Depression symptoms at 3-month follow-up BDI/BDI-II change score Follow-up: mean 13 weeks		The mean depression symptoms at 3-month follow-up in the intervention groups was 0.15 standard deviations lower (0.44 lower to 0.14 higher)		184 (3 studies)	low[1,3]
Depression symptoms at 6-8 month follow-up BDI-II/BDI-13 change score Follow-up: 26-34 weeks		The mean depression symptoms at 6-8 month follow-up in the intervention groups was 0.46 standard		228 (4 studies)	low[1,3]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Counselling (+/- TAU)	Corresponding risk Trauma-focused CBT (+/- TAU)			
		deviations lower (0.73 to 0.19 lower)			
Depression symptoms at 1-year follow-up BDI change score Follow-up: mean 52 weeks		The mean depression symptoms at 1-year follow-up in the intervention groups was 0.09 standard deviations lower (0.63 lower to 0.46 higher)		52 (1 study)	very low[1,4,5]
Depression symptoms at 2-year follow-up BDI change score Follow-up: mean 104 weeks		The mean depression symptoms at 2-year follow-up in the intervention groups was 0.23 standard deviations lower (0.87 lower to 0.4 higher)		39 (1 study)	very low[1,4,5]
Functional impairment - Endpoint SDS change score Follow-up: mean 14 weeks		The mean functional impairment - endpoint in the intervention groups was 0.92 standard deviations lower (1.45 to 0.39 lower)		61 (1 study)	low[1,3]
Functional impairment - 3-month follow-up SDS change score Follow-up: mean 13 weeks		The mean functional impairment - 3-month follow-up in the intervention groups was 1.01 standard deviations lower (1.55 to 0.48 lower)		61 (1 study)	low[1,3]
Functional impairment - 6-month follow-up SDS change score Follow-up: mean 26 weeks		The mean functional impairment - 6-month follow-up in the intervention groups was 0.92 standard deviations lower (1.44 to 0.39 lower)		61 (1 study)	low[1,3]
Global functioning -		The mean global functioning -		54 (1 study)	very low[1,3,5]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Counselling (+/- TAU)	Corresponding risk Trauma-focused CBT (+/- TAU)			
Endpoint GAF change score Follow-up: mean 12 weeks Better indicated by higher values		endpoint in the intervention groups was 1.55 standard deviations higher (0.94 to 2.17 higher)			
Global functioning - 3-month follow-up GAF change score Follow-up: mean 13 weeks Better indicated by higher values		The mean global functioning - 3-month follow-up in the intervention groups was 1.1 standard deviations higher (0.51 to 1.68 higher)		52 (1 study)	very low[1,3,5]
Global functioning - 1-year follow-up GAF change score Follow-up: mean 52 weeks Better indicated by higher values		The mean global functioning - 1-year follow-up in the intervention groups was 0.68 standard deviations higher (0.12 to 1.25 higher)		52 (1 study)	very low[1,3,5]
Global functioning - 2-year follow-up GAF change score Follow-up: mean 104 weeks Better indicated by higher values		The mean global functioning - 2-year follow-up in the intervention groups was 0.37 standard deviations higher (0.27 lower to 1.01 higher)		39 (1 study)	very low[1,4,5]
Relationship difficulties - Endpoint IIP change score Follow-up:		The mean relationship difficulties - endpoint in the intervention groups was		71 (1 study)	low[1,4]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Counselling (+/- TAU)	Corresponding risk Trauma-focused CBT (+/- TAU)			
mean 16 weeks		0.12 standard deviations lower (0.58 lower to 0.35 higher)			
Relationship difficulties - 3-month follow-up IIP change score Follow-up: mean 13 weeks		The mean relationship difficulties - 3-month follow-up in the intervention groups was 0.98 standard deviations lower (1.48 to 0.49 lower)		71 (1 study)	low[1,3]
Relationship difficulties - 6-month follow-up IIP change score Follow-up: mean 26 weeks		The mean relationship difficulties - 6-month follow-up in the intervention groups was 0.89 standard deviations lower (1.38 to 0.4 lower)		71 (1 study)	low[1,3]
Quality of life at endpoint QOLI/Q-LES-Q-SF/SF-12 change score Follow-up: 3-16 weeks Better indicated by higher values		The mean quality of life at endpoint in the intervention groups was 0.7 standard deviations higher (0.39 to 1.01 higher)		175 (3 studies)	very low[1,3,5]
Quality of life at 3-4 month follow-up Q-LES-Q-SF/SF-12 change score Follow-up: 13-17 weeks Better indicated by higher values		The mean quality of life at 3-4 month follow-up in the intervention groups was 0.89 standard deviations higher (0.21 to 1.56 higher)		89 (2 studies)	very low[1,2,3]
Quality of life at 6-month follow-up Q-LES-Q-SF change score Follow-up: mean 26 weeks		The mean quality of life at 6-month follow-up in the intervention groups was 0.86 standard deviations higher		61 (1 study)	low[1,3]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Counselling (+/- TAU)	Corresponding risk Trauma-focused CBT (+/- TAU)			
Better indicated by higher values		(0.33 to 1.38 higher)			
Quality of life at 1-year follow-up SF-12 change score Follow-up: mean 52 weeks Better indicated by higher values		The mean quality of life at 1-year follow-up in the intervention groups was 1.3 standard deviations higher (0.45 to 2.14 higher)		27 (1 study)	very low[1,3,5]
Discontinuation Number of participants lost to follow-up for any reason Follow-up: 3-16 weeks	302 per 1000	269 per 1000 (202 to 354)	RR 0.89 (0.67 to 1.17)	754 (11 studies)	low[1,4]

BAI=Beck Depression Inventory; BDI=Beck Depression Inventory; BSI=Brief Symptom Inventory; CAPS=Clinician-administered PTSD scale; CI=confidence interval; CIDI-PTSD=Composite International Diagnostic Interview-PTSD; GAF=Global Assessment of functioning; HAM-A=Hamilton anxiety rating scale; IIP=Inventory of Interpersonal problems; PCL=PTSD checklist; PDS=PTSD Diagnostic Scale; PSS-I/SR=PTSD symptom scale-interview/self-report; PTSD=post-traumatic stress disorder; RR=risk ratio; SDS=Sheehan Disability Scale; SF-12=Short form-12; SMD=standardised mean difference; STAI=State-Trait Anxiety Inventory; Q-LES-Q-SF=Quality of Life Enjoyment and Statisfaction Questionnaires; QOLI=Quality of life inventory

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

[2] *Substantial heterogeneity (I2=50-80%)*

[3] *OIS not met (N<400)*

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

[5] *Data is not reported/cannot be extracted for all outcomes*

[6] *Considerable heterogeneity (I2>80%)*

[7] *95% CI crosses line of no effect and threshold for both clinically important benefit and clinically important harm*

[8] *OIS not met (events<300)*

Table 17: Summary clinical evidence profile: Trauma-focused CBT (+/- TAU) versus present-centered therapy (+/- TAU) for delayed treatment (>3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Present-centered therapy (+/- TAU)	Corresponding risk Trauma-focused CBT (+/- TAU)			
PTSD symptomatology self-rated at endpoint PCL change score Follow-up: 10-30 weeks		The mean PTSD symptomatology self-rated at endpoint in the intervention groups was 1.29 standard deviations lower (2.59 lower to 0.02 higher)		766 (4 studies)	very low[1,2,3]
PTSD symptomatology self-rated at 2-3 month follow-up PCL change score Follow-up: 8-13 weeks		The mean PTSD symptomatology self-rated at 2-3 month follow-up in the intervention groups was 2.83 standard deviations lower (6.62 lower to 0.97 higher)		370 (2 studies)	very low[1,2,4]
PTSD symptomatology self-rated at 4-month follow-up PCL change score Follow-up: mean 17 weeks		The mean PTSD symptomatology self-rated at 4-month follow-up in the intervention groups was 0.26 standard deviations lower (0.7 lower to 0.17 higher)		86 (1 study)	very low[1,3]
PTSD symptomatology self-rated at 6-month follow-up PCL change score Follow-up: mean 26 weeks		The mean PTSD symptomatology self-rated at 6-month follow-up in the intervention groups was 2.43 standard deviations lower (5.8 lower to 0.94 higher)		370 (2 studies)	very low[1,2,4]
PTSD symptomatology clinician-rated at endpoint CAPS change		The mean PTSD symptomatology clinician-rated at endpoint in the intervention groups was		970 (6 studies)	very low[1,2]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Present-centered therapy (+/- TAU)	Corresponding risk Trauma-focused CBT (+/- TAU)			
score Follow-up: 10-30 weeks		0.65 standard deviations lower (1.17 to 0.14 lower)			
PTSD symptomatology clinician-rated at 1-3 month follow-up CAPS change score Follow-up: 4-13 weeks		The mean PTSD symptomatology clinician-rated at 1-3 month follow-up in the intervention groups was 0.91 standard deviations lower (1.7 to 0.13 lower)		602 (4 studies)	very low[1,2]
PTSD symptomatology clinician-rated at 4-month follow-up CAPS change score Follow-up: mean 17 weeks		The mean ptsd symptomatology clinician-rated at 4-month follow-up in the intervention groups was 1.6 standard deviations lower (2.1 to 1.1 lower)		86 (1 study)	very low[1,5]
PTSD symptomatology clinician-rated at 6-month follow-up CAPS change score Follow-up: mean 26 weeks		The mean PTSD symptomatology clinician-rated at 6-month follow-up in the intervention groups was 0.55 standard deviations lower (1.04 to 0.06 lower)		602 (4 studies)	very low[1,2]
Remission at endpoint Number of people no longer meeting diagnostic criteria for PTSD Follow-up: 10-20 weeks	224 per 1000	323 per 1000 (218 to 478)	RR 1.44 (0.97 to 2.13)	531 (3 studies)	very low[1,3,6]
Remission at 1-3 month follow-up	288 per 1000	410 per 1000 (323 to 519)	RR 1.42 (1.12 to 1.8)	516 (3 studies)	low[1,7]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Present-centered therapy (+/- TAU)	Corresponding risk Trauma-focused CBT (+/- TAU)			
Number of people no longer meeting diagnostic criteria for PTSD Follow-up: 4-13 weeks					
Remission at 6-month follow-up Number of people no longer meeting diagnostic criteria for PTSD Follow-up: mean 26 weeks	331 per 1000	394 per 1000 (281 to 556)	RR 1.19 (0.85 to 1.68)	516 (3 studies)	very low[1,3,6]
Response clinician-rated at endpoint Number of people showing clinically significant improvement based on reliable change indices (RCI) on PSS-I/at least 10-point improvement on CAPS Follow-up: 10-30 weeks	452 per 1000	519 per 1000 (447 to 601)	RR 1.15 (0.99 to 1.33)	680 (3 studies)	low[1,3]
Response clinician-rated at 3-month follow-up Number of people showing at least 10-point improvement	713 per 1000	777 per 1000 (678 to 892)	RR 1.09 (0.95 to 1.25)	284 (1 study)	moderate[3]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Present-centered therapy (+/- TAU)	Corresponding risk Trauma-focused CBT (+/- TAU)			
on CAPS Follow-up: mean 13 weeks					
Response clinician-rated at 6-month follow-up Number of people showing at least 10-point improvement on CAPS Follow-up: mean 26 weeks	685 per 1000	685 per 1000 (589 to 802)	RR 1 (0.86 to 1.17)	284 (1 study)	moderate[7]
Dissociative symptoms - Endpoint (ITT analysis) DES change score Follow-up: mean 20 weeks		The mean dissociative symptoms - endpoint (itt analysis) in the intervention groups was 0.34 standard deviations higher (0.22 lower to 0.89 higher)		51 (1 study)	very low[1,3,6]
Dissociative symptoms - 3-month follow-up (completer analysis) DES change score Follow-up: mean 13 weeks		The mean dissociative symptoms - 3-month follow-up (completer analysis) in the intervention groups was 0.47 standard deviations lower (1.15 lower to 0.21 higher)		34 (1 study)	very low[1,3,6]
Dissociative symptoms - 6-month follow-up (completer analysis) DES change score Follow-up: mean 26 weeks		The mean dissociative symptoms - 6-month follow-up (completer analysis) in the intervention groups was 0.6 standard deviations lower (1.29 lower to 0.09 higher)		34 (1 study)	very low[1,3,6]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Present-centered therapy (+/- TAU)	Corresponding risk Trauma-focused CBT (+/- TAU)			
Anxiety symptoms at endpoint BAI/STAI State/BSI Anxiety change score Follow-up: 10-20 weeks		The mean anxiety symptoms at endpoint in the intervention groups was 0.09 standard deviations lower (0.6 lower to 0.42 higher)		604 (4 studies)	very low[1,2,3,6]
Anxiety symptoms at 3-month follow-up BAI/STAI State change score Follow-up: mean 13 weeks		The mean anxiety symptoms at 3-month follow-up in the intervention groups was 0.16 standard deviations lower (0.43 lower to 0.11 higher)		516 (3 studies)	low[1,6]
Anxiety symptoms at 6-month follow-up BAI/STAI State change score Follow-up: mean 26 weeks		The mean anxiety symptoms at 6-month follow-up in the intervention groups was 0.09 standard deviations lower (0.26 lower to 0.08 higher)		516 (3 studies)	moderate[1]
Depression symptoms at endpoint BDI/BDI-II/QIDS/BSI Depression change score Follow-up: 10-20 weeks		The mean depression symptoms at endpoint in the intervention groups was 0.44 standard deviations lower (1.18 lower to 0.29 higher)		690 (5 studies)	very low[1,2,3,6]
Depression symptoms at 2-3 month follow-up BDI/BDI-II/QIDS change score Follow-up: 8-13 weeks		The mean depression symptoms at 2-3 month follow-up in the intervention groups was 0.77 standard deviations lower (1.34 to 0.19 lower)		602 (4 studies)	very low[1,2]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Present-centered therapy (+/- TAU)	Corresponding risk Trauma-focused CBT (+/- TAU)			
Depression symptoms at 4-month follow-up QIDS change score Follow-up: mean 17 weeks		The mean depression symptoms at 4-month follow-up in the intervention groups was 2.13 standard deviations lower (2.67 to 1.59 lower)		86 (1 study)	very low[1,5]
Depression symptoms at 6-month follow-up BDI/BDI-II/QIDS change score Follow-up: mean 26 weeks		The mean depression symptoms at 6-month follow-up in the intervention groups was 1.23 standard deviations lower (2.2 to 0.27 lower)		602 (4 studies)	very low[1,2,6]
Emotional and behavioural problems: Anger - Endpoint (ITT analysis) STAXI change score Follow-up: mean 20 weeks		The mean emotional and behavioural problems: anger - endpoint (itt analysis) in the intervention groups was 0.41 standard deviations lower (0.97 lower to 0.15 higher)		51 (1 study)	very low[1,3,6]
Emotional and behavioural problems: Anger - 3-month follow-up (completer analysis) STAXI change score Follow-up: mean 13 weeks		The mean emotional and behavioural problems: anger - 3-month follow-up (completer analysis) in the intervention groups was 0.02 standard deviations higher (0.65 lower to 0.7 higher)		34 (1 study)	very low[1,4,6]
Emotional and behavioural problems: Anger - 6-month follow-up (completer		The mean emotional and behavioural problems: anger - 6-month follow-up (completer analysis)		34 (1 study)	very low[1,3,6]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Present-centered therapy (+/- TAU)	Corresponding risk Trauma-focused CBT (+/- TAU)			
analysis) STAXI change score Follow-up: mean 26 weeks		in the intervention groups was 0.51 standard deviations lower (1.2 lower to 0.17 higher)			
Quality of life - Endpoint QOLI change score Follow-up: 10-30 weeks Better indicated by higher values		The mean quality of life - endpoint in the intervention groups was 0.23 standard deviations higher (0.05 lower to 0.51 higher)		660 (3 studies)	very low[1,3,8]
Quality of life - 3-month follow-up QOLI change score Follow-up: mean 13 weeks Better indicated by higher values		The mean quality of life - 3-month follow-up in the intervention groups was 0.27 standard deviations higher (0.02 lower to 0.55 higher)		318 (2 studies)	low[1,3]
Quality of life - 6-month follow-up QOLI change score Follow-up: mean 26 weeks Better indicated by higher values		The mean quality of life - 6-month follow-up in the intervention groups was 0.19 standard deviations higher (0.03 lower to 0.41 higher)		318 (2 studies)	low[1,5]
Discontinuation Number of participants lost to follow-up for any reason Follow-up: 10-30 weeks	153 per 1000	205 per 1000 (152 to 276)	RR 1.34 (0.99 to 1.8)	931 (6 studies)	low[1,3]

BAI=Beck Anxiety Inventory; BDI=Beck Depression inventory; BSI=Brief symptom inventory; CAPS=Clinician administered PTSD scale; CBT=cognitive behavioural therapy; CI=confidence interval; DES=Dissociative Experiences Scale; ITT=intention to treat; PCL=PTSD checklist; RR=risk ratio;

SMD=standardised mean difference; STAI=State-Trait Anxiety Inventory; STAXI=State-Trait Anger Expression Inventory; TAU=treatment as usual; QIDS=Quick inventory of depressive symptomology; QOLI=Quality of life inventory

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

[2] *Considerable heterogeneity (I2>80%)*

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

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

[5] *OIS not met (N<400)*

[6] *Data is not reported/cannot be extracted for all outcomes*

[7] *OIS not met (events<300)*

[8] *Substantial heterogeneity (I2=50-80%)*

Table 18: Summary clinical evidence profile: Trauma-focused CBT (+ TAU) versus metacognitive therapy (+ TAU) for delayed treatment (>3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Metacognitive therapy (+ TAU)	Corresponding risk Trauma-focused CBT (+ TAU)			
PTSD symptomatology self-rated - Endpoint PDS change score Follow-up: mean 8 weeks		The mean PTSD symptomatology self-rated - endpoint in the intervention groups was 1.56 standard deviations higher (0.53 to 2.59 higher)		20 (1 study)	very low[1,2,3]
PTSD symptomatology self-rated - 3-month follow-up PDS change score Follow-up: mean 13 weeks		The mean PTSD symptomatology self-rated - 3-month follow-up in the intervention groups was 0.67 standard deviations higher (0.24 lower to 1.58 higher)		20 (1 study)	very low[1,3,4]
Remission Number of people no longer meeting diagnostic criteria for PTSD Follow-up: mean 8 weeks	818 per 1000	638 per 1000 (376 to 1000)	RR 0.78 (0.46 to 1.32)	22 (1 study)	very low[1,3,5]
Response self-rated Number of	909 per 1000	727 per 1000 (482 to 1000)	RR 0.8 (0.53 to 1.2)	22 (1 study)	very low[1,3,4]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Metacognitive therapy (+ TAU)	Corresponding risk Trauma-focused CBT (+ TAU)			
people showing clinically significant improvement based on at least 10-point improvement on IES Follow-up: mean 8 weeks					
Anxiety symptoms - Endpoint BAI change score Follow-up: mean 8 weeks		The mean anxiety symptoms - endpoint in the intervention groups was 0.67 standard deviations higher (0.23 lower to 1.58 higher)		20 (1 study)	very low[1,3,4]
Anxiety symptoms - 3-month follow-up BAI change score Follow-up: mean 13 weeks		The mean anxiety symptoms - 3-month follow-up in the intervention groups was 0.11 standard deviations lower (0.98 lower to 0.77 higher)		20 (1 study)	very low[1,3,5]
Depression symptoms - Endpoint BDI-II change score Follow-up: mean 8 weeks		The mean depression symptoms - endpoint in the intervention groups was 0.86 standard deviations higher (0.07 lower to 1.79 higher)		20 (1 study)	very low[1,3,4]
Depression symptoms - 3-month follow-up BDI-II change score Follow-up:		The mean depression symptoms - 3-month follow-up in the intervention groups was		20 (1 study)	very low[1,3,5]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Metacognitive therapy (+ TAU)	Corresponding risk Trauma-focused CBT (+ TAU)			
mean 13 weeks		0.18 standard deviations higher (0.69 lower to 1.06 higher)			
Discontinuation Number of participants lost to follow-up for any reason Follow-up: mean 8 weeks	91 per 1000	91 per 1000 (6 to 1000)	RR 1 (0.07 to 14.05)	22 (1 study)	very low[1,5]

BAI=Beck Anxiety Inventory; BDI=Beck Depression Inventory; CBT=cognitive behavioural therapy; CI=confidence interval; IES=Impact of event scale; PDS=PTSD diagnostic scale; PTSD=Post-traumatic stress disorder; RR=risk ratio; SMD=standardised mean difference; TAU=treatment as usual

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

[2] OIS not met (N<400)

[3] Data is not reported/cannot be extracted for all outcomes

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

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

Table 19: Summary clinical evidence profile: Trauma-focused CBT versus interpersonal psychotherapy (IPT) for delayed treatment (>3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Interpersonal psychotherapy (IPT)	Corresponding risk Trauma-focused CBT			
PTSD symptomatology clinician-rated CAPS change score Follow-up: mean 14 weeks		The mean PTSD symptomatology clinician-rated in the intervention groups was 0.31 standard deviations lower (0.8 lower to 0.19 higher)		64 (1 study)	low[1,2]
PTSD symptomatology self-rated PSS-SR		The mean PTSD symptomatology self-rated		40 (1 study)	low[1,2]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Interpersonal psychotherapy (IPT)	Corresponding risk Trauma-focused CBT			
change score Follow-up: mean 14 weeks		in the intervention groups was 0.62 standard deviations lower (1.26 lower to 0.02 higher)			
Remission Number of people scoring <20 on CAPS Follow-up: mean 14 weeks	200 per 1000	184 per 1000 (74 to 458)	RR 0.92 (0.37 to 2.29)	78 (1 study)	very low[1,3]
Response Number of people showing ≥ 30% improvement on CAPS Follow-up: mean 14 weeks	600 per 1000	450 per 1000 (288 to 690)	RR 0.75 (0.48 to 1.15)	78 (1 study)	low[1,2]
Depression symptoms HAMD change score Follow-up: mean 14 weeks		The mean depression symptoms in the intervention groups was 0.58 standard deviations lower (1.08 to 0.07 lower)		63 (1 study)	low[1,4]
Functional impairment SAS change score Follow-up: mean 14 weeks		The mean functional impairment in the intervention groups was 0.24 standard deviations lower		37 (1 study)	low[1,2]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Interpersonal psychotherapy (IPT)	Corresponding risk Trauma-focused CBT			
		(0.9 lower to 0.41 higher)			
Quality of life Q-LES-Q-SF change score Follow-up: mean 14 weeks Better indicated by higher values		The mean quality of life in the intervention groups was 0.74 standard deviations higher (0.07 to 1.4 higher)		39 (1 study)	low[1,4]
Relationship difficulties IIP change score Follow-up: mean 14 weeks		The mean relationship difficulties in the intervention groups was 0 standard deviations higher (0.64 lower to 0.64 higher)		39 (1 study)	very low[1,3]
Discontinuation Number of participants lost to follow-up for any reason Follow-up: mean 14 weeks	150 per 1000	289 per 1000 (119 to 705)	RR 1.93 (0.79 to 4.7)	78 (1 study)	very low[1,3]

CAPS=Clinician-administered PTSD scale; CBT=cognitive behavioural therapy; CI=confidence interval; HAMD=Hamilton Anxiety Rating Scale; IIP=Inventory of Interpersonal problems; PSS-SR=PTSD symptom scale-self-report; RR=risk ratio; SAS=Social Adjustment Scale; SMD=standardised mean difference; Q-LES-Q-SF=Quality of Life Enjoyment and Satisfaction Questionnaire

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

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

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

[4] OIS not met (N<400)

Table 20: Summary clinical evidence profile: Trauma-focused CBT (+ TAU) versus psychodynamic therapy (+ TAU) for delayed treatment (>3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Psychodynamic therapy (+ TAU)	Corresponding risk Trauma-focused CBT (+ TAU)			
PTSD symptomatology self-rated - Endpoint IES change score Follow-up: mean 16 weeks		The mean PTSD symptomatology self-rated - endpoint in the intervention groups was 0.47 standard deviations lower (0.98 lower to 0.04 higher)		60 (1 study)	very low[1,2,3]
PTSD symptomatology self-rated - 3-month follow-up IES change score Follow-up: mean 13 weeks		The mean PTSD symptomatology self-rated - 3-month follow-up in the intervention groups was 0.24 standard deviations higher (0.27 lower to 0.75 higher)		60 (1 study)	very low[1,2,3]

CBT=cognitive behavioural therapy; CI=confidence interval; IES=Impact of event scale; RR=risk ratio; SMD=standardised mean difference; TAU=treatment as usual

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

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

[3] *Data is not reported/cannot be extracted for all outcomes*

Table 21: Summary clinical evidence profile: Trauma-focused CBT (+/- TAU) versus self-help (without support; +/- TAU) for delayed treatment (>3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Self-help (without support; +/- TAU)	Corresponding risk Trauma-focused CBT (+/- TAU)			
PTSD symptomatology clinician-rated CAPS change score Follow-up:		The mean PTSD symptomatology clinician-rated in the intervention groups was 0.83 standard deviations lower		126 (1 study)	moderate[1]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Self-help (without support; +/- TAU)	Corresponding risk Trauma-focused CBT (+/- TAU)			
mean 12 weeks		(1.19 to 0.47 lower)			
Remission at endpoint Number of people no longer meeting diagnostic criteria or scoring below clincal threshold on a scale Follow-up: mean 12 weeks	264 per 1000	612 per 1000 (224 to 1000)	RR 2.32 (0.85 to 6.31)	182 (2 studies)	very low[2,3,4]
Remission at 6-month follow-up Number of people scoring <14 on PDS Follow-up: mean 26 weeks	250 per 1000	858 per 1000 (442 to 1000)	RR 3.43 (1.77 to 6.63)	56 (1 study)	very low[2,5,6]
Response at endpoint Number of people showing ≥50% improvement on PDS Follow-up: mean 12 weeks	250 per 1000	822 per 1000 (423 to 1000)	RR 3.29 (1.69 to 6.39)	56 (1 study)	very low[2,5,6]
Response at 6-month follow-up Number of people showing ≥50% improvement on PDS Follow-up: mean 26 weeks	250 per 1000	892 per 1000 (465 to 1000)	RR 3.57 (1.86 to 6.87)	56 (1 study)	very low[2,5,6]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Self-help (without support; +/- TAU)	Corresponding risk Trauma-focused CBT (+/- TAU)			
Depression symptoms at endpoint BDI-II change score Follow-up: mean 12 weeks		The mean depression symptoms at endpoint in the intervention groups was 1.43 standard deviations lower (2.04 to 0.82 lower)		53 (1 study)	very low[1,2,6]
Depression symptoms at 6-month follow-up BDI-II change score Follow-up: mean 12 weeks		The mean depression symptoms at 6-month follow-up in the intervention groups was 1.37 standard deviations lower (1.97 to 0.76 lower)		53 (1 study)	very low[1,2,6]
Anxiety symptoms at endpoint BAI change score Follow-up: mean 12 weeks		The mean anxiety symptoms at endpoint in the intervention groups was 1.56 standard deviations lower (2.18 to 0.94 lower)		53 (1 study)	very low[1,2,6]
Anxiety symptoms at 6-month follow-up BAI change score Follow-up: mean 26 weeks		The mean anxiety symptoms at 6-month follow-up in the intervention groups was 1.56 standard deviations lower (2.18 to 0.94 lower)		53 (1 study)	very low[1,2,6]
Functional impairment at endpoint SDS change score Follow-up: mean 12 weeks		The mean functional impairment at endpoint in the intervention groups was 1 standard deviations lower (1.57 to 0.42 lower)		53 (1 study)	very low[1,2,6]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Self-help (without support; +/- TAU)	Corresponding risk Trauma-focused CBT (+/- TAU)			
Functional impairment at 6-month follow-up SDS change score Follow-up: mean 12 weeks		The mean functional impairment at 6-month follow-up in the intervention groups was 1.03 standard deviations lower (1.61 to 0.45 lower)		53 (1 study)	very low[1,2,6]
Discontinuation Number of participants lost to follow-up for any reason Follow-up: mean 12 weeks	44 per 1000	63 per 1000 (1 to 1000)	RR 1.43 (0.02 to 100.44)	182 (2 studies)	very low[3,7]

BAI=Beck anxiety inventory; BDI=Beck depression inventory; CAPS=Clinician-administered PTSD scale; CBT=cognitive behavioural therapy; CI=confidence interval; PDS=PTSD diagnostic scale; PTSD=post-traumatic stress disorder; SDS=Sheehan diability scale; RR=risk ratio; SMD=standardised mean difference; TAU=treatment as usual;

[1] OIS not met (N<400)

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

[3] Considerable heterogeneity (I2>80%)

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

[5] OIS not met (events<300)

[6] Data is not reported/cannot be extracted for all outcomes

[7] 95% CI crosses line of no effect and threshold for both clinically important benefit and clinically important harm

Table 22: Summary clinical evidence profile: Trauma-focused CBT versus self-help with support for delayed treatment (>3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Self-help with support	Corresponding risk Trauma-focused CBT			
PTSD symptomatology self-rated - 2-month follow-up IES change score		The mean PTSD symptomatology self-rated - 2-month follow-up in the intervention groups was 0.06 standard		85 (1 study)	very low[1,2,3]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Self-help with support	Corresponding risk Trauma-focused CBT			
Follow-up: mean 8 weeks		deviations lower (0.48 lower to 0.37 higher)			
PTSD symptomatology self-rated - 1-year follow-up IES change score Follow-up: mean 52 weeks		The mean PTSD symptomatology self-rated - 1-year follow-up in the intervention groups was 0.09 standard deviations higher (0.34 lower to 0.52 higher)		85 (1 study)	very low[1,3,4]
Dissociative symptoms - 2-month follow-up DES change score Follow-up: mean 8 weeks		The mean dissociative symptoms - 2-month follow-up in the intervention groups was 0.35 standard deviations higher (0.08 lower to 0.78 higher)		85 (1 study)	very low[1,3,4]
Dissociative symptoms - 1-year follow-up DES change score Follow-up: mean 52 weeks		The mean dissociative symptoms - 1-year follow-up in the intervention groups was 0.42 standard deviations higher (0.01 lower to 0.85 higher)		85 (1 study)	very low[1,3,4]
Anxiety symptoms - 2-month follow-up STAI State change score Follow-up: mean 8 weeks		The mean anxiety symptoms - 2-month follow-up in the intervention groups was 0.22 standard deviations lower (0.65 lower to 0.21 higher)		85 (1 study)	very low[1,3,4]
Anxiety symptoms - 1-year follow-up STAI State change score Follow-up: mean 52 weeks		The mean anxiety symptoms - 1-year follow-up in the intervention groups was 0.1 standard deviations lower (0.53 lower to 0.32 higher)		85 (1 study)	very low[1,3,4]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Self-help with support	Corresponding risk Trauma-focused CBT			
Depression symptoms - 2-month follow-up BDI change score Follow-up: mean 8 weeks		The mean depression symptoms - 2-month follow-up in the intervention groups was 0.26 standard deviations lower (0.68 lower to 0.17 higher)		85 (1 study)	very low[1,3,4]
Depression symptoms - 1-year follow-up BDI change score Follow-up: mean 52 weeks		The mean depression symptoms - 1-year follow-up in the intervention groups was 0.23 standard deviations lower (0.65 lower to 0.2 higher)		85 (1 study)	very low[1,3,4]

BDI=Beck Depression Inventory; CBT=cognitive behavioural therapy; CI=confidence interval; DES=; IES=impact of event scale; PTSD=post-traumatic stress disorder; RR=risk ratio; SMD=standardised mean difference; STAI=State-Trait Anxiety Inventory

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

[2] OIS not met (N<400)

[3] Data is not reported/cannot be extracted for all outcomes

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

Table 23: Summary clinical evidence profile: Trauma-focused CBT (+ TAU) versus hypnotherapy (+ TAU) for delayed treatment (>3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Hypnotherapy (+ TAU)	Corresponding risk Trauma-focused CBT (+ TAU)			
PTSD symptomatology self-rated - Endpoint IES change score Follow-up: mean 16 weeks		The mean PTSD symptomatology self-rated - endpoint in the intervention groups was 0.15 standard deviations lower (0.66 lower to 0.35 higher)		60 (1 study)	very low[1,2,3]
PTSD symptomatology self-rated - 3-month		The mean PTSD symptomatology self-rated - 3-month follow-up		60 (1 study)	very low[1,2,3]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Hypnotherapy (+ TAU)	Corresponding risk Trauma-focused CBT (+ TAU)			
follow-up IES change score Follow-up: mean 13 weeks		in the intervention groups was 0.2 standard deviations higher (0.31 lower to 0.71 higher)			

CBT=cognitive behavioural therapy; CI=confidence interval; IES=impact of event scale; RR=risk ratio; SMD=standardised mean difference; TAU=treatment as usual

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

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

[3] Data is not reported/cannot be extracted for all outcomes

Table 24: Summary clinical evidence profile: Trauma-focused CBT versus psychoeducational session for delayed treatment (>3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Psychoeducational session	Corresponding risk Trauma-focused CBT			
PTSD symptomatology self-rated at endpoint IES change score Follow-up: mean 13 weeks		The mean PTSD symptomatology self-rated at endpoint in the intervention groups was 0.25 standard deviations lower (0.51 lower to 0.01 higher)		230 (1 study)	very low[1,2,3]
PTSD symptomatology self-rated at 3-month follow-up IES change score Follow-up: mean 13 weeks		The mean PTSD symptomatology self-rated at 3-month follow-up in the intervention groups was 0.02 standard deviations higher (0.23 lower to 0.27 higher)		244 (1 study)	very low[1,3,4]
PTSD symptomatology self-rated at 6-month follow-up IES change		The mean PTSD symptomatology self-rated at 6-month follow-up in the intervention groups was		236 (1 study)	very low[1,3,4]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Psychoeducational session	Corresponding risk Trauma-focused CBT			
score Follow-up: mean 26 weeks		0.06 standard deviations lower (0.32 lower to 0.2 higher)			
Discontinuation Number of participants lost to follow-up for any reason Follow-up: mean 13 weeks	225 per 1000	407 per 1000 (292 to 569)	RR 1.81 (1.3 to 2.53)	336 (1 study)	low[1,5]

CBT=cognitive behavioural therapy; CI=confidence interval; IES=Impact of event scale; RR=risk ratio; SMD=standardised mean difference

[1] *Risk of bias is high or unclear across multiple domains*
[2] *95% CI crosses both line of no effect and threshold for clinically important effect*
[3] *Data is not reported/cannot be extracted for all outcomes*
[4] *OIS not met (N<400)*
[5] *OIS not met (events<300)*

Table 25: Summary clinical evidence profile: Trauma-focused CBT (+/- TAU) versus relaxation (+/- TAU) for delayed treatment (>3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Relaxation (+/- TAU)	Corresponding risk Trauma-focused CBT (+/- TAU)			
PTSD symptomatology self-rated at endpoint PCL/PSS-SR change score Follow-up: mean 14 weeks		The mean PTSD symptomatology self-rated at endpoint in the intervention groups was 1.18 standard deviations lower (2.16 to 0.2 lower)		84 (3 studies)	very low[1,2,3]
PTSD symptomatology self-rated at 3-month follow-up PCL/PSS-SR change score Follow-up:		The mean PSTD symptomatology self-rated at 3-month follow-up in the intervention groups was 1.47 standard deviations lower		54 (2 studies)	very low[1,2,3]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Relaxation (+/- TAU)	Corresponding risk Trauma-focused CBT (+/- TAU)			
mean 13 weeks		(2.66 to 0.28 lower)			
PTSD symptomatology clinician-rated at endpoint CAPS change score Follow-up: mean 14 weeks		The mean PTSD symptomatology clinician-rated at endpoint in the intervention groups was 0.56 standard deviations lower (1 to 0.12 lower)		82 (2 studies)	low[1,3]
PTSD symptomatology clinician-rated at 3-month follow-up CAPS change score Follow-up: mean 13 weeks		The mean PTSD symptomatology clinician-rated at 3-month follow-up in the intervention groups was 0.78 standard deviations lower (1.53 to 0.04 lower)		30 (1 study)	low[1,3]
Remission at endpoint Number of people scoring <20 on CAPS Follow-up: mean 14 weeks	157 per 1000	248 per 1000 (115 to 543)	RR 1.58 (0.73 to 3.46)	111 (2 studies)	very low[1,4]
Remission at 3-month follow-up Number of people scoring <20 on CAPS Follow-up: mean 13 weeks	211 per 1000	318 per 1000 (109 to 922)	RR 1.51 (0.52 to 4.38)	41 (1 study)	very low[1,4]
Response Number of people showing ≥ 30% improvement on CAPS Follow-up:	281 per 1000	447 per 1000 (231 to 863)	RR 1.59 (0.82 to 3.07)	70 (1 study)	low[1,5]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Relaxation (+/- TAU)	Corresponding risk Trauma-focused CBT (+/- TAU)			
mean 14 weeks					
Dissociative symptoms - Endpoint CAPS dissociation cluster change score		The mean dissociative symptoms - endpoint in the intervention groups was 0.1 standard deviations higher (0.62 lower to 0.82 higher)		30 (1 study)	very low[1,4]
Dissociative symptoms - 3-month follow-up CAPS dissociation cluster change score Follow-up: mean 13 weeks		The mean dissociative symptoms - 3-month follow-up in the intervention groups was 0.53 standard deviations lower (1.26 lower to 0.2 higher)		30 (1 study)	low[1,5]
Anxiety symptoms - Endpoint SCL-90: Anxiety, change score Follow-up: mean 14 weeks		The mean anxiety symptoms - endpoint in the intervention groups was 1.25 standard deviations lower (2.13 to 0.36 lower)		24 (1 study)	low[1,3]
Anxiety symptoms - 3-month follow-up SCL-90: Anxiety, change score Follow-up: mean 13 weeks		The mean anxiety symptoms - 3-month follow-up in the intervention groups was 1.23 standard deviations lower (2.12 to 0.35 lower)		24 (1 study)	low[1,3]
Depression symptoms at endpoint HAMD/BDI change score Follow-up:		The mean depression symptoms at endpoint in the intervention groups was		81 (2 studies)	low[1,5]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Relaxation (+/- TAU)	Corresponding risk Trauma-focused CBT (+/- TAU)			
mean 14 weeks		0.39 standard deviations lower (0.83 lower to 0.05 higher)			
Depression symptoms at 3-month follow-up BDI change score Follow-up: mean 13 weeks		The mean depression symptoms at 3-month follow-up in the intervention groups was 0.13 standard deviations lower (0.84 lower to 0.59 higher)		30 (1 study)	very low[1,4]
Functional impairment SAS change score Follow-up: mean 14 weeks		The mean functional impairment in the intervention groups was 1.21 standard deviations lower (2.02 to 0.41 lower)		29 (1 study)	low[1,3]
Quality of life Q-LES-Q-SF change score Follow-up: mean 14 weeks Better indicated by higher values		The mean quality of life in the intervention groups was 1.24 standard deviations higher (0.44 to 2.05 higher)		29 (1 study)	low[1,3]
Relationship difficulties IIP change score Follow-up: mean 14 weeks		The mean relationship difficulties in the intervention groups was 1.41 standard deviations lower (2.23 to 0.6 lower)		30 (1 study)	low[1,3]
Discontinuation Number of participants lost to follow-up for any reason Follow-up:	238 per 1000	238 per 1000 (133 to 426)	RR 1 (0.56 to 1.79)	135 (3 studies)	very low[1,4]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Relaxation (+/- TAU)	Corresponding risk Trauma-focused CBT (+/- TAU)			
mean 14 weeks					

BDI=Beck Depression Inventory; CAPS=Clinician-administered PTSD scale; CBT=cognitive behavioural therapy; CI=confidence interval; HAMD=Hamilton Rating Scale for Depression; IES=Impact of event scale; PCL=PTSD checklist; PSS-SR=PTSD symptom scale-self-report; SAS=Social Adjustment Scale; SCL-90=Symptom Checklist-90; RR=risk ratio; TAU=treatment as usual; Q-LES-Q-SF=Quality of Life Enjoyment and Satisfaction Questionnaire-Short-form

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

[2] Substantial heterogeneity (I2=50-80%)

[3] OIS not met (N<400)

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

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

Table 26: Summary clinical evidence profile: Trauma-focused CBT versus acupuncture for delayed treatment (>3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Acupuncture	Corresponding risk Trauma-focused CBT			
PTSD symptomatology self-rated - Endpoint PSS-SR change score Follow-up: mean 12 weeks		The mean PTSD symptomatology self-rated - endpoint in the intervention groups was 0.38 standard deviations higher (0.18 lower to 0.95 higher)		49 (1 study)	very low[1,2]
PTSD symptomatology self-rated - 3-month follow-up PSS-SR change score Follow-up: mean 13 weeks		The mean PTSD symptomatology self-rated - 3-month follow-up in the intervention groups was 0.01 standard deviations higher (0.55 lower to 0.57 higher)		49 (1 study)	very low[1,3]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Acupuncture	Corresponding risk Trauma-focused CBT			
Remission - Endpoint Number of people scoring <16 on PSS-SR Follow-up: mean 12 weeks	517 per 1000	321 per 1000 (171 to 610)	RR 0.62 (0.33 to 1.18)	57 (1 study)	very low[1,2]
Remission - 3-month follow-up Number of people scoring <16 on PSS-SR Follow-up: mean 13 weeks	517 per 1000	466 per 1000 (274 to 791)	RR 0.9 (0.53 to 1.53)	57 (1 study)	very low[1,3]
Depression symptoms - Endpoint HSCL-25: Depression, change score Follow-up: mean 12 weeks		The mean depression symptoms - endpoint in the intervention groups was 0.04 standard deviations lower (0.6 lower to 0.52 higher)		49 (1 study)	very low[1,3]
Depression symptoms - 3-month follow-up HSCL-25: Depression, change score Follow-up: mean 13 weeks		The mean depression symptoms - 3-month follow-up in the intervention groups was 0.2 standard deviations lower (0.76 lower to 0.36 higher)		49 (1 study)	very low[1,2]
Anxiety symptoms - Endpoint HSCL-25: Anxiety, change score		The mean anxiety symptoms - endpoint in the intervention		49 (1 study)	very low[1,2]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Acupuncture	Corresponding risk Trauma-focused CBT			
Follow-up: mean 12 weeks		groups was 0.37 standard deviations higher (0.19 lower to 0.94 higher)			
Anxiety symptoms - 3-month follow-up HSCL-25: Anxiety, change score Follow-up: mean 13 weeks		The mean anxiety symptoms - 3-month follow-up in the intervention groups was 0.49 standard deviations higher (0.08 lower to 1.05 higher)		49 (1 study)	very low[1,2]
Functional impairment - Endpoint SDS change score Follow-up: mean 12 weeks		The mean functional impairment - endpoint in the intervention groups was 0.01 standard deviations higher (0.55 lower to 0.57 higher)		49 (1 study)	very low[1,3]
Functional impairment - 3-month follow-up SDS change score Follow-up: mean 13 weeks		The mean functional impairment - 3-month follow-up in the intervention groups was 0.11 standard deviations lower (0.67 lower to 0.45 higher)		49 (1 study)	very low[1,2]
Discontinuation Number of participants lost to follow-up for any	345 per 1000	252 per 1000 (110 to 566)	RR 0.73 (0.32 to 1.64)	57 (1 study)	very low[1,3]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Acupuncture	Corresponding risk Trauma-focused CBT			
reason Follow-up: mean 12 weeks					

CBT= cognitive behavioural therapy; CI=confidence interval; HSCL-25= Hopkins Symptom Checklist-25; RR=risk ratio; PSS-SR=PTSD symptom scale-self-report; SDS= Sheehan Disability Scale; SMD=standardised mean difference;

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

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

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

Table 27: Summary clinical evidence profile: Trauma-focused CBT versus SSRIs for delayed treatment (>3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk SSRIs	Corresponding risk Trauma-focused CBT			
PTSD symptomatology self-rated at endpoint HTQ/PDS change score Follow-up: 12-26 weeks		The mean PTSD symptomatology self-rated at endpoint in the intervention groups was 0.35 standard deviations higher (0.06 to 0.63 higher)		226 (2 studies)	very low[1,2]
PTSD symptomatology self-rated at 1-year follow-up PDS change score Follow-up: mean 52 weeks		The mean PTSD symptomatology self-rated at 1-year follow-up in the intervention groups was 0.07 standard deviations higher (0.38 lower to 0.53 higher)		112 (1 study)	very low[1,3]
PTSD symptomatology clinician-rated PSS-I/SI–PTSD change score Follow-up: 10-12 weeks		The mean PTSD symptomatology clinician-rated in the intervention groups was 0.76 standard deviations lower (1.13 to 0.39 lower)		161 (2 studies)	low[1,2]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk SSRIs	Corresponding risk Trauma-focused CBT			
Remission Number of people no longer meeting diagnostic criteria for PTSD Follow-up: mean 12 weeks	228 per 1000	632 per 1000 (383 to 1000)	RR 2.77 (1.68 to 4.56)	171 (1 study)	very low[1,4]
Dissociative symptoms DES change score Follow-up: mean 10 weeks		The mean dissociative symptoms in the intervention groups was 1.24 standard deviations lower (1.86 to 0.61 lower)		49 (1 study)	very low[1,2,5]
Anxiety symptoms at endpoint HAM-A/STAI State change score Follow-up: 10-26 weeks		The mean anxiety symptoms at endpoint in the intervention groups was 0.43 standard deviations higher (0.14 to 0.73 higher)		275 (3 studies)	very low[1,4]
Anxiety symptoms at 1-year follow-up STAI State change score Follow-up: mean 12 weeks		The mean anxiety symptoms at 1-year follow-up in the intervention groups was 0.25 standard deviations higher (0.21 lower to 0.71 higher)		112 (1 study)	very low[1,3]
Depression symptoms at endpoint HAMD/BDI/BDI-II change score Follow-up: 10-26 weeks		The mean depression symptoms at endpoint in the intervention groups was 0.26 standard deviations higher (0.36 lower to 0.87 higher)		275 (3 studies)	very low[1,3,6]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk SSRIs	Corresponding risk Trauma-focused CBT			
Depression symptoms at 1-year follow-up BDI-II change score Follow-up: mean 12 weeks		The mean depression symptoms at 1-year follow-up in the intervention groups was 0.27 standard deviations higher (0.19 lower to 0.73 higher)		112 (1 study)	very low[1,3]
Functional impairment SDS change score Follow-up: 10-26 weeks		The mean functional impairment in the intervention groups was 0.06 standard deviations lower (1.19 lower to 1.07 higher)		163 (2 studies)	very low[1,6,7]
Quality of life WHO-5 change score Follow-up: mean 26 weeks Better indicated by higher values		The mean quality of life in the intervention groups was 0.24 standard deviations lower (0.61 lower to 0.13 higher)		114 (1 study)	very low[1,3]
Discontinuation Number of participants lost to follow-up for any reason Follow-up: 12-26 weeks	391 per 1000	309 per 1000 (66 to 1000)	RR 0.79 (0.17 to 3.59)	312 (2 studies)	very low[1,6,7]

BDI= Beck Depression Inventory; CI=confidence interval; CBT= cognitive behavioural therapy; DES= Dissociative Experiences Scales; HAM-A/D= Hamilton Rating Scale for Anxiety/Depression; HTQ= Harvard Trauma Questionnaire; PDS= Post-traumatic Diagnositic Scale; PSS-I= PTSD symptom scale-interview; RR=risk ratio; SDS=; SI-PTSD= Structured interview for PTSD; SMD=standardised mean difference; SSRI=selective serotonin reuptake inhibitors; STAI=State-Trait Anxiety Inventory

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

[2] *OIS not met (N<400)*

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

[4] *OIS not met (events<300)*

[5] *Data is not reported/cannot be extracted for all outcomes*

[6] *Considerable heterogeneity (I2>80%)*

[7] *95% CI crosses line of no effect and threshold for both clinically important benefit and clinically important harm*

Table 28: Summary clinical evidence profile: Trauma-focused CBT + SSRIs versus waitlist for delayed treatment (>3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist	Corresponding risk Trauma-focused CBT + SSRIs			
PTSD symptomatology self-rated HTQ change score Follow-up: mean 26 weeks		The mean PTSD symptomatology self-rated in the intervention groups was 0.24 standard deviations higher (0.15 lower to 0.63 higher)		103 (1 study)	very low[1,2]
Anxiety symptoms HAM-A change score Follow-up: mean 26 weeks		The mean anxiety symptoms in the intervention groups was 0.64 standard deviations lower (1.04 to 0.25 lower)		103 (1 study)	very low[1,3]
Depression symptoms HAMD change score Follow-up: mean 26 weeks		The mean depression symptoms in the intervention groups was 0.75 standard deviations lower (1.15 to 0.35 lower)		103 (1 study)	very low[1,3]
Functional impairment SDS change score Follow-up: mean 26 weeks		The mean functional impairment in the intervention groups was 0.5 standard deviations lower (0.9 to 0.11 lower)		103 (1 study)	very low[1,3]
Quality of life WHO-5 change score Follow-up: mean 26 weeks Better indicated by higher values		The mean quality of life in the intervention groups was 0.04 standard deviations lower (0.43 lower to 0.35 higher)		103 (1 study)	very low[1,3]
Discontinuation Number of participants lost to follow-up for any	529 per 1000	365 per 1000 (249 to 535)	RR 0.69 (0.47 to 1.01)	139 (1 study)	low[1,2]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist	Corresponding risk Trauma-focused CBT + SSRIs			
reason Follow-up: mean 26 weeks					

CBT= cognitive behavioural therapy; CI= confidence interval; HAM-A/D= Hamilton Rating Scale for Anxiety/Depression; HTQ= Harvard Trauma Questionnaire; RR= risk ratio; SDS= Sheehan Disability Scale; SMD= standardised mean difference; SSRI=selective serotonin reuptake inhibitors

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

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

[3] *OIS not met (N<400)*

See appendix F for full GRADE tables.

Sensitivity and subgroup analysis

Sub-analysis of the comparison, trauma-focused CBT versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD, by multiplicity of trauma revealed no statistically significant differences for self-rated PTSD symptomatology (K=14; N=618; Chi² = 2.00, p = 0.37), clinician-rated PTSD symptomatology (K=12; N=632; Chi² = 0.50, p = 0.78), or discontinuation (K=26; N=1834; Chi² = 1.96, p = 0.37).

Sub-analysis of the comparison, trauma-focused CBT versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD, by specific intervention revealed a statistically significant subgroup difference on self-rated PTSD symptomatology (Chi² = 23.64, p = 0.0006). Clinically important and statistically significant differences were observed for cognitive processing therapy, CBT individual, CBT group, exposure/prolonged exposure and narrative exposure therapy, whereas clinically important but not statistically significant differences were observed for brief individual CBT and cognitive therapy. However, within-subgroup heterogeneity was also high (for instance, narrative exposure therapy I^2=88% and cognitive therapy I^2=97%) suggesting heterogeneity cannot be fully accounted for by specific intervention. The test for subgroup differences for discontinuation due to any reason was also statistically significant (Chi² = 33.59, p < 0.0001), with more drop-out in exposure therapy/prolonged exposure and less drop-out in narrative exposure therapy. However, subgroup differences by specific intervention are not consistent or compelling. The subgroup test for differences for clinician-rated PTSD symptomatology is not statistically significant (Chi² = 10.48, p = 0.06).

Sub-analysis of the comparison, trauma-focused CBT versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD, by diagnostic status revealed a statistically significant subgroup difference for clinician-rated PTSD symptomatology (Chi² = 9.27, p = 0.002), with clinically important and statistically significant benefits observed for both the PTSD diagnosis and clinically important symptoms (without necessarily having a diagnosis) subgroups, although the effect was relatively larger for those with a diagnosis (SMD -1.70 [-2.19, -1.21] versus SMD -0.69 [-1.12, -0.25]). The test for subgroup differences for self-rated PTSD symptomatology (Chi² = 2.48, p = 0.12), and discontinuation (Chi² = 1.74, p = 0.19) were not statistically significant.

Sub-analysis of the comparison, trauma-focused CBT versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD, by trauma type revealed a statistically significant subgroup difference for self-rated PTSD symptomatology ($Chi^2 = 41.46$, $p < 0.00001$), with particularly large effects observed for natural disasters, accident (no further detail reported) or being an emergency responder. However, these subgroups were also all small single studies. The test for subgroup differences was also statistically significant for clinician-rated PTSD symptomatology ($Chi^2 = 28.72$, $p < 0.0001$), suggesting differential efficacy by trauma type. However, benefits were statistically significant across trauma types with one exception (terrorist attacks). In addition, there was considerable within-subgroup heterogeneity for both self-rated and clinician-rated PTSD symptomatology (for instance, childhood sexual abuse I^2=85-88%) suggesting heterogeneity cannot be fully accounted for by specific intervention. There was also a statistically significant subgroup difference for discontinuation ($Chi^2 = 13.37$, $p = 0.02$), with relatively more drop-out associated with terrorist attacks. However, this evidence comes from a single study and absolute differences are small.

Sub-analysis of the comparison, trauma-focused CBT + medication/TAU versus medication/TAU-only (or + attention-placebo) for delayed treatment (>3 months) of clinically important symptoms/PTSD, by multiplicity of trauma revealed a statistically significant subgroup difference on self-rated PTSD symptomatology (K=21; N=1179; $Chi^2 = 19.24$, $p < 0.0001$). The largest effect observed was for unclear multiplicity of trauma (SMD -3.19 [-4.19, -2.19]), relative to single incident (SMD -1.31 [-1.90, -0.71]) or multiple incident (SMD -0.79 [-1.20, -0.38]) trauma. However, the unclear multipllcity of trauma subgroup is composed of only two very small studies, and effects are clinically important and statistically significant across subgroups. The test for subgroup differences was not statistically significant for clinician-rated PTSD symptomatology (K=22; N=1640; $Chi^2 = 0.89$, $p = 0.64$), or discontinuation (K=35; N=2764; $Chi^2 = 3.46$, $p = 0.18$).

Sub-analysis of the comparison, trauma-focused CBT + medication/TAU versus medication/TAU-only (or + attention-placebo) for delayed treatment (>3 months) of clinically important symptoms/PTSD, by specific intervention revealed a statistically significant subgroup difference on self-rated PTSD symptomatology ($Chi^2 = 21.10$, $p = 0.004$). Clinically important and statistically significant differences were observed for cognitive processing therapy, CBT individual, exposure/prolonged exposure, narrative exposure therapy, exposure inhibition therapy and dialectical behaviour therapy (DBT), whereas clinically important but not statistically significant differences were observed for cognitive therapy and CBT group. However, within-subgroup heterogeneity was also high (for instance, exposure therapy/prolonged exposure I^2=87% and cognitive therapy I^2=94%) suggesting heterogeneity cannot be fully accounted for by specific intervention. The test for subgroup differences for clinician-rated PTSD symptomatology was also statistically significant ($Chi^2 = 38.27$, $p < 0.00001$), with relatively larger effects observed for CBT individual and exposure inhibition therapy, although effects were clinically important and statistically significant across all specific intervention types and within-subgroup heterogeneity remained high. The test for subgroup differences for discontinuation due to any reason was not statistically significant ($Chi^2 = 2.37$, $p = 0.94$).

Sub-analysis of the comparison, trauma-focused CBT + medication/TAU versus medication/TAU-only (or + attention-placebo) for delayed treatment (>3 months) of clinically important symptoms/PTSD, by diagnostic status showed non-significant subgroup differences for self-rated PTSD symptomatology ($Chi^2 = 0.66$, $p = 0.42$), clinician-rated PTSD symptomatology ($Chi^2 = 3.63$, $p = 0.06$), and discontinuation ($Chi^2 = 3.05$, $p = 0.08$).

Sub-analysis of the comparison, trauma-focused CBT + medication/TAU versus medication/TAU-only (or + attention-placebo) for delayed treatment (>3 months) of clinically important symptoms/PTSD, by trauma type revealed a statistically significant subgroup difference for self-rated PTSD symptomatology ($Chi^2 = 26.55$, p= 0.0004), with relatively larger effects observed for sexual abuse or assault (in adulthood) and military combat. There was also a statistically significant subgroup difference for clinician-rated PTSD symptomatology ($Chi^2 = 82.63$, $p < 0.00001$), with relatively larger effects observed for witnessing war as a civilian and domestic violence. Across both outcomes differential effects were not consistent and within-subgroup heterogeneity was high. The test for subgroup differences for discontinuation was not significant ($Chi^2 = 6.31$, $p = 0.79$).

For the comparison, trauma-focused CBT + medication/TAU versus medication/TAU-only (or + attention-placebo) for delayed treatment (>3 months) of clinically important symptoms/PTSD, one of the studies (Bohus 2013) examined the effects of personaility disorder on PTSD symptomatology (self-rated and clinician-rated), global functioning, dissociative symptoms and depression symptoms. The only statistically significant subgroup difference was for self-rated PTSD symptomatology (K=1; N=74; $Chi^2 = 4.27$, $p = 0.04$), with relatively larger benefits observed for those that met less than 5 of the borderline personality disorder criteria compared to those meeting at least 5 of the criteria, although benefits for both subgroups are statistically significant and clinically important.

Sub-analysis of the comparison, trauma-focused CBT (+/- TAU) versus eye movement desensitisation and reprocessing (EMDR; +/- TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD, by multiplicity of trauma revealed a non-statistically-significant subgroup difference for self-rated PTSD symptomatology (K=4; N=139; $Chi^2 = 3.99$, $p = 0.05$), clinician-rated PTSD symptomatology (K=5; N=204; $Chi^2 = 2.30$, $p = 0.13$), or discontinuation (K=6; N=346; $Chi^2 = 0.03$, $p = 0.86$).

Sub-analysis of the comparison, trauma-focused CBT (+/- TAU) versus eye movement desensitisation and reprocessing (EMDR; +/- TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD, by specific intervention revealed a statistically significant subgroup difference for self-rated PTSD symptomatology ($Chi^2 = 9.67$, $p = 0.002$), with a statistically significant and clinically important effect in favour of EMDR observed for CBT individual but non-significant difference found between exposure therapy/prolonged exposure and EMDR. The test for subgroup differences was not statistically significant for clinician-rated PTSD symptomatology ($Chi^2 = 5.33$, $p = 0.07$) or discontinuation ($Chi^2 = 0.40$, $p = 0.82$).

Sub-analysis of the comparison, trauma-focused CBT (+/- TAU) versus eye movement desensitisation and reprocessing (EMDR; +/- TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD, by diagnostic status was not possible for self-rated PTSD symptomatology (only one subgroup, PTSD diagnosis) or discontinuation (effect size not estimable for 1 of 2 subgroups due to no dropout in both arms). Sub-analysis by diagnostic status was non-significant for clinician-rated PTSD symptomatology ($Chi^2 = 0.15$, $p = 0.70$).

Sub-analysis of the comparison, trauma-focused CBT (+/- TAU) versus eye movement desensitisation and reprocessing (EMDR; +/- TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD, by trauma type revealed a statistically significant subgroup difference for self-rated PTSD symptomatology ($Chi^2 = 9.25$, $p = 0.010$), with only a clinically important and statistically significant effect observed for diagnosis of life-threatening condition (and non-significant effects for sexual abuse/assault and mixed trauma subgroups). However, only a small single

study was included in that subgroup. The test for subgroup differences was not statistically significant for clinician-rated PTSD symptomatology ($Chi^2 = 7.61$, $p = 0.05$) or discontinuation ($Chi^2 = 1.34$, $p = 0.51$).

See forest plots in Appendix K.

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

Included studies

Fourty-four studies of non-trauma-focused CBT for the treatment of PTSD in adults were identified for full-text review. Of these 44 studies, 13 RCTs (N=1316) were included. There were 5 comparisons for non-trauma-focused CBT. One RCT was included in two comparisons of non-trauma-focused CBT.

There were no studies for early treatment (intervention initiated 1-3 months post-trauma) of PTSD symptoms.

For delayed treatment (intervention initiated more than 3 months post-trauma) of PTSD symptoms, 9 RCTs (N=737) compared non-trauma-focused CBT (alone or in addition to treatment as usual) with waitlist or treatment as usual (Davis & Wright 2007; Davis et al. 2011; Ford et al. 2011; Krakow et al. 2000; Margolies et al. 2013; McGovern et al. 2011; McGovern et al. 2015; Talbot et al. 2014; Zlotnick et al. 1997); 2 RCTs (N=413) compared non-trauma-focused CBT (alone or in addition to treatment as usual) with attention-placebo (alone or in addition to treatment as usual) (Hien et al. 2009; Nakamura et al. 2017); 1 RCT (N=111) compared non-trauma-focused CBT (in addition to treatment as usual) with a psychoeducational group (in addition to treatment as usual) (Dunn et al. 2007); 1 RCT (N=55) compared non-trauma-focused CBT with counselling (Foa et al. 1991); 1 RCT (N=146) compared non-trauma-focused CBT with present-centered therapy (Ford et al. 2011).

Comparisons with trauma-focused CBT are presented in the Trauma-focused CBT section above.

Sub-analyses were possible for the delayed treatment non-trauma-focused CBT (alone or in addition to TAU) versus waitlist or TAU comparison, comparing effects by multiplicity of trauma, specific intervention, diagnostic status at baseline, and trauma type.

Excluded studies

Thirty-one studies were reviewed at full text and excluded from this review. The most common reasons for exclusion were subgroup or secondary analysis of an RCT already included and/or that is not relevant, systematic review with no new useable data and any meta-analysis results not appropriate to extract, and intervention not targeted at PTSD symptoms.

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

Summary of clinical studies included in the evidence review

Table 29, Table 30 and Table 31 provide brief summaries of the included studies and evidence from these are summarised in the clinical GRADE evidence profiles below (Table 32, Table 33, Table 34, Table 35 and Table 36).

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

Table 29: Summary of included studies: Non-trauma-focused CBT for delayed treatment (>3 months)-part 1

Comparison	Non-TF-CBT (+/- TAU) versus waitlist/TAU
Total no. of studies (N randomised)	9 (737)
Study ID	Davis 2007[1] Davis 2011[2] Ford 2011[3] Krakow 2000[4] Margolies 2013[5] McGovern 2011[6] McGovern 2015[7] Talbot 2014[8] Zlotnick 1997[9]
Country	US
Diagnostic status	Clinically important PTSD symptoms (scoring above a threshold on validated scale) [1,2,4,7] PTSD diagnosis according to ICD/DSM criteria[3,5,6,8,9]
Mean months since onset of PTSD	NR[1,3,4,5,6,7,9] NR (experiencing nightmares for mean 216 [148.9] months) [2] 221.8[8]
Mean age (range)	40 (range NR) [1] 47 (range NR) [2] 30.7 (18-45) [3] 37 (range NR) [4] 37.7 (21-54) [5] 37.7 (range NR) [6] 35 (range NR) [7] 37.2 (22-59) [8] 39 (range NR) [9]
Sex (% female)	82[1] 75[2] 100[3,4,9] 10[5] 57[6] 60[7] 69[8]
Ethnicity (% BME)	24[1] 19[2] 59[3] 3[4] 60[5] 9[6] 5[7] 29[8] 0.02[9]
Coexisting conditions	NR[1,2,5,9]

Comparison	Non-TF-CBT (+/- TAU) versus waitlist/TAU
	72% met DSM-IV criteria for a current Axis I disorder other than PTSD, including anxiety disorders (61%) and depressive (34%), bipolar (8%), or psychotic (9%) disorders[3] All participants had regular nightmares (≥1 a week for >6 months) and insomnia[4] 100% had alcohol or drug dependence[6] Mean number of psychiatric disorders 3.8 (SD=1.7). All participants met criteria for substance use disorder (mean number of substance use disorders 3 [SD=2]). 58% major depression; 43% generalized anxiety; 30% panic with agoraphobia; 28% social anxiety; 16% panic disorder; 15% OCD; 14% dysthymia; 13% agoraphobia; 9% bipolar type disorders[7] 20% had comorbid depression and 51% had another psychiatric comorbidity. The mean (SD) number of comorbidities was 1.09 (0.19) [8]
Mean months since traumatic event	NR[1,2,3,5,6,7,8] NR (mean duration of nightmares was 20 years) [4] NR (abuse from 6.86 years of age on average) [9]
Type of traumatic event	Mixed: Most frequently reported types of trauma: car accidents (59%); unwanted sexual contact (59%); physical assault with a weapon (53%)[1] Mixed: The most frequent types of trauma reported were unwanted sexual contact (60%), serious accidents (57%), physical assault with a weapon (57%), combat exposure (13%)[2] Mixed: Exposure to victimization or incarceration[3] Exposure to sexual abuse or assault: 97% reported history of sexual assault: 50% raped as adults; 54% raped as children; >60% experienced multiple episodes of sexual assault[4] Military combat: Veterans from Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) [5] Childhood sexual abuse: 68% experienced childhood sexual assault, 18% childhood physical assault, 9% adult sexual assault, 2% adult physical assault and 2% experienced trauma from an accident[6] Mixed: Childhood sexual assault and adult physical assault but numbers for each trauma type were not reported[7] Unclear: No details reported[8] Childhood sexual abuse: 77% reported intrafamilial sexual abuse (abuse by a relative) and 35% reported parental sexual abuse[9]
Single or multiple incident index trauma	Single[1,2] Multiple[3,4,5,6,7,9] Unclear[8]
Lifetime experience of trauma	Mean 4.6 traumatic events (SD=2.0; range 1-9) [1] Mean 5.5 traumatic events (SD=2.75; range: 1-11) [2] NR[3,6,7,8] 68% experienced non-sexual violent assaults as adults and 72% as children. 78% reported other traumatic events including unexpected deaths in the family, witnessing violence, motor vehicle accidents, or natural disasters[4]

Comparison	Non-TF-CBT (+/- TAU) versus waitlist/TAU
	65% of participants were receiving some form of treatment for PTSD[5] 77% had also experienced rape. Mean number of lifetime sexual abuse offenders reported was 3.71 (SD = 3.45) [9]
Intervention details	CBT for insomnia (CBT-I)[1,2] + TAU[5,8] TARGET (Trauma Affect Regulation: Guide for Education and Therapy; Ford & Russo 2006) [3] Nightmare imagery rehearsal therapy[4] Integrated CBT[6,7] Affect management group[9]
Intervention format	Individual[1,2,3,5,6,7,8] Group[4,9]
Intervention intensity	3x weekly 2-hour sessions (6 hours) [1,2] 12x 50-min sessions (10 hours) [3] 3x 1-3 hour sessions (7 hours; 2x 3-hour sessions + 1x 1-hour session) [4] 4x 1-hour sessions (4 hours) [5] 12-14x weekly 45-50 min sessions (9-11 hours) [6] 8-12x weekly 45-50 min sessions (6-10 hours) [7] 8x sessions[8] 15x 2-hour weekly sessions (30 hours) [9]
Comparator	Waitlist[1,2,3,4] TAU: Overall, 65% of veterans were involved in some form of treatment for PTSD (group and/or individual). Group treatment (45%) involved PTSD support groups focusing specifically on OEF/OIF veterans. Individual treatment (43%) involved evidenced based approaches including prolonged exposure therapy and cognitive processing therapy[5] TAU: Individual addiction counselling, based on the Individual Drug Counselling (IDC) treatment used in the NIDA Cocaine Collaborative Study (Mercer & Woody, 1999) [6] TAU: Standard care consists of intensive outpatient programme services, including group and individual therapies, and medication management[7] TAU: All participants were currently in treatment for PTSD that could include medication therapy or enrolment in a specialized PTSD program or individual psychotherapy with a licensed clinician and had been in one of more of these treatments for at least 3 months[8] TAU: All participants were also in individual therapy and reported the use of psychotropic medication[9]
Intervention length (weeks)	3[1,2] 12[3] 5[4] 6[5] 13[6] 26[7] 8[8] 15[9]
Note. [1]Davis 2007; [2]Davis 2011; [3]Ford 2011; [4]Krakow 2000; [5]Margolies 2013; [6]McGovern 2011; [7]McGovern 2015; [8]Talbot 2014; [9]Zlotnick 1997	

Table 30: Summary of included studies: Non-trauma-focused CBT for delayed treatment (>3 months)-part 2

Comparison	Non-TF-CBT (+/- TAU) versus attention-placebo (+/- TAU)	Non-TF-CBT (+ TAU) versus psychoeducational group (+ TAU)
Total no. of studies (N randomised)	2 (413)	1 (111)
Study ID	Hien 2009[1] Nakamura 2017[2]	Dunn 2007
Country	US	US
Diagnostic status	PTSD diagnosis according to ICD/DSM criteria[1] Clinically important PTSD symptoms (scoring above a threshold on validated scale) [2]	PTSD diagnosis according to ICD/DSM criteria
Mean months since onset of PTSD	NR	NR ('chronic')
Mean age (range)	39.2 (range NR) [1] 50.7 (39-69) [2]	54.9 (range NR)
Sex (% female)	100[1] 10[2]	0
Ethnicity (% BME)	55[1] 12[2]	45
Coexisting conditions	All participants had substance use. The most frequently diagnosed substance use disorder was cocaine dependence (70.5%), followed by alcohol (56.1%), marijuana (27.2%), and opioid dependence (25.6%) [1] All participants had self-reported sleep disturbance and Gulf War Illness[2]	All had comorbid depression (MDD [78% + 14% MDD in partial remission only] or dysthymia [0.01%], or both [0.07%]), 43.5% had an anxiety disorder, 0.08% had another Axis I disorder
Mean months since traumatic event	NR	NR
Type of traumatic event	Mixed: The majority of participants had experienced physical abuse (84.8%) or sexual abuse (67.6%) during adulthood[1] Military combat: Gulf War veterans[2]	Military combat: NR ('veterans')
Single or multiple incident index trauma	Multiple	Multiple
Lifetime experience of trauma	Very high rates of childhood abuse histories (70.1% sexual and 58.7% physical abuse) [1] NR[2]	NR

Comparison	Non-TF-CBT (+/- TAU) versus attention-placebo (+/- TAU)	Non-TF-CBT (+ TAU) versus psychoeducational group (+ TAU)
Intervention details	Seeking Safety (Najavits 2002) + standard substance abuse treatment[1] Sleep-focused Mind-Body Bridging (MBB) [2]	Self-management therapy + TAU (standard Trauma Recovery Program care of process-oriented and educational groups + 90% taking psychotropic medication)
Intervention format	Group	Group
Intervention intensity	12x 75-90-min biweekly sessions (15-18 hours). Mean 6.2 treatment sessions attended (+ 1.3 mental health appointments and 3.4 12-step meetings) [1] 3x weekly sessions[2]	14x 1.5-hour weekly sessions (21 hours)
Comparator	Women's Health Education (WHE; attention-placebo) + standard substance abuse treatment[1] Sleep Hygiene Education (SED) intervention[2]	Psychoeducational group (+ TAU)
Intervention length (weeks)	6[1] 3[2]	14
Note. [1]Hien 2009; [2]Nakamura 2017		

Table 31: Summary of included studies: Non-trauma-focused CBT for delayed treatment (>3 months)-part 3

Comparison	Non-TF-CBT versus counselling	Non-TF-CBT versus present-centered therapy
Total no. of studies (N randomised)	1 (55)	1 (146)
Study ID	Foa 1991	Ford 2011
Country	US	US
Diagnostic status	PTSD diagnosis according to ICD/DSM criteria	PTSD diagnosis according to ICD/DSM criteria
Mean months since onset of PTSD	NR	NR
Mean age (range)	31.8 (range NR)	30.7 (18-45)
Sex (% female)	100	100
Ethnicity (% BME)	26	59
Coexisting conditions	NR	Most (72%) participants met Structured Clinical Interview for DSM-IV criteria for a current Axis I disorder other than PTSD. These included anxiety disorders (61%) and depressive (34%), bipolar (8%), or psychotic (9%) disorders

Comparison	Non-TF-CBT versus counselling	Non-TF-CBT versus present-centered therapy
Mean months since traumatic event	72.7	NR
Type of traumatic event	Exposure to sexual abuse or assault: Rape or attempted rape. 54% perpetrator was a stranger; 46% perpetrator was an acquaintance. 60% weapon used	Mixed: Exposure to victimization or incarceration
Single or multiple incident index trauma	Single	Multiple
Lifetime experience of trauma	NR	NR
Intervention details	Stress inoculation training (SIT) adapted from Veronen and Kilpatrick (1983) protocol	TARGET (Trauma Affect Regulation: Guide for Education and Therapy; Ford & Russo 2006), psychoeducation about the link between PTSD symptoms and affect dysregulation (8 sessions), skills training to restore affect regulation capabilities (4 sessions)
Intervention format	Individual	Individual
Intervention intensity	9x twice-weekly 90-min sessions (13.5 hours)	12x 50-min sessions (10 hours)
Comparator	Supportive counselling intervention involved teaching a general problem-solving technique	Present-centered therapy, adapted from 14-session manual (McDonagh-Coyle et al 2005)
Intervention length (weeks)	4.5	12
Note. None		

See Appendix D for full evidence tables.

Quality assessment of clinical studies included in the evidence review

The clinical evidence profiles for this review (non-trauma-focused CBT for the treatment of PTSD in adults) are presented in Table 32, Table 33, Table 34, Table 35 and Table 36.

Table 32: Summary clinical evidence profile: Non-trauma-focused CBT (+/- TAU) versus waitlist or TAU for delayed treatment (>3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist or TAU	Corresponding risk Non-trauma-focused CBT (+/- TAU)			
PTSD symptomatology self-report PCL/DTS/PDS/PSS-SR/MPSS-SR change score Follow-up: 3-15 weeks		The mean PTSD symptomatology self-report in the intervention groups was 0.93 standard deviations lower (1.26 to 0.59 lower)		228 (5 studies)	low[1,2]
PTSD symptomatology clinician-rated at endpoint CAPS change score Follow-up: 3-26 weeks		The mean PTSD symptomatology clinician-rated at endpoint in the intervention groups was 0.59 standard deviations lower (0.81 to 0.37 lower)		339 (4 studies)	very low[1,2,3,4]
PTSD symptomatology clinician-rated at 3-month follow-up CAPS change score Follow-up: mean 13 weeks		The mean PTSD symptomatology clinician-rated at 3-month follow-up in the intervention groups was 0.3 standard deviations higher (0.25 lower to 0.86 higher)		53 (1 study)	very low[1,5]
Remission at endpoint Number of people no longer meeting diagnostic criteria/above threshold on a scale for PTSD Follow-up: 12-15 weeks	256 per 1000	496 per 1000 (166 to 1000)	RR 1.94 (0.65 to 5.83)	194 (3 studies)	very low[1,6,7]
Remission at 3-month follow-up Number of people no longer meeting diagnostic criteria	905 per 1000	778 per 1000 (624 to 986)	RR 0.86 (0.69 to 1.09)	53 (1 study)	very low[1,5]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist or TAU	Corresponding risk Non-trauma-focused CBT (+/- TAU)			
Follow-up: mean 13 weeks					
Dissociative symptoms DES change score Follow-up: mean 15 weeks		The mean dissociative symptoms in the intervention groups was 0.77 standard deviations lower (1.48 to 0.06 lower)		33 (1 study)	low[1,2]
Sleeping difficulties ISI/PSQI change score Follow-up: 3-8 weeks		The mean sleeping difficulties in the intervention groups was 1.02 standard deviations lower (1.29 to 0.75 lower)		263 (5 studies)	very low[1,2,4,6]
Depression symptoms at endpoint BDI/BDI-II change score Follow-up: 3-13 weeks		The mean depression symptoms at endpoint in the intervention groups was 0.32 standard deviations lower (0.83 lower to 0.18 higher)		234 (4 studies)	very low[1,3,5]
Depression symptoms at 3-month follow-up BDI change score Follow-up: mean 13 weeks		The mean depression symptoms at 3-month follow-up in the intervention groups was 1.03 standard deviations higher (0.44 to 1.62 higher)		53 (1 study)	low[1,2]
Alcohol use - Endpoint TLFB Number of drinking days; change score Follow-up: 13-26 weeks		The mean alcohol use - endpoint in the intervention groups was 0.27 standard deviations lower (0.56 lower to 0.01 higher)		199 (2 studies)	very low[1,4,5]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist or TAU	Corresponding risk Non-trauma-focused CBT (+/- TAU)			
Alcohol use - 3-month follow-up TLFB Number of drinking days; change score Follow-up: mean 13 weeks		The mean alcohol use - 3-month follow-up in the intervention groups was 0.03 standard deviations higher (0.52 lower to 0.58 higher)		53 (1 study)	very low[1,7]
Drug use - Endpoint TLFB Number of drug use days; change score Follow-up: 13-26 weeks		The mean drug use - endpoint in the intervention groups was 0.14 standard deviations lower (0.51 lower to 0.23 higher)		199 (2 studies)	very low[1,4,5]
Drug use - 3-month follow-up TLFB Number of drug use days; change score Follow-up: mean 13 weeks		The mean drug use - 3-month follow-up in the intervention groups was 0.62 standard deviations lower (1.18 to 0.06 lower)		53 (1 study)	low[1,2]
Discontinuation Number of participants lost to follow-up for any reason Follow-up: 3-26 weeks	325 per 1000	328 per 1000 (263 to 403)	RR 1.01 (0.81 to 1.24)	684 (9 studies)	low[1,8]

BDI= Beck Depression Inventory; CAPS= Clinician-administered PTSD symptom scale; CBT= cognitive behavioural therapy; CI=confidence interval; DES= Dissociative Experiences Scales; DTS=Davidson Trauma Scale; ISI=Insomnia severity index; MPSS-SR=Modified PTSD Symptom Scale-self-report; PCL= PTSD checklist; PDS= Post-traumatic Diagnositic Scale; PSS-SR= PTSD symptom scale-interview/self-report; PSQI=Pittsburgh Sleep quality index; RR=risk ratio; SMD= standardised mean difference; TAU=treatment as usual; TLFB=alcohol timeline followback

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

[2] OIS not met (N<400)

[3] Substantial heterogeneity (I2=50-80%)

[4] Data is not reported/cannot be extracted for all outcomes

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

[6] Considerable heterogeneity (I2>80%)

[7] 95% CI crosses line of no effect and threshold for both clinically important benefit and clinically important harm

[8] OIS not met (events<300)

Table 33: Summary clinical evidence profile: Non-trauma-focused CBT (+/- TAU) versus attention-placebo (+/- TAU) for delayed treatment (>3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Attention-placebo (+/- TAU)	Corresponding risk Non-trauma-focused CBT (+/- TAU)			
PTSD symptomatology self-report at endpoint PCL/PSS-SR change score Follow-up: 3-6 weeks		The mean PTSD symptomatology self-report at endpoint in the intervention groups was 0.14 standard deviations lower (0.34 lower to 0.05 higher)		413 (2 studies)	very low[1,2,3]
PTSD symptomatology self-report at 3-month follow-up PCL change score Follow-up: mean 13 weeks		The mean PTSD symptomatology self-report at 3-month follow-up in the intervention groups was 0.56 standard deviations lower (1.08 to 0.04 lower)		60 (1 study)	low[1,4]
PTSD symptomatology clinician-rated CAPS change score Follow-up: mean 6 weeks		The mean PTSD symptomatology clinician-rated in the intervention groups was 0.1 standard deviations higher (0.11 lower to 0.31 higher)		353 (1 study)	low[3,4]
Response Number of people showing clinically significant improvement, based on reliable change indices (RCI) Follow-up: mean 6 weeks	458 per 1000	476 per 1000 (380 to 595)	RR 1.04 (0.83 to 1.3)	353 (1 study)	low[3,5]
Depression symptoms - Endpoint CES-D change score Follow-up: mean 3 weeks		The mean depression symptoms - endpoint in the intervention groups was 0.12 standard		60 (1 study)	low[1,5]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Attention-placebo (+/- TAU)	Corresponding risk Non-trauma-focused CBT (+/- TAU)			
		deviations lower (0.63 lower to 0.38 higher)			
Depression symptoms - 3-month follow-up CES-D change score Follow-up: mean 13 weeks		The mean depression symptoms - 3-month follow-up in the intervention groups was 0.89 standard deviations lower (1.43 to 0.36 lower)		60 (1 study)	low[1,4]
Drug use Substance Use Inventory: Number of days participants used drugs during the past 7 days; change score Follow-up: mean 6 weeks		The mean drug use in the intervention groups was 0.05 standard deviations lower (0.26 lower to 0.16 higher)		353 (1 study)	low[3,4]
Quality of life at endpoint SF-36 change score Follow-up: mean 3 weeks Better indicated by higher values		The mean quality of life at endpoint in the intervention groups was 0.1 standard deviations higher (0.41 lower to 0.61 higher)		60 (1 study)	low[1,5]
Quality of life at 3-month follow-up SF-36 change score Follow-up: mean 13 weeks Better indicated by higher values		The mean quality of life at 3-month follow-up in the intervention groups was 0.25 standard deviations higher (0.26 lower to 0.76 higher)		60 (1 study)	low[1,5]
Discontinuation Number of participants lost to follow-up for any reason Follow-up: 3-6 weeks	319 per 1000	354 per 1000 (271 to 462)	RR 1.11 (0.85 to 1.45)	413 (2 studies)	moderate[5]

CAPS= Clinician-administered PTSD scale; CBT= cognitive behavioural therapy; CES-D= Centre of Epidemiological Studies-Depression; CI= confidence interval; PCL= PTSD checklist; PSS-SR= PTSD symptom scale-interview/self-report; RR= risk ratio; SF-36=Short form-36; SMD=standardised mean difference; TAU=treatment as usual

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

[2] *Substantial heterogeneity (I2=50-80%)*

[3] *Data is not reported/cannot be extracted for all outcomes*

[4] *OIS not met (N<400)*

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

Table 34: Summary clinical evidence profile: Non-trauma-focused CBT (+ TAU) versus psychoeducational group (+ TAU) for delayed treatment (>3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Psychoeducational group (+ TAU)	Corresponding risk Non-trauma-focused CBT (+ TAU)			
PTSD symptomatology self-report - Endpoint DTS change score Follow-up: mean 14 weeks		The mean PTD symptomatology self-report - endpoint in the intervention groups was 0.34 standard deviations lower (0.79 lower to 0.12 higher)		77 (1 study)	low[1,2]
PTSD symptomatology self-report - 3-month follow-up DTS change score Follow-up: mean 13 weeks		The mean PTSD symptomatology self-report - 3-month follow-up in the intervention groups was 0.31 standard deviations lower (0.78 lower to 0.17 higher)		70 (1 study)	low[1,2]
PTSD symptomatology self-report - 6-month follow-up DTS change score Follow-up: mean 26 weeks		The mean PTSD symptomatology self-report - 6-month follow-up in the intervention groups was 0.11 standard deviations lower (0.58 lower to 0.36 higher)		71 (1 study)	low[1,2]
PTSD symptomatology self-report - 1-year follow-up DTS change score Follow-up: mean 52 weeks		The mean PTSD symptomatology self-report - 1-year follow-up in the intervention groups was 0.22 standard deviations lower		66 (1 study)	low[1,2]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Psychoeducational group (+ TAU)	Corresponding risk Non-trauma-focused CBT (+ TAU)			
		(0.71 lower to 0.27 higher)			
PTSD symptomatology clinician-rated - Endpoint CAPS change score Follow-up: mean 14 weeks		The mean PTSD symptomatology clinician-rated - endpoint in the intervention groups was 0.25 standard deviations lower (0.71 lower to 0.2 higher)		77 (1 study)	moderate[2]
PTSD symptomatology clinician-rated - 3-month follow-up CAPS change score Follow-up: mean 13 weeks		The mean PTSD symptomatology clinician-rated - 3-month follow-up in the intervention groups was 0.2 standard deviations lower (0.67 lower to 0.27 higher)		70 (1 study)	moderate[2]
PTSD symptomatology clinician-rated - 6-month follow-up CAPS change score Follow-up: mean 26 weeks		The mean PTSD symptomatology clinician-rated - 6-month follow-up in the intervention groups was 0.18 standard deviations lower (0.65 lower to 0.29 higher)		71 (1 study)	moderate[2]
PTSD symptomatology clinician-rated - 1-year follow-up CAPS change score Follow-up: mean 52 weeks		The mean ptsd symptomatology clinician-rated - 1-year follow-up in the intervention groups was 0.53 standard deviations lower (1.03 to 0.04 lower)		66 (1 study)	moderate[3]
Depression symptoms - Endpoint HAMD change score Follow-up: mean 14 weeks		The mean depression symptoms - endpoint in the intervention groups was 1.01 standard		77 (1 study)	moderate[3]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Psychoeducational group (+ TAU)	Corresponding risk Non-trauma-focused CBT (+ TAU)			
		deviations lower (1.49 to 0.53 lower)			
Depression symptoms - 3-month follow-up HAMD change score Follow-up: mean 13 weeks		The mean depression symptoms - 3-month follow-up in the intervention groups was 0.53 standard deviations lower (1.01 to 0.05 lower)		70 (1 study)	moderate[3]
Depression symptoms - 6-month follow-up HAMD change score Follow-up: mean 26 weeks		The mean depression symptoms - 6-month follow-up in the intervention groups was 0.66 standard deviations lower (1.15 to 0.18 lower)		71 (1 study)	moderate[3]
Depression symptoms - 1-year follow-up HAMD change score Follow-up: mean 52 weeks		The mean depression symptoms - 1-year follow-up in the intervention groups was 0.1 standard deviations lower (0.59 lower to 0.39 higher)		66 (1 study)	moderate[2]
Discontinuation Number of participants lost to follow-up for any reason Follow-up: mean 14 weeks	214 per 1000	401 per 1000 (221 to 726)	RR 1.87 (1.03 to 3.39)	111 (1 study)	moderate[4]

CAPS= Clinician-administered PTSD scale; CI= confidence interval; DTS=Davidson trauma scale; HAMD= Hamilton Rating Scale for Depression; RR= risk ratio; SMD= standardised mean difference; TAU=treatment as usual

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

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

[3] OIS not met (N<400)

[4] OIS not met (events<300)

Table 35: Summary clinical evidence profile: Non-trauma-focused CBT versus counselling for delayed treatment (>3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Counselling	Corresponding risk Non-trauma-focused CBT			
PTSD symptomatology clinician-rated PSS-I change score Follow-up: mean 5 weeks		The mean PTSD symptomatology clinician-rated in the intervention groups was 1.47 standard deviations lower (2.38 to 0.57 lower)		25 (1 study)	very low[1,2,3]
Remission Number of people no longer meeting diagnostic criteria for PTSD Follow-up: mean 5 weeks	71 per 1000	411 per 1000 (57 to 1000)	RR 5.76 (0.8 to 41.43)	31 (1 study)	very low[1,3,4]
Response Number of people showing clinically significant improvement based on reliable change indices (RCI) on PSS-I Follow-up: mean 5 weeks	143 per 1000	589 per 1000 (153 to 1000)	RR 4.12 (1.07 to 15.78)	31 (1 study)	very low[1,3,5]
Anxiety symptoms STAI State change score Follow-up: mean 5 weeks		The mean anxiety symptoms in the intervention groups was 0.65 standard deviations lower (1.46 lower to 0.17 higher)		25 (1 study)	very low[1,3,4]
Depression symptoms BDI change score Follow-up: mean 5 weeks		The mean depression symptoms in the intervention groups was 0.81 standard deviations lower		25 (1 study)	very low[1,3,4]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Counselling	Corresponding risk Non-trauma-focused CBT			
		(1.64 lower to 0.02 higher)			
Discontinuation Number of participants lost to follow-up for any reason Follow-up: mean 5 weeks	214 per 1000	176 per 1000 (43 to 741)	RR 0.82 (0.2 to 3.46)	31 (1 study)	very low[1,6]

BDI= Beck Depression Inventory; CBT= cognitive behavioural therapy; CI= confidence interval; PSS-I= PTSD symptom scale-interview; RR=risk ratio; SMD= standardised mean difference; STAI= State-Trait Anxiety Inventory

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

[2] *OIS not met (N<400)*

[3] *Data is not reported/cannot be extracted for all outcomes*

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

[5] *OIS not met (events<300)*

[6] *95% CI crosses line of no effect and threshold for both clinically important benefit and clinically important harm*

Table 36: Summary clinical evidence profile: Non-trauma-focused CBT versus present-centered therapy for delayed treatment (>3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Present-centered therapy	Corresponding risk Non-trauma-focused CBT			
PTSD symptomatology clinician-rated - Endpoint CAPS change score Follow-up: mean 12 weeks		The mean PTSD symptomatology clinician-rated - endpoint in the intervention groups was 0.09 standard deviations lower (0.48 lower to 0.3 higher)		101 (1 study)	very low[1,2]
PTSD symptomatology clinician-rated - 3-month follow-up CAPS change score Follow-up: mean 13 weeks		The mean PTSD symptomatology clinician-rated - 3-month follow-up in the intervention groups was 0.04 standard deviations lower (0.43 lower to 0.35 higher)		101 (1 study)	very low[1,2]
PTSD symptomatology clinician-rated - 6-month follow-up		The mean PTSD symptomatology clinician-rated - 6-month follow-up in the intervention		101 (1 study)	very low[1,3]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Present-centered therapy	Corresponding risk Non-trauma-focused CBT			
CAPS change score Follow-up: mean 26 weeks		groups was 0.23 standard deviations higher (0.16 lower to 0.62 higher)			
Remission - Endpoint Number of people no longer meeting diagnostic criteria for PTSD Follow-up: mean 12 weeks	151 per 1000	208 per 1000 (89 to 485)	RR 1.38 (0.59 to 3.21)	101 (1 study)	very low[1,4]
Remission - 3-month follow-up Number of people no longer meeting diagnostic criteria for PTSD Follow-up: mean 13 weeks	189 per 1000	292 per 1000 (143 to 594)	RR 1.55 (0.76 to 3.15)	101 (1 study)	very low[1,4]
Remission - 6-month follow-up Number of people no longer meeting diagnostic criteria for PTSD Follow-up: mean 26 weeks	245 per 1000	334 per 1000 (179 to 618)	RR 1.36 (0.73 to 2.52)	101 (1 study)	very low[1,4]
Depression symptoms - Endpoint BDI change score Follow-up: mean 12 weeks		The mean depression symptoms - endpoint in the intervention groups was 0.2 standard deviations higher (0.19 lower to 0.59 higher)		101 (1 study)	very low[1,3]
Depression symptoms - 3-month follow-up BDI change score		The mean depression symptoms - 3-month follow-up in the intervention		101 (1 study)	very low[1,2]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Present-centered therapy	Corresponding risk Non-trauma-focused CBT			
Follow-up: mean 13 weeks		groups was 0.48 standard deviations higher (0.08 to 0.87 higher)			
Depression symptoms - 6-month follow-up BDI change score Follow-up: mean 26 weeks		The mean depression symptoms - 6-month follow-up in the intervention groups was 0.06 standard deviations higher (0.33 lower to 0.45 higher)		101 (1 study)	very low[1,2]
Discontinuation Number of participants lost to follow-up for any reason Follow-up: mean 12 weeks	340 per 1000	292 per 1000 (163 to 520)	RR 0.86 (0.48 to 1.53)	101 (1 study)	very low[1,4]

BDI= Beck Depression Inventory; CAPS= Clinician-administered PTSD scale; CI= confidence interval; RR= risk ratio; SMD= standardised mean difference

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

[2] OIS not met (N<400)

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

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

See appendix I for full GRADE tables.

Sensitivity and subgroup analysis

Sub-analysis of the comparison, non-trauma-focused CBT (alone or in addition to TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD, by multiplicity of trauma revealed no statistically significant differences for self-rated PTSD symptomatology (K=5; N=228; $Chi^2 = 3.62$, p = 0.16), clinician-rated PTSD symptomatology (K=4; N=339; $Chi^2 = 0.01$, p = 0.94), or discontinuation (K=9; N=684; $Chi^2 = 2.15$, p = 0.34).

Sub-analysis by specific intervention revealed no statistically significant subgroup differences for self-rated PTSD symptomatology ($Chi^2 = 0.45$, p = 0.80), or discontinuation ($Chi^2 = 4.85$, p = 0.30). A statistically significant subgroup difference was observed for clinician-rated PTSD symptomatology ($Chi^2 = 6.23$, p = 0.04), with relatively larger effects for affect regulation (SMD -1.06 [-1.50, -0.63]) relative to CBT for insomnia (CBT-I; SMD -0.57 [-1.16, 0.01]) or integrated CBT (SMD -0.40 [-0.68, -0.12]). However, there is only a single study in the affect regulation subgroup which may differ in any number of variables, thus, this effect may be spurious. It is also worth noting that effects are statistically significant across specific interventions.

Sub-analysis by diagnostic status at baseline revealed no statistically significant subgroup differences for self-rated PTSD symptomatology (Chi² = 1.30, p = 0.25), or discontinuation (Chi² = 0.31, p = 0.58). A statistically significant subgroup difference was observed for clinician-rated PTSD symptomatology (Chi² = 4.18, p = 0.04), with relatively larger effects observed for the PTSD diagnosis according to ICD/DSM criteria subgroup (SMD -0.87 [-1.21, -0.53]) compared to the clinically important PTSD symptoms (scoring above threshold on validated scale) subgroup (SMD -0.40 [-0.69, -0.12]). However, effects are statistically significant for both subgroups.

Sub-analysis by trauma type revealed no statistically significant subgroup differences for self-rated PTSD symptomatology (Chi² = 5.12, p = 0.27), clinician-rated PTSD symptomatology (Chi² = 0.03, p = 0.87), or discontinuation (Chi² = 2.74, p = 0.60).

See forest plots in Appendix E.

Present-centered therapy: clinical evidence

Included studies

Four studies of present-centered therapy for the treatment of PTSD in adults were identified for full-text review. Of these 4 studies, all 4 RCTs (N=350) were included. There were 2 comparisons for present-centered therapy.

For early treatment (intervention initiated 1-3 months post-trauma) of PTSD symptoms, 2 RCTs (N=130) compared present-centered therapy in addition to treatment as usual with treatment as usual-only (Johnson et al. 2011; Johnson et al. 2016).

For delayed treatment (intervention initiated more than 3 months post-trauma) of PTSD symptoms, 2 RCTs (N=220) compared present-centered therapy with waitlist (Ford et al. 2011; McDonagh et al. 2005).

Comparisons with trauma-focused CBT are presented in the Trauma-focused CBT section above.

Sub-analyses were not possible for present-centered therapy.

Excluded studies

No present-centered studies that were considered in full-text were excluded.

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

Summary of clinical studies included in the evidence review

Table 37and Table 38 provide brief summaries of the included studies and evidence from these are summarised in the clinical GRADE evidence profiles below (Table 39 and Table 40).

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

Table 37: Summary of included studies: Present-centered therapy for early treatment (1-3 months)

Comparison	Present-centered therapy (+ TAU) versus TAU
Total no. of studies (N randomised)	2 (130)
Study ID	Johnson 2011[1] Johnson 2016[2]
Country	US
Diagnostic status	PTSD diagnosis according to ICD/DSM criteria
Mean months since onset of PTSD	NR
Mean age (range)	32.6 (range NR) [1] 33.3 (range NR) [2]
Sex (% female)	100
Ethnicity (% BME)	57
Coexisting conditions	67% MDD, 18% anxiety disorders[1] 60% MDD, 43% other anxiety disorder[2]
Mean months since traumatic event	NR (inclusion criteria included experience of domestic violence within 1 month prior to entering shelter and mean time in shelter at baseline was 15[1]/21[2] days)
Type of traumatic event	Domestic violence
Single or multiple incident index trauma	Multiple
Lifetime experience of trauma	6.31 types of prior trauma, aside from index IPV. 73% had experienced prior lifetime IPV[1] 3.6 prior trauma. 66% had experienced prior lifetime IPV[2]
Intervention details	Helping to Overcome PTSD through Empowerment (HOPE) programme (Johnson & Zlotnick 2006) + standard shelter services
Intervention format	Individual
Intervention intensity	12x 1-1.5-hour twice-weekly sessions (12-15 hours). Mean 6.8 (sd=4.3) attended sessions[1] 16x 1-hour sessions (16 hours; 10x weekly sessions in shelter, 6x sessions over 3 months post-shelter). Mean 12.7 sessions attended, + 1.07 case management group attended[2]
Comparator	Standard shelter services (SSSs) which included case management, a supportive milieu environment, and attendance of educational groups offered through the shelter (i.e., parenting & support groups)
Intervention length (weeks)	6[1] 23[2]

Note. [1]Johnson 2011; [2]Johnson 2016

Table 38: Summary of included studies: Present-centered therapy for delayed treatment (>3 months)

Comparison	Present-centered therapy versus waitlist
Total no. of studies (N randomised)	2 (220)
Study ID	Ford 2011[1] McDonagh 2005[2]

Comparison	Present-centered therapy versus waitlist
Country	US
Diagnostic status	PTSD diagnosis according to ICD/DSM criteria
Mean months since onset of PTSD	NR[1] NR ('chronic')[2]
Mean age (range)	30.7 (18-45)[1] 40.4 (range NR)[2]
Sex (% female)	100
Ethnicity (% BME)	59[1] 7[2]
Coexisting conditions	72% met DSM-IV criteria for a current Axis I disorder other than PTSD, including anxiety disorders (61%) and depressive (34%), bipolar (8%), or psychotic (9%) disorders[1] 11% met criteria for borderline personality disorder[2]
Mean months since traumatic event	NR[1] NR (mean age of onset 6.6 years [SD=2.6])[2]
Type of traumatic event	Mixed: Exposure to victimization or incarceration[1] Childhood sexual abuse. Childhood sexual abuse characteristics: 23% experienced life threat; 34% injured; 64% penetrated. Perpetrator of worst CSA event: 32% father or stepfather; 35% other male relative; 31% known male; 1% male stranger[2]
Single or multiple incident index trauma	Multiple
Lifetime experience of trauma	NR[1] Mean number of trauma types 3.3 (SD=1.1). Trauma history: 80% childhood physical abuse; 62% adult physical abuse; 50% adult sexual trauma[2]
Intervention details	Present-centered therapy, adapted from 14-session manual (McDonagh-Coyle et al 2005), consists of psychoeducation linking traumatic events to relationship problems (6 sessions) and teaches social problem-solving skills (6 sessions)[1] Present-centered therapy (PCT) included psychoeducation, training in problem solving and journal writing. Although the role of trauma was acknowledged in assessing current difficulties, the trauma itself was never the focus of the treatment[2]
Intervention format	Individual
Intervention intensity	12x 50-min sessions (10 hours)[1] 14x 1.5-2 hour sessions (24.5 hours; first 7 sessions 2 hours and final 7 1.5 hours)[2]
Comparator	Waitlist
Intervention length (weeks)	12[1] 20[2]
Note. [1]Ford 2011; [2]McDonagh 2005	

1 See Appendix F for full evidence tables.

2 Quality assessment of clinical studies included in the evidence review

3 The clinical evidence profiles for this review (present-centered therapy for the
4 treatment of PTSD in adults) are presented in Table 39 and Table 40.

Table 39: Summary clinical evidence profile: Present-centered therapy (+ TAU) versus TAU for early treatment (1-3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk TAU	Corresponding risk Present-centered therapy (+ TAU)			
PTSD symptomatology clinician-rated - Endpoint CAPS change score Follow-up: 6-23 weeks		The mean PTSD symptomatology clinician-rated - endpoint in the intervention groups was 0.52 standard deviations lower (0.89 to 0.15 lower)		119 (2 studies)	very low[1,2,3]
PTSD symptomatology clinician-rated - 3-month follow-up CAPS change score Follow-up: mean 13 weeks		The mean PTSD symptomatology clinician-rated - 3-month follow-up in the intervention groups was 0.44 standard deviations lower (1.26 lower to 0.37 higher)		116 (2 studies)	very low[1,3,4,5]
PTSD symptomatology clinician-rated - 6-month follow-up CAPS change score Follow-up: mean 26 weeks		The mean PTSD symptomatology clinician-rated - 6-month follow-up in the intervention groups was 0.24 standard deviations lower (0.91 lower to 0.43 higher)		114 (2 studies)	very low[1,3,4,5]
Response - Endpoint Number of people showing improvement of at least 26 points on CAPS Follow-up: mean 23 weeks	667 per 1000	767 per 1000 (553 to 1000)	RR 1.15 (0.83 to 1.59)	60 (1 study)	low[1,5]
Response - 3-month follow-up Number of people showing improvement of at least 26 points on CAPS	667 per 1000	867 per 1000 (647 to 1000)	RR 1.3 (0.97 to 1.74)	60 (1 study)	low[1,5]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk TAU	Corresponding risk Present-centered therapy (+ TAU)			
Follow-up: mean 13 weeks					
Response - 6-month follow-up Number of people showing improvement of at least 26 points on CAPS Follow-up: mean 26 weeks	767 per 1000	797 per 1000 (613 to 1000)	RR 1.04 (0.8 to 1.36)	60 (1 study)	low[1,5]
Depression symptoms - Endpoint BDI change score Follow-up: 6-23 weeks		The mean depression symptoms - endpoint in the intervention groups was 1.01 standard deviations lower (1.69 to 0.32 lower)		119 (2 studies)	very low[1,2,3,4]
Depression symptoms - 3-month follow-up BDI change score Follow-up: mean 13 weeks		The mean depression symptoms - 3-month follow-up in the intervention groups was 0.77 standard deviations lower (1.14 to 0.39 lower)		116 (2 studies)	very low[1,2,3]
Depression symptoms - 6-month follow-up BDI change score Follow-up: mean 26 weeks		The mean depression symptoms - 6-month follow-up in the intervention groups was 0.79 standard deviations lower (1.17 to 0.4 lower)		114 (2 studies)	very low[1,2,3]
Discontinuation Number of participants lost to follow-up for any reason Follow-up: 6-23 weeks	92 per 1000	77 per 1000 (25 to 233)	RR 0.83 (0.27 to 2.52)	130 (2 studies)	very low[1,6]

BDI= Beck Depression Inventory; CAPS= Clinician-administered PTSD scale; CI= confidence interval; RR= risk ratio; SMD= standardised mean difference; TAU=treatment as usual

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

[2] *OIS not met (N<400)*

[3] *Data is not reported/cannot be extracted for all outcomes*

[4] *Substantial heterogeneity (I2=50-80%)*

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

[6] *95% CI crosses line of no effect and threshold for both clinically important benefit and clinically important harm*

Table 40: Summary clinical evidence profile: Present-centered therapy versus waitlist for delayed treatment (>3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist	Corresponding risk Present-centered therapy			
PTSD symptomatology clinician-rated CAPS change score Follow-up: 12-20 weeks		The mean PTSD symptomatology clinician-rated in the intervention groups was 1.02 standard deviations lower (1.37 to 0.67 lower)		143 (2 studies)	very low[1,2]
Remission Number of people no longer meeting diagnostic criteria for PTSD Follow-up: 12-20 weeks	59 per 1000	215 per 1000 (25 to 1000)	RR 3.65 (0.43 to 31)	143 (2 studies)	very low[1,3,4,5]
Dissociative symptoms DES change score Follow-up: mean 20 weeks		The mean dissociative symptoms in the intervention groups was 1.26 standard deviations lower (1.9 to 0.61 lower)		45 (1 study)	very low[1,2,5]
Anxiety symptoms STAI state change score Follow-up: mean 20 weeks		The mean anxiety symptoms in the intervention groups was 0.66 standard deviations lower (1.26 to 0.06 lower)		45 (1 study)	very low[1,2,5]
Depression symptoms BDI change score Follow-up: 12-20 weeks		The mean depression symptoms in the intervention groups was 0.66 standard		143 (2 studies)	very low[1,2]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist	Corresponding risk Present-centered therapy			
		deviations lower (1 to 0.32 lower)			
Emotional and behavioural problems: Anger STAXI change score Follow-up: mean 20 weeks		The mean emotional and behavioural problems: anger in the intervention groups was 0 standard deviations higher (0.58 lower to 0.58 higher)		45 (1 study)	very low[1,4,5]
Quality of life QOLI change score Follow-up: mean 20 weeks Better indicated by higher values		The mean quality of life in the intervention groups was 0.33 standard deviations higher (0.26 lower to 0.92 higher)		45 (1 study)	very low[1,5,6]
Discontinuation Number of participants lost to follow-up for any reason Follow-up: 12-20 weeks	191 per 1000	264 per 1000 (141 to 487)	RR 1.38 (0.74 to 2.55)	143 (2 studies)	very low[1,4]

BDI=Beck Depression Inventory; CAPS= Clinician-administered PTSD scale; CI= confidence interval; DES= Dissociative Experiences Scales; RR= risk ratio; SMD= standardised mean difference; STAI= State-Trait Anxiety Inventory; STAXI= State-Trait Anger Experssion Inventory; QOLI=Qualiy of life index

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

[2] OIS not met (N<400)

[3] Substantial heterogeneity (I2=50-80%)

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

[5] Data is not reported/cannot be extracted for all outcomes

[6] 95% CI crosses both line of no effect and threshold for clinically important effect

See Appendix F for full GRADE tables.

Cognitive therapies: clinical evidence

Included studies

Twenty-three studies of cognitive therapies for the treatment of PTSD in adults were identified for full-text review. Of these 23 studies, 2 RCTs (N=52) were included. There was 1 comparison for cognitive therapies.

For early treatment (intervention initiated 1-3 months post-trauma) of PTSD symptoms, no relevant RCTs were identified.

For delayed treatment (intervention initiated more than 3 months post-trauma) of PTSD symptoms, both RCTs (N=52) compared metacognitive therapy (alone or in addition to TAU) with waitlist or TAU (Wells & Colbear 2012; Wells et al. 2015).

Comparisons with trauma-focused CBT are presented in the Trauma-focused CBT section above.

Sub-analyses were not possible for cognitive therapies.

Excluded studies

Twenty-one studies were reviewed at full text and excluded from this review. The most common reasons for exclusion were systematic review with no new useable data and any meta-analysis results not appropriate to extract, non-systematic review, intervention not targeted at PTSD symptoms, and non-randomised group assignment.

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

Summary of clinical studies included in the evidence review

Table 41 provides brief summaries of the included studies and evidence from these are summarised in the clinical GRADE evidence profile below (Table 42).

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

Table 41: Summary of included studies: Cognitive therapies for delayed treatment (>3 months)

Comparison	Metacognitive therapy (+/- TAU) versus waitlist or TAU
Total no. of studies (N randomised)	2 (52)
Study ID	Wells 2012[1] Wells 2015[2]
Country	UK
Diagnostic status	PTSD diagnosis according to ICD/DSM criteria
Mean months since onset of PTSD	Median 13/15.5[1] Median 23.5 months[2]
Mean age (range)	37.4 (range NR) [1] 41.2 (range NR) [2]
Sex (% female)	55[1] 38[2]
Ethnicity (% BME)	NR
Coexisting conditions	15% minor depressive disorder; 45% major depressive disorder; 15% GAD[1] 56% coexisting psychiatric diagnosis: 28% major depressive disorder; 22% panic disorder; 6% major depressive disorder and panic disorder[2]
Mean months since traumatic event	NR (inclusion criteria included PTSD symptoms for >3 months) [1] NR[2]

Comparison	Metacognitive therapy (+/- TAU) versus waitlist or TAU
Type of traumatic event	Mixed: Assault (35%), MVC (20%), robbery (10%), sexual assault (15%), witness (10%), work accident (10%)[1] Mixed: Actual assault (28%); threatened assault (3%); sexual assault (9%); assaulted another (3%); road traffic accident (25%); witness (9%); fire (13%); war/combat (6%); armed robbery (3%)[2]
Single or multiple incident index trauma	Single
Lifetime experience of trauma	Median number of traumas=1/1.5[1] Total number of traumas median 2.0 (IQR 1.0-3.0)[2]
Intervention details	Metacognitive therapy (following manual by Wells 2009)[1] Metacognitive Therapy, following manual by Wells and Sembi (2004) + TAU (concurrent pharmacological treatment permitted)[2]
Intervention format	Individual
Intervention intensity	8x weekly sessions (length of sessions NR). Mean attended 6.4 sessions[1] 8x weekly 1-hour sessions (8 hours)[2]
Comparator	Waitlist[1] TAU[2]
Intervention length (weeks)	8
Note. [1]Wells 2012; [2]Wells 2015	

See appendix G for full evidence tables.

Quality assessment of clinical studies included in the evidence review

The clinical evidence profile for this review (cognitive therapy for the treatment of PTSD in adults) is presented in Table 42.

Table 42: Summary clinical evidence profile: Metacognitive therapy (+/- TAU) versus waitlist or TAU for delayed treatment (>3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist or TAU	Corresponding risk Metacognitive therapy (+/- TAU)			
PTSD symptomatology self-rated IES/PDS change score Follow-up: mean 8 weeks		The mean PTSD symptomatology self-rated in the intervention groups was 3.45 standard deviations lower (4.51 to 2.39 lower)		40 (2 studies)	very low[1,2,3]
Response self-rated at endpoint Number of people showing	100 per 1000	909 per 1000 (140 to 1000)	RR 9.09 (1.4 to 58.91)	21 (1 study)	very low[1,3,4]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist or TAU	Corresponding risk Metacognitive therapy (+/- TAU)			
clinically significant improvement based on at least 10-point improvement on IES Follow-up: mean 8 weeks					
Anxiety symptoms BAI change score Follow-up: mean 8 weeks		The mean anxiety symptoms in the intervention groups was 1.97 standard deviations lower (2.76 to 1.19 lower)		40 (2 studies)	very low[1,2,3]
Depression symptoms BDI-II change score Follow-up: mean 8 weeks		The mean depression symptoms in the intervention groups was 2.45 standard deviations lower (3.32 to 1.57 lower)		40 (2 studies)	very low[1,2,3]
Discontinuation Number of participants lost to follow-up for any reason Follow-up: mean 8 weeks	0 per 1000	0 per 1000 (0 to 0)	RR 2.87 (0.32 to 25.56)	41 (2 studies)	low[5]

BAI= Beck Anxiety Inventory; BDI= Beck Depression Inventory; CI= confidence interval; IES= Impact of Event Scale; PDS= Post-traumatic Diagnostic Scale; RR= risk ratio; SMD= standardised mean difference; TAU=treatment as usual;

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

[2] OIS not met (N<400)

[3] Data is not reported/cannot be extracted for all outcomes

[4] OIS not met (events<300)

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

See Appendix F for full GRADE tables.

Behavioural therapies: clinical evidence

Included studies

Eleven studies of behavioural therapies for the treatment of PTSD in adults were identified for full-text review. Of these 11 studies, 2 RCTs (N=90) were included. There was 1 comparison for behavioural therapies.

For early treatment (intervention initiated 1-3 months post-trauma) of PTSD symptoms, no relevant RCTs were identified.

For delayed treatment (intervention initiated more than 3 months post-trauma) of PTSD symptoms, both RCTs (N=90) compared single-session behavioural therapy with waitlist (Başoğlu et al. 2005; Başoğlu et al. 2007).

Sub-analyses were not possible for behavioural therapies.

Excluded studies

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

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

Summary of clinical studies included in the evidence review

Table 43 provides brief summaries of the included studies and evidence from these are summarised in the clinical GRADE evidence profile below (Table 44).

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

Table 43: Summary of included studies: Behavioural therapies for delayed treatment (>3 months)

Comparison	Single-session behavioural therapy versus waitlist
Total no. of studies (N randomised)	2 (90)
Study ID	Basoglu 2005[1] Basoglu 2007[2]
Country	Turkey
Diagnostic status	PTSD diagnosis according to ICD/DSM criteria
Mean months since onset of PTSD	NR
Mean age (range)	36.3 (range NR) [1] 34 (range NR) [2]
Sex (% female)	85[1] 87[2]
Ethnicity (% BME)	NR
Coexisting conditions	NR[1] Major depression: 36%, Panic disorder: 10%, panic disorder with agoraphobia: 19%[2]
Mean months since traumatic event	36[1] 54[2]
Type of traumatic event	Natural disaster: Earthquake in Turkey on August 17, 1999. 20% survivors were trapped under rubble, 39% suffered varying degrees of physical injury, 5% lost at least one first-degree relative, and 70% lost at least a second-degree relative or a friend. 19% survivors participated in rescue work[1]

Comparison	Single-session behavioural therapy versus waitlist
	Natural disaster: Earthquake in Turkey on August 17, 1999. 10% survivors had been trapped under rubble, 29% had physical injury, and 68% had lost second-degree relatives or friends[2]
Single or multiple incident index trauma	Single
Lifetime experience of trauma	63% previous trauma (MVCs, fire, floods) [1] NR[2]
Intervention details	Single session of modified behavioral treatment. Abridged CBT program (Basoglu 2002) focused on addressing fear of earthquakes and PTSD symptoms such as hyperarousal, modified by (1) limiting cognitive interventions to the explanation of the treatment rationale only, (2) focusing on reduction of fear and avoidance, and (3) shifting focus from habituation to anxiogenic stimuli to enhancement of sense of control over traumatic stressors[1] Behavioural therapy involved two steps: explanation of the treatment rationale, treatment target setting, and self-exposure instructions and the participants were asked to confront their fear until they felt in control but no systematic cognitive restructuring was undertaken; second step involved exposure to simulated earthquake tremors, and the session was terminated when the survivors felt in complete control of their distress or fear (mean session duration was 33 min [SD=18, range 9–70 min]) [2]
Intervention format	Individual
Intervention intensity	1x 60min session[1] 1x 60-min session and 1x exposure session[1]
Comparator	Waitlist
Intervention length (weeks)	0.1
Note. [1]Basoglu 2005; [2]Basoglu 2007	

1 See appendix G for full evidence tables.

2

3 ## Quality assessment of clinical studies included in the evidence review

4 The clinical evidence profile for this review (behavioural therapy for the treatment of
5 PTSD in adults) is presented in Table 44.

6 **Table 44: Summary clinical evidence profile: Single-session behavioural**
7 **therapy versus waitlist for delayed treatment (>3 months)**

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist	Corresponding risk Single-session behavioural therapy			
PTSD symptomatology self-rated at 6-		The mean PTSD symptomatology self-rated at 6-		59 (1 study)	very low[1,2,3]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist	Corresponding risk Single-session behavioural therapy			
week follow-up TSSC change score Follow-up: mean 6 weeks		week follow-up in the intervention groups was 0.98 standard deviations lower (1.52 to 0.43 lower)			
PTSD symptomatology clinician-rated at 6-8 week follow-up CAPS change score Follow-up: 6-8 weeks		The mean PTSD symptomatology clinician-rated at 6-8 week follow-up in the intervention groups was 1.2 standard deviations lower (1.65 to 0.75 lower)		90 (2 studies)	very low[1,2,3]
Response at 6-week follow-up Number of people rated as 'much' or 'very much' improved on CGI-I Follow-up: mean 6 weeks	143 per 1000	549 per 1000 (210 to 1000)	RR 3.84 (1.47 to 10.04)	59 (1 study)	very low[1,3,4]
Functional impairment at 6-8 week follow-up WSA change score Follow-up: 6-8 weeks		The mean functional impairment at 6-8 week follow-up in the intervention groups was 0.71 standard deviations lower (1.14 to 0.28 lower)		90 (2 studies)	very low[1,2,3]
Depression symptoms at 6-8 week follow-up BDI change score Follow-up: 6-8 weeks		The mean depression symptoms at 6-8 week follow-up in the intervention groups was 0.69 standard deviations lower (1.12 to 0.26 lower)		90 (2 studies)	very low[1,2,3]
Discontinuation Number of participants lost	0	0	Not estimable	90 (2 studies)	low[1,4]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist	Corresponding risk Single-session behavioural therapy			
to follow-up for any reason Follow-up: 6-8 weeks					

CAPS= Clinician-administered PTSD scale; CGI-I=Clinical Global impression-improvement; BDI= Beck Depression Inventory; CI=confidence interval; RR=risk ratio; SMD=standardised mean difference; TSSC=total symptom severity complex; WSA=Work and Social Adjustment

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

[2] OIS not met (N<400)

[3] Data is not reported/cannot be extracted for all outcomes

[4] OIS not met (events<300)

See appendix I for full GRADE tables.

Problem solving: clinical evidence

Included studies

One study of problem solving for the treatment of PTSD in adults was identified for full-text review, and this RCT (N=309) was included in a single comparison for problem solving.

For early treatment (intervention initiated 1-3 months post-trauma) of PTSD symptoms, the single included RCT (N=309) compared problem solving with supportive counselling (Sahler et al. 2013).

For delayed treatment (intervention initiated more than 3 months post-trauma) of PTSD symptoms, no relevant RCTs were identified.

Sub-analyses were not possible for problem solving interventions.

Excluded studies

There were no studies that met criteria for full-text review that were excluded.

Summary of clinical studies included in the evidence review

Table 45 provides a brief summary of the included study and evidence from this study is summarised in the clinical GRADE evidence profile below (Table 46).

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

Table 45: Summary of included studies: Problem solving for early treatment (1-3 months)

Comparison	Problem solving versus supportive counselling
Total no. of studies (N randomised)	1 (309)
Study ID	Sahler 2013

Comparison	Problem solving versus supportive counselling
Country	US
Diagnostic status	Clinically important PTSD symptoms (scoring above a threshold on validated scale)
Mean months since onset of PTSD	NR
Mean age (range)	37.3 (range NR)
Sex (% female)	100
Ethnicity (% BME)	43
Coexisting conditions	NR
Mean months since traumatic event	NR (children diagnosed 2 to 16 weeks before recruitment)
Type of traumatic event	Family member or carer of person with life-threatening illness or injury: Parent of child newly diagnosed with cancer
Single or multiple incident index trauma	Single
Lifetime experience of trauma	NR
Intervention details	Problem-solving Skills Training (PSST; following protocol used in Sahler et al. 2002, 2005 and Varni et al. 1999)
Intervention format	Individual
Intervention intensity	8x weekly 1-hour sessions (8 hours). 58% completed at least 6 sessions
Comparator	Supportive counselling (following protocol by Rogers 1961)
Intervention length (weeks)	8
Note. None	

1 See Appendix F for full evidence tables.

2

3 ## Quality assessment of clinical studies included in the evidence review

4 The clinical evidence profile for this review (problem solving for the treatment of
5 PTSD in adults) is presented in Table 46.

6 **Table 46: Summary clinical evidence profile: Problem solving versus**
7 **supportive counselling for early treatment (1-3 months)**

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Supportive counselling	Corresponding risk Problem solving			
PTSD symptomatology self-report - Endpoint IES-R endpoint score Follow-up: mean 8 weeks		The mean PTSD symptomatology self-report - endpoint in the intervention groups was 0.08 standard deviations lower		309 (1 study)	very low[1,2,3]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Supportive counselling	Corresponding risk Problem solving			
		(0.3 lower to 0.15 higher)			
PTSD symptomatology self-report - 3-month follow-up IES-R endpoint score Follow-up: mean 13 weeks		The mean PTSD symptomatology self-report - 3-month follow-up in the intervention groups was 0.17 standard deviations lower (0.39 lower to 0.05 higher)		309 (1 study)	very low[1,2,3]
Discontinuation Number of participants lost to follow-up for any reason Follow-up: mean 8 weeks	312 per 1000	368 per 1000 (268 to 502)	RR 1.18 (0.86 to 1.61)	309 (1 study)	low[1,4]

CI=confidence interval; IES-R= Impact of Event Scale-Revised; RR=risk ratio; SMD=standardised mean difference
[1] Risk of bias is high or unclear across multiple domains
[2] OIS not met (N<400)
[3] Data is not reported/cannot be extracted for all outcomes
[4] OIS not met (events<300)

See Appendix F for full GRADE tables.

Eye movement desensitisation and reprocessing (EMDR): clinical evidence

Included studies

Fifty-two studies of eye movement desensitisation and reprocessing (EMDR) for the treatment of PTSD in adults were identified for full-text review. Of these 52 studies, 16 RCTs (N=942) were included. Some of these 16 RCTs were three- or four-armed trials and as such were included in more than one comparison. There were 9 comparisons for EMDR.

For early treatment (intervention initiated 1-3 months post-trauma) of PTSD symptoms, there was evidence for one relevant comparison: 1 RCT (N=39) compared EMDR with supportive counselling (Jarero et al. 2013).

For delayed treatment (intervention initiated more than 3 months post-trauma) of PTSD symptoms, 1 RCT (N=88) compared EMDR with pill placebo (Van der Kolk et al. 2007). 9 RCTs (N=518) compared EMDR (alone or in addition to TAU) with waitlist or TAU (Acarturk et al. 2015; Acarturk et al. 2016; Aldahadha et al. 2012; Carlson et al. 1998; Edmond et al. 1999/ Edmond & Rubin 2004 [one study reported across two papers]; Himmerich et al. 2016; Jensen 1994; Power et all. 2002; Rothbaum et al. 2005). 1 RCT (N=67) compared EMDR with supportive counselling (Scheck et al. 1998). 1 RCT (N=74) compared EMDR with non-trauma-focused CBT

(Ter Heide et al. 2016). 1 RCT (N=59) compared EMDR with 'other active psych intervention' (Edmond et al. 1999/ Edmond & Rubin 2004 [one study reported across two papers]). 3 RCTs (N=145) compared EMDR (alone or in addition to TAU) with relaxation (alone or in addition to TAU) (Carletto et al. 2016; Carlson et al. 1998; Taylor et al. 2003). 1 RCT (N=46) compared EMDR with a combined somatic and cognitive therapy, emotional freedom technique (EFT) (Karatzias et al. 2011). Finally, 1 RCT (N=88) compared EMDR with fluoxetine (Van der Kolk et al. 2007).

Comparisons with trauma-focused CBT are presented in the Trauma-focused CBT section above.

Sub-analyses were possible for the delayed treatment EMDR (alone or in addition to TAU) versus waitlist or TAU comparison, comparing effects by multiplicity of trauma, diagnostic status at baseline, and trauma type.

Excluded studies

Thirty-six studies were reviewed at full text and excluded from this review. The most common reasons for exclusion were non-randomised group assignment, small sample size (N<10 per arm), efficacy or safety data could not be extracted, and systematic review with no new useable data and any meta-analysis results not appropriate to extract.

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

Summary of clinical studies included in the evidence review

Table 47, Table 48, Table 49 and Table 50 provide brief summaries of the included studies and evidence from these are summarised in the clinical GRADE evidence profiles below (Table 51, Table 52, Table 53, Table 54, Table 55, Table 56, Table 57, Table 58 and Table 59).

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

Table 47: Summary of included studies: Eye movement desensitisation and reprocessing (EMDR) for early treatment (1-3 months)

Comparison	EMDR versus supportive counselling
Total no. of studies (N randomised)	1 (39)
Study ID	Jarero 2013
Country	Mexico
Diagnostic status	Clinically important PTSD symptoms (scoring above a threshold on validated scale)
Mean months since onset of PTSD	NR
Mean age (range)	Mean NR (18-60)
Sex (% female)	49
Ethnicity (% BME)	NR
Coexisting conditions	NR
Mean months since traumatic event	NR (during assessment and treatment participants asked to focus on the worst work experience in the past 3 months)

Comparison	EMDR versus supportive counselling
Type of traumatic event	Being an emergency responder in a traumatic event: First responders
Single or multiple incident index trauma	Multiple
Lifetime experience of trauma	Active duty first responders (38% Red Cross paramedics; 38% emergency line operators; 23% firefighters)
Intervention details	EMDR individual protocol for paraprofessional use in acute trauma situations (EMDR-PROPARA; modification of Shapiro 2001 protocol)
Intervention format	Individual
Intervention intensity	2x 1.5-hour sessions (3 hours)
Comparator	Supportive counselling included: psychoeducation; problem solving skills; unconditional emotional support. Supportive counselling specifically avoided exposure or anxiety management techniques
Intervention length (weeks)	2
Note. None	

Table 48: Summary of included studies: Eye movement desensitisation and reprocessing (EMDR) for delayed treatment (>3 months)-part 1

Comparison	EMDR versus pill placebo	EMDR (+/- TAU) versus waitlist/TAU
Total no. of studies (N randomised)	1 (88)	9 (518)
Study ID	van der Kolk 2007	Acarturk 2015[1] Acarturk 2016[2] Aldahadha 2012[3] Carlson 1998[4] Edmond 1999/2004[5] Himmerich 2016[6] Jensen 1994[7] Power 2002[8] Rothbaum 2005[9]
Country	US	Turkey[1,2] Oman[3] US[4,5,7,9] Germany[6] UK[8]
Diagnostic status	PTSD diagnosis according to ICD/DSM criteria	Clinically important PTSD symptoms (scoring above a threshold on validated scale) [1,5,7] PTSD diagnosis according to ICD/DSM criteria[2,3,4,6,8,9]
Mean months since onset of PTSD	NR	NR[1,2,3,4,5,6,7,8] NR ('chronic') [9]
Mean age (range)	36.1 (range NR)	36.6 (19-63) [1] 33.7 (17-64) [2]

Comparison	EMDR versus pill placebo	EMDR (+/- TAU) versus waitlist/TAU
		26.4 (19-37) [3] 48 (41-70) [4] 35 (range NR) [5] 28.5 (range NR) [6] 43.1 (40-55) [7] 39.2 (range NR) [8] 33.8 (range NR) [9]
Sex (% female)	83	76[1] 74[2] 53[3] 0[4,6,7] 100[5,9] 42[8]
Ethnicity (% BME)	33	NR[1,2,3,6,7,8] 46[4] 15[5] 32[9]
Coexisting conditions	Mean 3.2 comorbid Axis I/II diagnoses	NR[1,2,3,4,5,6,8] 40% had a recent VA diagnosis of alcohol abuse or alcohol dependence and were receiving inpatient treatment for these disorders[7] 40% had one comorbid diagnosis, 25% had two or more diagnoses in addition to PTSD[9]
Mean months since traumatic event	154.8	NR (mean duration at the camp 14.4 months) [1] NR[2,3,4,7] 264[5] NR (≤24 months) [6] 45.7[8] 143.2[9]
Type of traumatic event	Mixed: 28% child sexual abuse; 5% child physical abuse; 9% child sexual and physical abuse; 9% adult sexual assault; 6% adult physical assault; 8% domestic violence; 7% other adult victimization; 9% traumatic loss; 3% war/terrorism/violence; 16% injury/accident	Witnessing war as a civilian: Syrian refugees[1] Witnessing war as a civilian: Syrian refugees. Traumatic events included: death of family members; threatened death to self or others; serious injury to self or loved ones; husband being at war; arrested family members; not being able to bury significant others who have died in Syria; lack of shelter[2] Motor Vehicle Collision[3] Military combat: 97% Vietnam veterans; 3% other combat theatre[4] Childhood sexual abuse: Childhood sexual abuse lasted for mean of 6.5 years (the mean age

Comparison	EMDR versus pill placebo	EMDR (+/- TAU) versus waitlist/TAU
		at which abuse began was 6.5 years, and the mean age at which it stopped was 13 years)[5] Military combat: German soldiers who had served deployments abroad[6] Military combat: Vietnam veterans[7] Mixed: Motor vehicle collision (31%; 24% passenger, 7% pedestrian); occupational accident (22%); physical assault (18%); sexual assault (4%); traumatic death (4%); real/implied physical threat (13%); other (7%)[8] Exposure to sexual abuse or assault: Rape in adulthood (12 or older) or a single incident of rape in childhood by either a family member or non-family member. The majority of assaults (43%) were perpetrated by friends, relatives, dates, and significant others; 33% by strangers; and 23% by acquaintances[9]
Single or multiple incident index trauma	Multiple	Multiple[1,2,4,5,6,7] Single[3,8,9]
Lifetime experience of trauma	NR	NR[1,2,3,4,6,7,8] 58% of participants also experienced childhood physical abuse and 66% some form of adult revictimization, such as domestic violence and rape[5] Including the index assault, participants experienced a mean of 6.0 traumas (SD = 4.1) prior to study entry[9]
Intervention details	Eye movement desensitisation and reprocessing (EMDR; following study-specific protocol [Korn & Spinazzola 2006] based on Shapiro 1995 protocol)	Eye movement desensitisation and reprocessing (EMDR), following standard Shapiro protocol[1,3,4,5,7,8,9] Eye movement desensitisation and reprocessing, Recent Traumatic Episode Protocol (EMDR R-TEP; Shapiro & Laub, 2008, 2013)[2] Inpatient psychotherapy treatment package included individual eye movement desensitization and reprocessing (EMDR) treatment[6]
Intervention format	Individual	Individual
Intervention intensity	8x weekly 90-minute sessions (12 hours)	7x weekly 90-min sessions (10.5 hours). Mean number of sessions

Comparison	EMDR versus pill placebo	EMDR (+/- TAU) versus waitlist/TAU
		attended 4.13 (SD=1.73; range=2-7) [1] 7x weekly sessions (length NR). Mean number of attended sessions 4.2 (SD=1.3, range 2-7). 76% completed all sessions[2] 2-3x sessions[3] 12x 60-75min sessions (12-15 hours) [4] 6 x 90-min session (9 hours) [5] NR[6] 3x sessions[7] 10x weekly 90-min sessions (15 hours) [8] 9x twice-weekly 90-min sessions (13.5 hours) [9]
Comparator	Pill placebo	Waitlist[1,2,3,5] TAU (no further detail reported) [4,7,9] Outpatient clinical management included less structured supportive psychological therapy sessions and no EMDR treatment[6] 67% were taking psychotropic medication[8]
Intervention length (weeks)	8	7[1,2] 9[3] 6[4,5,6,9] 2[7] 10[8]
Note. [1]Acarturk 2015; [2]Acarturk 2016; [3]Aldahadha 2012; [4]Carlson 1998; [5]Edmond 1999/2004; [6]Himmerich 2016; [7]Jensen 1994; [8]Power 2002; [9]Rothbaum 2005		

Table 49: Summary of included studies: Eye movement desensitisation and reprocessing (EMDR) for delayed treatment (>3 months)-part 2

Comparison	EMDR versus supportive counselling	EMDR versus non-TF-CBT	EMDR versus 'other active psych intervention'
Total no. of studies (N randomised)	1 (67)	1 (74)	1 (59)
Study ID	Scheck 1998	Ter Heide 2016	Edmond 1999/2004
Country	US	Netherlands	US
Diagnostic status	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	PTSD diagnosis according to ICD/DSM criteria	Clinically important PTSD symptoms (scoring above a threshold on validated scale)
Mean months since onset of PTSD	NR	95.4	NR

Comparison	EMDR versus supportive counselling	EMDR versus non-TF-CBT	EMDR versus 'other active psych intervention'
Mean age (range)	20.9 (16-25)	41.5 (range NR)	35 (range NR)
Sex (% female)	100	28	100
Ethnicity (% BME)	38	NR	15
Coexisting conditions	NR	74% comorbid depression	NR
Mean months since traumatic event	NR	NR	264
Type of traumatic event	Mixed: 90% childhood physical/emotional abuse, >50% traumatic sexual experiences, such as rape or child molestation	Witnessing war as a civilian: Refugee sample, with most frequently reported traumatic events being close to death (83%), murder of family or friend (75%) and threatened with torture (72%)	Childhood sexual abuse: Childhood sexual abuse lasted for mean of 6.5 years (the mean age at which abuse began was 6.5 years, and the mean age at which it stopped was 13 years)
Single or multiple incident index trauma	Multiple	Multiple	Multiple
Lifetime experience of trauma	NR	Mean number of types of traumatic events: 13.8 (SD=5.5)	58% of participants also experienced childhood physical abuse and 66% some form of adult revictimization, such as domestic violence and rape
Intervention details	Eye movement desensitisation and reprocessing (EMDR) following standard protocol (Shapiro 1995)	Eye movement desensitisation and reprocessing (EMDR) following the Dutch version of the EMDR protocol (De Jongh & Ten Broeke 2003)	Eye movement desensitisation and reprocessing (EMDR), 8-phase intervention
Intervention format	Individual	Individual	Individual
Intervention intensity	2x weekly 90-min sessions (3 hours)	9 sessions: 3x 60-min planning/preparation followed by 6x 90-min desensitisation/reprocessing (12 hours in total)	6x 90-min session (9 hours). Mean treatment duration: 10.4 weeks
Comparator	Active listening condition followed a nondirective,	Stabilisation as usual	Other active psych intervention: Therapy in the routine

Comparison	EMDR versus supportive counselling	EMDR versus non-TF-CBT	EMDR versus 'other active psych intervention'
	Rogerian-based model outlined by Gordon (1974)		treatment condition involved a variety of methods, techniques and theories that were incorporated into an approach best suited to address the therapeutic target introduced by each participant
Intervention length (weeks)	2	12	6
Note. None			

Table 50: Summary of included studies: Eye movement desensitisation and reprocessing (EMDR) for delayed treatment (>3 months)-part 3

Comparison	EMDR (+/- TAU) versus relaxation (+/- TAU)	EMDR versus combined somatic and cognitive therapy (EFT)	EMDR versus fluoxetine
Total no. of studies (N randomised)	3 (145)	1 (46)	1 (88)
Study ID	Carletto 2016[1] Carlson 1998[2] Taylor 2003[3]	Karatzias 2011	van der Kolk 2007
Country	Italy[1] US[2] Canada[3]	UK	US
Diagnostic status	PTSD diagnosis according to ICD/DSM criteria	PTSD diagnosis according to ICD/DSM criteria	PTSD diagnosis according to ICD/DSM criteria
Mean months since onset of PTSD	NR (inclusion criteria included that PTSD symptoms had been present for at least 3 months) [1] NR[2] 104.4[3]	95.2	NR
Mean age (range)	40.1 (range NR) [1] 48 (41-70) [2] 37 (range NR) [3]	40.6 (18-65)	36.1 (range NR)
Sex (% female)	81[1] 0[2] 75[3]	57	83
Ethnicity (% BME)	NR[1] 46[2] 23[3]	NR	33

Comparison	EMDR (+/- TAU) versus relaxation (+/- TAU)	EMDR versus combined somatic and cognitive therapy (EFT)	EMDR versus fluoxetine
Coexisting conditions	NR[1,2] 42% major depression, 31% panic disorder, 12% social anxiety disorder[3]	NR	Mean 3.2 comorbid Axis I/II diagnoses
Mean months since traumatic event	84[1] NR (Vietnam veterans) [2] NR[3]	97.2	154.8
Type of traumatic event	Diagnosis of life-threatening condition: Diagnosis of Multiple Sclerosis[1] Military combat: 97% Vietnam veterans; 3% other combat theatre[2] Mixed: The most common forms of traumatic event reported were sexual assault (45%), transportation accidents (43%), physical assault (43%), and being exposed to a sudden death (e.g., witnessing a homicide, 22%)[3]	Mixed: Accident (37%), assault/murder (43%), 'other' (20%)	Mixed: 28% child sexual abuse; 5% child physical abuse; 9% child sexual and physical abuse; 9% adult sexual assault; 6% adult physical assault; 8% domestic violence; 7% other adult victimization; 9% traumatic loss; 3% war/terrorism/violence; 16% injury/accident
Single or multiple incident index trauma	Single[1] Multiple[2] Unclear[3]	Single	Multiple
Lifetime experience of trauma	Mean number of previous traumas: 4.3 (6.5) [1] NR[2] Most participants (65%) had experienced more than one type of traumatic event[3]	NR	NR
Intervention details	Eye movement desensitisation and reprocessing (EMDR; Shapiro 2001) [1]	Eye movement desensitisation and reprocessing (EMDR) following standard protocol (Shapiro 2002)	Eye movement desensitisation and reprocessing (EMDR; following study-specific protocol [Korn & Spinazzola 2006]

Comparison	EMDR (+/- TAU) versus relaxation (+/- TAU)	EMDR versus combined somatic and cognitive therapy (EFT)	EMDR versus fluoxetine
	Eye movement desensitisation and reprocessing (EMDR) following standard protocol (Shapiro 1995)[2] + TAU (48% taking psychotropic medication)[3]		based on Shapiro 1995 protocol)
Intervention format	Individual	Individual	Individual
Intervention intensity	10x 1-hour sessions (10 hours)[1] 12x 60-75min sessions (12-15 hours)[2] 8x 90-min sessions (12 hours)[3]	Up to 8x 1-hour sessions (8 hours). Mean 3.7 (SD=2.3) sessions received	8x weekly 90-minute sessions (12 hours)
Comparator	Relaxation therapy (following protocol of van Kessel et al. 2008)[1] Bio-feedback assisted relaxation[2] Relaxation training based on manual by Marks et al. (1998) + TAU[3]	Emotional freedom technique (EFT)	Fluoxetine, 10-60mg/day
Intervention length (weeks)	15[1] 6[2] NR[3]	8	8
Note. [1]Carletto 2016; [2]Carlson 1998; [3]Taylor 2003			

1 See Appendix F for full evidence tables.

2 Quality assessment of clinical studies included in the evidence review

3 The clinical evidence profiles for this review (EMDR for the treatment of PTSD in
4 adults) are presented in Table 51, Table 52, Table 53, Table 54, Table 55, Table 56,
5 Table 57, Table 58 and Table 59Table 46.

Table 51: Summary clinical evidence profile: Eye movement desensitisation and reprocessing (EMDR) versus supportive counselling for early treatment (1-3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Supportive counselling	Corresponding risk Eye movement desensitisation and reprocessing (EMDR)			
PTSD symptomatology clinician-rated - Endpoint SPRINT change score Follow-up: mean 2 weeks		The mean PTSD symptomatology clinician-rated - endpoint in the intervention groups was 2.19 standard deviations lower (3 to 1.38 lower)		39 (1 study)	very low[1,2]
PTSD symptomatology clinician-rated - 1-month follow-up SPRINT change score Follow-up: mean 4 weeks		The mean PTSD symptomatology clinician-rated - 1-month follow-up in the intervention groups was 3 standard deviations lower (3.94 to 2.06 lower)		39 (1 study)	very low[1,2]
PTSD symptomatology clinician-rated - 3-month follow-up SPRINT change score Follow-up: mean 13 weeks		The mean PTSD symptomatology clinician-rated - 3-month follow-up in the intervention groups was 3.68 standard deviations lower (4.75 to 2.61 lower)		39 (1 study)	very low[1,2]
Discontinuation Number of participants lost to follow-up for any reason Follow-up: mean 2 weeks	See comment	See comment	Not estimable	39 (1 study)	low[1,3]

BDI= Beck Depression Inventory; CAPS= Clinician-administered PTSD scale; CI=confidence interval; DES= Dissociative Experiences Scales; HAM-A= Hamilton Rating Scale for Anxiety; IES-R= Impact of Event Scale-Revised; MADRS=Montgomery-Asberg Depression Rating Scale; M-PTSD=Missisippi Scale for Combat-Related PTSD; PDS= Post-traumatic Diagnostic Scale; PSS-SR= PTSD symptom scale-interview/self-report; RR=risk ratio; SDS= Sheehan Disability Scale; SI-PTSD= Structured interview for PTSD; SMD=standardised mean difference; STAI= State-Trait Anxiety Inventory; TAU=Treatment as usual; ;

[1] *Risk of bias is high or unclear across multiple domains*
[2] *OIS not met (N<400)*
[3] *OIS not met (events<300)*

Table 52: Summary clinical evidence profile: Eye movement desensitisation and reprocessing (EMDR) versus pill placebo for delayed treatment (>3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Pill placebo	Corresponding risk Eye movement desensitisation and reprocessing (EMDR)			
PTSD symptomatology clinician-rated CAPS change score Follow-up: mean 8 weeks		The mean PTSD symptomatology clinician-rated in the intervention groups was 0.52 standard deviations lower (1.04 lower to 0.01 higher)		58 (1 study)	low[1,2]
Remission Number of people scoring <20 on CAPS Follow-up: mean 8 weeks	115 per 1000	276 per 1000 (82 to 931)	RR 2.39 (0.71 to 8.07)	55 (1 study)	very low[1,3]
Depression symptoms BDI II change score Follow-up: mean 8 weeks		The mean depression symptoms in the intervention groups was 0.12 standard deviations lower (0.63 lower to 0.4 higher)		58 (1 study)	low1,2
Discontinuation Number of participants lost to follow-up for any reason Follow-up: mean 8 weeks	115 per 1000	172 per 1000 (46 to 652)	RR 1.49 (0.4 to 5.65)	55 (1 study)	very low[1,3]

[1] *Risk of bias is high or unclear across multiple domains*
[2] *95% CI crosses both line of no effect and threshold for clinically important effect*
[3] *95% CI crosses line of no effect and threshold for both clinically important benefit and clinically important harm*

Table 53: Summary clinical evidence profile: Eye movement desensitisation and reprocessing (EMDR; +/- TAU) versus waitlist or TAU for delayed treatment (>3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist or TAU	Corresponding risk Eye movement desensitisation and reprocessing (EMDR; +/- TAU)			
PTSD symptomatology self-report at endpoint IES/IES-R/Trauma Symptoms Inventory/PDS/PSS-SR change scores/M-PTSD endpoint Follow-up: 2-10 weeks		The mean PTSD symptomatology self-report at endpoint in the intervention groups was 1.64 standard deviations lower (2.49 to 0.8 lower)		393 (9 studies)	very low[1,2,3,4]
PTSD symptomatology self-report at 1-month follow-up IES-R change score Follow-up: mean 4 weeks		The mean PTSD symptomatology self-report at 1-month follow-up in the intervention groups was 2.21 standard deviations lower (2.71 to 1.7 lower)		98 (1 study)	low[1,3]
PTSD symptomatology clinician-rated SI–PTSD/CAPS change score Follow-up: 2-6 weeks		The mean PTSD symptomatology clinician-rated in the intervention groups was 1.42 standard deviations lower (2 to 0.84 lower)		65 (2 studies)	very low[1,2,3,4]
Remission at endpoint Number of people no longer meeting diagnostic criteria for PTSD Follow-up: 6-7 weeks	68 per 1000	600 per 1000 (253 to 1000)	RR 8.76 (3.69 to 20.82)	147 (2 studies)	moderate[5]
Remission at 1-month follow-up Number of people	41 per 1000	490 per 1000 (122 to 1000)	RR 12 (3 to 48.04)	98 (1 study)	moderate[5]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist or TAU	Corresponding risk Eye movement desensitisation and reprocessing (EMDR; +/- TAU)			
no longer meeting diagnostic criteria for PTSD Follow-up: mean 4 weeks					
Response self-rated Number of people showing clinically significant improvement, based on reliable change indices (RCI) on IES Follow-up: mean 10 weeks	34 per 1000	436 per 1000 (61 to 1000)	RR 12.64 (1.78 to 89.63)	68 (1 study)	very low[1,4,5]
Dissociative symptoms DES change score Follow-up: mean 6 weeks		The mean dissociative symptoms in the intervention groups was 1.32 standard deviations lower (2.01 to 0.63 lower)		40 (1 study)	low[1,3]
Anxiety symptoms STAI State/HAM-A change score Follow-up: 6-10 weeks		The mean anxiety symptoms in the intervention groups was 1.72 standard deviations lower (2.17 to 1.27 lower)		113 (3 studies)	very low[1,2,3,4]
Depression symptoms at endpoint BDI/BDI-II/MADRS change score Follow-up: 6-10 weeks		The mean depression symptoms at endpoint in the intervention groups was 1.7 standard deviations lower (2.26 to 1.15 lower)		279 (6 studies)	very low[1,3,6]
Depression symptoms at 1-month follow-up BDI-II change score		The mean depression symptoms at 1-month follow-up		98 (1 study)	low[1,3]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist or TAU	Corresponding risk Eye movement desensitisation and reprocessing (EMDR; +/- TAU)			
Follow-up: mean 4 weeks		in the intervention groups was 1.6 standard deviations lower (2.06 to 1.14 lower)			
Functional impairment SDS change score Follow-up: mean 10 weeks		The mean functional impairment in the intervention groups was 1.63 standard deviations lower (2.27 to 0.99 lower)		51 (1 study)	very low[1,3,4]
Discontinuation Number of participants lost to follow-up for any reason Follow-up: 6-10 weeks	168 per 1000	166 per 1000 (106 to 262)	RR 0.99 (0.63 to 1.56)	356 (7 studies)	low[1,5]

BDI= Beck Depression Inventory; CAPS= Clinician-administered PTSD scale; CI=confidence interval; RR=risk ratio; SMD=standardised mean difference

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

[2] *Considerable heterogeneity (I2>80%)*

[3] *OIS not met (N<400)*

[4] *Data is not reported/cannot be extracted for all outcomes*

[5] *OIS not met (events<300)*

[6] *Substantial heterogeneity (I2=50-80%)*

Table 54: Summary clinical evidence profile: Eye movement desensitisation and reprocessing (EMDR) versus supportive counselling for delayed treatment (>3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Supportive counselling	Corresponding risk Eye movement desensitisation and reprocessing (EMDR)			
PTSD symptomatology self-rated		The mean PTSD symptomatology self-rated in the		57 (1 study)	very low[1,2,3]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Supportive counselling	Corresponding risk Eye movement desensitisation and reprocessing (EMDR)			
IES change score Follow-up: mean 2 weeks		intervention groups was 1.35 standard deviations lower (1.93 to 0.78 lower)			
Anxiety symptoms STAI State change score Follow-up: mean 2 weeks		The mean anxiety symptoms in the intervention groups was 0.86 standard deviations lower (1.4 to 0.33 lower)		59 (1 study)	very low[1,2,3]
Depression symptoms BDI change score Follow-up: mean 2 weeks		The mean depression symptoms in the intervention groups was 0.74 standard deviations lower (1.27 to 0.22 lower)		60 (1 study)	very low[1,2,3]
Discontinuation Number of participants lost to follow-up for any reason Follow-up: mean 2 weeks	91 per 1000	117 per 1000 (28 to 485)	RR 1.29 (0.31 to 5.34)	67 (1 study)	low[4]

BDI= Beck Depression Inventory; CI=confidence interval; IES= Impact of Event Scale; RR=risk ratio; SMD=standardised mean difference; STAI= State-Trait Anxiety Inventory

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

[2] OIS not met (N<400)

[3] Data is not reported/cannot be extracted for all outcomes

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

Table 55: Summary clinical evidence profile: Eye movement desensitisation and reprocessing (EMDR) versus non-trauma-focused CBT for delayed treatment (>3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Non-trauma-focused CBT	Corresponding risk Eye movement desensitisation and reprocessing (EMDR)			
PTSD symptomatology clinician-rated - Endpoint CAPS change score Follow-up: mean 12 weeks		The mean PTSD symptomatology clinician-rated - endpoint in the intervention groups was 0.12 standard deviations higher (0.38 lower to 0.63 higher)		61 (1 study)	very low[1,2]
PTSD symptomatology clinician-rated - 3-month follow-up CAPS change score Follow-up: mean 13 weeks		The mean PTSD symptomatology clinician-rated - 3-month follow-up in the intervention groups was 0.24 standard deviations higher (0.26 lower to 0.73 higher)		63 (1 study)	very low[1,2]
PTSD symptomatology self-rated - Endpoint HTQ change score Follow-up: mean 12 weeks		The mean PTSD symptomatology self-rated - endpoint in the intervention groups was 0.3 standard deviations lower (0.8 lower to 0.2 higher)		62 (1 study)	very low[1,2]
PTSD symptomatology self-rated - 3-month follow-up HTQ change score Follow-up: mean 13 weeks		The mean PTSD symptomatology self-rated - 3-month follow-up in the intervention groups was 0.02 standard deviations higher (0.47 lower to 0.52 higher)		63 (1 study)	very low[1,2]
Response at 3-month follow-up number of people showing improvement of	351 per 1000	351 per 1000 (190 to 654)	RR 1 (0.54 to 1.86)	74 (1 study)	very low[1,3]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Non-trauma-focused CBT	Corresponding risk Eye movement desensitisation and reprocessing (EMDR)			
at least 10 points on CAPS Follow-up: mean 13 weeks					
Anxiety symptoms - Endpoint HSCL-25: Anxiety change score Follow-up: mean 12 weeks		The mean anxiety symptoms - endpoint in the intervention groups was 0.06 standard deviations lower (0.56 lower to 0.43 higher)		62 (1 study)	very low[1,2]
Anxiety symptoms - 3-month follow-up HSCL-25: Anxiety change score Follow-up: mean 13 weeks		The mean anxiety symptoms - 3-month follow-up in the intervention groups was 0.08 standard deviations higher (0.41 lower to 0.58 higher)		63 (1 study)	very low[1,2]
Depression symptoms - Endpoint HSCL-25: Depression change score Follow-up: mean 12 weeks		The mean depression symptoms - endpoint in the intervention groups was 0.05 standard deviations higher (0.45 lower to 0.54 higher)		62 (1 study)	very low[1,2]
Depression symptoms - 3-month follow-up HSCL-25: Depression change score Follow-up: mean 13 weeks		The mean depression symptoms - 3-month follow-up in the intervention groups was 0.09 standard deviations higher (0.4 lower to 0.59 higher)		63 (1 study)	very low[1,2]
Discontinuation Number of participants lost to follow-up for any reason	135 per 1000	135 per 1000 (43 to 428)	RR 1 (0.32 to 3.17)	74 (1 study)	very low[1,3]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Non-trauma-focused CBT	Corresponding risk Eye movement desensitisation and reprocessing (EMDR)			
Follow-up: mean 12 weeks					

CAPS= Clinician-administered PTSD scale; CBT= cognitive behavioural therapy; CI=confidence interval; HSCL-25= Hopkins Symptom Checklist-25; HTQ= Harvard Trauma Questionnaire; RR=risk ratio; SMD=standardised mean difference

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

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

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

Table 56: Summary clinical evidence profile: Eye movement desensitisation and reprocessing (EMDR) versus 'other active psych intervention' for delayed treatment (>3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk 'other active psych intervention'	Corresponding risk Eye movement desensitisation and reprocessing (EMDR)			
PTSD symptomatology self-rated-Endpoint IES change score Follow-up: mean 6 weeks		The mean PTSD symptomatology self-rated-endpoint in the intervention groups was 0.35 standard deviations lower (0.98 lower to 0.27 higher)		40 (1 study)	very low[1,2]
PTSD symptomatology self-rated - 3-month follow-up IES change score Follow-up: mean 13 weeks		The mean PTSD symptomatology self-rated - 3-month follow-up in the intervention groups was 1.06 standard deviations lower (1.78 to 0.34 lower)		35 (1 study)	very low[1,3]
PTSD symptomatology self-rated - 18-month follow-up IES change score		The mean PTSD symptomatology self-rated - 18-month follow-up in the intervention groups was 0.75 standard		31 (1 study)	very low[1,3]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk 'other active psych intervention'	Corresponding risk Eye movement desensitisation and reprocessing (EMDR)			
Follow-up: mean 78 weeks		deviations lower (1.49 to 0.02 lower)			
Depression symptoms - Endpoint BDI change score Follow-up: mean 6 weeks		The mean depression symptoms - endpoint in the intervention groups was 0.13 standard deviations lower (0.75 lower to 0.49 higher)		40 (1 study)	very low[1,2]
Depression symptoms - 3-month follow-up BDI change score Follow-up: mean 13 weeks		The mean depression symptoms - 3-month follow-up in the intervention groups was 1.14 standard deviations lower (1.87 to 0.41 lower)		34 (1 study)	very low[1,3]
Depression symptoms - 18-month follow-up BDI change score Follow-up: mean 78 weeks		The mean depression symptoms - 18-month follow-up in the intervention groups was 0.67 standard deviations lower (1.4 lower to 0.06 higher)		31 (1 study)	very low[1,2]
Discontinuation Number of participants lost to follow-up for any reason Follow-up: mean 6 weeks	See comment	See comment	Not estimable	40 (1 study)	low[1,4]

BDI= Beck Depression Inventory; CI=confidence interval; IES= Impact of Event Scale; RR=risk ratio; SMD=standardised mean difference

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

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

[3] *OIS not met (N<400)*

[4] *OIS not met (events<300)*

Table 57: Summary clinical evidence profile: Eye movement desensitisation and reprocessing (EMDR; +/- TAU) versus relaxation (+/- TAU) for delayed treatment (>3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Relaxation (+/- TAU)	Corresponding risk Eye movement desensitisation and reprocessing (EMDR; +/- TAU)			
PTSD symptomatology self-rated at endpoint IES/PSS-SR change score Follow-up: mean 6 weeks		The mean PTSD symptomatology self-rated at endpoint in the intervention groups was 0.26 standard deviations lower (0.82 lower to 0.3 higher)		52 (2 studies)	low[1,2]
PTSD symptomatology self-rated at 3-month follow-up PSS-SR change score Follow-up: mean 13 weeks		The mean PTSD symptomatology self-rated at 3-month follow-up in the intervention groups was 0.54 standard deviations lower (1.27 lower to 0.19 higher)		30 (1 study)	low[1,2]
PTSD symptomatology self-rated at 6-month follow-up IES-R change score Follow-up: mean 26 weeks		The mean PTSD symptomatology self-rated at 6-month follow-up in the intervention groups was 0.16 standard deviations lower (0.77 lower to 0.45 higher)		42 (1 study)	very low[1,2,3]
PTSD symptomatology clinician-rated at endpoint CAPS change score		The mean PTSD symptomatology clinician-rated at endpoint in the intervention		30 (1 study)	low[1,2]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Relaxation (+/- TAU)	Corresponding risk Eye movement desensitisation and reprocessing (EMDR; +/- TAU)			
		groups was 0.24 standard deviations lower (0.96 lower to 0.48 higher)			
PTSD symptomatology clinician-rated at 3-month follow-up CAPS change score Follow-up: mean 13 weeks		The mean PTSD symptomatology clinician-rated at 3-month follow-up in the intervention groups was 0.45 standard deviations lower (1.18 lower to 0.27 higher)		30 (1 study)	low[1,2]
PTSD symptomatology clinician-rated at 6-month follow-up CAPS change score Follow-up: mean 26 weeks		The mean PTSD symptomatology clinician-rated at 6-month follow-up in the intervention groups was 0.3 standard deviations lower (0.91 lower to 0.3 higher)		42 (1 study)	very low[1,2,3]
Remission at endpoint Number of people no longer meeting diagnostic criteria or no longer above clinical threshold on a scale for PTSD	432 per 1000	402 per 1000 (186 to 868)	RR 0.93 (0.43 to 2.01)	88 (2 studies)	very low[1,3,4]
Remission at 3-month follow-up Number of people no	211 per 1000	211 per 1000 (61 to 722)	RR 1 (0.29 to 3.43)	38 (1 study)	very low[1,4]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Relaxation (+/- TAU)	Corresponding risk Eye movement desensitisation and reprocessing (EMDR; +/- TAU)			
longer above clinical threshold on a scale for PTSD Follow-up: mean 13 weeks					
Remission at 6-month follow-up Number of people no longer meeting diagnostic criteria for PTSD Follow-up: mean 26 weeks	680 per 1000	802 per 1000 (571 to 1000)	RR 1.18 (0.84 to 1.64)	50 (1 study)	very low[1,2,3]
Dissociative symptoms - Endpoint CAPS dissociation cluster change score		The mean dissociative symptoms - endpoint in the intervention groups was 0.09 standard deviations higher (0.63 lower to 0.8 higher)		30 (1 study)	very low[1,4]
Dissociative symptoms - 3-month follow-up CAPS dissociation cluster change score Follow-up: mean 13 weeks		The mean dissociative symptoms - 3-month follow-up in the intervention groups was 0.45 standard deviations lower (1.18 lower to 0.27 higher)		30 (1 study)	low[1,2]
Anxiety symptoms at endpoint/follow-up HADS-A/STAI state change score		The mean anxiety symptoms at endpoint/follow-up in the intervention groups was 0.22 standard		64 (2 studies)	very low[1,2,3]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Relaxation (+/- TAU)	Corresponding risk Eye movement desensitisation and reprocessing (EMDR; +/- TAU)			
Follow-up: 6-41 weeks		deviations lower (0.72 lower to 0.27 higher)			
Depression symptoms ar endpoint BDI change score Follow-up: mean 6 weeks		The mean depression symptoms ar endpoint in the intervention groups was 0.64 standard deviations lower (1.2 to 0.08 lower)		52 (2 studies)	low[1,5]
Depression symptoms at 3-6 month follow-up BDI/HADS-D change score Follow-up: 13-26 weeks		The mean depression symptoms at 3-6 month follow-up in the intervention groups was 0.19 standard deviations lower (0.65 lower to 0.27 higher)		72 (2 studies)	very low[1,2,3]
Quality of life Functional Assessment of Quality of Life in MS change score Follow-up: mean 15 weeks Better indicated by higher values		The mean quality of life in the intervention groups was 0.03 standard deviations higher (0.57 lower to 0.64 higher)		42 (1 study)	very low[1,3,4]
Discontinuation Number of participants lost to follow-up for any reason Follow-up: 6-15 weeks	140 per 1000	163 per 1000 (69 to 389)	RR 1.16 (0.49 to 2.77)	111 (3 studies)	very low[1,4]

1 *BDI= Beck Depression Inventory; CAPS= Clinician-administered PTSD symptom scale; CI=confidence*
2 *interval; HADS-A= Hospital Anxiety and Depression Scale-Anxiety; IES= Impact of Event Scale; PSS-*

SR= PTSD symptom scale- self-report; RR=risk ratio; SMD=standardised mean difference; STAI= State-Trait Anxiety Inventory; TAU=treatment as usual
[1] Risk of bias is high or unclear across multiple domains
[2] 95% CI crosses both line of no effect and threshold for clinically important effect
[3] Data is not reported/cannot be extracted for all outcomes
[4] 95% CI crosses line of no effect and threshold for both clinically important benefit and clinically important harm
[5] OIS not met (N<400)

Table 58: Summary clinical evidence profile: Eye movement desensitisation and reprocessing (EMDR) versus combined somatic and cognitive therapies for delayed treatment (>3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Combined somatic and cognitive therapies	Corresponding risk Eye movement desensitisation and reprocessing (EMDR)			
PTSD symptomatology self-report - Endpoint PCL-C change score Follow-up: mean 8 weeks		The mean PTSD symptomatology self-report - endpoint in the intervention groups was 0.14 standard deviations lower (0.72 lower to 0.44 higher)		46 (1 study)	low[1,2]
PTSD symptomatology self-report - 3-month follow-up PCL-C change score Follow-up: mean 13 weeks		The mean PTSD symptomatology self-report - 3-month follow-up in the intervention groups was 0.04 standard deviations higher (0.54 lower to 0.62 higher)		46 (1 study)	very low[1,3]
PTSD symptomatology clinician-rated - Endpoint CAPS change score Follow-up: mean 8 weeks		The mean PTSD symptomatology clinician-rated - endpoint in the intervention groups was 0.15 standard deviations lower (0.73 lower to 0.43 higher)		46 (1 study)	low[1,2]
PTSD symptomatology clinician-rated - 3-month follow-up CAPS		The mean PTSD symptomatology clinician-rated - 3-month follow-up in the intervention groups was 0.01 standard		46 (1 study)	very low[1,3]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Combined somatic and cognitive therapies	Corresponding risk Eye movement desensitisation and reprocessing (EMDR)			
change score Follow-up: mean 13 weeks		deviations lower (0.59 lower to 0.57 higher)			
Response self-rated - Endpoint Number of people showing clinically significant improvement, based on reliable change indices (RCI) on PCL-C Follow-up: mean 8 weeks	87 per 1000	348 per 1000 (83 to 1000)	RR 4 (0.95 to 16.84)	46 (1 study)	low[1,2]
Response self-rated - 3-month follow-up Number of people showing clinically significant improvement, based on reliable change indices (RCI) on PCL-C Follow-up: mean 13 weeks	174 per 1000	261 per 1000 (85 to 803)	RR 1.5 (0.49 to 4.62)	46 (1 study)	very low[1,3]
Response clinician-rated - Endpoint Number of people showing clinically significant improvement, based on RCI	391 per 1000	434 per 1000 (219 to 869)	RR 1.11 (0.56 to 2.22)	46 (1 study)	very low[1,3]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Combined somatic and cognitive therapies	Corresponding risk Eye movement desensitisation and reprocessing (EMDR)			
on CAPS Follow-up: mean 8 weeks					
Response clinician-rated - 3-month follow-up Number of people showing clinically significant improvement, based on RCI on CAPS Follow-up: mean 13 weeks	391 per 1000	348 per 1000 (164 to 740)	RR 0.89 (0.42 to 1.89)	46 (1 study)	very low[1,3]
Anxiety symptoms - Endpoint HADS-A change score Follow-up: mean 8 weeks		The mean anxiety symptoms - endpoint in the intervention groups was 0.04 standard deviations higher (0.53 lower to 0.62 higher)		46 (1 study)	very low[1,3]
Anxiety symptoms - 3-month follow-up HADS-A change score Follow-up: mean 13 weeks		The mean anxiety symptoms - 3-month follow-up in the intervention groups was 0.09 standard deviations lower (0.67 lower to 0.49 higher)		46 (1 study)	low[1,2]
Depression symptoms - Endpoint HADS-D change score Follow-up: mean 8 weeks		The mean depression symptoms - endpoint in the intervention groups was 0.24 standard deviations lower (0.82 lower to 0.34 higher)		46 (1 study)	low[1,2]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Combined somatic and cognitive therapies	Corresponding risk Eye movement desensitisation and reprocessing (EMDR)			
Depression symptoms - 3-month follow-up HADS-D change score Follow-up: mean 13 weeks		The mean depression symptoms - 3-month follow-up in the intervention groups was 0.19 standard deviations lower (0.77 lower to 0.39 higher)		46 (1 study)	low[1,2]
Quality of life - Endpoint Satisfaction with Life Scale; change score Follow-up: mean 8 weeks Better indicated by higher values		The mean quality of life - endpoint in the intervention groups was 0.11 standard deviations higher (0.47 lower to 0.68 higher)		46 (1 study)	low[1,2]
Quality of life - 3-month follow-up Satisfaction with Life Scale change score Follow-up: mean 13 weeks Better indicated by higher values		The mean quality of life - 3-month follow-up in the intervention groups was 0.51 standard deviations higher (0.08 lower to 1.09 higher)		46 (1 study)	low[1,2]
Discontinuation Number of participants lost to follow-up for any reason Follow-up: mean 8 weeks	391 per 1000	434 per 1000 (219 to 869)	RR 1.11 (0.56 to 2.22)	46 (1 study)	low[3]

CAPS= Clinician-administered PTSD scale; CI=confidence interval; HADS-A/D= Hospital Anxiety and Depression Scale-Anxiety/Depression; PCL-C= PTSD checklist-Civilian; RR=risk ratio; SMD=standardised mean difference

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

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

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

Table 59: Summary clinical evidence profile: Eye movement desensitisation and reprocessing (EMDR) versus fluoxetine for delayed treatment (>3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Fluoxetine	Corresponding risk Eye movement desensitisation and reprocessing (EMDR)			
PTSD symptomatology clinician-rated - Endpoint CAPS change score Follow-up: mean 8 weeks		The mean PTSD symptomatology clinician-rated - endpoint in the intervention groups was 0.38 standard deviations lower (0.9 lower to 0.13 higher)		59 (1 study)	low[1,2]
PTSD symptomatology clinician-rated - 6-month follow-up CAPS change score Follow-up: mean 26 weeks		The mean PTSD symptomatology clinician-rated - 6-month follow-up in the intervention groups was 0.91 standard deviations lower (1.5 to 0.33 lower)		50 (1 study)	low[1,3]
Remission - Endpoint Number of people scoring <20 on CAPS Follow-up: mean 8 weeks	133 per 1000	276 per 1000 (93 to 817)	RR 2.07 (0.7 to 6.13)	59 (1 study)	very low[1,4]
Remission - 6-month follow-up Number of people scoring <20 on CAPS Follow-up: mean 26 weeks	0 per 1000	0 per 1000 (0 to 0)	RR 31.32 (1.97 to 497.93)	50 (1 study)	low[1,5]
Depression symptoms - Endpoint BDI-II change score Follow-up: mean 8 weeks		The mean depression symptoms - endpoint in the intervention groups was 0.29 standard deviations lower		59 (1 study)	low[1,2]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Fluoxetine	Corresponding risk Eye movement desensitisation and reprocessing (EMDR)			
		(0.81 lower to 0.22 higher)			
Depression symptoms - 6-month follow-up BDI-II change score Follow-up: mean 26 weeks		The mean depression symptoms - 6-month follow-up in the intervention groups was 1.05 standard deviations lower (1.64 to 0.45 lower)		50 (1 study)	low[1,3]
Discontinuation Number of participants lost to follow-up for any reason Follow-up: mean 8 weeks	133 per 1000	172 per 1000 (51 to 579)	RR 1.29 (0.38 to 4.34)	59 (1 study)	low[4]

BDI=Beck Depression Inventory CAPS= Clinician-administered PTSD scale; CI=confidence interval; RR=risk ratio; SMD=standardised mean difference

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

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

[3] OIS not met (N<400)

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

[5] OIS not met (events<300)

See Appendix F for full GRADE tables.

Sensitivity and subgroup analysis

Sub-analysis of the comparison, EMDR (alone or in addition to TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD, by multiplicity of trauma revealed a statistically significant subgroup difference for self-rated PTSD symptomatology (K=9; N=393; Chi² = 5.74, p = 0.02), with relatively larger effects observed for those who had experienced single incident index trauma (SMD -2.61 [-3.06, -2.15]) relative to multiple incident index trauma (SMD -1.16 [-2.25, -0.07]), although effects are clinically important and statistically significant across both subgroups. The same pattern of results is observed for clinician-rated PTSD symptomatology, although there is only 1 study in each subgroup (K=2; N=65; Chi² = 10.23, p = 0.001). There are no significant differences by multiplicity of trauma for discontinuation.

Sub-analysis by diagnostic status at baseline revealed a non-significant subgroup difference for self-rated PTSD symptomatology (Chi² = 0.21, p = 0.64). The test for subgroup differences is not possible for discontinuation as the 2 studies in the clinically important PTSD symptoms subgroup had no drop-out in either arm. The test

for subgroup differences for clinician-rated PTSD symptomatology is statistically significant (Chi² = 10.23, p = 0.001), with a larger effect observed for the PTSD diagnosis according to ICD/DSM criteria subgroup (SMD -2.40 [-3.23, -1.57]) than the clinically important PTSD symptoms (scoring above threshold on validated scale) subgroup (SMD -0.52 [-1.32, 0.28]). However, the effects are clinically important across both subgroups, and there is only 1 study in each subgroup that could differ on any number of other variables.

Sub-analysis by trauma type revealed a statistically significant subgroup difference for self-rated PTSD symptomatology (Chi² = 89.56, p < 0.00001), with non-siignificant effects observed for military combat trauma (SMD -0.03 [-0.46, 0.40]), but clinically important and statistically significant effects observed for all other trauma types included (motor vehicle collisions, witnessing war as a civilian, childhood sexual abuse, sexual abuse or assault in adulthood, and mixed trauma types). The same pattern of effects was observed for clinician-rated PTSD symptomaology (Chi² = 10.23, p = 0.001), with a relatively larger effect observed for sexual abuse or assault in adulthood (SMD -2.40 [-3.23, -1.57]) and a smaller and non-statistically significant effect observed for military combat (SMD -0.52 [-1.32, 0.28]). However, there is only 1 study in each subgroup that could differ on any number of other variables for the clinician-rated PTSD symptomatology outcome. The test for subgroup differences for discontinuation is not statistically significant (Chi² = 2.50, p = 0.47).

Hypnotherapy: clinical evidence

Included studies

Seven studies of hypnotherapy for the treatment of PTSD in adults were identified for full-text review. Of these 7 studies, 3 RCTs (N=253) were included, and each involved a different comparison, so there were 3 comparisons for hypnotherapy.

For early treatment (intervention initiated 1-3 months post-trauma) of PTSD symptoms, there were no relevant RCTs included.

For delayed treatment (intervention initiated more than 3 months post-trauma) of PTSD symptoms, 1 RCT (N=112) compared hypnotherapy in addition to TAU with TAU-only (Brom et al. 1989), 1 RCT (N=108) compared hypnotherapy followed by trauma-focused CBT with symptom monitoring followed by trauma-focused CBT (Galovski 2008/ Galovski et al. 2016 [protocol and paper]), and 1 RCT (N=33) compared hypnotherapy (in addition to TAU) with zolpidem (in addition to TAU) (Abramowitz et al. 2008).

Comparisons with trauma-focused CBT are presented in the Trauma-focused CBT section above.

Sub-analyses were not possible for hypnotherapy.

Excluded studies

Four studies were reviewed at full text and excluded from this review. The most common reason for exclusion was systematic review with no new useable data and any meta-analysis results not appropriate to extract.

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

Summary of clinical studies included in the evidence review

Table 60 provides brief summaries of the included studies and evidence from these are summarised in the clinical GRADE evidence profiles below (Table 61, Table 62 and Table 63).

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

Table 60: Summary of included studies: Hypnotherapy for delayed treatment (>3 months)

Comparison	Hypnotherapy + TAU versus TAU	Hypnotherapy followed by TF-CBT versus symptom monitoring followed by TF-CBT	Hypnotherapy (+ TAU) versus zolpidem (+ TAU)
Total no. of studies (N randomised)	1 (112)	1 (108)	1 (33)
Study ID	Brom 1989	Galovski 2008/2016	Abramowitz 2008
Country	Netherlands	US	Israel
Diagnostic status	PTSD diagnosis according to ICD/DSM criteria	PTSD diagnosis according to ICD/DSM criteria	PTSD diagnosis according to ICD/DSM criteria
Mean months since onset of PTSD	NR	NR	NR ('chronic')
Mean age (range)	42 (18-73)	36.9 (18-70)	31.7 (21-40)
Sex (% female)	79	100	0
Ethnicity (% BME)	NR	50	NR
Coexisting conditions	NR	NR	NR
Mean months since traumatic event	NR (<5 years)	195.6	NR
Type of traumatic event	Mixed: Loss of a loved one as a result of murder/suicide, traffic accidents, acute or chronic illness (74%); violent crime (17%); traffic accident (4%); other (5%)	Mixed: Interpersonal trauma including child sexual abuse (71%), child physical abuse (58%), adult sexual assault (63%), adult criminal victimization (32%), and domestic violence (56%)	Military combat: Combat-related PTSD (no further details reported)
Single or multiple incident index trauma	Single	Multiple	Multiple

Comparison	Hypnotherapy + TAU versus TAU	Hypnotherapy followed by TF-CBT versus symptom monitoring followed by TF-CBT	Hypnotherapy (+ TAU) versus zolpidem (+ TAU)
Lifetime experience of trauma	NR	NR	NR
Intervention details	Hypnotherapy + TAU. The emphasis of the hypnotherapists in this study was on behavioral therapy	Hypnotherapy followed by trauma-focused CBT. Participants began with 3 sessions of sleep-directed hypnosis, following an unpublished manual (and monitored symptoms similarly to the control group). After the 3 weeks of hypnotherapy, participants received cognitive processing therapy (following protocol of Resick et al. 2010)	Hypnotherapy + TAU (SSRI antidepressants and supportive psychotherapy)
Intervention format	Individual	Individual	Individual
Intervention intensity	Planned intensity NR. Mean number of sessions attended 14.4 (SD=1.4)	3x weekly 1-hour sleep hypnosis sessions (3 hours) + 12x weekly 1-hour CPT (12 hours; 15 hours in total)	4x twice-weekly 1.5-hour sessions (6 hours)
Comparator	TAU (participants in this arm received treatment outside of the research setting)	Symptom monitoring followed by trauma-focused CBT. Participants began with 3 weeks of daily monitoring of PTSD, depressive symptoms, and sleep. After the 3 weeks of daily symptom monitoring, participants received cognitive processing therapy (following protocol of Resick et al. 2010)	Zolpidem, 10mg/day + TAU (SSRI antidepressants and supportive psychotherapy)
Intervention length (weeks)	16	15	2

Note. None

See appendix G for full evidence tables.

Quality assessment of clinical studies included in the evidence review

The clinical evidence profiles for this review (hypnotherapy for the treatment of PTSD in adults) are presented in Table 61, Table 62 and Table 63Table 46.

Table 61: Summary clinical evidence profile: Hypnotherapy + TAU versus TAU for delayed treatment (>3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk TAU	Corresponding risk Hypnotherapy + TAU			
PTSD symptomatology self-rated IES change score Follow-up: mean 16 weeks		The mean PTSD symptomatology self-rated in the intervention groups was 0.89 standard deviations lower (1.46 to 0.31 lower)		52 (1 study)	very low[1,2,3]

CI=confidence interval; IES=Impact of event scale; RR=risk ratio; SMD=standardised mean difference; TAU=treatment as usual

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

[2] *OIS not met (N<400)*

[3] *Data is not reported/cannot be extracted for all outcomes*

Table 62: Summary clinical evidence profile: Hypnotherapy followed by trauma-focused CBT versus symptom monitoring followed by trauma-focused CBT for delayed treatment (>3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Symptom monitoring followed by trauma-focused CBT	Corresponding risk Hypnotherapy followed by trauma-focused CBT			
PTSD symptomatology clinician-rated - Endpoint CAPS change score Follow-up: mean 15 weeks		The mean PTSD symptomatology clinician-rated - endpoint in the intervention groups was 0.29 standard deviations lower (0.83 lower to 0.24 higher)		54 (1 study)	very low[1,2]
PTSD symptomatology clinician-rated - 3-month follow-up		The mean PTSD symptomatology clinician-rated - 3-month follow-up in		65 (1 study)	very low[1,2]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Symptom monitoring followed by trauma-focused CBT	Corresponding risk Hypnotherapy followed by trauma-focused CBT			
CAPS change score Follow-up: mean 13 weeks		the intervention groups was 0.16 standard deviations lower (0.65 lower to 0.33 higher)			
Depression symptoms - Endpoint BDI-II change score Follow-up: mean 15 weeks		The mean depression symptoms - endpoint in the intervention groups was 0.62 standard deviations lower (1.17 to 0.07 lower)		54 (1 study)	very low[1,3]
Depression symptoms - 3-month follow-up BDI-II change score Follow-up: mean 13 weeks		The mean depression symptoms - 3-month follow-up in the intervention groups was 0.25 standard deviations lower (0.74 lower to 0.24 higher)		65 (1 study)	very low[1,2]
Sleeping difficulties - Endpoint PSQI change score Follow-up: mean 15 weeks		The mean sleeping difficulties - endpoint in the intervention groups was 0.41 standard deviations lower (0.95 lower to 0.13 higher)		54 (1 study)	very low[1,2]
Sleeping difficulties - 3-month follow-up PSQI change score Follow-up: mean 13 weeks		The mean sleeping difficulties - 3-month follow-up in the intervention groups was 0.31 standard deviations lower (0.8 lower to 0.18 higher)		65 (1 study)	very low[1,2]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Symptom monitoring followed by trauma-focused CBT	Corresponding risk Hypnotherapy followed by trauma-focused CBT			
Discontinuation Number of participants lost to follow-up for any reason Follow-up: mean 15 weeks	554 per 1000	443 per 1000 (299 to 648)	RR 0.8 (0.54 to 1.17)	108 (1 study)	low[1,2]

BDI= Beck Depression Inventory; CAPS= Clinician-administered PTSD scale; CBT= cognitive behavioural therapy; CI=confidence interval; PSQI=Pittsburgh Sleep Quality Index; RR=risk ratio; SMD=standardised mean difference

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

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

[3] OIS not met (N<400)

Table 63: Summary clinical evidence profile: Hypnotherapy (+ TAU) versus zolpidem (+ TAU) for delayed treatment (>3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Zolpidem (+ TAU)	Corresponding risk Hypnotherapy (+ TAU)			
PTSD symptomatology self-report - Endpoint IES change score Follow-up: mean 2 weeks		The mean PTSD symptomatology self-report - endpoint in the intervention groups was 0.91 standard deviations lower (1.64 to 0.17 lower)		32 (1 study)	low[1,2]
PTSD symptomatology self-report - 1-month follow-up IES change score Follow-up: mean 4 weeks		The mean PTSD symptomatology self-report - 1-month follow-up in the intervention groups was 1.16 standard deviations lower (1.91 to 0.4 lower)		32 (1 study)	low[1,2]
Depression symptoms - Endpoint BDI change score		The mean depression symptoms - endpoint in the intervention		32 (1 study)	low[1,2]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Zolpidem (+ TAU)	Corresponding risk Hypnotherapy (+ TAU)			
Follow-up: mean 2 weeks		groups was 0.78 standard deviations lower (1.51 to 0.06 lower)			
Depression symptoms - 1-month follow-up BDI change score Follow-up: mean 4 weeks		The mean depression symptoms - 1-month follow-up in the intervention groups was 0.87 standard deviations lower (1.6 to 0.14 lower)		32 (1 study)	low[1,2]
Discontinuation Number of participants lost to follow-up for any reason Follow-up: mean 2 weeks	62 per 1000	19 per 1000 (1 to 451)	RR 0.31 (0.01 to 7.21)	33 (1 study)	very low[1,3]
Discontinuation due to adverse events Number of participants who dropped out due to adverse events Follow-up: mean 2 weeks	62 per 1000	19 per 1000 (1 to 451)	RR 0.31 (0.01 to 7.21)	33 (1 study)	very low[1,3]

BDI= Beck Depression Inventory; CI=confidence interval; IES= Impact of Event Scale; RR=risk ratio; SMD=standardised mean difference; TAU=treatment as usual

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

[2] OIS not met (N<400)

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

See Appendix F for full GRADE tables.

Interpersonal psychotherapy (IPT): clinical evidence

Included studies

Four studies of interpersonal psychotherapy (IPT) for the treatment of PTSD in adults were identified for full-text review. Of these 4 studies, 2 RCTs (N=158) were included, and each involved a different comparison, so there were 2 comparisons for IPT.

For early treatment (intervention initiated 1-3 months post-trauma) of PTSD symptoms, there were no relevant RCTs included.

For delayed treatment (intervention initiated more than 3 months post-trauma) of PTSD symptoms, 1 RCT (N=48) compared IPT with waitlist (Krupnick et al. 2008), and 1 RCT (N=110) compared IPT with relaxation (Markowitz et al. 2015).

Comparisons with trauma-focused CBT are presented in the Trauma-focused CBT section above.

Sub-analyses were not possible for IPT.

Excluded studies

Two studies were reviewed at full text and excluded from this review due to small sample size (N<10 per arm) or subgroup/secondary analysis of RCT already included.

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

Summary of clinical studies included in the evidence review

Table 64 provides brief summaries of the included studies and evidence from these are summarised in the clinical GRADE evidence profiles below (Table 65 and Table 66).

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

Table 64: Summary of included studies: Interpersonal psychotherapy (IPT) for delayed treatment (>3 months)

Comparison	IPT versus waitlist	IPT versus relaxation
Total no. of studies (N randomised)	1 (48)	1 (110)
Study ID	Krupnick 2008	Markowitz 2015a
Country	US	US
Diagnostic status	PTSD diagnosis according to ICD/DSM criteria	PTSD diagnosis according to ICD/DSM criteria
Mean months since onset of PTSD	NR ('all participants had highly chronic PTSD')	NR ('chronic')
Mean age (range)	32 (range NR)	40.1 (range NR)
Sex (% female)	100	70
Ethnicity (% BME)	94	35
Coexisting conditions	NR	Current major depressive disorder (50%); recurrent major depressive disorder (34%); current generalised anxiety disorder (13%). Any axis II diagnosis (49%): 25% paranoid;

Comparison	IPT versus waitlist	IPT versus relaxation
		14% narcissistic; 5% borderline; 21% avoidant; 3% dependent; 25% obsessive-compulsive; 25% depressive; 15% passive-aggressive
Mean months since traumatic event	NR (majority first assaulted before age 12)	169.2
Type of traumatic event	Mixed: Study participants had experienced multiple episodes of trauma, usually beginning in childhood. 98% sexual assault (96% first assualted before age 12); 96% physical assault before age 12	Domestic violence: 93% reported interpersonal trauma (42% acute; 58% chronic)
Single or multiple incident index trauma	Multiple	Multiple
Lifetime experience of trauma	Mean 6.4 prior traumas	Mean number of traumas 2.8 (SD=1.8). 36% reported trauma in childhood or adolescence
Intervention details	Interpersonal psychotherapy (IPT) group	Interpersonal psychotherapy (IPT). IPT addressed not trauma but its interpersonal aftermath, and no homework was assigned
Intervention format	Group	Individual
Intervention intensity	16x 2-hour sessions (32 hours)	14x weekly 50-min sessions (11.7 hours). Mean attended sessions 12.6 (SD=3.4)
Comparator	Waitlist	Relaxation therapy, highly scripted, induces progressive muscle and mental relaxation
Intervention length (weeks)	17	14
Note. None		

See Appendix F for full evidence tables.

Quality assessment of clinical studies included in the evidence review

The clinical evidence profiles for this review (IPT for the treatment of PTSD in adults) are presented in Table 65 and Table 66.

Table 65: Summary clinical evidence profile: Interpersonal psychotherapy (IPT) versus waitlist for delayed treatment (>3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist	Corresponding risk Interpersonal psychotherapy (IPT)			
PTSD symptomatology clinician-rated - Endpoint CAPS change score Follow-up: mean 17 weeks		The mean PTSD symptomatology clinician-rated - endpoint in the intervention groups was 1.19 standard deviations lower (1.84 to 0.54 lower)		48 (1 study)	very low[1,2,3]
PTSD symptomatology clinician-rated - 4-month follow-up CAPS change score Follow-up: mean 17 weeks		The mean PTSD symptomatology clinician-rated - 4-month follow-up in the intervention groups was 0.38 standard deviations lower (0.99 lower to 0.22 higher)		48 (1 study)	very low[1,3,4]
Remission Number of people no longer meeting diagnostic criteria for PTSD Follow-up: mean 17 weeks	125 per 1000	500 per 1000 (131 to 1000)	RR 4 (1.05 to 15.31)	48 (1 study)	very low[1,3,5]
Depression symptoms - Endpoint HAMD change score Follow-up: mean 17 weeks		The mean depression symptoms - endpoint in the intervention groups was 0.96 standard deviations lower (1.59 to 0.33 lower)		48 (1 study)	very low[1,2,3]
Depression symptoms - 4-month follow-up HAMD change score Follow-up: mean 17 weeks		The mean depression symptoms - 4-month follow-up in the intervention groups was 0.39 standard deviations lower		48 (1 study)	very low[1,3,4]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist	Corresponding risk Interpersonal psychotherapy (IPT)			
		(0.99 lower to 0.22 higher)			
Discontinuation Number of participants lost to follow-up for any reason Follow-up: mean 17 weeks	562 per 1000	377 per 1000 (203 to 698)	RR 0.67 (0.36 to 1.24)	48 (1 study)	low[1,4]

CAPS= Clinician-administered PTSD scale; CI=confidence interval; HAMD= Hamilton Rating Scale for Depression; IPT=interpersonal psychotherapy; RR=risk ratio; SMD=standardised mean difference

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

[2] OIS not met (N<400)

[3] Data is not reported/cannot be extracted for all outcomes

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

[5] OIS not met (events<300)

Table 66: Summary clinical evidence profile: Interpersonal psychotherapy (IPT) versus relaxation for delayed treatment (>3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Relaxation	Corresponding risk Interpersonal psychotherapy (IPT)			
PTSD symptomatology clinician-rated CAPS change score Follow-up: mean 14 weeks		The mean PTSD symptomatology clinician-rated in the intervention groups was 0.36 standard deviations lower (0.88 lower to 0.16 higher)		60 (1 study)	low[1,2]
PTSD symptomatology self-rated PSS-SR change score Follow-up: mean 14 weeks		The mean PTSD symptomatology self-rated in the intervention groups was 0.77 standard deviations lower (1.48 to 0.07 lower)		36 (1 study)	low[1,3]
Remission Number of people scoring <20 on CAPS Follow-up: mean 14 weeks	156 per 1000	200 per 1000 (72 to 553)	RR 1.28 (0.46 to 3.54)	72 (1 study)	very low[1,4]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Relaxation	Corresponding risk Interpersonal psychotherapy (IPT)			
Response Number of people showing ≥30% improvement on CAPS Follow-up: mean 14 weeks	281 per 1000	599 per 1000 (326 to 1000)	RR 2.13 (1.16 to 3.92)	72 (1 study)	low[1,5]
Depression symptoms HAMD change score Follow-up: mean 14 weeks		The mean depression symptoms in the intervention groups was 0.28 standard deviations higher (0.24 lower to 0.81 higher)		58 (1 study)	low[1,2]
Funtional impairment SAS change score Follow-up: mean 14 weeks		The mean funtional impairment in the intervention groups was 0.98 standard deviations lower (1.69 to 0.27 lower)		36 (1 study)	low[1,3]
Quality of life Q-LES-Q-SF change score Follow-up: mean 14 weeks Better indicated by higher values		The mean quality of life in the intervention groups was 0.59 standard deviations higher (0.09 lower to 1.26 higher)		38 (1 study)	low[1,2]
Relationship difficulties IIP change score Follow-up: mean 14 weeks		The mean relationship difficulties in the intervention groups was 1.32 standard deviations lower (2.06 to 0.58 lower)		37 (1 study)	low[1,3]
Discontinuation Number of participants lost to follow-up for any reason Follow-up: mean 14 weeks	344 per 1000	151 per 1000 (62 to 361)	RR 0.44 (0.18 to 1.05)	72 (1 study)	low[1,2]

CAPS= Clinician-administered PTSD scale; CI=confidence interval; HAMD= Hamilton Rating Scale for Depression; IIP=Inventory of interpersonal problems; PSS-SR= PTSD symptom scale-self-report; RR=risk ratio; SAS= Social Adjustment Scale; SMD=standardised mean difference; Q-LES-Q-SF=Quality of Life Enjoyment and Satisfaction Questionnaire

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

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

[3] OIS not met (N<400)

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

[5] OIS not met (events<300)

See Appendix F for full GRADE tables.

Psychodynamic therapies: clinical evidence

Included studies

Twelve studies of psychodynamic therapies for the treatment of PTSD in adults were identified for full-text review. Of these 12 studies, 2 RCTs (N=198) were included in 1 comparison for psychodynamic therapies.

For early treatment (intervention initiated 1-3 months post-trauma) of PTSD symptoms, there were no relevant RCTs included.

For delayed treatment (intervention initiated more than 3 months post-trauma) of PTSD symptoms, 2 RCTs (N=198) compared psychodynamic therapy (alone or in addition to TAU) with waitlist (alone or in addition to TAU) (Brom et al. 1989; Steinert et al. 2017).

Comparisons with trauma-focused CBT are presented in the Trauma-focused CBT section above.

Sub-analyses were not possible for psychodynamic therapies.

Excluded studies

Ten studies were reviewed at full text and excluded from this review. The most common reasons for exclusion were non-randomised group assignment, non-systematic review, and paper unavailable.

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

Summary of clinical studies included in the evidence review

Table 67 provides brief summaries of the included studies and evidence from these are summarised in the clinical GRADE evidence profile below (Table 68).

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

Table 67: Summary of included studies: Psychodynamic therapies for delayed treatment (>3 months)

Comparison	Psychodynamic therapy (+/- TAU) versus waitlist (+/- TAU)
Total no. of studies (N randomised)	2 (198)
Study ID	Brom 1989[1]

Comparison	Psychodynamic therapy (+/- TAU) versus waitlist (+/- TAU)
	Steinert 2017[2]
Country	Netherlands[1] Cambodia[2]
Diagnostic status	PTSD diagnosis according to ICD/DSM criteria
Mean months since onset of PTSD	NR
Mean age (range)	42 (18-73) [1] 27.5 (range NR) [2]
Sex (% female)	79[1] 61[2]
Ethnicity (% BME)	NR
Coexisting conditions	NR
Mean months since traumatic event	NR (<5 years) [1] NR[2]
Type of traumatic event	Mixed: Loss of a loved one as a result of murder/suicide, traffic accidents, acute or chronic illness (74%); violent crime (17%); traffic accident (4%); other (5%)[1] Mixed: Domestic violence (23%), sexual abuse (15%), traffic accident (24%), other serious accident, e.g. stepping on a mine (7%), witnessing death of someone close (12%), assault (10%), 'other' such as combat or trafficking (10%)[2]
Single or multiple incident index trauma	Single
Lifetime experience of trauma	NR
Intervention details	Brief psychodynamic therapy (Horowitz, 1976) + TAU [1] Resource activation, ROTATE, a psychodynamic therapy (following the manual by Wöller & Mattheß 2016) [2]
Intervention format	Individual
Intervention intensity	Planned intensity NR. Mean number of sessions attended 18.8 (SD=2.6) [1] 5x weekly 1-hour sessions (5 hours) [2]
Comparator	TAU (received treatment outside of the research setting) [1] Waitlist[2]
Intervention length (weeks)	16[1] 5[2]
Note. [1]Brom 1989; [2]Steinert 2017	

See appendix G for full evidence tables.

Quality assessment of clinical studies included in the evidence review

The clinical evidence profile for this review (psychodynamic therapies for the treatment of PTSD in adults) is presented in Table 68.

Table 68: Summary clinical evidence profile: Psychodynamic therapy (+/- TAU) versus waitlist (+/- TAU) for delayed treatment (>3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist (+/- TAU)	Corresponding risk Psychodynamic therapy (+/- TAU)			
PTSD symptomatology self-rated IES change score Follow-up: mean 16 weeks		The mean PTSD symptomatology self-rated in the intervention groups was 0.83 standard deviations lower (1.4 to 0.25 lower)		52 (1 study)	very low[1,2,3]
Remission Number of people no longer met criteria for PTSD based on HTQ DSM-IV PTSD algorithm Follow-up: mean 5 weeks	241 per 1000	958 per 1000 (502 to 1000)	RR 3.97 (2.08 to 7.6)	78 (1 study)	very low[1,3,4]
Anxiety symptoms HSCL-25: Anxiety change score Follow-up: mean 5 weeks		The mean anxiety symptoms in the intervention groups was 2.73 standard deviations lower (3.35 to 2.12 lower)		84 (1 study)	very low[1,2,3]
Depression symptoms HSCL-25: Depression change score Follow-up: mean 5 weeks		The mean depression symptoms in the intervention groups was 3.03 standard deviations lower (3.67 to 2.39 lower)		84 (1 study)	very low[1,2,3]
Discontinuation Number of participants lost to follow-up for any reason Follow-up: mean 5 weeks	30 per 1000	19 per 1000 (1 to 292)	RR 0.62 (0.04 to 9.62)	86 (1 study)	very low[1,5]

CI=confidence interval; HSCL-25= Hopkins Symptom Checklist-25; HTQ DSM-IV PTSD=Harvard Trauma Questionnaire for PTSD; IES= Impact of Event Scale; RR=risk ratio; SMD=standardised mean difference; TAU=treatment as usual

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

[2] OIS not met (N<400)

[3] Data is not reported/cannot be extracted for all outcomes

[4] OIS not met (events<300)

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

See appendix F for full GRADE tables.

Counselling: clinical evidence

Included studies

Thirteen studies of counselling for the treatment of PTSD in adults were identified for full-text review. Of these 13 studies, 6 RCTs (N=842) were included in 1 comparison for counselling.

For early treatment (intervention initiated 1-3 months post-trauma) of PTSD symptoms, there were no relevant RCTs included.

For delayed treatment (intervention initiated more than 3 months post-trauma) of PTSD symptoms, 6 RCTs (N=842) compared counselling (alone or in addition to TAU) with TAU or waitlist (Bass et al. 2016; Blanchard 2002/Blanchard et al. 2003/2004 [one study reported across three papers]; Ehlers et al. 2014; Neuner et al. 2004; Neuner et al. 2008; Yeomans et al. 2010).

Comparisons with trauma-focused CBT are presented in the Trauma-focused CBT section above.

Sub-analyses were not possible for counselling.

Excluded studies

Seven studies were reviewed at full text and excluded from this review. The most common reason for exclusion was that the comparison was outside protocol (within-class comparison).

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

Summary of clinical studies included in the evidence review

Table 69 provides brief summaries of the included studies and evidence from these are summarised in the clinical GRADE evidence profile below (Table 70).

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

Table 69: Summary of included studies: Counselling for delayed treatment (>3 months)

Comparison	Counselling (+/- TAU) versus TAU/waitlist
Total no. of studies (N randomised)	6 (842)
Study ID	Bass 2016[1] Blanchard 2002/2003/2004[2] Ehlers 2014[3] Neuner 2004[4] Neuner 2008[5] Yeomans 2010[6]
Country	Iraq[1] US[2]

Comparison	Counselling (+/- TAU) versus TAU/waitlist
	UK[3] Uganda[4,5] Burundi[6]
Diagnostic status	Clinically important PTSD symptoms (scoring above a threshold on validated scale) [1,6] PTSD diagnosis according to ICD/DSM criteria[2,3,4,5]
Mean months since onset of PTSD	NR[1,4,5,6] NR ('chronic [6-24 months]') [2] NR ('chronic') [3]
Mean age (range)	40.4 (18-82)[1] 39.7 (range NR)[2] 38.7 (range NR)[3] 33.2 (range NR)[4] 35 (range NR)[5] 38.6 (range NR)[6]
Sex (% female)	33[1] 73[2] 58[3] 60[4] 51[5] 44[6]
Ethnicity (% BME)	NR[1,4,5,6] 10[2] 31[3]
Coexisting conditions	NR[1,4,5,6] 49% major depressive disorder (MDD); 35% generalized anxiety disorder (GAD) [2] Depressive disorder (35%); anxiety disorder (30%); substance abuse (15%); Axis II disorder (19%) [3]
Mean months since traumatic event	NR[1,5,6] 13.7[2] Mean NR (40% 3 months-1 year; 20% 1-2 years; 24% 2-4 years; 15% >4 years) [3] 90[4]
Type of traumatic event	Witnessing war as a civilian: Experiencing torture (defined as personally experiencing or witnessing physical torture, imprisonment, and/or military attacks) [1] Motor Vehicle Collision[2] Mixed: Interpersonal violence (36%); Accidents/disaster (38%); Death/harm to others (8%); Other (18%)[3] Witnessing war as a civilian: Refugees from Sudanese civil war. 52% reported the witnessing of people badly injured or killed as worst event type (which included the killing of relatives as well as massacres and mutilations); further worst event types were threats with weapons and kidnappings (17%), physical attacks (12%), torture (7%), combat experiences (7%), sexual assaults (5%) and natural disasters (2%)[4] Witnessing war as a civilian: Rwandan and Somalian refugees settled in a refugee camp in Uganda[5]

Comparison	Counselling (+/- TAU) versus TAU/waitlist
	Witnessing war as a civilian: Almost all participants had been directly victimized by violence during or since the onset of conflict in Burundi in 1993[6]
Single or multiple incident index trauma	Multiple[1,4,5,6] Single[2] Unclear[3]
Lifetime experience of trauma	NR[1,2] 70% history of other trauma; 10% reported history of childhood abuse[3] Mean number of traumatic event types 10.1 (SD=6.5)[4] Mean number of trauma event types 14.1 (SD=5.2)[5] Mean number of types of events experienced was 9.9 (SD=2.1). The mean number of types of events experienced or witnessed was 12.6 (SD = 3.2)[6]
Intervention details	Supportive counselling + TAU[1,4] Supportive psychotherapy (SUPPORT) intervention[2] Emotion-focused supportive therapy, following unpublished manual[3] Trauma counselling (TC)[5] Data combined for two arms: Trauma healing and reconciliation workshops, with or without psychoeducation[6]
Intervention format	Individual[1,2,3,4,5] Group[6]
Intervention intensity	6-12 sessions. Mean number of sessions attended 11.29 (range 7-12)[1] 8-12 x weekly sessions. Mean sessions attended 10.0 (1.2)[2] 12x weekly sessions (up to 20 hours in total). Mean attended 10.27 (SD=3.21) sessions[3] 4x 1.5-2 hour sessions (6-8 hours)[4] 6x twice-weekly 1-2 hour sessions (6-12 hours)[5] 3-day workshop + 1-day follow-up session 1 month later[6]
Comparator	TAU (no further detail reported)[1] Waitlist[2,3,5,6] TAU: All participants received a single session of psychoeducation[4]
Intervention length (weeks)	26[1] 12[2] 14[3] 3[4,5] 4[6]
Note. [1]Bass 2016; [2]Blanchard 2002/2003/2004; [3]Ehlers 2014; [4]Neuner 2004; [5]Neuner 2008; [6]Yeomans 2010	

See appendix F for full evidence tables.

Quality assessment of clinical studies included in the evidence review

The clinical evidence profile for this review (counselling for the treatment of PTSD in adults) is presented in Table 70.

Table 70: Summary clinical evidence profile: Counselling (+/- TAU) versus TAU or waitlist for delayed treatment (>3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk TAU or waitlist	Corresponding risk Counselling (+/- TAU)			
PTSD symptomatology self-rated at endpoint PCL/PDS/HTQ change score Follow-up: 3-14 weeks		The mean PTSD symptomatology self-rated at endpoint in the intervention groups was 0.97 standard deviations lower (1.24 to 0.69 lower)		249 (4 studies)	very low[1,2,3]
PTSD symptomatology self-rated at 1-4 month follow-up HTQ/PDS change score Follow-up: 4-17 weeks		The mean PTSD symptomatology self-rated at 1-4 month follow-up in the intervention groups was 0.63 standard deviations lower (1.51 lower to 0.25 higher)		234 (2 studies)	very low[1,4,5]
PTSD symptomatology self-rated at 8-12 month follow-up PDS change score Follow-up: 32-52 weeks		The mean PTSD symptomatology self-rated at 8-12 month follow-up in the intervention groups was 1.03 standard deviations lower (1.68 to 0.38 lower)		190 (2 studies)	very low[1,2,3,4]
PTSD symptomatology clinician-rated at endpoint CAPS change score Follow-up: 12-14 weeks		The mean PTSD symptomatology clinician-rated at endpoint in the intervention groups was 0.94 standard deviations lower (1.39 to 0.49 lower)		111 (2 studies)	low[1,2]
PTSD symptomatology clinician-rated at 1-year follow-up CIDI-PTSD change score Follow-up: mean 52 weeks		The mean PTSD symptomatology clinician-rated at 1-year follow-up in the intervention groups was 0.22 standard deviations lower		24 (1 study)	very low[1,3,6]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk TAU or waitlist	Corresponding risk Counselling (+/- TAU)			
		(1.03 lower to 0.58 higher)			
Remission at endpoint Number of people no longer meeting diagnostic criteria or no longer above clinical threshold on a scale for PTSD Follow-up: 12-14 weeks	118 per 1000	280 per 1000 (124 to 633)	RR 2.38 (1.05 to 5.38)	102 (2 studies)	very low[1,3,7]
Remission at 8-12 month follow-up Number of people no longer meeting diagnostic criteria for PTSD Follow-up: 32-52 weeks	134 per 1000	261 per 1000 (132 to 517)	RR 1.94 (0.98 to 3.85)	192 (2 studies)	very low[1,3,5]
Anxiety symptoms at endpoint BAI/STAI State change score Follow-up: 12-14 weeks		The mean anxiety symptoms at endpoint in the intervention groups was 0.77 standard deviations lower (1.16 to 0.39 lower)		111 (2 studies)	low[1,2]
Anxiety symptoms at 1-month follow-up HSCL Anxiety change score Follow-up: mean 4 weeks		The mean anxiety symptoms at 1-month follow-up in the intervention groups was 0.3 standard deviations lower (0.61 lower to 0.02 higher)		209 (1 study)	low[1,5]
Depression symptoms at endpoint BDI change score Follow-up: 12-14 weeks		The mean depression symptoms at endpoint in the intervention groups was 0.73 standard		111 (2 studies)	low[1,2]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk TAU or waitlist	Corresponding risk Counselling (+/- TAU)			
		deviations lower (1.12 to 0.35 lower)			
Depression symptoms at 1-month follow-up HSCL Depression change score Follow-up: mean 4 weeks		The mean depression symptoms at 1-month follow-up in the intervention groups was 0.36 standard deviations lower (0.68 to 0.04 lower)		209 (1 study)	low[1,2]
Functional impairment SDS change score Follow-up: mean 14 weeks		The mean functional impairment in the intervention groups was 0.93 standard deviations lower (1.47 to 0.4 lower)		60 (1 study)	low[1,2]
Global functioning GAF change score Follow-up: mean 12 weeks Better indicated by higher values		The mean global functioning in the intervention groups was 0.44 standard deviations higher (0.12 lower to 0.99 higher)		51 (1 study)	very low[1,3,5]
Quality of life at endpoint Q-LES-Q-SF/SF-12 change score Follow-up: 3-14 weeks Better indicated by higher values		The mean quality of life at endpoint in the intervention groups was 0.05 standard deviations lower (1.4 lower to 1.3 higher)		85 (2 studies)	very low[1,6,8]
Quality of life at 4-month follow-up SF-12 change score Follow-up: mean 17 weeks Better indicated by higher values		The mean quality of life at 4-month follow-up in the intervention groups was 1.48 standard deviations lower (2.39 to 0.58 lower)		25 (1 study)	very low[1,2,3]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk TAU or waitlist	Corresponding risk Counselling (+/- TAU)			
Quality of life at 1-year follow-up SF-12 change score Follow-up: mean 52 weeks Better indicated by higher values		The mean quality of life at 1-year follow-up in the intervention groups was 0.93 standard deviations lower (1.79 to 0.08 lower)		24 (1 study)	very low[1,2,3]
Discontinuation Number of participants lost to follow-up for any reason Follow-up: 3-26 weeks	224 per 1000	240 per 1000 (132 to 440)	RR 1.07 (0.59 to 1.96)	646 (6 studies)	very low[1,6]

BAI= Beck Anxiety Inventory; BDI= Beck Depression Inventory; CAPS= Clinician-administered PTSD symptom scale; CI=confidence interval; CIDI-PTSD=Composite International Diagnostic Interview-PTSD; GAF=Global Assessment of Functioning; HSCL= Hopkins Symptom Checklist-; HTQ= Harvard Trauma Questionnaire; PCL= PTSD checklist; PDS= Post-traumatic Diagnositic Scale; RR=risk ratio; SDS= Sheehan Disability Scale; SF-12=Short-form-12; SMD=standardised mean difference; STAI= State-Trait Anxiety Inventory; TAU=treatment as usual; Q-LES-W-SF= Quality of Life Enjoyment and Satisfaction Questionnaire;

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

[2] OIS not met (N<400)

[3] Data is not reported/cannot be extracted for all outcomes

[4] Substantial heterogeneity (I2=50-80%)

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

[6] 95% CI crosses line of no effect and threshold for both clinically important benefit and clinically important harm

[7] OIS not met (events<300)

[8] Considerable heterogeneity (I2>80%)

See appendix Ffor full GRADE tables.

Combined somatic and cognitive therapies: clinical evidence

Included studies

Seven studies of combined somatic and cognitive therapies for the treatment of PTSD in adults were identified for full-text review. Of these 7 studies, 5 RCTs (N=607) were included in 1 comparison for combined somatic and cognitive therapies.

For early treatment (intervention initiated 1-3 months post-trauma) of PTSD symptoms, there were no relevant RCTs included.

For delayed treatment (intervention initiated more than 3 months post-trauma) of PTSD symptoms, 5 RCTs (N=607) compared combined somatic and cognitive therapies (alone or in addition to TAU) with waitlist (alone or in addition to TAU) (Brom et al. 2017; Church et al. 2013/ Church 2014 [one study reported across two papers]; Connolly & Sakai 2011; Geronilla et al. 2016; Robson et al. 2016).

Sub-analyses were possible for this comparison, comparing effects by multiplicity of trauma, specific intervention, diagnostic status at baseline, and trauma type.

Excluded studies

Two studies were reviewed at full text and excluded from this review due to small sample size (N<10 per arm) or non-randomised group assignment.

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

Summary of clinical studies included in the evidence review

Table 71 provides brief summaries of the included studies and evidence from these are summarised in the clinical GRADE evidence profile below (Table 72).

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

Table 71: Summary of included studies: Combined somatic and cognitive therapies for delayed treatment (>3 months)

Comparison	Combined somatic and cognitive therapies (+/- TAU) versus waitlist (+/- TAU)
Total no. of studies (N randomised)	5 (607)
Study ID	Brom 2017[1] Church 2013/2014[2] Connolly 2011[3] Geronilla 2016[4] Robson 2016[5]
Country	Israel[1] US[2] Rwanda[3] Unclear (US and/or UK)[4] Uganda[5]
Diagnostic status	PTSD diagnosis according to ICD/DSM criteria[1] Clinically important PTSD symptoms (scoring above a threshold on validated scale)[2,3,4,5]
Mean months since onset of PTSD	NR
Mean age (range)	40.5 (range NR)[1] 51.7 (24-86)[2] 38 (18-73)[3] 50 (23-85)[4] 44.7 (range NR)[5]
Sex (% female)	51[1] 10[2] 82[3] 12[4] 85[5]

Comparison	Combined somatic and cognitive therapies (+/- TAU) versus waitlist (+/- TAU)
Ethnicity (% BME)	NR
Coexisting conditions	NR[1,2,3,5] 91% have some insomnia (41% severe and 34% moderately severe) [4]
Mean months since traumatic event	48.5[1] NR[2,3,4,5]
Type of traumatic event	Mixed: Vehicle accidents (44%); assault (13%); terrorist attacks (13%); other types of accidents (18%); death or injury of a family member (8%); medical trauma (6%); combat (3%); threat (2%)[1] Military combat: 41% Gulf war era deployments; 58% other deployments. Mean number of tours 1.2 (SD=0.4) [2] Witnessing war as a civilian: Rwandan genocide (1994) survivors. Reported experiences during the 1994 genocide included: being beaten (60%), having been abused (55.2%), witnessing others being beaten (80%), witnessing others being killed (85.5%), hearing others being hit or beaten (81.4%) and being forced to do things they were against (22.1%)[3] Military combat: Veterans (33% Vietnam war) [4] Witnessing war as a civilian: Western Uganda, where there had been intermittent conflict since Uganda gained independence in 1963[5]
Single or multiple incident index trauma	Single[1] Multiple[2,3,4,5]
Lifetime experience of trauma	NR
Intervention details	Somatic experiencing (SE), following an unpublished protocol + TAU[1] Emotional Freedom Technique (EFT; Craig 2010) + TAU[2] Thought Field Therapy (TFT; following protocol of Callahan & Callahan 2000) [3,5] Emotional freedom technique (EFT; following manuals by Craig & Fowlie 1995 and Church 2013) + TAU (mean treatment medications 4.1 [SD=4.2]) [4]
Intervention format	Individual
Intervention intensity	15x weekly 1-hour sessions (15 hours) [1] 6x 1-hour sessions (6 hours) [2,4] 1 session. Mean duration of intervention session: 41 mins (SD=2.9) [3] 1x 30-60 min session[5]
Comparator	TAU (no further detail reported) [1] Waitlist[2,3,5] TAU: Mean number of treatment medications 3.3 (SD=2.9) [4]
Intervention length (weeks)	15[1] 4[2] 0.1[3,5] 6[4]
Note. [1]Brom 2017; [2]Church 2013/2014; [3]Connolly 2011; [4]Geronilla 2016; [5]Robson 2016	

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See appendix F for full evidence tables.

Quality assessment of clinical studies included in the evidence review

The clinical evidence profile for this review (combined somatic and cognitive therapies for the treatment of PTSD in adults) is presented in Table 72.

Table 72: Summary clinical evidence profile: Combined somatic and cognitive therapies (+/- TAU) versus waitlist (+/- TAU) for delayed treatment (>3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist (+/- TAU)	Corresponding risk Combined somatic and cognitive therapies (+/- TAU)			
PTSD symptomatology self-rated PCL/PDS/MPSS change score Follow-up: 0.1-15 weeks		The mean PTSD symptomatology self-rated in the intervention groups was 1.97 standard deviations lower (3.03 to 0.9 lower)		544 (5 studies)	very low[1,2,3]
PTSD symptomatology clinician-rated CAPS change score Follow-up: mean 15 weeks		The mean PTSD symptomatology clinician-rated in the intervention groups was 1.15 standard deviations lower (1.7 to 0.6 lower)		60 (1 study)	very low[1,3,4]
Remission Number of people scoring <50 on PCL Follow-up: mean 6 weeks	77 per 1000	812 per 1000 (212 to 1000)	RR 10.56 (2.76 to 40.42)	58 (1 study)	low[1,5]
Anxiety symptoms SA-45 Anxiety T-score change score Follow-up: mean 4 weeks		The mean anxiety symptoms in the intervention groups was 1.81 standard deviations lower (2.45 to 1.17 lower)		54 (1 study)	very low[1,3,4]
Depression symptoms CES-D/SA-45 Depression T-score change		The mean depression symptoms in the intervention groups was		114 (2 studies)	very low[1,3,4,6]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist (+/- TAU)	Corresponding risk Combined somatic and cognitive therapies (+/- TAU)			
score Follow-up: 4-15 weeks		1.47 standard deviations lower (1.89 to 1.04 lower)			
Sleeping difficulties ISI change score Follow-up: mean 6 weeks		The mean sleeping difficulties in the intervention groups was 1.71 standard deviations lower (2.37 to 1.04 lower)		49 (1 study)	low[1,4]
Discontinuation Number of participants lost to follow-up for any reason Follow-up: 0.1-15 weeks	90 per 1000	116 per 1000 (58 to 236)	RR 1.29 (0.64 to 2.62)	607 (5 studies)	very low[1,7]

CAPS= Clinician-administered PTSD scale; CES-D= Clinician-administered PTSD symptom scale; CI=confidence interval; ISI=Insomnia severity index; MPSS=Modified PTSD symptom scale; PCL= PTSD checklist; PDS= Post-traumatic Diagnositic Scale; RR=risk ratio; SA-45=Symptom assessment-45; SMD=standardised mean difference; TAU=treatment as usual

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

[2] Considerable heterogeneity (I2>80%)

[3] Data is not reported/cannot be extracted for all outcomes

[4] OIS not met (N<400)

[5] OIS not met (events<300)

[6] Substantial heterogeneity (I2=50-80%)

[7] 95% CI crosses line of no effect and threshold for both clinically important benefit and clinically important harm

See appendix I for full GRADE tables.

Sensitivity and subgroup analysis

Sub-analysis of this comparison, by multiplicity of trauma revealed no statistically significant subgroup difference for self-rated PTSD symptomatology (K=5; N= 544; $Chi^2 = 0.98$, p = 0.32), or discontinuation (K=5; N=607; $Chi^2 = 2.07$, p = 0.15). It was not possible to test for subgroup differences for clinician-rated PTSD symptomatology as only one study included.

Sub-analysis by specific intervention revealed a statistically significant subgroup difference for self-rated PTTSD symptomatology ($Chi^2 = 6.88$, p = 0.03), with relatively larger effects observed for emotional freedom technique (EFT; SMD -3.19 [-4.45, -1.93]), relative to somatic experiencing (SE; SMD -1.39 [-1.96, -0.82]) or thought field therapy (TFT; SMD -1.13 [-2.85, 0.58]), although clinically important

effects were observed across subgroups. There was no significant subgroup difference for discontinuation (Chi² = 3.11, p = 0.21).

Sub-analysis by diagnostic status at baseline revealed no statistically significant subgroup differences for self-rated PTSD symptomatology (Chi² = 0.98, p = 0.32), or discontinuation (Chi² = 2.07, p = 0.15).

Sub-analysis by trauma type revealed a statistically significant subgroup difference for self-rated PTSD symptomatology (Chi² = 6.88, p = 0.03), with relatively larger effects observed for military combat-related trauma (SMD -3.19 [-4.45, -1.93]) relative to mixed trauma types (SMD -1.39 [-1.96, -0.82]) or witnessing war as a civilian (SMD -1.13 [-2.85, 0.58]), although clinically important effects were observed across subgroups. There was no significant subgroup difference for discontinuation (Chi² = 3.11, p = 0.21).

Resilience-oriented treatment: clinical evidence

Included studies

Two studies of resilience-oriented treatment for the treatment of PTSD in adults were identified for full-text review. Of these 2 studies, 1 RCT (N=39) was included in 1 comparison for resilience-oriented treatment.

For early treatment (intervention initiated 1-3 months post-trauma) of PTSD symptoms, there were no relevant RCTs included.

For delayed treatment (intervention initiated more than 3 months post-trauma) of PTSD symptoms, 1 RCT (N=39) compared resilience-oriented treatment with waitlist (Kent et al. 2011).

Sub-analyses were not possible for resilience-oriented treatment.

Excluded studies

One study was reviewed at full text and excluded from this review as efficacy or safety data cannot be extracted.

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

Summary of clinical studies included in the evidence review

Table 73 provides a brief summary of the included study and evidence from this study is summarised in the clinical GRADE evidence profile below (Table 74).

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

Table 73: Summary of included studies: Resilience-oriented treatment for delayed treatment (>3 months)

Comparison	Resilience-oriented treatment versus waitlist (+/- TAU)
Total no. of studies (N randomised)	1 (39)
Study ID	Kent 2011
Country	US

Comparison	Resilience-oriented treatment versus waitlist (+/- TAU)
Diagnostic status	Clinically important PTSD symptoms (scoring above a threshold on validated scale)
Mean months since onset of PTSD	144
Mean age (range)	54 (34-66)
Sex (% female)	33
Ethnicity (% BME)	24
Coexisting conditions	NR
Mean months since traumatic event	NR
Type of traumatic event	Mixed: All participants were veterans from the Vietnam war era up through the Gulf war. The traumas indexed by the CAPS were combat (31%), childhood sexual abuse (21%), childhood physical abuse (18%), violent unexpected death of another (14%), sexual assault (6%), physical assault (5%), and accident (5%)
Single or multiple incident index trauma	Multiple
Lifetime experience of trauma	NR
Intervention details	Resilience-oriented treatment (following unpublished manual) included: psychoeducation about resilience; increasing attention to bodily sensations; building positive experiences and emotional bonds; revisiting stressors and traumas and using learnt skills to manage these; planning for sustained change
Intervention format	Group
Intervention intensity	12x 90-minute weekly sessions (18 hours). Mean number of sessions attended 9.75 (SD=2.24, range 2-12)
Comparator	Waitlist
Intervention length (weeks)	12
Note. None	

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2 See appendix F for full evidence tables.

3 Quality assessment of clinical studies included in the evidence review

4 The clinical evidence profile for this review (resilience-oriented treatment for the
5 treatment of PTSD in adults) is presented in Table 74.

Table 74: Summary clinical evidence profile: Resilience-oriented treatment versus waitlist for delayed treatment (>3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist	Corresponding risk Resilience-oriented treatment			
PTSD symptomatology self-report PDS change score Follow-up: mean 12 weeks		The mean PTSD symptomatology self-report in the intervention groups was 1.6 standard deviations lower (2.33 to 0.87 lower)		39 (1 study)	low[1,2]
Anxiety symptoms STAI state change score Follow-up: mean 12 weeks		The mean anxiety symptoms in the intervention groups was 1.33 standard deviations lower (2.03 to 0.63 lower)		39 (1 study)	low[1,2]
Depression symptoms BDI-II change score Follow-up: mean 12 weeks		The mean depression symptoms in the intervention groups was 1.19 standard deviations lower (1.88 to 0.51 lower)		39 (1 study)	low[1,2]
Discontinuation Number of participants lost to follow-up for any reason Follow-up: mean 12 weeks	105 per 1000	49 per 1000 (5 to 507)	RR 0.47 (0.05 to 4.82)	39 (1 study)	very low[1,3]

BDI= Beck Depression Inventory; CI=confidence interval; PDS=; RR=risk ratio; SMD=standardised mean difference; STAI= State-Trait Anxiety Inventory

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

[2] OIS not met (N<400)

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

See appendix F for full GRADE tables.

Attention bias modification: clinical evidence

Included studies

Six studies of attention bias modification for the treatment of PTSD in adults were identified for full-text review. Of these 6 studies, 3 RCTs (N=200) were included in 1 comparison for attention bias modification.

For early treatment (intervention initiated 1-3 months post-trauma) of PTSD symptoms, there were no relevant RCTs included.

For delayed treatment (intervention initiated more than 3 months post-trauma) of PTSD symptoms, 3 RCTs (N=200) compared attention bias modification with attention-placebo (Bar-Haim & Fruchter 2011/ Badura-Brack et al. 2015 study 1 [protocol and paper]; Bar-Haim & Fruchter 2011/ Badura-Brack et al. 2015 study 2 [protocol and paper]; Schoorl et al. 2013).

Sub-analyses were not possible for attention bias modification.

Excluded studies

Three studies were reviewed at full text and excluded from this review due to small sample size (N<10 per arm), subgroup/secondary analysis of RCT already included, or trials of soldiers on active service (population outside scope).

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

Summary of clinical studies included in the evidence review

Table 75 provides brief summaries of the included studies and evidence from these are summarised in the clinical GRADE evidence profile below (Table 76).

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

Table 75: Summary of included studies: Attention bias modification for delayed treatment (>3 months)

Comparison	Attention bias modification versus attention-placebo
Total no. of studies (N randomised)	3 (200)
Study ID	Bar-Haim 2011/Badura-Brack 2015 study 1[1] Bar-Haim 2011/Badura-Brack 2015 study 2[2] Schoorl 2013[3]
Country	Israel[1] US[2] Netherlands[3]
Diagnostic status	PTSD diagnosis according to ICD/DSM criteria
Mean months since onset of PTSD	NR[1,2] NR (inclusion criteria included that PTSD symptoms had been present for at least 3 months)[3]
Mean age (range)	36.1 (22-65)[1] 32 (24-65)[2] 37.1 (range NR)[3]

Comparison	Attention bias modification versus attention-placebo
Sex (% female)	0[1,2] 75[3]
Ethnicity (% BME)	NR
Coexisting conditions	55% depression; 39% GAD; 15% Personality Disorder-Cluster B[1] 59% depression; 8% GAD; 16% panic disorder; 4% social phobia; 4% Personality Disorder- Cluster B[2] 2.7 additional diagnoses per patient. Depression: 70%, Dysthymia: 13%, Panic: 33%, Social anxiety: 36%, GAD: 38%, OCD: 16%, Somatization: 8%[3]
Mean months since traumatic event	169.2[1] NR[2,3]
Type of traumatic event	Military combat: Israel Defence Forces veterans[1] Military combat: US military veterans who served in recent conflicts in Iraq and Afghanistan[2] Unclear (no details on index trauma reported) [3]
Single or multiple incident index trauma	Multiple
Lifetime experience of trauma	NR[1,2] 93% 2+ traumas. Most of the patients had experienced multiple traumas (93.1%). More than half (56.9%) of the patients had been traumatized in childhood and 40.6% had experienced both childhood trauma and more recent trauma[3]
Intervention details	Attention Bias Modification (ABM), amended version of the dot-probe task[1,2] Attention bias modification[3]
Intervention format	Individual
Intervention intensity	4x weekly sessions[1] 8x bi-weekly sessions[2] 8x 15-min sessions (2 hours) [3]
Comparator	Attention control training, counterbalanced version of attention bias modification training (same number and trials) [1,2] Attention control; The control treatment was similar to the AB assessment but lasted 200 instead of 96 trials and the assessment did not contain neutral/neutral trials[3]
Intervention length (weeks)	4[1,2] 3[3]

Note. [1]Bar-Haim 2011/Badura-Brack 2015 study 1; [2]Bar-Haim 2011/Badura-Brack 2015 study 2; [3]Schoorl 2013

See appendix F for full evidence tables.

Quality assessment of clinical studies included in the evidence review

The clinical evidence profile for this review (attention bias modification for the treatment of PTSD in adults) is presented in Table 76.

Table 76: Summary clinical evidence profile: Attention bias modification versus attention-placebo for delayed treatment (>3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Attention-placebo	Corresponding risk Attention bias modification			
PTSD symptomatology self-report PCL/SRIP change score Follow-up: 3-4 weeks		The mean PTSD symptomatology self-report in the intervention groups was 2.48 standard deviations higher (0.32 lower to 5.28 higher)		170 (3 studies)	very low[1,2,3,4]
PTSD symptomatology clinician-rated - Endpoint CAPS change score Follow-up: 3-4 weeks		The mean PTSD symptomatology clinician-rated - endpoint in the intervention groups was 1.62 standard deviations higher (2.31 lower to 5.55 higher)		118 (2 studies)	very low[1,2,4,5]
Anxiety symptoms - Endpoint HADS-A change score Follow-up: mean 3 weeks		The mean anxiety symptoms - endpoint in the intervention groups was 0.04 standard deviations lower (0.5 lower to 0.43 higher)		72 (1 study)	low[3,4]
Anxiety symptoms - 3-week follow-up HADS-A change score Follow-up: mean 3 weeks		The mean anxiety symptoms - 3-week follow-up in the intervention groups was 0.22 standard deviations lower (0.68 lower to 0.25 higher)		72 (1 study)	low[3,4]
Depression symptoms - Endpoint PHQ-9/HADS-D change score Follow-up: 3-4 weeks		The mean depression symptoms - endpoint in the intervention groups was 1.82 standard deviations higher (0.4 lower to 4.05 higher)		170 (3 studies)	very low[1,2,3,4]
Depression symptoms - 3-		The mean depression		72 (1 study)	low[3,4]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Attention-placebo	Corresponding risk Attention bias modification			
week follow-up HADS-D change score Follow-up: mean 3 weeks		symptoms - 3-week follow-up in the intervention groups was 0.26 standard deviations lower (0.72 lower to 0.21 higher)			
Discontinuation Number of participants lost to follow-up for any reason Follow-up: 3-4 weeks	340 per 1000	296 per 1000 (194 to 445)	RR 0.87 (0.57 to 1.31)	200 (3 studies)	very low[1,5]

CAPS=; CI=confidence interval; HADS-A/D= Hospital Anxiety and Depression Scale-Anxiety/Depression; PCL= PTSD checklist; PHQ-9=patient health questionnaire-9; RR=risk ratio; SMD=standardised mean difference; SRIP= Self-Rating Inventory for PTSD

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

[2] Considerable heterogeneity (I2>80%)

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

[4] Data is not reported/cannot be extracted for all outcomes

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

See appendix F for full GRADE tables.

Couple interventions: clinical evidence

Included studies

Nine studies of couple interventions for the treatment of PTSD in adults were identified for full-text review. Of these 9 studies, 2 RCTs (N=97) were included. There were 2 comparisons for couple interventions.

For early treatment (intervention initiated 1-3 months post-trauma) of PTSD symptoms, no relevant RCTs were included.

For delayed treatment (intervention initiated more than 3 months post-trauma) of PTSD symptoms, 1 RCT (N=40) compared a couple intervention with waitlist (Monson & Vorstenbosch 2008/Monson et al. 2012 [protocol and paper]), and 1 RCT (N=57) compared a couple intervention with psychoeducational sessions (Sautter et al. 2015).

Sub-analyses were not possible for couple interventions.

Excluded studies

Seven studies were reviewed at full text and excluded from this review. The most common reason for exclusion was subgroup/secondary analysis of RCT already included and/or that is not relevant.

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

Summary of clinical studies included in the evidence review

Table 77 provides brief summaries of the included studies and evidence from these are summarised in the clinical GRADE evidence profiles below (Table 78 and Table 79).

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

Table 77: Summary of included studies: Couple interventions for delayed treatment (>3 months)

Comparison	Couple intervention versus waitlist	Couple intervention versus psychoeducation sessions
Total no. of studies (N randomised)	1 (40)	1 (57)
Study ID	Monson 2008/2012	Sautter 2015
Country	US and Canada	US
Diagnostic status	PTSD diagnosis according to ICD/DSM criteria	PTSD diagnosis according to ICD/DSM criteria
Mean months since onset of PTSD	NR	NR
Mean age (range)	37.1 (range NR)	33.1 (range NR)
Sex (% female)	75	2
Ethnicity (% BME)	28	34
Coexisting conditions	63% any comorbidity, 40% mood disorder, 30% anxiety disorder, 0% substance abuse, 10% 'other'	NR
Mean months since traumatic event	Median 78/156	NR
Type of traumatic event	Mixed: Adult sexual trauma (20%); child sexual trauma (28%); noncombat physical assault (15%); motor vehicle collision (8%); witnessing/learning about death/illness (13%); combat (5%); other (13%)	Military combat: Veterans of Operation Iraqi Freedom (OIF)/Operation Enduring Freedom (OEF)
Single or multiple incident index trauma	Unclear	Multiple
Lifetime experience of trauma	NR	NR

Comparison	Couple intervention versus waitlist	Couple intervention versus psychoeducation sessions
Intervention details	Cognitive-behavioural conjoint therapy (following manual by Monson et al. 2012)	Structured Approach Therapy (SAT; following manual by Sautter 2011), included a stress inoculation therapy framework
Intervention format	Couple	Couple
Intervention intensity	15x sessions (biweekly for phases 1-2 and weekly for phase 3)	12x 1-hour sessions (12 hours). Mean attended 10.31 sessions
Comparator	Waitlist	PTSD Family Education, conjoint psychoeducational sessions, using material adapted from the SAFE (Support and Family Education) and BFT (Behavioural Family Therapy) programs
Intervention length (weeks)	12	12
Note. None		

See appendix G for full evidence tables.

Quality assessment of clinical studies included in the evidence review

The clinical evidence profiles for this review (couple interventions for the treatment of PTSD in adults) are presented in Table 78 and Table 79.

Table 78: Summary clinical evidence profile: Couple intervention versus waitlist for delayed treatment (>3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist	Corresponding risk Couple intervention			
Response Number of people showing improvement of at least 10 points on CAPS Follow-up: mean 12 weeks	600 per 1000	648 per 1000 (402 to 1000)	RR 1.08 (0.67 to 1.75)	40 (1 study)	very low[1,2,3]
Remission Number of people who no longer met DSM-IV-TR diagnostic criteria and CAPS score<45 Follow-up: mean 12 weeks	200 per 1000	650 per 1000 (256 to 1000)	RR 3.25 (1.28 to 8.27)	40 (1 study)	very low[1,3,4]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist	Corresponding risk Couple intervention			
Response for relationship difficulties Number of participants showing improvement of at least 10 points on DAS Follow-up: mean 12 weeks	250 per 1000	400 per 1000 (157 to 1000)	RR 1.6 (0.63 to 4.05)	40 (1 study)	very low[1,2,3]
Remission for relationship difficulties Number of participants scoring ≥98 on DAS Follow-up: mean 12 weeks	650 per 1000	650 per 1000 (409 to 1000)	RR 1 (0.63 to 1.58)	40 (1 study)	very low[1,2,3]
Discontinuation Number of participants lost to follow-up for any reason Follow-up: mean 12 weeks	50 per 1000	200 per 1000 (25 to 1000)	RR 4 (0.49 to 32.72)	40 (1 study)	very low[1,2]

CAPS= Clinician-administered PTSD scale; CI=confidence interval; DAS=Dyadic Adjustment Scale; DSM-IV-TR=Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition (Text Revision); RR=risk ratio; SMD=standardised mean difference

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

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

[3] Data is not reported/cannot be extracted for all outcomes

[4] OIS not met (events<300)

Table 79: Summary clinical evidence profile: Couple intervention versus psychoeducation sessions for delayed treatment (>3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Psychoeducation sessions	Corresponding risk Couple intervention			
PTSD symptomatology self-rated - Endpoint PCL-M change score Follow-up: mean 12 weeks		The mean PTSD symptomatology self-rated - endpoint in the intervention groups was 1.44 standard deviations lower		43 (1 study)	very low[1,2]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Psychoeducation sessions	Corresponding risk Couple intervention			
		(2.12 to 0.76 lower)			
PTSD symptomatology self-rated - 3-month follow-up PCL-M change score Follow-up: mean 13 weeks		The mean PTSD symptomatology self-rated - 3-month follow-up in the intervention groups was 1.49 standard deviations lower (2.19 to 0.79 lower)		41 (1 study)	very low[1,2]
PTSD symptomatology clinician-rated - Endpoint CAPS change score Follow-up: mean 12 weeks		The mean PTSD symptomatology clinician-rated - endpoint in the intervention groups was 2.15 standard deviations lower (2.91 to 1.38 lower)		43 (1 study)	very low[1,2]
PTSD symptomatology clinician-rated - 3-month follow-up CAPS change score Follow-up: mean 13 weeks		The mean PTSD symptomatology clinician-rated - 3-month follow-up in the intervention groups was 2.39 standard deviations lower (3.21 to 1.57 lower)		41 (1 study)	very low[1,2]
Remission Number of people scoring <45 on CAPS at endpoint Follow-up: mean 12 weeks	71 per 1000	517 per 1000 (130 to 1000)	RR 7.24 (1.82 to 28.81)	57 (1 study)	very low[1,3]
Anxiety symptoms - Endpoint STAI State change score Follow-up: mean 12 weeks		The mean anxiety symptoms - endpoint in the intervention groups was 0.83 standard deviations lower (1.46 to 0.2 lower)		43 (1 study)	very low[1,2]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Psychoeducation sessions	Corresponding risk Couple intervention			
Anxiety symptoms - 3-month follow-up STAI State change score Follow-up: mean 13 weeks		The mean anxiety symptoms - 3-month follow-up in the intervention groups was 1.09 standard deviations lower (1.75 to 0.43 lower)		41 (1 study)	very low[1,2]
Depression symptoms - Endpoint CES-D change score Follow-up: mean 12 weeks		The mean depression symptoms - endpoint in the intervention groups was 0.56 standard deviations lower (1.17 lower to 0.05 higher)		43 (1 study)	very low[1,4]
Depression symptoms - 3-month follow-up CES-D change score Follow-up: mean 13 weeks		The mean depression symptoms - 3-month follow-up in the intervention groups was 0.85 standard deviations lower (1.49 to 0.2 lower)		41 (1 study)	very low[1,2]
Relationship difficulties - Endpoint DAS change score Follow-up: mean 12 weeks		The mean relationship difficulties - endpoint in the intervention groups was 0.89 standard deviations higher (0.26 to 1.52 higher)		43 (1 study)	very low[1,2]
Relationship difficulties - 3-month follow-up DAS change score Follow-up: mean 13 weeks		The mean relationship difficulties - 3-month follow-up in the intervention groups was 1 standard		41 (1 study)	very low[1,2]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Psychoeducation sessions	Corresponding risk Couple intervention			
		deviations higher (0.35 to 1.66 higher)			
Discontinuation Number of participants lost to follow-up for any reason Follow-up: mean 12 weeks	250 per 1000	242 per 1000 (97 to 600)	RR 0.97 (0.39 to 2.4)	57 (1 study)	very low[1,5]

CAPS= Clinician-administered PTSD scale; CES-D= Centre of Epidemiological Studies-Depression; DAS=Dyadic Adjustment Scale; CI=confidence interval; PCL-M= PTSD checklist-Military; RR=risk ratio; SMD=standardised mean difference; STAI= State-Trait Anxiety Inventory;
[1] Risk of bias is high or unclear across multiple domains
[2] OIS not met (N<400)
[3] OIS not met (events<300)
[4] 95% CI crosses both line of no effect and threshold for clinically important effect
[5] 95% CI crosses line of no effect and threshold for both clinically important benefit and clinically important harm

See appendix F for full GRADE tables.

Parent training/family interventions: clinical evidence

Included studies

Two studies of family interventions for the treatment of PTSD in adults were identified for full-text review. Of these 2 studies, both RCTs (N=221) were included. There were 2 comparisons for family interventions.

For early treatment (intervention initiated 1-3 months post-trauma) of PTSD symptoms, no relevant RCTs were included.

For delayed treatment (intervention initiated more than 3 months post-trauma) of PTSD symptoms, 1 RCT (N=146) compared family therapy with waitlist (Kazak et al. 2004), and 1 RCT (N=75) compared child-parent psychotherapy (using play) with case management and individual treatment (for parent-only) (Lieberman et al. 2005/2006/Ghosh Ippen et al. 2011 [one study reported across three papers]).

Sub-analyses were not possible for family interventions.

Excluded studies

No family intervention studies that were considered in full-text were excluded.

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

Summary of clinical studies included in the evidence review

Table 80 provides brief summaries of the included studies and evidence from these are summarised in the clinical GRADE evidence profiles below (Table 81 and Table 82).

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

Table 80: Summary of included studies: Family interventions for delayed treatment (>3 months)

Comparison	Family therapy versus waitlist	Child-parent psychotherapy (using play) versus case management and individual treatment (for parent-only)
Total no. of studies (N randomised)	1 (146)	1 (75)
Study ID	Kazak 2004	Lieberman 2005/2006/Ghosh Ippen 2011
Country	US	US
Diagnostic status	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	Clinically important PTSD symptoms (scoring above a threshold on validated scale)
Mean months since onset of PTSD	NR	NR
Mean age (range)	Median: 42.9 (26-59)	NR
Sex (% female)	100	100
Ethnicity (% BME)	12	76
Coexisting conditions	NR	NR
Mean months since traumatic event	63.6 (SD=35.0) since completion of child's cancer treatment	NR
Type of traumatic event	Family member or carer of person with life-threatening illness or injury: Mothers of childhood cancer survivors	Domestic violence (no further detail reported)
Single or multiple incident index trauma	Single	Multiple
Lifetime experience of trauma	NR	Most mothers reported multiple traumatic stressors in addition to marital violence (mean = 12.36, range 2–26). Maternal childhood trauma included witnessing marital violence (48%), physical abuse (49%), sexual molestation (42%), and the sudden/traumatic death of someone close (44%)

Comparison	Family therapy versus waitlist	Child-parent psychotherapy (using play) versus case management and individual treatment (for parent-only)
Intervention details	Surviving Cancer Competently Intervention Program (SCCIP; following manual by Kazak et al. 1999), integrates cognitive–behavioral treatment with family therapy	Child-parent psychotherapy using play
Intervention format	Group	Group
Intervention intensity	4-sessions in 1-day (5 hours of direct therapeutic contact and an additional 2 hours of informal contact during breaks). All families completed all four sessions	50x weekly 1-hour sessions (50 hours). Mean sessions attended 32.09 (SD=15.20)
Comparator	Waitlist	Case management plus individual psychotherapy
Intervention length (weeks)	0.1	50

Note. None

See appendix G for full evidence tables.

Quality assessment of clinical studies included in the evidence review

The clinical evidence profiles for this review (family interventions for the treatment of PTSD in adults) are presented in Table 81 and Table 82.

Table 81: Summary clinical evidence profile: Family therapy versus waitlist for delayed treatment (>3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist	Corresponding risk Family therapy			
PTSD symptomatology self-report at 4-month follow-up UCLA PTSD-RI change score Follow-up: mean 17 weeks		The mean PTSD symptomatology self-report at 4-month follow-up in the intervention groups was 0.15 standard deviations higher (0.18 lower to 0.48 higher)		142 (1 study)	very low[1,2,3]
Anxiety symptoms at 4-month follow-up STAI State change score		The mean anxiety symptoms at 4-month follow-up in the intervention groups was 0.12 standard		142 (1 study)	very low[1,2,3]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist	Corresponding risk Family therapy			
Follow-up: mean 17 weeks		deviations higher (0.21 lower to 0.45 higher)			

CI=confidence interval; RR=risk ratio; SMD=standardised mean difference; STAI= State-Trait Anxiety Inventory; UCLA PTSD-RI=UCLA PTSD-Reaction Index
[1] Risk of bias is high or unclear across multiple domains
[2] OIS not met (N<400)
[3] Data is not reported/cannot be extracted for all outcomes

Table 82: Summary clinical evidence profile: Child-parent psychotherapy (using play) versus case management and individual treatment (for parent-only) for delayed treatment (>3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Case management and individual treatment (for parent-only)	Corresponding risk Child-parent psychotherapy (using play)			
PTSD symptomatology clinician-rated CAPS change score Follow-up: mean 50 weeks		The mean PTSD symptomatology clinician-rated in the intervention groups was 0.67 standard deviations lower (1.17 to 0.17 lower)		65 (1 study)	very low[1,2,3]
Remission Number of people no longer meeting diagnostic criteria for PTSD Follow-up: mean 50 weeks	417 per 1000	750 per 1000 (363 to 1000)	RR 1.8 (0.87 to 3.72)	28 (1 study)	very low[1,3,4]
Discontinuation Number of participants lost to follow-up for any reason Follow-up: mean 50 weeks	121 per 1000	143 per 1000 (44 to 465)	RR 1.18 (0.36 to 3.84)	75 (1 study)	very low[1,5]

CAPS= *Clinician-administered PTSD scale*; CI=confidence interval; RR=risk ratio; SMD=standardised mean difference
[1] Risk of bias is high or unclear across multiple domains
[2] OIS not met (N<400)
[3] Data is not reported/cannot be extracted for all outcomes

[4] 95% CI crosses both line of no effect and threshold for clinically important effect
[5] 95% CI crosses line of no effect and threshold for both clinically important benefit and clinically important harm

See appendix F for full GRADE tables.

Self-help with support: clinical evidence

Included studies

Seventeen studies of self-help with support for the treatment of PTSD in adults were identified for full-text review. Of these 17 studies, 9 RCTs (N=885) were included. There were 2 comparisons for self-help with support.

There were no studies for early treatment (intervention initiated 1-3 months post-trauma) of PTSD symptoms.

For delayed treatment (intervention initiated more than 3 months post-trauma) of PTSD symptoms, 8 RCTs (N=798) compared self-help with support (alone or in addition toTAU) with waitlist or TAU (Ivarsson et al. 2014; Knaevelsrud & Maercker 2007; Knaevelsrud et al. 2015; Knaevelsrud et al. 2017; Lange et al. 2003; Lewis et al. 2017; van Dam et al. 2013; Van Emmerik et al. 2008), and 1 RCT (N=87) compared self-help with support with self-help without support (Littleton et al. 2016).

Comparisons with trauma-focused CBT are presented in the Trauma-focused CBT section above.

Sub-analyses were possible for the delayed treatment self-help with support (alone or in addition to TAU) versus waitlist or TAU, comparing effects by multiplicity of trauma, specific intervention, diagnostic status at baseline, trauma type, and baseline severity.

Excluded studies

Eight studies were reviewed at full text and excluded from this review. The most common reason for exclusion was that the comparison was outside protocol (within-class comparison).

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

Summary of clinical studies included in the evidence review

Table 83 provides brief summaries of the included studies and evidence from these are summarised in the clinical GRADE evidence profiles below (Table 84 and Table 85).

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

Table 83: Summary of included studies: Self-help with support for delayed treatment (>3 months)

Comparison	Self-help with support (+/- TAU) versus waitlist/TAU	Self-help with support versus self-help without support
Total no. of studies (N randomised)	8 (798)	1 (87)
Study ID	Ivarsson 2014[1] Knaevelsrud 2007[2] Knaevelsrud 2015[3] Knaevelsrud 2017[4] Lange 2003[5] Lewis 2017[6] van Dam 2013[7] van Emmerik 2008[8]	Littleton 2016
Country	Sweden[1] Germany and Switzerland[2] Iraq[3] Germany[4] Netherlands[5,7,8] UK[6]	US
Diagnostic status	PTSD diagnosis according to ICD/DSM criteria[1,6,8] Clinically important PTSD symptoms (scoring above a threshold on validated scale) [2,3,4,5,7]	PTSD diagnosis according to ICD/DSM criteria
Mean months since onset of PTSD	NR (inclusion criteria included that PTSD symptoms had been present for at least 3 months) [1] NR[2,3,4,5,6,7] NR (50% acute; 46% chronic) [8]	NR
Mean age (range)	46 (21-67) [1] 35 (18-68) [2] 28.1 (18-56) [3] 71.4 (63-85) [4] NR - 39 for completers in intervention group (19-71 for completers in intervention group) [5] 39.3 (20-65) [6] 42.3 (range NR) [7] 40.2 (range NR) [8]	22 (18-42)
Sex (% female)	82[1] 90[2] 72[3] 65[4] NR (80 for completers in intervention group) [5] 60[6] 32[7] 67[8]	100

Comparison	Self-help with support (+/- TAU) versus waitlist/TAU	Self-help with support versus self-help without support
Ethnicity (% BME)	NR	54
Coexisting conditions	NR[1,2,3,4,5,6,8] 88% Substance Dependence; 3% Substance Abuse. Primary SUD diagnosis: Alcohol, not in remission (44%); Drugs, not in remission (44%); Cannabis (12%); Cocaine (29%); Other (3%). 32% Depressive disorder; 9% Panic disorder; 6% Panic disorder with agoraphobia; 12% Social Phobia; 6% Specific phobia; 3% General anxiety disorder[7]	NR
Mean months since traumatic event	NR[1,7] 126[2] NR (predominantly >3 years ago) [3] 783.4[4] NR (108 for completers in intervention group) [5] 37.3[6] 8[8]	48
Type of traumatic event	Mixed: Sexual, physical, and/or psychological abuse by partner (23%); life-threatening disease (13%); severe offense by significant other (perceived as threatening to integrity) (10%); life-threatening accident (8%); non-sexual assault by stranger (8%); murder of close relative (6%); non-sexual assault by family member (5%); death of close relative (5%); severe maltreatment in health care (5%); multiple stressors (5%); life-threatening disease of close relative (3%); military combat (3%); torture (2%); rape by stranger (2%); rape by family member (2%); tsunami disaster (2%)[1] Mixed: Sexual abuse/Rape (32%); Death of close person (42%); Accident (6%); Physical disease (9%)[2] Witnessing war as a civilian: Sexual violence (war-related and sexual abuse; 40%); experienced the killing of a family member or close person (15%); being exposed to violence (eg, kidnapping, witnessing bomb attacks) and war or torture (19%); Others (eg, kidnapping, witnessing bomb attacks) (33%)[3]	Exposure to sexual abuse or assault: Women who had experienced a completed rape since the age of 14

Comparison	Self-help with support (+/- TAU) versus waitlist/TAU	Self-help with support versus self-help without support
	Witnessing war as a civilian: World War II[4] Mixed: Traumatic loss, sexual abuse, physical abuse/robbery, abrupt change in personal circumstance, MVCs, divorce[5] Mixed: Transportation accidents (21%); witnessing a sudden, violent, or accidental death (21%); traumatic childbirth or stillbirth (19%); sexual assault or rape (12%); physical attack (10%); life threatening illness or injury (7%); serious accident (2%); learning of the violent death of a loved one (2%); seeing a mutilated body (2%); and being held hostage/detained (2%)[6] Unclear (no further details reported) [7] Exposure to non-sexual violence: Nonsexual violence (50%); Traffic accident (23%); Sexual violence (11%); Other (16%)[8]	
Single or multiple incident index trauma	Single[1,2,5,6,8] Multiple[3,4] Unclear[7]	Single
Lifetime experience of trauma	41% had experienced more than one traumatic event[1] NR[2,4,5,6,7,8] Mean 3.4 traumatic events[3]	>50% had experienced some other form of interpersonal violence, with childhood/adolescent physical and/or sexual abuse being most commonly reported, followed by physical abuse by a romantic partner
Intervention details	Guided internet-based cognitive behavior therapy (ICBT) [1] Internet-based cognitive behavioural therapy (Interapy) [2] A Dutch Internet-based CBT manual (Interapy [Lange et al. 2003]) was translated into Arabic and culturally adapted[3] Internet-based CBT called Integrative Testimonial Therapy (Integrative TT) [4] Interapy intervention, 10x 45min writing sessions with therapist feedback on trauma-focused essays and how to proceed[5] Internet-based guided self-help[6] Structured Writing Therapy for PTSD (SWT), based on protocol of Van Emmerik 2004 + TAU[7]	Computerised trauma-focused CBT with support, From Survivor to Thriver program

Comparison	Self-help with support (+/- TAU) versus waitlist/TAU	Self-help with support versus self-help without support
	Structured writing therapy (SWT) [8]	
Intervention format	Indvidual	Individual
Intervention intensity	8 modules. Mean time spent for therapist-participant communication was 28 min/week (SD = 19.8; range 11-52 min). Participants completed an average of 5.1 modules (SD = 3.2, range = 0 to 8). 39% completed all modules, and 19% did not complete a single module (in terms of sending in homework assignments) [1] 10x biweekly 45-min sessions[2,3] 11x biweekly 45-min sessions[4] 10x biweeky 45-min sessions for participants (7x feedback sessions) [5] 8 modules (up to 3 hours of therapist assistance) [6] 10x weekly 45-60 min sessions (7.5-10 hours; + TAU) [7] 5-10x 90-min sessions (7.5 hours for those with ASD or acute PTSD; 15 hours for those with chronic PTSD) [8]	9x online modules. 29% completed at least part of phase one (modules 1–3) of the program, 34% completed at least part of phase 2 (modules 4–5), 29%) completed at least part of phase 3
Comparator	Waitlist[1,2,3,4,5,6,8] Treatment as usual (TAU) consisted of a regular intensive treatment program for SUD based on CBT principles[7]	Self-help without support: Psychoeducational website contained the written informational content of the first three modules of the interactive program including the symptoms of PTSD, information about relaxation and grounding, and information about healthy coping strategies
Intervention length (weeks)	8[1] 5[2,3,5] 6[4] 10[6,7] 5-10[8]	14

Note. [1]Ivarsson 2014; [2]Knaevelsrud 2007; [3]Knaevelsrud 2015; [4]Knaevelsrud 2017; [5]Lange 2003; [6]Lewis 2017; [7]van Dam 2013; [8]van Emmerik 2008

See appendix F for full evidence tables.

Quality assessment of clinical studies included in the evidence review

The clinical evidence profiles for this review (self-help with support for the treatment of PTSD in adults) are presented in Table 84 and Table 85.

Table 84: Summary clinical evidence profile: Self-help with support (+/- TAU) versus waitlist or TAU for delayed treatment (>3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist or TAU	Corresponding risk Self-help with support (+/- TAU)			
PTSD symptomatology self-rated at endpoint IES endpoint/IES-R/PDS/PCL-5 change score Follow-up: 5-10 weeks		The mean PTSD symptomatology self-rated at endpoint in the intervention groups was 1.38 standard deviations lower (1.8 to 0.97 lower)		484 (6 studies)	low[1,2]
PTSD symptomatology self-rated at 1-3 month follow-up IES/PCL-5/PDS change score Follow-up: 4-13 weeks		The mean PTSD symptomatology self-rated at 1-3 month follow-up in the intervention groups was 0.85 standard deviations lower (1.18 to 0.52 lower)		161 (3 studies)	very low[1,3,4,5]
PTSD symptomatology self-rated at 1-year follow-up IES change score Follow-up: mean 52 weeks		The mean PTSD symptomatology self-rated at 1-year follow-up in the intervention groups was 0.83 standard deviations lower (1.27 to 0.38 lower)		85 (1 study)	very low[1,4,5]
PTSD symptomatology clinician-rated - Endpoint CAPS change score Follow-up: mean 10 weeks		The mean PTSD symptomatology clinician-rated - endpoint in the intervention groups was 2.44 standard deviations lower (3.26 to 1.62 lower)		42 (1 study)	low[1,4]
PTSD symptomatology clinician-rated - 1-month follow-up CAPS change score Follow-up: mean 4 weeks		The mean PTSD symptomatology clinician-rated - 1-month follow-up in the intervention groups was 2.02 standard deviations lower		42 (1 study)	low[1,4]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist or TAU	Corresponding risk Self-help with support (+/- TAU)			
		(2.78 to 1.27 lower)			
Response Number of people showing clinically significant improvement, based on reliable change indices (RCI) on IES-R/PDS Follow-up: 5-8 weeks	90 per 1000	513 per 1000 (126 to 1000)	RR 5.69 (1.4 to 23.05)	221 (2 studies)	very low[1,2,6]
Remission Number of people no longer above threshold on CAPS/<20 on PDS Follow-up: 5-8 weeks	179 per 1000	540 per 1000 (117 to 1000)	RR 3.01 (0.65 to 14)	211 (2 studies)	very low[1,3,7]
Functional impairment - Endpoint SDS change score Follow-up: mean 10 weeks		The mean functional impairment - endpoint in the intervention groups was 1.69 standard deviations lower (2.41 to 0.98 lower)		42 (1 study)	low[1,4]
Functional impairment - 1-month follow-up SDS change score Follow-up: mean 4 weeks		The mean functional impairment - 1-month follow-up in the intervention groups was 0.96 standard deviations lower (1.6 to 0.32 lower)		42 (1 study)	low[1,4]
Quality of life QOLI/EUROHIS-QOL change score Follow-up: 5-8 weeks Better indicated by higher values		The mean quality of life in the intervention groups was 0.95 standard deviations higher (0.64 to 1.26 higher)		307 (3 studies)	very low[1,4]
Sleeping difficulties SCL-90 Sleeping problems change		The mean sleeping difficulties in the		101 (1 study)	very low[1,4,5]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist or TAU	Corresponding risk Self-help with support (+/- TAU)			
score Follow-up: mean 5 weeks		intervention groups was 0.83 standard deviations lower (1.27 to 0.4 lower)			
Anxiety symptoms at endpoint BAI/BSI Anxiety/HSCL-25 Anxiety/SCL-90 Anxiety change score Follow-up: 5-10 weeks		The mean anxiety symptoms at endpoint in the intervention groups was 0.94 standard deviations lower (1.24 to 0.63 lower)		545 (6 studies)	very low[1,2,5]
Anxiety symptoms at 1-2 month follow-up BAI/STAI State change score Follow-up: 4-8 weeks		The mean anxiety symptoms at 1-2 month follow-up in the intervention groups was 0.64 standard deviations lower (1 to 0.28 lower)		127 (2 studies)	very low[1,2,4,5]
Anxiety symptoms at 1-year follow-up STAI State change score Follow-up: mean 52 weeks		The mean anxiety symptoms at 1-year follow-up in the intervention groups was 0.58 standard deviations lower (1.01 to 0.14 lower)		85 (1 study)	very low[1,4,5]
Depression symptoms at endpoint BDI/BDI-II/BSI Depression/HSCL-25 Depression/SCL-90 Depression change score) Follow-up: 5-10 weeks		The mean depression symptoms at endpoint in the intervention groups was 1.1 standard deviations lower (1.51 to 0.7 lower)		545 (6 studies)	very low[1,2,5]
Depression symptoms at 1-2 month follow-up BDI change score Follow-up: 4-8 weeks		The mean depression symptoms at 1-2 month follow-up in the intervention groups was 0.53 standard deviations lower		127 (2 studies)	very low[1,2,4,5]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist or TAU	Corresponding risk Self-help with support (+/- TAU)			
		(0.89 to 0.17 lower)			
Depression symptoms at 1-year follow-up BDI change score Follow-up: mean 52 weeks		The mean depression symptoms at 1-year follow-up in the intervention groups was 0.46 standard deviations lower (0.89 to 0.03 lower)		85 (1 study)	very low[1,4,5]
Alcohol use disorder symptoms - Endpoint AUDIT change score Follow-up: mean 10 weeks		The mean alcohol use disorder symptoms - endpoint in the intervention groups was 0.17 standard deviations lower (0.77 lower to 0.44 higher)		42 (1 study)	low[1,8]
Alcohol use disorder symptoms - 1-month follow-up AUDIT change score Follow-up: mean 4 weeks		The mean alcohol use disorder symptoms - 1-month follow-up in the intervention groups was 0.02 standard deviations higher (0.59 lower to 0.62 higher)		42 (1 study)	very low[1,7]
Substance use disorder symptoms - Endpoint TLFB: Number of days abstinent from alcohol in the last 90 days; change score Follow-up: mean 10 weeks		The mean substance use disorder symptoms - endpoint in the intervention groups was 0.53 standard deviations higher (0.16 lower to 1.22 higher)		34 (1 study)	low[1,8]
Substance use disorder symptoms - 3-month follow-up TLFB: Number of days abstinent from alcohol in the last 90 days; change score		The mean substance use disorder symptoms - 3-month follow-up in the intervention groups was		34 (1 study)	very low[1,7]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist or TAU	Corresponding risk Self-help with support (+/- TAU)			
Follow-up: mean 13 weeks		0.11 standard deviations higher (0.57 lower to 0.79 higher)			
Discontinuation Number of participants lost to follow-up for any reason Follow-up: 5-10 weeks	262 per 1000	268 per 1000 (205 to 349)	RR 1.02 (0.78 to 1.33)	673 (7 studies)	very low[1,7]

AUDIT=Alcohol use disorders identification test; BAI= Beck Anxiety Inventory ; BDI= Beck Depression Inventory; BSI=Brief Symptom Inventory; CAPS= Clinician-administered PTSD scale; CI=confidence interval; EUROHIS-QOL=an instrument to meaure quality of life derived from WHOQOL project; HSCL-25= Hopkins Symptom Checklist-25; IES-R= Impact of Event Scale-Revised; PCL= PTSD checklist; PDS= Post-traumatic Diagnostic Scale; RR=risk ratio; SCL-90=Symptom Checklist-90; SDS= Sheehan Disability Scale; SMD=standardised mean difference; STAI= State-Trait Anxiety Inventory; TAU=treatment as usual; QOLI=Quality of life inventory; TLFB=alcohol timeline feedback;

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

[2] Substantial heterogeneity (I2=50-80%)

[3] Considerable heterogeneity (I2>80%)

[4] OIS not met (N<400)

[5] Data is not reported/cannot be extracted for all outcomes

[6] OIS not met (events<300)

[7] 95% CI crosses line of no effect and threshold for both clinically important benefit and clinically important harm

[8] 95% CI crosses both line of no effect and threshold for clinically important effect

Table 85: Summary clinical evidence profile: Self-help with support versus self-help without support for delayed treatment (>3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Self-help without support	Corresponding risk Self-help with support			
PTSD symptomatology clinician-rated - Endpoint PSS-I change score Follow-up: mean 14 weeks		The mean PTSD symptomatology clinician-rated - endpoint in the intervention groups was 0.02 standard deviations higher (0.53 lower to 0.57 higher)		51 (1 study)	very low[1,2]
PTSD symptomatology clinician-rated - 3-month follow-up		The mean PTSD symptomatology clinician-rated - 3-month follow-up in		41 (1 study)	very low[1,2]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Self-help without support	Corresponding risk Self-help with support			
PSS-I change score Follow-up: mean 13 weeks		the intervention groups was 0.08 standard deviations higher (0.53 lower to 0.7 higher)			
Response - Endpoint Number of people showing clinically significant improvement, based on reliable change indices (RCI) on PSS-I Follow-up: mean 14 weeks	512 per 1000	369 per 1000 (230 to 599)	RR 0.72 (0.45 to 1.17)	87 (1 study)	very low[1,3]
Response - 3-month follow-up Number of people showing clinically significant improvement, based on reliable change indices (RCI) on PSS-I Follow-up: mean 13 weeks	366 per 1000	348 per 1000 (198 to 611)	RR 0.95 (0.54 to 1.67)	87 (1 study)	very low[1,2]
Anxiety symptoms - Endpoint FDAS change score Follow-up: mean 14 weeks		The mean anxiety symptoms - endpoint in the intervention groups was 0.82 standard deviations higher (0.2 to 1.45 higher)		43 (1 study)	very low[1,4]
Anxiety symptoms - 3-month follow-up FDAS change score Follow-up: mean 13 weeks		The mean anxiety symptoms - 3-month follow-up in the intervention groups was 0.27 standard deviations higher (0.39 lower to 0.92 higher)		36 (1 study)	very low1,3
Depression symptoms - Endpoint CES-D change		The mean depression symptoms - endpoint in the		42 (1 study)	very low[1,3]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Self-help without support	Corresponding risk Self-help with support			
score Follow-up: mean 14 weeks		intervention groups was 0.32 standard deviations higher (0.29 lower to 0.94 higher)			
Depression symptoms - 3-month follow-up CES-D change score Follow-up: mean 13 weeks		The mean depression symptoms - 3-month follow-up in the intervention groups was 0.61 standard deviations higher (0.05 lower to 1.27 higher)		37 (1 study)	very low[1,3]
Discontinuation Number of participants lost to follow-up for any reason Follow-up: mean 14 weeks	293 per 1000	436 per 1000 (243 to 776)	RR 1.49 (0.83 to 2.65)	87 (1 study)	low[1,3]

CES-D= Centre of Epidemiological Studies-Depression; CI=confidence interval; FDAS=Four Dimensional Anxiety Scale; PSS-I= PTSD symptom scale-interview; RR=risk ratio; SMD=standardised mean difference

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

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

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

[4] OIS not met (N<400)

See appendix F for full GRADE tables.

Sensitivity and subgroup analysis

Sub-analysis of the comparison, self-help with support (alone or in addition to TAU) versus waitlist or TAU, by multiplicity of trauma revealed no statistically significant subgroup difference for self-rated PTSD symptomatology (K=6; N= 484; $Chi^2 = 2.67$, $p = 0.26$), or discontinuation (K=7; N=673; $Chi^2 = 0.06$, $p = 0.97$). It was not possible to test for subgroup differences for clinician-rated PTSD symptomatology as only 1 study was included.

Sub-analysis by specific intervention revealed no statistically significant subgroup difference for self-rated PTSD symptomatology ($Chi^2 = 0.48$, $p = 0.49$), or discontinuation ($Chi^2 = 0.01$, $p = 0.91$).

Sub-analysis by diagnostic status at baseline revealed no statistically significant subgroup difference for self-rated PTSD symptomatology ($Chi^2 = 2.56$, $p = 0.11$), or discontinuation ($Chi^2 = 0.00$, $p = 0.95$).

Sub-analysis by trauma type revealed no statistically significant subgroup difference for self-rated PTSD symptomatology (Chi² = 2.67, p = 0.26), or discontinuation (Chi² = 0.06, p = 0.97).

Sub-analysis by baseline severity revealed no statistically significant subgroup difference for self-rated PTSD symptomatology (Chi² = 0.17, p = 0.92).

Self-help (without support): clinical evidence

Included studies

Fourty-two studies of self-help (without support) for the treatment of PTSD in adults were identified for full-text review. Of these 39 studies, 13 RCTs (N=904) were included. There were 2 comparisons for self-help (without support).

There were no studies for early treatment (intervention initiated 1-3 months post-trauma) of PTSD symptoms.

For delayed treatment (intervention initiated more than 3 months post-trauma) of PTSD symptoms, 7 RCTs (N=462) compared self-help (without support) with waitlist (Ehlers et al. 2003; Hirai & Clum 2005; Kuhn et al. 2017; Miner et al. 2016; Sloan et al. 2012; Spence et al. 2011; Xu et al. 2016), and 6 RCTs (N=442) compared self-help (without support) with attention-placebo (Henderson et al. 2007; Meshberg-Cohen et al. 2014; Sloan & Marx 2004; Sloan et al. 2007; Sloan et al. 2011; Truijens & van Emmerik 2014).

Comparisons with trauma-focused CBT are presented in the Trauma-focused CBT section above.

Sub-analyses were possible for the delayed treatment self-help (without support) versus waitlist, or self-help (without support) versus attention-placebo, comparing effects by multiplicity of trauma, specific intervention, diagnostic status at baseline, trauma type, and baseline severity.

Excluded studies

Twenty-nine studies were reviewed at full text and excluded from this review. The most common reasons for exclusion were systematic review with no new useable data and any meta-analysis results not appropriate to extract, the comparison was outside the protocol (within-class comparison), or efficacy or safety data could not be extracted.

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

Summary of clinical studies included in the evidence review

Table 86 provides brief summaries of the included studies and evidence from these are summarised in the clinical GRADE evidence profiles below (Table 87 and Table 88).

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

Table 86: Summary of included studies: Self-help (without support) for delayed treatment (>3 months)

Comparison	Self-help (without support) versus waitlist	Self-help (without support) versus attention-placebo
Total no. of studies (N randomised)	7 (462)	6 (442)
Study ID	Ehlers 2003[1] Hirai 2005[2] Kuhn 2017[3] Miner 2016[4] Sloan 2012[5] Spence 2011[6] Xu 2016[7]	Henderson 2007[8] Meshberg-Cohen 2014[9] Sloan 2004[10] Sloan 2007[11] Sloan 2011[12] Truijens 2014[13]
Country	UK[1] US[2,3,4,5] Australia[6] China[7]	US[8,9,10,11,12] Netherlands[13]
Diagnostic status	PTSD diagnosis according to ICD/DSM criteria[1,5,6] Clinically important PTSD symptoms (scoring above a threshold on validated scale) [2,3,4,7]	Clinically important PTSD symptoms (scoring above a threshold on validated scale) [8,9,10,11,13] PTSD diagnosis according to ICD/DSM criteria[12]
Mean months since onset of PTSD	NR	NR
Mean age (range)	Mean NR (18-65) [1] 29.4 (range NR) [2] 39.3 (range NR) [3] 45.7 (range NR) [4] 40.7 (range NR) [5] 42.6 (21-68) [6] NR[7]	18.4 (18-23) [8] 36.3 (range NR) [9] 18.9 (range NR) [10,12] 18.7 (range NR) [11] 23.7 (range NR) [13]
Sex (% female)	NR[1] 78[2] 69[3] 82[4] 65[5] 81[6] 75[7]	78[8] 100[9,10] 80[11] NR[12] 82[13]
Ethnicity (% BME)	NR[1,6,7] 22[2] 33[3] 43[4] 63[5]	NR[8,13] 75[9] 51[10] 41[11] 43[12]
Coexisting conditions	NR[1,2,3,4,7] 25% major depressive episode, 10% alcohol abuse[5] 57% reported taking medication for anxiety or depression at baseline[6]	NR[8,10,11,12,13] All participants in a residential treatment facility for substance use disorder. DSM-IV substance dependence diagnosis (current): Alcohol (29%);

Comparison	Self-help (without support) versus waitlist	Self-help (without support) versus attention-placebo
		Amphetamine/Stimulant (0.7%); Cannabis (10%); Cocaine (82%); Hallucinogen (0.7%); Opioid (45%); Sedative (5%); More than one drug (57%)[9]
Mean months since traumatic event	6[1] 48[2] 118[3] NR[4] 42.5[5] NR (inclusion criteria >1 month) [6,7]	NR[8,9,10] NR (inclusion criteria >3 months) [11] NR (inclusion criteria >3 months; over 75% of the participants indicated that their index trauma occurred at least 6 months prior; 30% indicated the event happened more than 5 years prior) [12] NR (events were experienced within a year prior to the study by 21.3%, between 1 and 3 years prior to the study by 34.4%, and over 3 years prior to the study by 44.3%)[13]
Type of traumatic event	Motor Vehicle Collision: Involvement in a MVC that required A & E attendance[1] Mixed: MVCs (33%), interpersonal violence (22%), eye-witnessed traumatic events (11%), life-threatening disease (11%), illness or traumatic loss (22%)[2] Mixed: Physical assault (47%); sexual assault (14%); serious accident (21%); life-threatening illness or injury (6%); disaster exposure (3%); combat exposure (3%); other event (7%)[3] Unclear (no details reported) [4] Motor Vehicle Collision[5] Mixed: Trauma types reported to have been experienced personally or witnessed by more than 50% of the treatment group: physical assault (74%), other unwanted sexual experience (70%), sexual assault (57%), transportation accidents (52%), and other stressful experiences (52%)[6] Mixed: Witnessing others sudden death (37%); Physical abuse (30%), sexual abuse (17%), serious accident in workplace or at home (17%), fire or natural disasters (8%), traffic accidents (7%), hurting others seriously (4%)[7]	Mixed: Assault (8%); motor vehicle accident (11%); death or suicide of a family member or close friend (19%), physical abuse (11%); separation of parents or other family stressor (11%); serious health concern of family or self (11%); sexual abuse (11%); verbal abuse (6%); witness to a traumatic event (11%)[8] Unclear (no details reported) [9] Mixed: The types of traumatic events endorsed by the participants included rape, witness to murder, physical assault by stranger, life-threatening car accident, and childhood sexual assault by family member[10] Mixed: The most frequently reported traumatic events were sexual assault (65%), physical assault by stranger (48%), motor vehicle accident (43%), and witness to murder (15%)[11] Mixed: Index traumatic events included sexual assault (40%), physical assault by stranger (31%), motor vehicle accident (14%), witness to a murder (7%) and warzone experience (7%)[12] Mixed: Traumatic events reported by the participants included having experienced or witnessed an accident (16.4%); physical, mental, or sexual abuse (34.5%); severe illness or death of a loved one

Comparison	Self-help (without support) versus waitlist	Self-help (without support) versus attention-placebo
		(34.5%); and natural disaster or war (14.6%)[13]
Single or multiple incident index trauma	Single[1,2,3,5] Unclear[4] Multiple[6,7]	Single[8,12,13] Unclear[9,10,11]
Lifetime experience of trauma	NR[1,2,4,7] Mean number of traumatic event types 8.5 (SD=3.5). Lifetime trauma exposure: Physical assault (87%); Sexual assault (73%); Serious accident (79%); Life-threatening illness or injury (60%); Disaster exposure (74%); Combat exposure (7%); Other event (93%)[3] Median=10.0 events that met DSM-IV PTSD Criterion A for a traumatic stressor. Approximately 85% of the sample reported a history of physical assault and approximately 60% reported a history of sexual assault[5] Mean number of traumatic events: 6.3. Most participants had experienced multiple types of trauma[6]	NR[8,12,13] Mean number of different types of trauma events: 3.7 (SD=2.3) [9] 63% reported experiencing more than one traumatic event[10] 68% reported experiencing more than one traumatic event[11]
Intervention details	Cognitive bibliotherapy, 64-page booklet (approximately 18000 words) entitled 'Understanding Your Reactions to Trauma' (Herbert, 1996) [1] Computerised interactive trauma-focused CBT, 'self-help program for traumatic event-related consequences (SHTC)'[2] Computerised non-trauma-focused CBT, PTSD Coach[3,4] Computerised written exposure therapy[5] Internet-based cognitive behavioral therapy (CBT) for PTSD [trauma-focused] [6] Chinese My Trauma Recovery (CMTR) website, Chinese version of My Trauma Recovery (MTR), computerised trauma-focused CBT[7]	Mandala-creation group (methods and techniques based on Pennebaker's expressive writing model) [8] Expressive writing (writing instructions were based on protocols used by Pennebaker et al. 1997 and Sloan & Marx 2004) [9] Written emotional disclosure condition (writing instructions were based on Pennebaker 1997 protocol) [10] Expressive writing, two arms combined: emotional expression arm where participants were asked to write about the most traumatic experience of their lives with as much emotion and feeling as possible; insight and cognitive assimilation arm where participants asked to write about the most traumatic experience of their lives with a focus on what the event has meant to them, how the event has changed their lives and to challenge their dissonant thoughts about the event[11] Expressive writing (following protocol by Pennebaker 1997) [12]

Comparison	Self-help (without support) versus waitlist	Self-help (without support) versus attention-placebo
		Expressive writing, two arms combined: Expressive writing with visual feedback (W+F) and expressive writing without visual feedback (W–F) [13]
Intervention format	Individual	Individual
Intervention intensity	NR[1] 8x modules[2] Planned intensity NR. Average of 1.29 days of use per week (SD=0.77) [3] No instructions for planned intensity, participants free to use as little or often as they wished. Mean weekly usage of 2.65 times (SD=1.03) [4] 5x weekly sessions (4 hours; contact time with therapist: 1-hour) [5] 7x online sessions. 4% completed only 5 sessions; 17% completed only 6 sessions; 78% completed all 7 sessions. The mean therapist time per Treatment group participant was 103.91 min (SD=96.53 min), including monitoring of the discussion forum, sending and reading instant messages, and telephoning participants[6] 6x modules[7]	3x 20-min sessions (1 hour) [8] 4x 20-min sessions (1.3 hours). 94% completed all 4 sessions[9] 3x 20-min sessions (1 hour). All (analysed) participants completed all 3 writing sessions[10,11,12] 1x 45-min session (0.75 hours) [13]
Comparator	Waitlist	Control drawing condition (drawing a different object each day: cup, bottle, or pens) [8] Control writing (writing about a neutral topic) [9] Control writing condition (writing about how they spent their time without describing any emotion or opinions) [10,11,12] Control writing condition (describe their first day in their current and previous educational institutions) [13]
Intervention length (weeks)	12[1] 8[2,6] 13[3] 4[4,7] 6[5]	0.4[8,10,11,12] 0.6[9] 0.1[13]

Note. [1]Ehlers 2003; [2]Hirai 2005; [3]Kuhn 2017; [4]Miner 2016; [5]Sloan 2012; [6]Spence 2011; [7]Xu 2016; [8]Henderson 2007; [9]Meshberg-Cohen 2014; [10]Sloan 2004; [11]Sloan 2007; [12]Sloan 2011; [13]Truijens 2014

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See appendix F for full evidence tables.

Quality assessment of clinical studies included in the evidence review

The clinical evidence profiles for this review (self-help [without support] for the treatment of PTSD in adults) are presented in Table 87 and Table 88.

Table 87: Summary clinical evidence profile: Self-help (without support) versus waitlist for delayed treatment (>3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist	Corresponding risk Self-help (without support)			
PTSD symptomatology self-rated IES-R/PCL-C/PDS change scores Follow-up: 4-13 weeks		The mean PTSD symptomatology self-rated in the intervention groups was 0.65 standard deviations lower (0.9 to 0.4 lower)		288 (5 studies)	low[1,2]
Remission - Endpoint Number of people no longer meeting diagnostic criteria for PTSD or no longer above clinical threshold on scale Follow-up: 6-12 weeks	208 per 1000	542 per 1000 (295 to 998)	RR 2.61 (1.42 to 4.81)	103 (2 studies)	very low[1,3,4,5]
Remission - 3-6 month follow-up Number of people no longer meeting diagnostic criteria for PTSD or no longer above clinical threshold on scale Follow-up: 13-26 weeks	377 per 1000	577 per 1000 (381 to 883)	RR 1.53 (1.01 to 2.34)	103 (2 studies)	very low[1,3,4,5]
Response at endpoint Number of people showing improvement of at least 10 points on	200 per 1000	478 per 1000 (222 to 1000)	RR 2.39 (1.11 to 5.14)	272 (4 studies)	very low[1,4,6]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist	Corresponding risk Self-help (without support)			
PCL-C/clinically significant improvement, based on reliable change indices (RCI) on CAPS/≥50% improvement on PDS Follow-up: 4-13 weeks					
Response at 3-6 month follow-up Number of people showing clinically significant improvement, based on reliable change indices (RCI) on CAPS/≥50% improvement on PDS Follow-up: 13-26 weeks	415 per 1000	581 per 1000 (398 to 851)	RR 1.4 (0.96 to 2.05)	103 (2 studies)	very low[1,3,5,7]
Functional impairment at endpoint SDS/B-IPF change score Follow-up: 8-13 weeks		The mean functional impairment at endpoint in the intervention groups was 0.58 standard deviations lower (0.85 to 0.3 lower)		214 (3 studies)	low[1,2]
Functional impairment at 6-month follow-up SDS change score Follow-up: mean 26 weeks		The mean functional impairment at 6-month follow-up in the intervention groups was 0 standard deviations higher (0.54 lower to 0.54 higher)		52 (1 study)	very low[1,5,8]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist	Corresponding risk Self-help (without support)			
Anxiety symptoms at endpoint BAI/STAI State/GAD-7 change score Follow-up: 8-12 weeks		The mean anxiety symptoms at endpoint in the intervention groups was 0.67 standard deviations lower (1.43 lower to 0.09 higher)		121 (3 studies)	very low[1,5,6,7]
Anxiety symptoms at 6-month follow-up BAI change score Follow-up: mean 26 weeks		The mean anxiety symptoms at 6-month follow-up in the intervention groups was 0.4 standard deviations higher (0.15 lower to 0.95 higher)		52 (1 study)	very low[1,5,7]
Depression symptoms at endpoint BDI-II/PHQ-8/PHQ-9 change score Follow-up: 8-13 weeks		The mean depression symptoms at endpoint in the intervention groups was 0.68 standard deviations lower (1.08 to 0.27 lower)		241 (4 studies)	very low[1,2,5,6]
Depression symptoms at 6-month follow-up BDI-II change score Follow-up: mean 26 weeks		The mean depression symptoms at 6-month follow-up in the intervention groups was 0.49 standard deviations higher		52 (1 study)	very low[1,5,7]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist	Corresponding risk Self-help (without support)			
		(0.06 lower to 1.04 higher)			
Discontinuation Number of participants lost to follow-up for any reason Follow-up: 4-13 weeks	140 per 1000	205 per 1000 (138 to 307)	RR 1.47 (0.99 to 2.2)	434 (7 studies)	low[1,7]

B-IPF=Brief Inventory Psycosocial Functioning; CAPS= Clinician-administered PTSD scale; CI=confidence interval; GAD-7=Generalised Anxiety Disorder; IES-R= Impact of Event Scale-Revised; PCL-C= PTSD checklist-Civilian; PDS= Post-traumatic Diagnostic Scale; PHQ-8/9=Patient health questionnaire for depression; RR=risk ratio; SDS= Sheehan Disability Scale; SMD=standardised mean difference; STAI= State-Trait Anxiety Inventory;

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

[2] OIS not met (N<400)

[3] Considerable heterogeneity (I2>80%)

[4] OIS not met (events<300)

[5] Data is not reported/cannot be extracted for all outcomes

[6] Substantial heterogeneity (I2=50-80%)

[7] 95% CI crosses both line of no effect and threshold for clinically important effect

[8] 95% CI crosses line of no effect and threshold for both clinically important benefit and clinically important harm

Table 88: Summary clinical evidence profile: Self-help (without support) versus attention-placebo for delayed treatment (>3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Attention-placebo	Corresponding risk Self-help (without support)			
PTSD symptomatology self-report at endpoint PDS/IES change score Follow-up: 0.1-0.6 weeks		The mean PTSD symptomatology self-report at endpoint in the intervention groups was 0.69 standard deviations lower (1.09 to 0.29 lower)		377 (5 studies)	very low[1,2,3]
PTSD symptomatology self-report at 1-month follow-up PDS change		The mean PSTD symptomatology self-report at 1-month		185 (2 studies)	very low[1,2,4]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Attention-placebo	Corresponding risk Self-help (without support)			
score Follow-up: mean 4 weeks		follow-up in the intervention groups was 0.5 standard deviations lower (1.32 lower to 0.31 higher)			
PTSD symptomatology clinician-rated at endpoint PSS-I change score Follow-up: mean 0.4 weeks		The mean PTSD symptomatology clinician-rated at endpoint in the intervention groups was 0.27 standard deviations higher (0.34 lower to 0.88 higher)		42 (1 study)	moderate[4]
Remission Number of people no longer meeting diagnostic criteria for PTSD Follow-up: mean 0.4 weeks	217 per 1000	291 per 1000 (109 to 789)	RR 1.34 (0.5 to 3.63)	47 (1 study)	low[5]
Depression symptoms at endpoint CES-D/BDI-II change score Follow-up: 0.4-0.6 weeks		The mean depression symptoms at endpoint in the intervention groups was 0.5 standard deviations lower (1.11 lower to 0.12 higher)		358 (5 studies)	very low[1,4,6]
Depression symptoms at 1-month follow-up CES-D/BDI-II change score Follow-up: mean 4 weeks		The mean depression symptoms at 1-month follow-up in the intervention groups was 0.28 standard deviations		185 (2 studies)	very low[1,4]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Attention-placebo	Corresponding risk Self-help (without support)			
		lower (0.57 lower to 0.01 higher)			
Anxiety symptoms at endpoint STAI State change score Follow-up: mean 0.4 weeks		The mean anxiety symptoms at endpoint in the intervention groups was 0.14 standard deviations higher (0.52 lower to 0.79 higher)		36 (1 study)	very low[1,5]
Anxiety symptoms at 1-month follow-up STAI State change score Follow-up: mean 4 weeks		The mean anxiety symptoms at 1-month follow-up in the intervention groups was 0.34 standard deviations higher (0.32 lower to 1 higher)		36 (1 study)	very low[1,4]
Discontinuation Number of participants lost to follow-up for any reason Follow-up: 0.4-0.6 weeks	85 per 1000	84 per 1000 (40 to 177)	RR 0.99 (0.47 to 2.09)	283 (4 studies)	very low[1,5]

BDI= Beck Depression Inventory; CES-D= Centre of Epidemiological Studies-Depression; CI=confidence interval; IES= Impact of Event Scale; PDS= Post-traumatic Diagnositic Scale; PSS-I= PTSD symptom scale-interview; RR=risk ratio; SMD=standardised mean difference; STAI= State-Trait Anxiety Inventory

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

[2] Substantial heterogeneity (I2=50-80%)

[3] OIS not met (N<400)

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

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

[6] Considerable heterogeneity (I2>80%)

See appendix F for full GRADE tables.

Sensitivity and subgroup analysis

Sub-analysis of the comparison, self-help (without support) versus waitlist, by multiplicity of trauma revealed no statistically significant subgroup difference for self-rated PTSD symptomatology (K=5; N= 288; Chi² = 3.93, p = 0.14), or discontinuation (K=7; N=434; Chi² = 0.99, p = 0.61), I² = 0%).

Sub-analysis of the comparison, self-help (without support) versus waitlist, by specific intervention revealed no statistically significant subgroup difference for self-rated PTSD symptomatology (Chi² = 1.20, p = 0.27), or discontinuation (Chi² = 1.07, p = 0.78).

Sub-analysis of the comparison, self-help (without support) versus waitlist, by diagnostic status at baseline revealed no statistically significant subgroup difference for self-rated PTSD symptomatology (Chi² = 1.50, p = 0.22), or discontinuation (Chi² = 0.11, p = 0.74).

Sub-analysis of the comparison, self-help (without support) versus waitlist, by trauma type at baseline revealed no statistically significant subgroup difference for self-rated PTSD symptomatology (Chi² = 1.11, p = 0.29), or discontinuation (Chi² = 0.99, p = 0.61).

Sub-analysis of the comparison, self-help (without support) versus waitlist, by baseline severity revealed no statistically significant subgroup difference for self-rated PTSD symptomatology (Chi² = 1.51, p = 0.47).

Sub-analysis of the comparison, self-help (without support) versus attention-placebo, by multiplicity of trauma revealed no statistically significant subgroup difference for self-rated PTSD symptomatology (K=5; N= 377; Chi² = 2.36, p = 0.12), or discontinuation (K=4; N=283; Chi² = 0.23, p = 0.63).

Sub-analysis of the comparison, self-help (without support) versus attention-placebo, by specific intervention revealed no statistically significant subgroup difference for self-rated PTSD symptomatology (Chi² = 2.48, p = 0.12). Test for subgroup differences was not possible for discontinuation or clinician-rated PTSD symptomatology.

Sub-analysis of the comparison, self-help (without support) versus attention-placebo, by diagnostic status revealed no statistically significant subgroup difference for discontinuation (Chi² = 0.23, p = 0.63). Test for subgroup differences was not possible for PTSD symptomatology (self-rated or clinician-rated).

Sub-analysis of the comparison, self-help (without support) versus attention-placebo, by trauma type revealed no statistically significant subgroup difference for self-rated PTSD symptomatology (Chi² = 1.36, p = 0.24), or discontinuation (Chi² = 1.37, p = 0.24).

Economic evidence

Included studies

The systematic search of economic literature identified 5 studies that assessed the cost effectiveness of psychological interventions for the treatment of adults with PTSD (Chatterton et al., 2016; Dunn et al., 2007; Le et al., 2014; Mihalopoulos et al., 2015; Tuerk et al., 2013); one of the studies (Le et al., 2014) was a comparison between a psychological and a pharmacological intervention. The search strategy for economic studies is provided in Appendix B.

Excluded studies

Four economic studies were reviewed at full text and excluded from this review. The reasons for exclusion were: assessment of a mixture of interventions ("optimal" versus "current" treatment), lack of reporting of results for each arm, >50% of population having psychosis, and military setting.

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

Summary of studies included in the economic evidence review

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

Trauma-focused CBT was found to be less costly and more effective than psychoeducation (i.e. it was dominant) in carers with PTSD and high distress. In carers with PTSD but low distress, trauma-focused CBT was more costly and less effective than psychoeducation (i.e. it was dominated by psychoeducation). The probability of trauma-focused CBT being cost-effective compared with psychoeducation at a cost effectiveness threshold of $50,000/QALY (£23,750/QALY in 2016 prices) was 0.89 for carers with PTSD and high distress and only 0.21 for carers with PTSD and low distress. The study is partially applicable to the UK context as it was conducted in Australia, so unit costs and resource use reflect the Australian healthcare system; in addition, estimated QALYs reflect the Australian population's preferences. The study is characterised by minor limitations.

Mihalopoulos and colleagues (2015) conducted a model-based cost-utility analysis to compare trauma-focused CBT (consisting of 8-12 individual sessions delivered by a psychologist) with non-evidence-based treatment as usual, comprising consultation with healthcare professionals, for adults with PTSD in Australia. Eligible study population comprised prevalent cases (12-month prevalence) of PTSD among the adult Australian population in 2012, who were currently seeking care, had consulted any health professional for a mental health problem during the previous 12 months but had not received evidence-based care. The perspective of the analysis was that of the health sector (government and service user out-of-pocket expenses). Only

intervention costs were included (psychologist's, psychiatrist's or GP's time). Efficacy data were taken from meta-analysis of trial data. Resource use data were based on trial and epidemiological data and expert opinion; national unit costs were used. The measure of outcome was the QALY, estimated using utility scores elicited from the Australian population using the Assessment of Quality of Life (AQoL-4D) instrument. The Disability-Adjusted Life Year (DALY) was also used. The time horizon of the analysis was 5 years; a 3% annual discount rate was used. However, only benefits were measured for a period of 5 years; costs were measured over the duration of treatment (i.e. up to 8-12 weeks).

Trauma-focused CBT was found to be more costly and more effective than treatment as usual, with an ICER of Aus$19,000/QALY in 2012 prices (£8,441/QALY in 2016 prices). The probability of trauma-focused CBT being cost-effective was 1 at a willingness to pay of $50,000/QALY (£22,214/QALY). Results were most sensitive to utility scores, participation and adherence to treatment, likelihood of being offered CBT and effectiveness of CBT. The study is partially applicable to the NICE decision-making context as it was conducted in Australia and the method of QALY estimation is not consistent with NICE recommendations. The study is characterised by potentially serious limitations, including the short time horizon used for measuring costs (until end of treatment) and the fact that only intervention costs (therapist's time) were considered.

Tuerk and colleagues (2013) assessed the cost effectiveness of trauma-focused CBT (exposure therapy /prolonged exposure) relative to no treatment in veterans with combat-related PTSD in the US using a before-after study design (N=60). The analysis adopted a mental healthcare perspective. Costs comprised medicine management, psychotherapy, supportive counselling, motivational interviewing, case management and other relevant mental healthcare resource use; primary care costs were excluded from the analysis. The analysis utilised national unit costs; in all cases the minimum associated cost per appointment was used. The measure of outcome was the change in the PCL–military version score. The time horizon of the analysis was 12 months. Trauma-focused CBT was shown to reduce costs and improve outcomes overtime, and therefore was dominant over no treatment. The study is partially applicable to the UK context as it was conducted in the US and is characterised by potentially serious limitations, including its design (before-after analysis), the small study sample (N=60) and the lack of statistical analysis of costs.

Le and colleagues (2014) assessed the cost effectiveness of trauma-focused CBT (exposure therapy /prolonged exposure) relative to sertraline in adults with PTSD in the US, in an analysis conducted alongside a RCT with a preference arm (N=200; preference arm n=97, completers n=69; RCT n=103; completers n=58). The analysis adopted a societal perspective. Costs consisted of intervention costs (exposure therapist's or psychiatrist's time, medication), outpatient care (general medical care, mental health care, substance abuse care, professional supportive services), inpatient care, emergency department services, pharmacy and other supportive services, productivity losses due to time spent in weekly treatment sessions and travel time to/from clinic. Unit costs were taken from national sources. The outcome measure was the QALY estimated based on EQ-5D ratings (US tariff). The time horizon of the analysis was one year.

Trauma-focused CBT was found to be less costly and more effective than sertraline (i.e. it was the dominant option). The probability of TF-CBT being cost-effective in the RCT was 0.93 at a WTP of $100,000/QALY (£73,153/QALY in 2016 prices), ranging from 0.91 to 0.95, for use of highest and lowest estimates of unit costs, respectively; at zero WTP, the probability of TF-CBT being cost-effective was 0.60. The study is

partially applicable to the UK context as it was conducted in the US, so unit costs and resource use reflect the Australian healthcare system; in addition, estimated QALYs reflect the US population's preferences. The study is characterised by potentially serious limitations, mainly the small study sample completing the RCT, including the preference arm.

Dunn and colleagues (2007) performed a cost-consequence analysis alongside a RCT (Dunn 2007) that compared non-trauma-focused CBT with psychoeducation for male veterans with chronic combat-related PTSD and depressive disorder in the US (N=101; at 1-year follow up: n=66). The perspective of the analysis was that of the health service. Costs consisted of intervention costs, psychiatric, medical and surgical care, as well as medication. National unit costs were used. The study assessed a variety of outcomes: PTSD symptoms were measured by the PTSD Scale (CAPS) & the Davidson Traumatic Stress Scale (DTSS); depressive symptoms were measured by the 18-item Hamilton Depression Rating Scale (HAMD) & the Beck Depression Inventory (BDI-II). Other measures included treatment compliance, satisfaction measured by the abbreviated Moos Group Environment Scale (GES) and other scales, treatment-targeted constructs, and functioning measured by the Brief Symptom Inventory (BSI) & the Addiction Severity Index (ASI). The time horizon of the analysis was 12 months.

Non-trauma-focused CBT was found to result in lower total costs. In terms of outcomes, no significant differences between groups at follow-up, except depressive symptoms and functioning, where psychoeducation demonstrated modestly greater improvements. The study is partially applicable to the UK and the NICE context as it was conducted in the US and QALY was not used as the outcome measure. The study is characterised by potentially serious limitations, including lack of statistical analysis of costs and the relatively small study sample with high attrition rates.

The references of included studies and the economic evidence tables are provided in Appendix H. The economic evidence profiles are shown in Appendix I.

Economic model

A decision-analytic model was developed to assess the relative cost effectiveness of psychological interventions for the treatment of PTSD in adults. The objective of economic modelling, the methodology adopted, the results and the conclusions from this economic analysis are described in detail in Appendix J. This section provides a summary of the methods employed and the results of the economic analysis.

Overview of economic modelling methods

A hybrid decision-analytic model consisting of a decision-tree followed by a three-state Markov model was constructed to evaluate the relative cost effectiveness of a range of interventions for the treatment of adults with PTSD in a community setting. The time horizon of the analysis was 3 years, consisting of the 6 months of the decision tree and another 2.5 years (10 x 3-month cycles) in the Markov component of the economic model. The range of interventions assessed in the economic analysis was determined by the availability of relevant clinical data included in the guideline systematic review of interventions for the treatment of adults with clinically important PTSD symptoms. Network meta-analysis (NMA) was employed for synthesis of the available efficacy data. The guideline economic analysis assessed psychological, pharmacological and combined psychological and pharmacological interventions that were connected to the network of evidence and were thus possible to include in the NMA. Based on the advice of the committee, only effective

interventions that had been tested on at least 50 people across the RCTs included in the NMAs assessing efficacy at treatment endpoint were considered in the economic analysis, as this was deemed as the minimum evidence that would be adequate to support a practice recommendation. Interventions that belonged to the trauma-focused cognitive behavioural therapy (TF-CBT) class were not considered separately according to their type, as the description of the type of TF-CBT was not always clear in the publications, and in some studies the intervention included elements of more types of TF-CBT. However, based on reported resource use in each RCT included in the NMA, TF-CBT interventions were categorised according to their mode of delivery in individual, group and mixed (where the intervention was delivered by a combination of individual and group sessions). Each of these categories was further subdivided, as relevant, to those comprising fewer than 8 sessions, 8-12 sessions, and more than 12 sessions, and were considered separately in the NMA and the economic analysis, to reflect the different intervention costs and, potentially, different efficacy associated with each sub-category

Based on the available evidence, the following interventions were considered in the economic analysis of interventions for the treatment of adults with PTSD:

- Psychoeducation
- Counselling
- TF-CBT individual <8 sessions
- TF-CBT individual 8-12 sessions
- TF-CBT individual >12 sessions
- TF-CBT group 8-12 sessions
- non-TF-CBT
- Eye Movement Desensitisation Reprocessing (EMDR)
- Present-centered therapy
- Interpersonal psychotherapy
- Combined somatic and cognitive therapies
- Self-help with support
- Self-help without support
- Selective serotonin reuptake inhibitors (SSRIs)
- TF-CBT individual 8-12 sessions + SSRIs
- No treatment, reflected in the waitlist arms of RCTs included in the guideline systematic review and NMA.

According to the model structure, hypothetical cohorts of adults with PTSD were initiated on each of the treatment options assessed, including no treatment. Following a course of treatment, people in each cohort either remitted (that is, they did not meet criteria for a PTSD diagnosis) or did not remit. In the 3 months of follow-up after treatment completion, people who remitted could remain in remission, relapse to a PTSD state or die. Those who did not remit, could remain in the PTSD state, remit or die. After that point, people in each cohort, both those who remitted and those who did not remit, were entered into the Markov component of the economic model, in either the ‘PTSD’ or the ‘no PTSD’ health states, depending on their state at the end of the decision-tree. In each cycle of the Markov model, they could remain in the same health state or move between the two states of ‘PTSD’ and ‘no PTSD’ or move to the death state (absorbing state).

Efficacy data were derived from the guideline systematic review and NMAs; other clinical input parameters (baseline risk of remission, risk of relapse, probability of developing side effects from SSRIs, mortality) were derived from published literature and the committee's expert opinion where evidence was lacking. The measure of outcome of the economic analysis was the number of QALYs gained. Utility data were selected after a systematic review of the literature. The perspective of the analysis was that of health and personal social care services. Resource use was based on published literature, national statistics and, where evidence was lacking, the committee's expert opinion. National UK unit costs were used. The cost year was 2017. Model input parameters were synthesised in a probabilistic analysis. This approach allowed more comprehensive consideration of the uncertainty characterising the input parameters and captured the non-linearity characterising the economic model structure. Three probabilistic analyses were carried out:

- Analysis A (base-case) utilised efficacy data at treatment endpoint from a NMA of continuous data (changes in PTSD symptom scores), transformed to log-odds ratios of remission, and assumed no beneficial effect of interventions beyond treatment endpoint
- Analysis B utilised efficacy data at treatment endpoint from the NMA of continuous data (changes in PTSD symptom scores), transformed to log-odds ratios of remission, and efficacy data at 3 months post-treatment from the NMA of changes in PTSD symptom scores between baseline and 1-4 month follow-up, also transformed to log-odds ratios of remission
- Analysis C utilised efficacy data at treatment endpoint from the NMA of dichotomous remission data; the probability of remission of all active interventions at 3-6 months was assumed to equal that of no treatment, as dichotomous remission follow-up data were very limited.

A number of one-way deterministic sensitivity analyses were also carried out.

Results have been expressed in the form of Incremental Cost Effectiveness Ratios (ICERs) following the principles of incremental analysis. Net Monetary Benefits (NMBs) have also been estimated. Incremental mean costs and effects (QALYs) of each intervention versus no treatment have been presented in the form of cost effectiveness planes. Results of probabilistic analysis have been summarised in the form of cost effectiveness acceptability curves (CEACs), which express the probability of each intervention being cost effective at various cost effectiveness thresholds. Cost effectiveness acceptability frontiers (CEAFs) have also been plotted; these show the treatment option with the highest mean NMB over different cost effectiveness thresholds, and the probability that the option with the highest NMB is the most cost-effective among those assessed.

Overview of economic modelling results and conclusions

In the base-case analysis (which utilised continuous data at treatment endpoint and assumed no treatment effect beyond treatment endpoint), the order of interventions from the most to the least cost-effective for the treatment of PTSD in adults was: TF-CBT individual < 8 sessions, psychoeducation, EMDR, combined somatic and cognitive therapies, self-help with support, SSRI, TF-CBT individual 8-12 sessions, self-help without support, non-TF-CBT, IPT, present-centered therapy, TF-CBT group 8-12 sessions, combined TF-CBT individual 8-12 sessions + SSRI, no treatment, counselling, and TF-CBT individual >12 sessions. The probability of TF-CBT individual < 8 sessions being the most cost-effective treatment option was 0.26.

When a beneficial effect of up to 3 months post-treatment was assumed, there were no dramatic changes in the results; however, the relative cost effectiveness of combined somatic and cognitive therapies and, in a lesser degree, IPT and non-TF-CBT improved. The order of interventions became TF-CBT individual < 8 sessions, combined somatic and cognitive therapies, EMDR, psychoeducation, self-help with support, self-help without support, SSRI, IPT, non-TF-CBT, TF-CBT individual 8-12 sessions, TF-CBT individual >12 sessions, present-centered therapy, TF-CBT group 8-12 sessions, TF-CBT individual 8-12 sessions + SSRI, counselling, and no treatment. The probability of TF-CBT individual < 8 sessions being the most cost-effective treatment option was 0.14.

When dichotomous remission data were used, there were more important changes in the results with non-TF-CBT becoming the most effective and cost-effective intervention followed by EMDR, TF-CBT individual 8-12 sessions, IPT, SSRI, self-help without support, self-help with support, present-centered therapy, TF-CBT individual 8-12 sessions + SSRI, TF-CBT individual >12 sessions, counselling, TF-CBT group 8-12 sessions, and no treatment. The probability of non-TF-CBT being the most cost-effective treatment was 0.38.

Results of the economic analysis were robust to changes in input parameters tested in deterministic sensitivity analysis.

The guideline base-case economic analysis is based on the best quality efficacy data derived from NMA. However, the result for psychoeducation, which was found to be among the most cost-effective interventions, should be interpreted with great caution due to limitations in the evidence base and the considerably high uncertainty characterising its efficacy estimate. Moreover, the NMA that informed the base-case analysis was characterised by high between-study heterogeneity, as well as large effects and considerable uncertainty for some interventions, and this should be taken into account when interpreting the results of the analysis.

Results from the alternative scenarios explored in the other two probabilistic analyses (i.e. consideration of efficacy data derived from the NMAs of continuous 1-4 month follow-up data and of dichotomous remission data) should also be interpreted with caution due to the limitations characterising the respective evidence base and the NMAs that informed them (limited evidence base, evidence of inconsistency between direct and indirect evidence, high between-study heterogeneity, large effects and considerable uncertainty for some interventions).

Resource impact

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

Clinical evidence statements

Trauma-focused CBT for early treatment (1-3 months)

- Very low quality single-RCT evidence (N=152) suggests a statistically significant small-to-moderate delayed benefit (significant only at 10-month follow-up) of early treatment with trauma-focused CBT (initiated 1-3 months after trauma), relative to no treatment, on improving self-rated PTSD symptomatology and the rate of response, in adults with PTSD. Very low quality evidence from another single RCT

(N=143) suggests a clinically important benefit, that just misses statistical significance, of trauma-focused CBT on the rate of remission at endpoint. However, this effect is not maintained at 4-month follow-up. Low to very low quality evidence from 1-2 RCTs (N=98-265) suggests neither clinically important nor statistically significant effects on clinician-rated PTSD symptomatology. No clinically important and statistically significant effects were observed for anxiety symptoms, depression symptoms or discontinuation

Trauma-focused CBT for delayed treatment (>3 months)

- Very low quality evidence from 12-14 RCTs (N=618-632) suggests a large and statistically significant benefit of trauma-focused CBT, relative to waitlist, on improving PTSD symptomatology (self-rated and clinician-rated) in adults with PTSD over 3 months after trauma. Evidence from 1-2 RCTs (N=63-145) suggests benefits on self-rated PTSD symptomatology are maintained up to 1-year follow-up (with the exception of a non-significant effect at 3-months), and evidence from 4 RCTs (N=507) suggests benefits on clinician-rated PTSD symptomatology are maintained up to 3-5 month follow-up (longest follow-up). Very low quality evidence from 14 RCTs (N=628) suggests a clinically important and statistically significant benefit of trauma-focused CBT on the rate of remission, and evidence from 1-3 RCTs (N=166-175) suggests benefits are maintained at 3-6 month and 8-month follow-up. Very low quality evidence from 3 RCTs (N=89-111) suggests a clinically important and statistically significant benefit of trauma-focused CBT on the rate of response (based on self-rated and clinician-rated measures) and single-RCT (N=57) evidence suggests this effect (self-rated) is maintained at 6-month follow-up. Very low quality evidence from 15-19 RCTs (N=760-972) suggests large and statistically significant benefits of trauma-focused CBT on anxiety and depression symptoms and evidence from 1-5 RCTs (N=82-550) suggests these benefits are maintained up to 1-year follow-up. In addition, there is low to very low quality evidence from 1-6 RCTs (N=46-339) for large and statistically significant benefits of trauma-focused CBT on dissociative symptoms, global functioning, functional impairment and relationship difficulties at endpoint, although the evidence for follow-up is more limited. However, in addition to the considerable evidence for benefit of trauma-focused CBT relative to waitlist for the delayed treatment of PTSD, there is low quality evidence from 26 RCTs (N=1834) for higher drop-out associated with trauma-focused CBT relative to waitlist. There is also very high heterogeneity observed across outcomes. Sub-analyses by specific intervention suggests some differential effects but within-subgroup heterogeneity remains high and benefits are observed across all interventions (although statistical significance varies). Sub-analyses by diagnostic status at baseline suggests larger effect sizes for those with a diagnosis at baseline but again within-subgroup heterogeneity is high. Finally, sub-analyses by trauma type suggests some differences with larger effects associated with some trauma types but these are difficult to disentangle as the larger effects are associated with the single smaller study subgroups.
- Very low quality evidence from 21-22 RCTs (N=1179-1640) suggests a large and statistically significant benefit of trauma-focused CBT (in addition to medication or TAU), relative to medication or TAU-only, on improving PTSD symptomatology (self-rated and clinician-rated) in adults with PTSD over 3 months after trauma. Very low quality evidence from 2-7 RCTs (N=94-648) suggests large and statistically significant benefits are maintained up to 6-month follow-up, and clinically important (but not statistically significant) benefits are maintained up to 1-year follow-up. Very low quality evidence from 12 RCTs (N=917) suggests a clinically important and statistically significant benefit of trauma-focused CBT (in addition to TAU or medication) on the rate of remission, and low to very low quality

evidence from 4 RCTs (N=324) suggests clinically important and statistically significant benefits are maintained at 6-month follow-up, and clinically important (but not statistically significant) benefits are observed at 1-3 month and 1-year follow-ups. Very low quality evidence from 4-5 RCTs (N=245-328) suggests a clinically important and statistically significant benefit of trauma-focused CBT (in addition to TAU or medication) on the rate of response (based on self-rated and clinician-rated measures) at endpoint, with some evidence that this benefit is maintained at 1-6 month follow-up. Very low quality evidence from 13-22 RCTs (N=647-1536) suggests moderate-to-large and statistically significant benefits of trauma-focused CBT (in addition to TAU or medication) on anxiety and depression symptoms, although evidence for effects at follow-ups are less consistent. In addition, low to very low quality evidence from 1-5 RCTs (N=59-295) suggests large and statistically significant benefits of trauma-focused CBT (in addition to TAU or medication) on dissociative symptoms, personality disorder symptoms, global functioning, functional impairment and relationship difficulties, and very low quality evidence from 2 RCTs (N=89) suggests a small-to-moderate benefit on anger/aggression. Evidence for effects on substance misuse outcomes are more mixed but for at least some of these studies the comparator is standard substance misuse services. Moderate quality evidence from 35 RCTs (N=2764) suggests higher drop-out associated with trauma-focused CBT, however, although this effect is statistically significant it does not meet the threshold for clinical importance. Heterogeneity across outcomes is very high. Sub-analyses by specific intervention suggests some differential effects but within-subgroup heterogeneity remains high and benefits are observed across all interventions (although statistical significance varies). Sub-analyses by diagnostic status at baseline was non-significant. Sub-analyses by trauma type suggests some differences but again within-subgroup heterogeneity remains high.

- Very low quality evidence from 6 RCTs (N=277-321) suggests moderate to large benefits of trauma-focused CBT, relative to counselling, on improving self-rated and clinician-rated PTSD symptomatology at endpoint in adults with PTSD over 3 months after trauma. Low to very low quality evidence from 1-5 RCTs (N=39-434) suggests clinically important and statistically significant effects are maintained up to 2-year follow-up for clinician-rated PTSD symptomatology. Effects on self-rated PTSD symptomatology are not statistically significant at follow-up although a trend remains up to 2-year follow-up. Low quality evidence from 6 RCTs (N=320) suggests a clinically important and statistically significant benefit of trauma-focused CBT on remission at endpoint and very low quality evidence from 2-5 RCTs (N=70-472) suggests that this effect is maintained up to 1-year follow-up. Low quality evidence from 8 RCTs (N=358) suggests a large and statistically significant benefit of trauma-focused CBT on anxiety symptoms at endpoint that is maintained up to 2-year follow-up. Evidence from these same 8 RCTs also suggests a small-to-moderate but statistically significant benefit of trauma-focused CBT on depression symptoms at endpoint and 6-8 month follow-up but effects are neither clinically important nor statistically significant at 3-months, 1-year or 2-year follow-ups. Low to very low quality evidence from 1-3 RCTs (N=61-175) suggests a moderate to large benefit of trauma-focused CBT on quality of life at endpoint that is maintained up to 1-year follow-up. Low to very low quality evidence from single-RCT (N=39-61) analyses also suggests large and statistically significant benefits of trauma-focused CBT on functional impairment (maintained up to 6-month follow-up [longest follow-up]) and global functioning (maintained up to 1-year but not 2-year follow-up), and delayed large benefits (significant at 3- and 6-month follow-up but not endpoint) on relationship difficulties. Very low quality single-RCT (N=28) evidence suggests no statistically significant difference between trauma-focused CBT and counselling for response. Low quality evidence

from 11 RCTs (N=754) suggests a neither clinically important nor statistically significant difference between trauma-focused CBT and counselling for discontinuation.

- Low to very low quality evidence from 1-6 RCTs (N=86-970) suggests clinically important and statistically significant benefits of trauma-focused CBT (alone or in addition to TAU), relative to present-centered therapy (alone or in addition to TAU), on improving PTSD symptomatology (clinician-rated) at endpoint and up to 6-month follow-up, the rate of remission at 1-3 month follow-up (clinically important that just misses statistical significance at endpoint but non-significant at 6-month follow-up), and depression symptoms at 2-3 month, 4-month and 6-month follow-ups (non-significant at endpoint) in adults with PTSD over 3 months after trauma. The effect on self-rated PTSD symptomatology is also clinically important but just misses statistical significance (p=0.05). Moderate to very low quality evidence from 1-3 RCTs (N=34-680) suggests no statistically significant differences between trauma-focused CBT and present-centered therapy on clinician-rated response, dissociative symptoms, anxiety symptoms, anger, or quality of life, at endpoint or 3- or 6- month follow-up. Low quality evidence from 6 RCTs (N=931) suggests higher drop-out associated with trauma-focused CBT relative to present-centered therapy, however this effect is not statistically significant.
- Low quality single-RCT (N=40) evidence suggests a clinically important benefit, that just misses statistical significance (p=0.06), of trauma-focused CBT relative to interpersonal psychotherapy (IPT) on improving self-rated PTSD symptomatology in adults with PTSD over 3 months after trauma. However, evidence from the same RCT (N=37-78) suggests neither clinically important nor statistically significant differences between trauma-focused CBT and IPT on clinician-rated PTSD symptomatology, remission, response, functional impairment, or relationship difficulties. This study (N=39-63) did find evidence for clinically important and statistically significant benefits of trauma-focused CBT relative to IPT on depression symptoms and quality of life. There is some evidence from the same RCT for higher drop-out with trauma-focused CBT relative to IPT, however, this effect is not statistically significant.
- Moderate to very low quality evidence from 1-2 RCTs (N=53-182) suggests clinically important and statistically significant benefits of trauma-focused CBT (alone or in addition to TAU) relative to self-help without support (alone or in addition to TAU) on clinician-rated PTSD symptomatology, remission at 6-month follow-up (clinically important but not statistically significant at endpoint), response (at endpoint and 6-month follow-up), depression symptoms (at endpoint and 6-month follow-up), anxiety symptoms (at endpoint and 6-month follow-up), and functional impairment (at endpoint and 6-month follow-up) in adults with PTSD over 3 months after trauma. Very low quality evidence from both RCTs (N=182) suggests there may be higher drop-out associated with trauma-focused CBT relative to self-help without support, however, heterogeneity is very high and this effect is not statistically significant.
- Very low quality single-RCT (N=230-244) evidence suggests neither clinically important nor statistically significant differences between brief trauma-focused CBT and a psychoeducational session on self-rated PTSD symptomatology at endpoint, 3- and 6- month follow-up, in adults with PTSD over 3 months after trauma. Although, low quality evidence from this same RCT (N=336) does suggest a higher rate of discontinuation associated with trauma-focused CBT relative to psychoeducation.
- Low to very low quality evidence from 1-3 RCTs (N=24-84) suggests moderate to large and statistically significant benefits of trauma-focused CBT (alone or in

addition to TAU) relative to relaxation (alone or in addition to TAU) on improving PTSD symptomatology (self-rated and clinician-rated) and anxiety symptoms at endpoint and 3-month follow-up, and functional impairment, quality of life, and relationship difficulties at endpoint (no follow-up data), in adults with PTSD over 3 months after trauma. Low to very low quality evidence from 1-2 RCTs (N=30-111) suggests clinically important but not statistically significant benefits of trauma-focused CBT on remission (at endpoint and 3-month follow-up), response, and dissociative symptoms at 3-month follow-up (non-significant effect at endpoint). Low to very low quality evidence from 1-3 RCTs (N=30-135) suggests non-significant differences between trauma-focused CBT and relaxation for depression symptoms at endpoint and 3-month follow-up, and discontinuation.

- Very low quality single-RCT (N=49-57) evidence suggests non-significant differences between trauma-focused CBT and acupuncture for self-rated PTSD symptomatology, remission, depression symptoms, anxiety symptoms, functional impairment, and discontinuation, in adults with PTSD over 3 months after trauma.
- Very low quality evidence from 2-3 RCTs (N=161-275) suggests small but statistically significant benefits of SSRIs relative to trauma-focused CBT on improving self-rated PTSD symptomatology and anxiety symptoms at endpoint in adults with PTSD over 3 months after trauma. Although, very low quality evidence from 1 of these RCTs (N=112) suggests effects are not maintained at 1-year follow-up. Conversely, low to very low quality evidence from 1-2 RCTs (N=49-171) suggests large and statistically significant benefits of trauma-focused CBT relative to SSRIs on clinician-rated PTSD symptomatology, remission, and dissociative symptoms at endpoint (no follow-up available). Very low quality evidence from 1-3 RCTs (N=112-275) suggests neither clinically important nor statistically significant differences between trauma-focused CBT and SSRIs on depression symptoms at endpoint and 1-year follow-up, functional impairment and quality of life at endpoint (no follow-up available), and discontinuation.

Combined trauma-focused CBT and medication for delayed treatment (>3 months)

- Very low quality single-RCT (N=103) evidence suggests neither clinically important nor statistically significant effects of combined trauma-focused CBT and sertraline relative to waitlist, on self-rated PTSD symptomatology or quality of life, in adults with PTSD over 3 months after trauma. However, evidence from this same RCT suggests a moderate and statistically significant benefit of combined trauma-focused CBT and sertraline relative to watlist on improving anxiety and depression symptoms, and functional impairment. Low quality evidence (N=139) from this study also suggests a clinically important benefit, that just misses statistical significance, on discontinuation with less drop-out associated with combined trauma-focused CBT and sertraline treatment.

Non-trauma-focused CBT for delayed treatment (>3 months)

- Low to very low quality evidence from 4-5 RCTs (N=228-339) suggests a moderate to large and statistically significant benefit of non-trauma-focused CBT (alone or in addition to TAU), relative to waitlist or TAU, on improving PTSD symptomatology (self-rated and clinician-rated) at endpoint in adults with PTSD over 3 months after trauma. Low to very low quality evidence from 1-5 RCTs (N=33-263) also suggests clinically important and statistically significant benefits on dissociative symptoms and sleeping difficulties. However, very low quality evidence from 1-3 RCTs (N=53-194) suggests effects on the rate of remission are not statistically significant at endpoint, and neither clinically important nor statistically significant at 3-month follow-up. Very low quality evidence from 2-4 RCTs (N=199-234) also suggests neither clinically important nor statistically

significant effects of non-trauma-focused CBT on depression symptoms, alcohol use or drug use, at endpoint. Low quality evidence from 9 RCTs (N=684) suggests neither a clinically important nor statistically significant effect of non-trauma-focused CBT on discontinuation.

- Low to very low quality single-RCT (N=60) evidence suggests potential benefits of non-trauma-focused CBT, relative to attention-placebo, on self-reported PTSD symptomatology in adults with PTSD over 3 months after trauma. However, when data is considered together with a much larger RCT (N=353) effects are non-significant.
- Very low quality evidence from 1-2 RCTs (N=24-121) suggests neither clinically important nor statistically significant differences between trauma-focused CBT (alone or in addition to TAU) and non-trauma-focused CBT (alone or in addition to TAU) on self-rated PTSD symptomatology at 1-month, 3-month or 6-month follow-ups (no endpoint data available) or clinician-rated PTSD symptomatology at endpoint or 3-month follow-up, although there is very low quality single-RCT (N=22) evidence for a large and statistically significant benefit of trauma-focused, relative to non-trauma-focused, CBT on clinician-rated PTSD symptomatology at 6-month follow-up. Very low quality evidence from 1-2 RCTs (24-121) suggests no statistically significant difference between trauma-focused and non-trauma-focused CBT on remission (at endpoint, or 1-3 month, 6-month or 1-year follow-ups), response, anxiety symptoms, depression symptoms (at endpoint, or 1-, 3-, or 6- month follow-ups), or sleeping difficulties (at 1-, 3-, or 6- month follow-ups). Very low quality single-RCT (N=95) evidence suggests a moderate and statistically significant benefit of trauma-focused CBT, relative to non-trauma-focused CBT, on quality of life at 1-month follow-up (no endpoint data available), however, this effect is not maintained at 3- or 6- month follow-up. Low quality evidence from 3 RCTs (N=183) suggests higher drop-out associated with trauma-focused, relative to non-trauma-focused, CBT.
- Moderate quality single-RCT (N=66) evidence suggests a delayed and moderate benefit of non-trauma-focused CBT (in addition to TAU) relative to a psychoeducational group (in addition to TAU) on clinician-rated PTSD symptomatology at 1-year follow-up (non-significant effects at endpoint, 3-month and 6-month follow-up) in adults with PTSD over 3 months after trauma. Moderate quality evidence from this RCT (N=66-77) also suggests moderate to large benefits of non-trauma-focused CBT on depression symptoms at endpoint, and 3-month and 6-month follow-up, although these are not maintained at 1-year follow-up. However, low quality evidence from this same RCT (N=66-77) suggests neither clinically important nor statistically significant differences between non-trauma-focused CBT and a psychoeducational group on self-rated PTSD symptomatology at endpoint, or at 3-month, 6-month or 1-year follow-ups. Moderate quality evidence from this RCT (N=111) also suggests higher drop-out associated with non-trauma-focused CBT relative to a psychoeducational group.
- Very low quality single-RCT (N=25-31) evidence suggests large and statistically significant benefits of non-trauma-focused CBT relative to supportive counselling on improving clinician-rated PTSD symptomatology and the rate of response in adults with PTSD over 3 months after trauma. Evidence from the same RCT also suggests clinically important, but not statistically significant, benefits of non-trauma-focused CBT on remission, anxiety symptoms and depression symptoms. There was a non-significant difference between non-trauma-focused CBT and counselling for discontinuation.
- Very low quality single-RCT (N=101) evidence suggests non-significant differences between non-trauma-focused CBT and present-centered therapy for

clinician-rated PTSD symptomaology, remission, depression symptoms and discontinuation, in adults with PTSD over 3 months after trauma.

Present-centered therapy for delayed treatment (>3 months)

- Very low quality evidence from 1-2 RCTs (N=45-143) suggests moderate to large and statistically significant benefits of present-centered therapy relative to waitlist on improving clinician-rated PTSD symptomatology, dissociative symptoms, anxiety symptoms and depression symptoms, in adults with PTSD over 3 months after trauma. Evidence from these same 2 RCTs also suggests a clinically important, but not statistically significant, benefit of present-centered therapy on remission. Very low quality evidence from 1 of these RCTs (N=45) suggests a neither clinically important nor statistically significant effect of present-centered therapy on anger or quality of life. Very low quality evidence from both RCTs suggests there may be higher drop-out associated with present-centered therapy, however, this effect is not statistically significant.
- Very low quality evidence from 2 RCTs (N=114-119) suggests a moderate and statistically significant benefit of present-centered therapy in addition to TAU relative to TAU-only on improving clinician-rated PTSD symptomatology at endpoint, and a large and statistically significant benefit on improving depression symptoms at endpoint and 3-month and 6-month follow-up, in adults with PTSD over 3 months after trauma. However, the effect on PTSD symptomatology was not maintained at 3-month or 6-month follow-up. Low to very low quality evidence from 1-2 of these RCTs (N=60-130) also found non-significant effects on response (at endpoint, and 3- and 6-month follow-up) and discontinuation.

Cognitive therapies for delayed treatment (>3 months)

- Very low quality evidence from 1-2 RCTs (N=21-40) suggests large and statistically significant benefits of metacognitive therapy (alone or in addition to TAU) relative to waitlist or TAU on self-rated PTSD symptomatology, response, anxiety symptoms and depression symptoms, in adults with PTSD over 3 months after trauma. Low quality evidence from both RCTs (N=41) suggests higher drop-out may be associated with metacognitive therapy, however, this effect is not statistically significant.
- Very low quality single-RCT (N=20) evidence suggests a large and statistically significant benefit of metacognitive therapy (in addition to TAU) relative to trauma-focused CBT (in addition to TAU) on improving self-rated PTSD symptomatology at endpoint, in adults with PTSD over 3 months after trauma. However, this effect is not maintained at 3-month follow-up. In addition, evidence from this same RCT suggests non-significant differences between metacognitive therapy and trauma-focused CBT on remission, response, anxiety symptoms, depression symptoms, and discontinuation.

Behavioural therapies for delayed treatment (>3 months)

- Very low quality evidence from 1-2 RCTs (N=59-90) suggests large and statistically significant benefits of single-session behavioural therapy relative to waitlist on improving PTSD symptomatology (self-rated and clinician-rated), the rate of response, functional impairment, and depression symptoms in adults with PTSD over 3 months after trauma. Discontinuation is only reported by 1 of these RCTs (N=31) and there was no drop-out in either arm.

Problem solving for delayed treatment (>3 months)

- Low to very low quality single-RCT (N=309) evidence suggests non-significant differences between problem solving and supportive counselling on self-rated

PTSD symptomatology (at endpoint and 3-month follow-up) and discontinuation, in adults with PTSD over 3 months after trauma.

Eye movement desensitisation and reprocessing (EMDR) for early treatment (1-3 months)

- Very low quality single-RCT (N=39) evidence suggests a large and statistically significant benefit of early treatment with EMDR (initiated 1-3 months after trauma), relative to supportive counselling, on improving clinician-rated PTSD symptomatology and this benefit is maintained up to 3-month follow-up (longest follow-up). No participants dropped out of this study.

Eye movement desensitisation and reprocessing (EMDR) for delayed treatment (>3 months)

- Low to very low quality single-RCT (N=55-58) evidence suggests no statistically significant effects of EMDR relative to pill placebo on clinician-rated PTSD symptomatology, remission, depression symptoms or discontinuation, in adults with PTSD over 3 months after trauma.
- Very low quality evidence from 9 RCTs (N=393) suggests a large and statistically significant benefit of EMDR (in addition to TAU or alone), relative to TAU or waitlist, on improving self-rated PTSD symptomatology at endpoint in adults with PTSD over 3 months after trauma. Low quality single-RCT evidence (N=98) suggests that this benefit is maintained at 1-month follow-up. Moderate to very low quality evidence from 1-2 RCTs (N=40-147) also suggests clinically important and statistically significant benefits of EMDR on clinician-rated PTSD symptomatology, remission at endpoint and 1-month follow-up, response, dissociative symptoms and functional impairment. In addition, very low quality evidence from 3-6 RCTs (N=113-279) suggests large and statistically significant benefits of EMDR on anxiety and depression symptoms at endpoint, and low quality single-RCT evidence (N=51) suggests effects on depression are maintained at 1-month follow-up. Low quality evidence from 7 RCTs (N=356) suggests a neither clinically important nor statistically significant effect of EMDR on discontinuation.
- Low to very low quality evidence from 1-5 RCTs (N=30-230) suggests no statistically significant differences between EMDR and trauma-focused CBT on PTSD outcomes (self-rated and clinician-rated symptomatology, remission and response), although there is a trend in favour of EMDR for adults who had experienced single incident index trauma more than 3 months ago.
- Very low quality single-RCT (N=57-60) evidence suggests moderate to large and statistically significant benefits of EMDR relative to supportive counselling on improving self-rated PTSD symptomatology, anxiety symptoms, and depression symptoms in adults with PTSD over 3 months after trauma. Low quality evidence from this same RCT (N=67) suggests there may be higher drop-out associated with EMDR, however, this effect is not statistically significant.
- Very low quality single-RCT (N=61-74) evidence suggests non-significant differences between EMDR and non-trauma-focused CBT on PTSD symptomatology (clinician-rated and self-rated), anxiety symptoms and depression symptoms at endpoint and 3-month follow-up, and response and discontinuation at endpoint, in adults with PTSD over 3 months after trauma.
- Very low quality single-RCT (N=31-40) evidence suggests moderate to large and delayed benefits of EMDR relative to 'other active psychological intervention' on improving self-rated PTSD symptomatology at 3-month and 18-month follow-up (non-significant at endpoint), and depression symptoms at 3-month follow-up (non-significant at endpoint and 18-month follow-up), in adults with PTSD over 3 months after trauma. No participants discontinued this study in either arm.

- Low to very low quality evidence from 1-3 RCTs (N=30-88) suggests non-significant differences between EMDR (alone or in addition to TAU) and relaxation (alone or in addition to TAU) on PTSD symptomatology (self-rated and clinician-rated) and remission at endpoint, 3-month and 6-month follow-up, dissociative symptoms at endpoint and 3-month follow-up (longest follow-up), and anxiety symptoms, quality of life and discontinuation at endpoint, in adults with PTSD over 3 months after trauma. Low quality evidence from 2 of these RCTs (N=52) suggests a moderate and statistically significant benefit of EMDR relative to relaxation on improving depression symptoms at endpoint, however, this effect is not maintained at 3-6 month follow-up.
- Low to very low quality single-RCT (N=46) evidence suggests non-significant differences between EMDR and emotional freedom technique (EFT) on PTSD symptomatology (self-rated and clinician-rated), response (based on self-rated and clinician-rated measures), anxiety symptoms, depression symptoms and quality of life, at endpoint and 3-month follow-up, and discontinuation, in adults with PTSD over 3 months after trauma.
- Low quality single-RCT evidence (N=50) suggests a delayed, large and statistically significant benefit of EMDR relative to fluoxetine on improving clinician-rated PTSD symptomatology, remission and depression symptoms at 6-month follow-up (non-significant at endpoint) in adults with PTSD over 3 months after trauma. Low quality evidence from this same RCT (N=59) suggests EMDR may be associated with higher drop-out, however, this effect is not statistically significant.

Hypnotherapy for delayed treatment (>3 months)

- Very low quality single-RCT (N=52) evidence suggests a large and statistically significant benefit of hypnotherapy in addition to TAU relative to TAU-only on improving self-rated PTSD symptomatology in adults with PTSD over 3 months after trauma. Evidence is not available for any other outcomes.
- Very low quality single-RCT (N=60) evidence suggests neither clinically important nor statistically significant differences between hypnotherapy (in addition to TAU) and trauma-focused CBT (in addition to TAU) on self-rated PTSD symptomatology at endpoint and 3-month follow-up, in adults with PTSD over 3 months after trauma.
- Very low quality single-RCT (N=54-108) evidence suggests non-significant differences between hypnotherapy followed by trauma-focused CBT and symptom monitoring followed by trauma-focused CBT on clinician-rated PTSD symptomatology and sleeping difficulties at endpoint and 3-month follow-up, and on discontinuation, in adults with PTSD over 3 months after trauma. Very low quality evidence from this same RCT (N=54) suggests a moderate and statistically significant benefit of hypnotherapy followed by trauma-focused CBT on depression symptoms, however, this effect is not maintained at 3-month follow-up.
- Low quality single-RCT (N=32) evidence suggests large and statistically significant benefits of hypnotherapy (in addition to TAU) relative to zolpidem (in addition to TAU) on improving self-rated PTSD symptomatology and depression symptoms at endpoint and 1-month follow-up, in adults with PTSD over 3 months after trauma. Very low quality evidence from this same RCT (N=33) suggests higiher drop-out may be associated with zolpidem, however, absolute numbers are small and this effect is not statistically significant.

Interpersonal psychotherapy (IPT) for delayed treatment (>3 months)

- Very low quality single-RCT (N=48) evidence suggests large and statistically significant benefits of IPT relative to waitlist on improving clinician-rated PTSD

symptomatology, remission and depression symptoms at endpoint, in adults with PTSD over 3 months after trauma. However, these effects are not maintained at 4-month follow-up. Low quality evidence from this same RCT suggests non-significant effects on discontinuation.

- Low quality single-RCT (N=36-72) evidence suggests moderate to large and statistically significant benefits of IPT relative to relaxation on improving self-rated PTSD symptomatology, the rate of response, functional impairment and relationship difficulties, in adults with PTSD over 3 months after trauma. However, low to very low quality evidence from this same RCT (N=38-72) suggests non-significant effects on clinician-rated PTSD symptomatology, remission, depression symptoms, quality of life and discontinuation.

Psychodynamic therapies for delayed treatment (>3 months)

- Very low quality evidence from single-study analyses (N=52-84) suggests large and statistically significant benefits of psychodynamic therapy (alone or in addition to TAU) relative to waitlist (alone or in addition to TAU) on improving self-rated PTSD symptomatology, remission, anxiety and depression symptoms, in adults with PTSD over 3 months after trauma. Evidence from one of these RCTs (N=86) suggests non-significant effects on discontinuation.
- Very low quality single-RCT (N=60) evidence suggests non-significant differences between psychodynamic therapy (in addition to TAU) and trauma-focused CBT (in addition to TAU) on self-rated PTSD symptomatology in adults with PTSD over 3 months after trauma.

Counselling for delayed treatment (>3 months)

- Low to very low quality evidence from 1-4 RCTs (N=60-249) suggests large and statistically significant benefits of counselling (alone or in addition to TAU) relative to TAU or waitlist, on improving PTSD symptomatology (self-rated and clinician-rated) and functional impairment at endpoint, in adults with PTSD over 3 months after trauma. Very low quality evidence from 2-RCT-analyses (N=190-234) suggests the effect on self-rated PTSD symptomatology is maintained at 8-12 month follow-up and clinically important but not statistically significant at 1-4 month follow-up. Very low quality single-RCT (N=24) evidence suggests the effect on clinician-rated PTSD symptomatology is not maintained at 1-year follow-up. Evidence from 2 RCTs (N=102) suggests a clinically important and statistically significant benefit of counselling on remission at endpoint and very low quality evidence from 2 other RCTs (N=192) shows a trend for the same effect at 8-12 month follow-up. Low quality evidence from 2 RCTs (N=111) suggests moderate and statistically significant benefits of counselling on anxiety and depression symptoms at endpoint, and low quality evidence from another single RCT (N=209) suggests a trend for benefits to be observed at 1-month follow-up. However, very low quality single-RCT (N=24-25) evidence suggests counselling may be associated with lower quality of life scores than treatment as usual at 4-month and 1-year follow-up for adults who had experienced multiple incident index trauma (non-significant effects at endpoint). Very low quality evidence from 1-6 RCTs (N=51-646) suggests non-significant effects on global functioning and discontinuation.

Combined somatic and cognitive therapies for delayed treatment (>3 months)

- Low to very low quality evidence from 1-5 RCTs (49-544) suggests large and statistically significant benefits of combined somatic and cognitive therapies (alone or in addition to TAU), relative to waitlist (alone or in addition to TAU), on improving PTSD symptomatology (self-rated and clinician-rated), the rate of

remission, anxiety and depression symptoms, and sleeping difficulties in adults with PTSD over 3 months after trauma. However, hetergeneity is very high for self-rated PTSD symptomatology. Sub-analysis by specific intervention suggests some differential effects of combined somatic and cognitive therapies, with the largest effect observed for emotional freedom technique (EFT). Sub-analysis by trauma type also suggests some differential effects with larger effects observed for military combat veterans. Very low quality evidence from 5 RCTs (N=607) suggests there may be higher discontinuation associated with combined somatic and cognitive therapies, however, this effect is not statistically significant.

Resilience-oriented treatment for delayed treatment (>3 months)

- Low quality single-RCT (N=39) evidence suggests large and statistically significant benefits of resilience-oriented treatment relative to waitlist on improving self-rated PTSD symptomatology, anxiety and depression symptoms, in adults with PTSD over 3 months after trauma. Very low quality evidence from the same RCT suggests a non-significant effect on discontinuation.

Attention bias modification for delayed treatment (>3 months)

- Very low quality evidence from 2-3 RCTs (N=118-170) suggests clinically important but not statistically significant effects in favour of attention-placebo relative to attention bias modification on PTSD symptomatology (self-rated and clinician-rated) at endpoint, in adults with PTSD over 3 months after trauma. Low to very low quality evidence from 1-3 RCTs (N=72-170) suggests non-significant effects on anxiety and depression symptoms and discontinuation.

Couple interventions for delayed treatment (>3 months)

- Very low quality single-RCT (N=40) evidence suggests a large and statistically significant benefit of cognitive-behavioural conjoint therapy relative to waitlist on the rate of remission for PTSD symptoms, in adults with PTSD over 3 months after trauma. However, evidence from the same RCT suggests non-significant effects in the rate of response for PTSD symptoms, response for relationship difficulties, and remission for relationship difficulties. There is some evidence for higher drop-out associated with cognitive-behavioural conjoint therapy, however, this effect is not statistically significant.
- Very low quality single-RCT (N=41-57) evidence suggests large and statistically significant benefits of cognitive-behavioural conjoint therapy relative to psychoeducation sessions on PTSD symptomatology (self-rated and clinician-rated), anxiety symptoms and relationship difficulties at endpoint and 3-month follow-up, the rate of remission at endpoint (no follow-up available), and depression symptoms at 3-month follow-up (clinically important but not statistically significant at endpoint), in adults with PTSD over 3 months after trauma. Evidence from this same RCT suggests non-significant differences between cognitive-behavioural conjoint therapy and psychoeducation on discontinuation.

Parent training/family interventions for delayed treatment (>3 months)

- Very low quality single-RCT (N=142) evidence suggests non-significant effects of family therapy relative to waitlist on self-rated PTSD symptomatology and anxiety symptoms in adults with PTSD over 3 months after trauma. No other outcomes are available.
- Very low quality single-RCT (N=28-65) evidence suggests a moderate and statistically significant benefit of child-parent psychotherapy (using play) versus case management and individual treatment (for parent-only) on improving clinician-rated PTSD symptomatology, and a clinically important but not

statistically significant benefit on the rate of remission, in adults with PTSD over 3 months after trauma. Evidence from this same RCT suggests a non-significant effect on discontinuation.

Self-help with support for delayed treatment (>3 months)

- Low to very low quality evidence from 1-6 RCTs (N=42-545) suggests large and statistically significant benefits of self-help with support (alone or in combination with TAU) relative to waitlist or TAU on improving self-rated PTSD symptomatology and anxiety and depression symptoms (at endpoint, 1-3 month and 1-year follow-up), clinician-rated PTSD symptomatology and functional impairment (at endpoint and 1-month follow-up [longest follow-up]), response, quality of life and sleeping difficulties (at endpoint), in adults with PTSD over 3 months after trauma. Very low quality evidence from 2 RCTs (N=211) suggests a clinically important but not statistically significant benefit of self-help with support on the rate of remission. Low to very low quality evidence from 1-7 RCTs (N=34-673) suggests non-significant effects of self-help with support on alcohol use disorder symptoms, substance use disorder symptoms (at endpoint and 3-month follow-up) and discontinuation. Sub-analysis of self-rated PTSD symptomatology by baseline severity showed non-significant subgroup differences.
- Very low quality single-RCT (N=85) evidence suggests neither clinically important nor statistically significant differences between self-help with support and trauma-focused CBT on self-rated PTSD symptomatology, dissociative symptoms, anxiety symptoms, or depression symptoms, at 2-month or 1-year follow-up (no endpoint data available) in adults with PTSD over 3 months after trauma.
- Very low quality single-RCT (N=43) evidence suggests a large and statistically significant benefit of a psychoeducational website without support relative to computerised trauma-focused CBT with support on anxiety symptoms at endpoint, in adults with PTSD over 3 months after trauma. However, this effect was not maintained at 3-month follow-up. Low to very low quality evidence from this same RCT (N=41-87) also suggests non-significant effects on clinician-rated PTSD symptomatology, response and depression symptoms at endpoint and 3-month follow-up, and discontinuation.

Self-help without support for delayed treatment (>3 months)

- Low to very low quality evidence from 2-5 RCTs (N=103-288) suggests moderate and statistically significant benefits of self-help without support relative to waitlist on improving self-rated PTSD symptomatology, the rate of remission (at endpoint and 3-6 month follow-up), response at endpoint (clinically important but not statistically significant at 3-6 month follow-up), and functional impairment and depression symptoms at endpoint (non-significant at 6-month follow-up), in adults with PTSD over 3 months after trauma. Very low quality evidence from 3 RCTs (N=121) suggests a clinically important but not statistically significant benefit of self-help without support on anxiety symptoms at endpoint (non-significant at 6-month follow-up). Low quality evidence from 7 RCTs (N=434) suggests higher drop-out may be associated with self-help without support, however, this effect is not statistically significant. Sub-analysis of self-rated PTSD symptomatology by baseline severity showed non-significant subgroup differences.
- Very low quality evidence from 5 RCTs (N=358-377) suggests moderate and statistically significant benefits of self-help without support relative to attention-placebo on improving self-rated PTSD symptomatology at endpoint, and a clinically important but not statistically significant benefit on improving depression symptoms at endpoint, in adults with PTSD over 3 months after trauma. These effects were not maintained at 1-month follow-up. Moderate to very low quality

evidence from 1-4 RCTs (N=36-283) also suggests non-significant effects on clinician-rated PTSD symptomatology, remission, anxiety symptoms and discontinuation.

Economic evidence statements

Trauma-focused CBT

- Evidence from 1 Australian economic evaluation conducted alongside a RCT (N = 354; missing data on approximately 27% of participants were imputed by multiple imputation) suggests that, compared with psychoeducation, trauma-focused CBT is likely to be cost-effective for the treatment of PTSD in adults with PTSD and at high distress but unlikely to be cost-effective for the treatment of PTSD in adults with PTSD and at low distress. This evidence is partially applicable to the UK context and is characterised by minor methodological limitations.
- Evidence from 1 Australian model-based economic study suggests that trauma-focused CBT is likely to be cost-effective for the treatment of PTSD in adults compared with treatment as usual. This evidence is partially applicable to the UK context and is characterised by potentially serious limitations.
- Evidence from 1 US before-after study suggests that trauma-focused CBT (exposure therapy /prolonged exposure) is likely to be more cost-effective compared with no treatment. This evidence is partially applicable to the UK and is characterised by potentially serious limitations.
- Evidence from 1 US economic evaluation conducted alongside a RCT with a preference arm (N=200; preference arm n=97, completers n=69; RCT n=103; completers n=58) suggests that trauma-focused CBT (exposure therapy / prolonged exposure) is likely to be more cost-effective compared with sertraline. This evidence is partially applicable to the UK and is characterised by potentially serious limitations.

Non-trauma-focused CBT

- Evidence from 1 US economic evaluation conducted alongside a RCT (N=101; at 1-year follow up: n=66) suggests that, compared with psychoeducation, non-trauma-focused CBT results in lower costs, similar effects on PTSD symptoms and modestly lower effects on depressive symptoms and functioning in adults with chronic combat-related PTSD and depressive disorder. This evidence is partially applicable to the UK and is characterised by potentially serious limitations.

Psychological, pharmacological and combined interventions

- Evidence from the guideline economic analysis suggests that brief TF-CBT individual (<8 sessions), psychoeducation, EMDR, combined somatic and cognitive therapies and self-help with support are the 5 most cost-effective interventions for the treatment of PTSD in adults. TF-CBT individual >12 sessions, counselling combined TF-CBT + SSRI, group TF-CBT and present-centered therapy appear to be less cost-effective relative to other active interventions. Counselling and TF-CBT individual > 12 sessions were also found to be less cost-effective than no treatment in the base-case analysis. In-between, there is another group of interventions (SSRIs, TF-CBT individual 8-12 sessions, self-help without support, non-TF-CBT and IPT) that occupied middle cost effectiveness rankings (i.e. places 6-10) in the base-case analysis. The result for psychoeducation, which was found to be among the most cost-effective interventions, should be interpreted with great caution due to the limitations in the evidence. The economic analysis is directly applicable to the NICE decision-making context and is overall

characterised by minor limitations, mainly relating to the NMAs that informed the analysis.

Recommendations

1. **Offer individual trauma-focused CBT to adults with a diagnosis of PTSD or clinically important symptoms of PTSD more than 1 month after a traumatic event.**

2. **Trauma-focused CBT for adults should:**
   - be based on a manual of evidence-based treatment
   - typically be provided over 8–12 sessions
   - include psychoeducation about reactions to trauma, strategies for managing arousal and safety planning
   - involve family members or carers as appropriate
   - involve elaboration and processing of the trauma memories
   - involve restructuring trauma-related meanings for the individual
   - provide help to overcome avoidance
   - have a focus on re-establishing a healthy lifestyle, for example work and social relationships
   - prepare them for the end of treatment
   - include planning booster sessions if needed, particularly in relation to significant dates (for example trauma anniversaries).

3. **Offer eye movement desensitisation and reprocessing (EMDR) as an option for non-combat-related trauma to adults with a diagnosis of PTSD or clinically important symptoms of PTSD more than 3 months after a traumatic event.**

4. **EMDR for adults should:**
   - be based on a validated manual
   - typically be provided over 8–12 sessions but more if clinically indicated, for example, where people have experienced multiple traumas
   - be delivered in a phased manner and include psychoeducation about reactions to trauma; managing distressing memories and situations; identifying and treating target memories (often visual images); and promoting alternative positive beliefs about the self
   - use repeated in-session bilateral stimulation (for example, eye movements, taps, or tones) for specific target memories until the memories are no longer distressing
   - use self-calming techniques in session.

5. **Consider supported trauma-focused computerised CBT for adults with a diagnosis of PTSD or clinically important symptoms of PTSD more than 3 months after a traumatic event who do not want or have not been able to engage in face-to-face trauma-focused CBT or EMDR.**

6. **Consider symptom-specific CBT interventions (for symptoms such as those for sleep disturbance or anger) for adults with a diagnosis of PTSD or clinically important symptoms of PTSD more than 3 months after a traumatic event who:**
    - are unable or unwilling to engage in a trauma-focused intervention that specifically targets PTSD **or**
    - have residual symptoms after a trauma-focused intervention.

7. **For people with additional needs, including those with complex PTSD:**
    - help the person manage any symptoms, such as dissociation or emotional dysregulation, that might be a barrier to engaging with trauma-focused therapies
    - ensure adequate time is included in treatment for the person to establish trust
    - take into account the safety and stability of the person's personal circumstances (for example their housing situation) and how this might impact on engagement with and success of treatment
    - increase the number of trauma-focused therapy sessions according to the person's needs
    - plan any ongoing support the person needs, for example to start or return to everyday activities and ongoing symptom management.

8. **Do not offer psychologically-focused debriefing to adults for the prevention or treatment of PTSD.**

Rationale and impact

Why the committee made the recommendations

Trauma-focused CBT

There was extensive evidence that trauma-focused CBT improves PTSD symptoms as well as other important outcomes, and that these improvements can be maintained up to a year later. Benefits were seen across a wide range of specific types of trauma-focused CBT intervention of varying durations, and for different types of trauma. Trauma-focused CBT was effective both alone and in addition to treatment as usual and/or medication.

There was good evidence that offering up to 12 sessions of individual trauma-focused CBT was clinically and cost-effective. Group trauma-focused CBT was not seen to be clinically or cost-effective based on the guideline network meta-analysis and economic analysis, although the evidence was limited.

The committee used their experience to agree the structure and content of individual trauma-focused CBT sessions to make sure these interventions are delivered in a consistent way because they were concerned that this may not happen in practice.

Psychoeducation was found to be highly clinically and cost effective in comparisons with psychological interventions according to the guideline network meta-analysis and economic analysis, but its evidence base was very limited and uncertain. The

committee agreed that the evidence could not support a recommendation for psychoeducation on its own but it should be delivered as part of individual trauma-focused CBT.

Eye movement desensitisation and reprocessing (EMDR)

Less evidence was found on EMDR than on trauma-focused CBT, but the committee agreed that what was available justified recommending EMDR as an option. Although studies that compared EMDR directly with trauma-focused CBT did not show significant differences, there was a trend towards EMDR. This trend in favour of EMDR was also present in the cost effectiveness results. The evidence suggested EMDR may be less effective in people with military combat-related trauma, so the committee restricted their recommendation to non-combat-related trauma.

Although EMDR uses the same broad approach, the committee was concerned that psychological interventions are not always delivered in a consistent way, so they used their experience to agree a specific structure and content.

Complex PTSD

The evidence was limited on interventions for people who have complex PTSD, but it suggested that trauma-focused therapies could also benefit this group. Based on their experience, the committee proposed ways of modifying interventions to address the barriers people with complex PTSD might have to engaging in treatment, like offering more sessions and avoiding an abrupt end to treatment by planning ongoing support.

Supported trauma-focused computerised CBT

There was evidence that both supported and unsupported self-help, and computerised trauma-focused CBT in particular, were beneficial in terms of self-rated PTSD symptoms and other important outcomes. These benefits were maintained up to a year later. Both interventions were cost-effective compared with other psychological interventions. The evidence was limited for some of the outcomes that were looked at, and it was unclear whether self-help was effective across different types of trauma. Although both supported and unsupported self-help were found to be effective, the former was more clinically and cost effective. Taking the evidence for efficacy, together with the gaps in the evidence, the committee agreed that supported computerised trauma-focused CBT should be an option for adults with PTSD who would find it difficult to engage in face-to-face trauma-focused CBT or EMDR.

Non-trauma-focused interventions

There was some evidence that non-trauma-focused CBT is beneficial when targeted at associated symptoms such as sleep disturbance or anger, and also leads to improvements in PTSD symptoms, but it was not clear how long these benefits would be maintained. Non-trauma-focused CBT was less cost-effective than individual trauma-focused CBT, EMDR and self-help, but more cost-effective than other interventions such as interpersonal psychotherapy (IPT), present-centered therapy, group trauma-focused CBT, combined individual trauma-focused CBT and SSRIs, counselling and no treatment. The committee agreed the potential benefits of non-trauma-focused CBT were important, but that symptom-specific interventions should not be seen as an alternative to a trauma-focused first-line treatment. Instead, they could be an option when people are not ready to directly confront memories of the trauma and could promote uptake and engagement with a trauma-focused intervention that specifically targets PTSD.

Psychologically-focused debriefing

There was no evidence on psychologically-focused debriefing for the treatment of PTSD. However, based on evidence showing no clinically important benefit and potentially harmful effects for debriefing within the first month of trauma and the committee's own concerns about the use of this intervention for treatment, the committee agreed it should not be offered. See evidence review C for more evidence and discussion on debriefing.

Other psychological interventions

The committee agreed not to make recommendations about other psychological interventions that were not well supported by the evidence. There was no evidence that any of the other interventions would be more suitable in specific clinical circumstances than the ones they had already recommended. The committee noted that counselling was shown to be less cost-effective than no treatment in the guideline economic analysis.

There was evidence on the clinical and cost effectiveness of combined somatic and cognitive therapies. However, the evidence for outcomes other than PTSD symptoms was very limited, no follow-up data were available, and there were concerns about the generalisability of results given the more restricted trauma types and limited evidence from those with a diagnosis of PTSD.

Timing of interventions

The evidence for providing treatment for PTSD between 1 and 3 months after a traumatic event was limited across different interventions. Based on this limited evidence and their own experience, the committee agreed that it was important to focus treatment on the time period when they were most certain that people would benefit – that is, more than 3 months after the trauma. One exception to this is for trauma-focused CBT where the committee extrapolated from limited evidence showing benefits between 1 and 3 months after trauma, and the broader evidence base that showed benefits within the first month and more than 3 months after trauma. It is unlikely that effects would be different in this 2-month time period, so the committee recommended trauma-focused CBT for adults with a diagnosis of PTSD or clinically important symptoms of PTSD more than 1 month after a traumatic event.

Impact of the recommendations on practice

Previous treatment recommendations were made for adults with PTSD, whereas current recommendations are relevant to adults with a diagnosis of PTSD or with clinically important symptoms of PTSD. The committee noted that the structure, content and time of the assessment, as well as the benefits from treatment are broadly the same for both populations and expressed the view that the population covered in the current treatment recommendations does not represent a significant broadening of the population that was covered by the previous guideline recommendations, and indeed many individuals with clinically important symptoms of PTSD that are below the diagnostic threshold for PTSD will eventually develop a diagnosis of PTSD.

Both trauma-focused CBT and EMDR were recommended by the 2005 guideline, and the committee did not think there was wide variation in practice. The new recommendation for non-trauma-focused symptom-specific CBT interventions represents a bigger change in practice because the 2005 guideline recommended that non-trauma-focused interventions should not be routinely offered to people with

chronic PTSD. The impact on resources is difficult to predict because it is recommended only as an option to consider, but it might bring potential savings by improving uptake and engagement with trauma-focused therapies that should reduce missed appointments and early drop-out.

The recommendation for supported computerised trauma-focused CBT is also thought to represent a bigger change in practice. There was no 2005 recommendation for self-help-based interventions and the committee were not aware of such interventions being in widespread use in routine clinical practice. The cost of supported computerised trauma-focused CBT includes, in addition to therapist's time, the cost of the digital mental health programmes and equipment (computers) needed for delivery. If the intervention is delivered in a public place, such as a library, or the person's home, there is no equipment cost. If the computer is used in a clinical practice setting, it can be shared by many people having computerised therapy, minimising the equipment cost. It could therefore lead to cost savings if part of routine practice is shifted from the more resource-intensive individual trauma-focused CBT and EMDR to the less resource-intensive supported computerised trauma-focused CBT.

The committee acknowledged that there would be a cost associated with providing extra trauma-focused therapy sessions for people with complex PTSD if they are necessary. Previous recommended practice was to consider more than 12 sessions for people after multiple incident trauma, or who have chronic disability or significant coexisting conditions or social problems. However, in clinical practice the provision of additional sessions is variable.

The committee's discussion of the evidence

Interpreting the evidence

Outcomes that matter the most

Critical outcomes were measures of PTSD symptom improvement on validated scales, remission (as defined as a loss of diagnosis or scoring below threshold on a validated scale), and response (as measured by an agreed percentage improvement in symptoms and/or by a dichotomous rating of much or very much improved). Attrition from treatment (for any reason) was also considered an important outcome, as a proxy for the acceptability and/or tolerability of treatment. The committee considered dissociative symptoms, personal/social/occupational functioning (including global functioning/functional impairment, sleeping or relationship difficulties, and quality of life), and symptoms of a coexisting condition (including anxiety, depression and substance use disorder symptoms) as important but not critical outcomes. This distinction was based on the primacy of targeting the core PTSD symptoms, whilst acknowledging the influence that wider benefits may have on decision-making about the efficacy of a given intervention. Generally change scores were favoured over final scores as although in theory randomisation should balance out any differences at baseline, this assumption can be violated by small sample sizes. The committee also expressed a general preference for self-rated PTSD symptomatology, however, in considering psychological interventions (relative to pharmacological interventions) a greater emphasis was placed on triangulating effects on self-rated PTSD symptomatology with clinician-rated outcome measures, given that the latter but not the former could be blinded.

The quality of the evidence

With the exception of less than a handful of outcomes of moderate quality, all the evidence reviewed was of low or very low quality, reflecting the high risk of bias associated with the studies (including for instance, high risk of bias associated with randomisation method as reflected by significant group differences at baseline, and lack of/unclear blinding of outcome assessment), the small numbers in many trials and the imprecision of many of the results (in terms of both the width of the confidence intervals and the failure to meet the optimal information size).

The quality of the NMAs that informed the economic analysis has been affected by the quality and limitations of the studies included in each of them. The NMA of changes in PTSD symptom scale scores at treatment endpoint, which informed the guideline base-case economic analysis, showed no evidence of inconsistency between direct and indirect evidence. On the other hand, some evidence of inconsistency was identified in the NMA of continuous data at 1-4 month follow-up and the NMA of dichotomous remission data at treatment endpoint, both of which informed secondary economic analyses. Heterogeneity across all NMAs was found to be high. In all NMAs, relative effects of most interventions versus waitlist were very large and characterised, in many cases, by considerably wide 95% credible intervals. The committee noted these limitations when interpreting the results of the NMAs but also the cost effectiveness results.

Effects for some interventions in the NMA were informed by limited evidence: group trauma-focused CBT offered in 8-12 sessions, present centered therapy and IPT were tested on fewer than 100 individuals regarding the change in PTSD symptoms scores at treatment endpoint. In the outcome of remission, non-trauma-focused CBT, group trauma-focused CBT offered in 8-12 sessions, IPT, present-centered therapy, self-help without support, and individual trauma-focused CBT offered in 8-12 sessions combined with SSRI were also tested on fewer than 100 participants each. Even more limited evidence was available in the NMA of continuous follow-up data: effects for combined somatic and cognitive therapies, IPT and self-help without support were based on data from fewer than 50 participants for each intervention, whereas effects for individual trauma-focused CBT offered in more than12 sessions, present-centered therapy and self-help with support were based on data from 50-100 participants each. The committee noted that individual trauma-focused CBT offered in 8-12 sessions had the most robust evidence base across all outcomes assessed in the NMA.

However, the committee agreed to make strong recommendations despite uncertainty in the evidence, as the breadth of outcomes considered allowed triangulation of effects, and greater confidence was conferred where long-term follow-up was available. Strong recommendations were also supported by economic evidence. The committee decided to make weaker ('consider') recommendations on interventions that were supported by a more limited evidence base.

Consideration of clinical benefits and harms

The committee discussed the strength and breadth of the evidence for trauma-focused CBT, with benefits observed on both clinician-rated and self-rated measures of PTSD symptomatology, the rate of remission and response, and on other outcomes including depression, anxiety, dissociative symptoms, global functioning, functional impairment, and relationship difficulties. Clinical efficacy was also observed across: a range of trauma types (including motor vehicle collisions, terrorist attacks, natural disasters, witnessing war as a civilian, military combat, being an emergency responder, childhood sexual abuse, and sexual assault or abuse in adulthood); both single and multiple incident index traumas; both those with a diagnosis of PTSD and those with clinically important symptoms (who may not

necessarily have a diagnosis); and across specific trauma-focused intervention types (both those that place emphasis on exposure and those that place emphasis on cognitive techniques). Taken together with evidence suggesting that benefits are potentially long-lasting, the committee agreed that trauma-focused CBT should be offered as a first-line treatment to adults with PTSD. The committee discussed the limited evidence for the efficacy of trauma-focused CBT as early treatment (initiated within 1-3 months of trauma). However, they agreed that this evidence is weaker and judged it to be more important to focus therapeutic attention on the time periods associated with greatest certainty of benefit, namely within the first month of trauma for those with clinically important symptoms (see Evidence Report C)and for adults with PTSD who have been exposed to trauma more than 3 months ago.

The committee noted that although interventions within the trauma-focused CBT class are using the same broad approach, efficacy is considered to be equivalent across specific interventions, and there is considerable overlap in the techniques and proposed mechanisms of the various versions of trauma-focused CBT. Given this class is a somewhat broad umbrella, it was therefore important to specify the content and structure of the recommended intervention. The committee also expressed concern that psychological interventions are not always implemented consistently. For example, audits have suggested less-than-recommended number of sessions are used in practice. The recommended structure and content of trauma-focused CBT (number of sessions, manualised, included content) is informed by the interventions in the RCTs, and modified by the expert advice of the committee. This recommendation seeks to ensure clarity and consistency, and that use in routine practice reflects the interventions in the clinical trials on which efficacy estimates are based. In discussing this recommendation, the committee were also mindful that although the evidence for trauma-focused CBT is compelling, heterogeneity is high across outcomes and could not be accounted for by planned sub-analyses (by multiplicity of trauma, specific intervention, diagnostic status at baseline, or trauma type). The committee speculated on other potential causes of this heterogeneity, including sub-optimal patient to treatment matching. Based on these discussions, the committee drafted the recommendation about the content and structure of trauma-focused CBT in a way that allowed enough flexibility for the clinician to modify treatment to the individual, but enough specificity to ensure a minimum standard is set.

In the NMAs that informed the economic analysis, the committee attempted to assess the effect of trauma-focused CBT in relation to its mode of delivery (individually or in groups) and the number of sessions provided. According to the NMA findings, individual trauma-focused CBT was effective, but increasing the number of sessions of individual trauma-focused CBT did not appear to translate into higher efficacy in terms of PTSD symptomatology. The committee attributed these findings to the populations in the studies that assessed individual trauma-focused CBT of different intensity: the committee expressed the view (which was confirmed by inspection of the clinical data) that it was likely that study participants who were recruited in trials that assessed a higher number of sessions of individual trauma-focused CBT also had more severe symptoms of PTSD at baseline, and therefore were likely to have a more limited response to treatment compared with study participants in trials that tested a smaller number of individual trauma-focused CBT sessions. The committee noted that there was evidence that the treatment effect was sustained beyond treatment endpoint for individual trauma-focused CBT of 8 to 12 sessions, and that the evidence on the effects beyond treatment endpoint for fewer or more sessions of individual trauma-focused CBT was uncertain.

The committee noted that 8-12 sessions of group trauma-focused CBT were not effective, that the evidence for group trauma-focused CBT of more than 12 sessions was very limited and uncertain, and that there was no evidence for the effects of group trauma-focused CBT beyond treatment endpoint. The committee therefore decided to make a recommendation specifically for individual trauma-focused CBT.

Although the evidence (clinical and economic) favoured briefer individual-based trauma-focused CBT (up to 8 sessions), the committee chose to recommend 8-12 sessions as the standard. This is based on the standard number of sessions outlined in most validated treatment manuals, and was also motivated by the committee's concern that if less than 8 sessions were recommended, no one would ever be offered more than 8 sessions, and this could be a particular problem for people who need additional time to build a trusting therapeutic relationship. The committee were also mindful of the recommendation for supported computerised trauma-focused CBT (see below), which meant that an alternative lower intensity psychological intervention was available where this is clinically appropriate.

The NMA suggested that psychoeducation was highly effective compared with other psychological interventions, however, the evidence base was very limited and highly uncertain and did not warrant a recommendation for psychoeducation on its own. Nevertheless, the evidence supported a recommendation on psychoeducation as part of individual trauma-focused CBT.

The evidence also suggests large benefits of EMDR, with significant effects relative to waitlist or treatment as usual, and relative to less directive psychological interventions (suggesting that efficacy cannot be accounted for solely by non-specific factors). The committee discussed how best to sequence these two psychological interventions. In considering the relative efficacy of trauma-focused CBT and EMDR, the committee grappled with the greater weight of evidence for trauma-focused CBT in terms of the number of RCTs, the direct head-to-head comparison suggesting non-significant differences but a trend for EMDR, and the more restricted evidence base for EMDR in terms of the breadth of outcome meaures used/reported (for instance, much less data for clinician-rated PTSD symptomatology) and the length of follow-up. Moreover, the guideline NMA suggested that EMDR was among the most effective psychological treatment options, less than trauma-focused CBT offered in 8 sessions, but more than trauma-focused CBT offered in 8-12 sessions. Therefore, a strong recommendation for EMDR was considered appropriate. This follows on from the evidence and promotes patient choice. However, this recommendation was restricted to those with non-combat-related trauma as the evidence suggests non-significant effects of EMDR for those who have experienced military combat-related trauma.

In discussing the evidence for trauma-focused therapies for the treatment of PTSD in adults, the committee were mindful of proposed changes to the World Health Organization's (WHO) International Statistical Classification of Diseases and Related Health Problems, 11th Edition (ICD-11), that adopts complex PTSD as a diagnostic category. Given that the evidence on which these recommendations are based predates the formal release of the new diagnosis, the strength of the evidence in relation to complex PTSD is inevitably weaker than in relation to PTSD. The committee attempted to address the issue of potential differential efficacy by using multiple incident index trauma as a proxy for complexity. Sub-analyses by trauma type were also examined. The committee recognised that this proxy was imperfect but were limited by the evidence available. The results suggest that both trauma-focused CBT and EMDR could be effective for complex PTSD, and this makes theoretical sense as complex PTSD is by definition a subset of ICD-11 PTSD. There

is some evidence that even without modification, interventions that are effective for PTSD can also be effective for complex PTSD, but possibly to a lesser extent (e.g. Dorrepaal et al. 2012). However, the committee discussed that those with complex PTSD are likely to have more severe symptoms and consequently greater impairment of function and thus interventions may require some minor modifications whilst maintaining the core components of the intervention when offered to those with complex PTSD, such as an increase in the number of sessions. The committee also discussed particular difficulties that may be experienced in establishing a trusting therapeutic relationship for those who have experienced repetitive and prolonged relational trauma, and recommended that where necessary more time should be taken to establish the person's trust in treatment. The committee also noted the importance of planning for ongoing support needs in order to ameliorate the risk arising from residual symptoms, relapse and the ending of the supportive therapeutic relationship. The committee prioritised this area as one for further research (see Appendix L).

The committee discussed the evidence for benefits of self-help (both with and without support) in general, with a specific focus on computerised trauma-focused CBT, and were both surprised and encouraged by the strength of the evidence as at the time of the previous guideline only one trial of guided self-help had been conducted, which failed to show any benefit from this intervention. The results from this review, although not entirely anticipated, are in line with many other anxiety and depressive disorders, where there is good evidence for the efficacy of self-help-based interventions. There is no direct evidence for the relative efficacy of supported versus non-supported computerised trauma-focused CBT and other comparisons are confounded by differences in the type of self-help. Results of the NMA did, however, suggest a greater effect size associated with self-help with support compared with self-help without support. The committee discussed that although evidence was good for self-rated PTSD symptomatology and other important outcomes (including quality of life, anxiety symptoms and depression symptoms), and there is some evidence for longer-lasting effects, there are areas where evidence is much more limited, including clinician-rated PTSD symptomatology, remission and response. There is also more uncertainty regarding the generalisability of findings, for example, the trauma types examined are much more restricted. Taking the evidence for efficacy, together with the gaps in the evidence, the committee agreed that supported computerised trauma-focused CBT should be considered as an option for adults with PTSD. The committee also noted that the greater opportunity for patient choice that this recommendation offers is also in line with results from the qualitative evidence meta-synthesis (see Evidence report H) that suggests that service users require flexibility in the delivery of treatment, often favouring treatments that can be accessed in non-clinical environments.

The committee considered the benefits of non-trauma-focused symptom-specific CBT interventions, in the context of the considerable distress that can be caused by specific PTSD symptoms, for example intrusive recollections or nightmares concerning the event, specific sleep disturbance, social withdrawal, irritability or more generalised distress, and the potential for these symptoms to significantly interfere with social, educational and occupational functioning. The committee also noted that specific or associated symptoms can lead people to self-medicate with drugs or alcohol, which in turn can lead to additional functional impairments. The NMA on continuous outcomes at treatment endpoint (which was the NMA of best quality) suggested that non-trauma-focused CBT had a modest effect and ranked in the middle of the range of psychological interventions. However, the committee agreed that symptom-specific CBT interventions should not be used as a stand-alone treatment for PTSD and a 'consider' rather than 'offer' recommendation was judged

to be appropriate. The committee discussed that not everyone will be ready to directly confront troubling memories of the traumatic event and the personal meanings of the event and its consequences (as required by trauma-focused CBT and EMDR), and for some a symptom-specific CBT intervention might promote access to, uptake of, and engagement with a trauma-focused intervention that specifically targets PTSD.

Given the considerable evidence for trauma-focused CBT, EMDR, self-help and non-trauma-focused symptom-specific CBT, the committee considered it appropriate to set a relatively high bar for other interventions. No evidence was identified for psychologically-focused debriefing (for treatment of PTSD symptoms more than 1 month after trauma) or for human givens therapy. There was limited evidence for neither significant benefits nor harms for problem solving or attention-bias modification. For some interventions (such as metacognitive therapy, single-session behavioural therapy, hypnotherapy, psychodynamic therapy, IPT, resilience-oriented treatment, cognitive-behavioural conjoint therapy, family therapy, child-parent psychotherapy using play), there was limited evidence for efficacy but the evidence base was considered too small to be confident that the benefits observed are true effects and thus a recommendation could not be supported. For other interventions, such as present-centered therapy and counselling, the committee noted their inferiority to recommended interventions, in terms of both clinical and cost effectiveness, and decided that a recommendation was not appropriate. Combined somatic and cognitive therapies, looked potentially more promising and required greater scrutiny and deliberation. The NMA of changes in PTSD symptom scale scores at treatment endpoint showed a high effect and good ranking for combined somatic and cognitive therapies relative to other interventions. However, given that less is known about the breadth of effects (very limited evidence for clinician-rated PTSD symptomatology, remission, other important associated symptoms and no follow-up), and that there is no evidence that they might be appropriate in cases where the recommended interventions are not (i.e. for specific indications), the committee came to the decision that the evidence was not quite sufficient to warrant a recommendation at this time. However, the committee did not prioritise this topic as an area for further research.

Although the evidence for trauma-focused CBT was overwhelmingly positive, the committee discussed the evidence suggesting a potential harm of trauma-focused CBT in terms of a significantly higher rate of drop-out relative to waitlist, and a small but still statistically significant higher drop-out where trauma-focused CBT augmented treatment as usual or medication relative to treatment as usual/medication-only. The committee discussed potential reasons for this higher rate of discontinuation, and speculated that trauma-focused CBT may be less acceptable to people who are not ready to directly confront traumatic memories, are not able to engage due to functional impairment from associated symptoms, and/or have difficulties in building a trusting therapeutic relationship. As existing recommendations for non-trauma-focused symptom-specific CBT interventions, modifications of trauma-focused therapies for those with additional needs (including complex PTSD), and engagement strategies for those with difficulties in building trust in the therapeutic relationship (based on the qualitative evidence [see evidence review H]) have the potential to address some of these reasons for discontinuation, the committee agreed that the potential for benefit was greater than the potential for harm. The committee also noted that effects on discontinuation only reached the threshold for clinical importance for the comparison against waitlist where there may be an additional incentive for waitlist participants not to drop-out, given that access to the intervention is contingent upon continuing in the trial. Furthermore, offering EMDR as an option for those with non-combat-related PTSD, or supported

computerised trauma-focused CBT as an alternative lower intensity intervention, allows people who may not find trauma-focused CBT acceptable to access another psychological intervention if they prefer.

Cost effectiveness and resource use

Existing economic evidence suggested that trauma-focused CBT is a cost-effective option for the treatment of PTSD in adults, compared with other active interventions (psychoeducation, sertraline), TAU or no treatment. Non-trauma-focused CBT also appears to be cost-effective relative to psychoeducation, based on very limited evidence. The committee took existing economic evidence into account but noted that this is only partially applicable to the UK, it assesses the relative cost effectiveness of a limited number of interventions, and the quality of the evidence is variable, with most of this evidence being characterised by potentially serious limitations.

The committee considered the results of the guideline base-case economic analysis when making recommendations, which was informed by a NMA of overall good quality, as the secondary economic analyses utilised NMAs that were characterised by potential inconsistency between direct and indirect evidence and a more limited evidence base. Results of the guideline economic analysis were directly applicable to the NICE decision-making context and were thus given more weight than existing evidence. The guideline base-case economic analysis was overall characterised by minor limitations, so the committee were confident to use its findings to support recommendations.

Results suggested that brief individual trauma-focused CBT (up to 8 sessions), psychoeducation, EMDR, combined somatic and cognitive therapies and self-help with support are among the 5 most cost-effective interventions for the treatment of PTSD in adults. Individual TF-CBT above 12 sessions, counselling, combined trauma-focused CBT + SSRI, group TF-CBT and present-centered therapy do not appear to be cost-effective relative to other active interventions assessed, as they all ranked in the bottom 5 places among active interventions across all analyses. Counselling and individual trauma-focused CBT above 12 sessions were also found to be less cost-effective than no treatment in the base-case analysis. In-between, there was another group of psychological interventions (individual trauma-focused TF-CBT 8-12 sessions, self-help without support, non-trauma-focused CBT and IPT) that occupied middle cost effectiveness rankings in the base-case analysis. These results were characterised by high uncertainty as no single intervention stood out clearly as the most cost-effective option. On the other hand, results were robust to alternative scenarios tested through deterministic sensitivity analysis.

The committee noted that individual trauma-focused CBT of fewer than 8 sessions was the most clinically and cost-effective form of individual trauma-focused CBT. Consistent with the results of the NMA, increasing the number of sessions of individual trauma-focused CBT reduced its cost effectiveness. The committee attributed this finding to the populations in the studies assessing individual trauma-focused CBT of different intensity: they expressed the opinion that participants who were recruited in trials that assessed a higher number of individual trauma-focused CBT sessions were likely to have more severe symptoms of PTSD at baseline, and therefore they were likely to have a more limited response to treatment compared with participants in trials that tested a smaller number of individual TF-CBT sessions. Nevertheless, individual trauma-focused CBT of 8-12 sessions was also a cost-effective option (albeit less cost-effective than individual trauma-focused CBT of fewer than 8 sessions, EMDR, psychoeducation, combined somatic and cognitive therapies, and supported self-help) and had the most solid evidence base among all

interventions assessed in the economic analysis. Therefore, the committee expressed the opinion that the economic evidence did support a recommendation for 8-12 sessions of trauma-focused CBT delivered individually as the standard offer, which is the standard number of sessions outlined in most validated treatment manuals and represents good practice as described in the previous section. In contrast, group trauma-focused CBT, individual trauma-focused CBT above 12 sessions and combined individual trauma-focused CBT + SSRI were not cost-effective options and were not considered for recommendation.

The committee noted that the result for psychoeducation should be interpreted with great caution due to the limited and uncertain evidence base, and decided not to recommend psychoeducation on its own, but as part of individual trauma-focused CBT.

The committee expressed the view that the high cost effectiveness of EMDR, alongside clinical evidence, justified a strong recommendation. It was noted that EMDR was offered in 6 sessions in economic modelling, based on the average resource use reported in the trials that informed the NMA and economic analysis. Nevertheless, the committee tested also 10 sessions of EMDR in the economic model and noted that its relative cost effectiveness was not substantially affected (it dropped only one place in cost effectiveness ranking). Therefore, they decided to recommend 8-12 sessions of EMDR, in line with validated treatment manuals.

The committee took into account the relatively high cost effectiveness of self-help with support when making a recommendation for supported computerised trauma-focused CBT, and noted that the greater effect sizes associated with self-help with support were sufficient to offset its greater costs compared with self-help without support. However, as supported self-help was less cost-effective than brief trauma-focused CBT and EMDR and had a narrower evidence base, the committee made a weaker ('consider') recommendation for adults who do not want or have not been able to engage in face-to-face trauma-focused CBT or EMDR.

The committee considered the high relative cost effectiveness of combined somatic and cognitive therapies. However, taking into account the very limited evidence for a variety of important clinical outcomes and the lack of specific indications for these interventions, they decided not to make a recommendation.

Finally, among the interventions that occupied middle cost effectiveness rankings, non-trauma-focused CBT had the wider evidence base after self-help with support. The committee considered the relative cost effectiveness of non-trauma-focused CBT together with its clinical benefits and decided that this evidence warranted a 'consider' recommendation for adults who are unable or unwilling to engage in a trauma-focused intervention that specifically targets PTSD or for those who have residual symptoms after a trauma-focused intervention.

The committee judged that economic evidence for other interventions considered in the economic analysis, combined with clinical evidence, was not compelling and therefore decided not to make further recommendations.

When assessing the impact of treatment recommendations on available resources, the committee was aware that previous recommendations were made for adults with PTSD, whereas current recommendations are relevant to adults with a diagnosis of PTSD or with clinically important symptoms of PTSD. The latter are identified when people score above a pre-determined threshold on a validated PTSD symptom scale, which is indicative but not confirmatory of a diagnosis of PTSD. The committee noted that the assessment of a person with suspected PTSD includes a general

assessment of mental state, specific questions about the traumatic event(s), enquiries into specific traumatic hyper vigilance and intrusive thoughts and assessment of the impact of the symptoms on personal and social functioning. In current practice, the structure, content and time of the assessment is the same for people for whom a diagnosis of PTSD has been made and for people who have been identified to experience clinically important symptoms of PTSD. The committee noted that the decision to start treatment in both populations is influenced by the severity of symptoms, the trajectory of symptoms, any co-morbid mental disorders and the individual's preference for treatment. The committee expressed the opinion that the impact of experiencing clinically important PTSD symptoms on the person's social and personal functioning may be broadly similar to the impact of a formal diagnosis of PTSD, depending on the presence and/or intensity of the factors described above (i.e. severity and trajectory of symptoms and any co-morbid mental disorders) and decided that treatment recommendations should focus on both populations. The committee expressed the view that the population covered in the current treatment recommendations does not represent a significant broadening of the population that was covered by the previous guideline recommendations, and indeed many individuals with clinically important symptoms of PTSD that are below the diagnostic threshold for PTSD will eventually develop a diagnosis of PTSD.

The committee anticipated that the recommendations for individual trauma-focused CBT and EMDR will only result in a moderate change in practice, as both interventions were recommended by the previous guideline, and the committee did not think there was wide variation in practice. The committee expressed the view that the resource impact of the recommendation for non-trauma-focused symptom-specific CBT interventions might be bigger because the previous guideline recommends that non-trauma-focused interventions (which do not address traumatic memories) should not routinely be offered to people who present with chronic PTSD. However, as the recommendation is weak ('consider'), the extent of implementation and its impact on resources is difficult to predict. The committee agreed that implementation of this recommendation might bring potential savings by improving uptake and engagement with trauma-focused therapies that should reduce missed appointments and early drop-out.

The recommendation for supported computerised trauma-focused CBT is also thought to represent a bigger change in practice, as there was no recommendation for self-help-based interventions in the previous guideline and the committee were not aware of such interventions being in widespread use in routine clinical practice. The cost of supported computerised trauma-focused CBT includes, in addition to therapist's time, the cost of the provider of digital mental health programmes and related equipment required for delivery (e.g. personal computers). However, if the intervention is delivered in a public place (e.g. library) or the person's home, the equipment cost is zero. On the other hand, if a personal computer is used in a clinical practice setting, it can be shared by people with the same or other indications for computerised therapy (e.g. depression), thus minimising the relevant equipment cost. The committee expressed the view that implementation of this recommendation may lead to potential cost-savings, if part of routine practice is shifted from the more resource-intensive individual trauma-focused CBT and EMDR to the less resource-intensive supported computerised trauma-focused CBT. Nevertheless, since this recommendation is weak ('consider'), the extent of implementation and its impact on resources is difficult to predict.

The committee also made a negative ('do not offer') recommendation for psychologically-focused debriefing after considering clinical outcomes. This

recommendation is in line with what the previous guideline recommended and therefore no impact on resources is anticipated.

Other considerations

The committee noted how encouraging the evidence is for psychological treatments such as trauma-focused CBT for treating PTSD. However, they agreed that there is very little evidence to help professionals decide what to do next to treat or manage PTSD symptoms. It is essential to provide effective support to people who have not responded well to a first-line treatment, especially given the damaging effect of persistent PTSD on quality of life and mental and physical health. Therefore they prioritised this area as one for further research (see Appendix L).

The committee also discussed that there is limited evidence on how certain subpopulations with PTSD have differential response to alternative psychological treatments. For professionals this means that when they are discussing treatment options with people where there is no good evidence on which to base advice about which treatment they are most likely to benefit from. This increases the chance that people will have ineffective treatments. Therefore, they prioritised this area as one for further research (see Appendix L).

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Sijbrandij M, Olff M, Reitsma JB, et al. (2007) Treatment of acute posttraumatic stress disorder with brief cognitive behavioral therapy: a randomized controlled trial. American Journal of Psychiatry 164(1), 82-90

Sloan 2016a/2018

Sloan DM, Marx BP and Resick PA (2016) Brief treatment for PTSD: A non-inferiority trial. Contemporary clinical trials 48, 76-82

Sloan DM, Marx BP, Lee DJ and Resick PA (2018) A Brief Exposure-Based Treatment vs Cognitive Processing Therapy for Posttraumatic Stress Disorder: A Randomized Noninferiority Clinical Trial. JAMA psychiatry

Sloan 2016b/unpublished

Sloan DM, Unger W and Beck JG (2016) Cognitive-behavioral group treatment for veterans diagnosed with PTSD: Design of a hybrid efficacy-effectiveness clinical trial. Contemporary clinical trials 47, 123-30

Sloan DM, Unger W, Lee DJ and Beck JG (unpublished) A randomised controlled trail of cognitive-behavioural group treatment for veterans diagnosed with PTSD. [Under review]

Spence 2011

Spence J, Titov N, Dear BF, et al. (2011) Randomized controlled trial of Internet-delivered cognitive behavioral therapy for posttraumatic stress disorder. Depression and anxiety 28(7), 541-50

Stenmark 2013

Stenmark H, Catani C, Neuner F, et al. (2013) Treating PTSD in refugees and asylum seekers within the general health care system. A randomized controlled multicenter study. Behaviour research and therapy 51(10), 641-647

Suris 2013

Surís A, Link-Malcolm J, Chard K, et al. (2013) A randomized clinical trial of cognitive processing therapy for veterans with PTSD related to military sexual trauma. Journal of Traumatic Stress 26(1), 28-37

Taylor 2003

Taylor S, Thordarson DS, Maxfield L, et al. (2003) Comparative efficacy, speed, and adverse effects of three PTSD treatments: exposure therapy, EMDR and relaxation training. Journal of Consulting & Clinical Psychology 71(2), 330-338

van Emmerik 2008

Van Emmerik AA, Kamphuis JH and Emmelkamp PM (2008) Treating acute stress disorder and posttraumatic stress disorder with cognitive behavioral therapy or structured writing therapy: a randomized controlled trial. Psychotherapy and psychosomatics 77(2), 93-100

Weiss 2015 (study 1)

Weiss WM, Murray LK, Zangana GA, et al. (2015) Community-based mental health treatments for survivors of torture and militant attacks in Southern Iraq: a randomized control trial. BMC psychiatry 15(1), 249

Weiss 2015 (study 2)

Weiss WM, Murray LK, Zangana GA, et al. (2015) Community-based mental health treatments for survivors of torture and militant attacks in Southern Iraq: a randomized control trial. BMC psychiatry 15(1), 249

Wells 2015

Wells A, Walton D, Lovell K and Proctor D (2015) Metacognitive therapy versus prolonged exposure in adults with chronic post-traumatic stress disorder: A parallel randomized controlled trial. Cognitive Therapy and Research 39(1), 70-80

Zang 2014

Zang Y, Hunt N and Cox T (2014) Adapting narrative exposure therapy for Chinese earthquake survivors: A pilot randomised controlled feasibility study. BMC psychiatry 14(1), 1.v

Non-trauma-focused CBT

Davis 2007

Davis JL and Wright DC (2007) Randomized clinical trial for treatment of chronic nightmares in trauma-exposed adults. Journal of Traumatic Stress 20(2), 123-33

Davis 2011

Davis JL, Rhudy JL, Pruiksma KE, et al. (2011) Physiological predictors of response to exposure, relaxation, and rescripting therapy for chronic nightmares in a randomized clinical trial. Journal of clinical sleep medicine: JCSM: official publication of the American Academy of Sleep Medicine 7(6), 622

Dunn 2007

Dunn NJ, Rehm LP, Schillaci J, et al. (2007) A randomized trial of self-management and psychoeducational group therapies for comorbid chronic posttraumatic stress disorder and depressive disorder. Journal of Traumatic Stress 20(3), 221-37

Foa 1991

Foa EB, Rothbaum BO, Riggs DS, et al. (1991) Treatment of posttraumatic stress disorder in rape victims: a comparison between cognitive-behavioral procedures and counseling. Journal of Consulting & Clinical Psychology 59, 715-723

Hien 2009

Hien DA, Wells EA, Jiang H, et al. (2009) Multisite randomized trial of behavioral interventions for women with co-occurring PTSD and substance use disorders. Journal of consulting and clinical psychology 77(4), 607

Krakow 2000

Krakow B, Hollifield M, Schrader R, et al.(2000) A controlled study of imagery rehearsal for chronic nightmares in sexual assault survivors with PTSD: a preliminary report. J Trauma Stress 13(4), 589-609

Margolies 2013

Margolies SO, Rybarczyk B, Vrana SR, et al. (2013) Efficacy of a cognitive-behavioral treatment for insomnia and nightmares in Afghanistan and Iraq veterans with PTSD. Journal of Clinical Psychology 69(10), 1026-42

McGovern 2011

McGovern MP, Lambert-Harris C, Alterman AI, et al. (2011) A randomized controlled trial comparing integrated cognitive behavioral therapy versus individual addiction counseling for co-occurring substance use and posttraumatic stress disorders. Journal of dual diagnosis 7(4), 207-27

McGovern 2015

McGovern MP, Lambert-Harris C, Xie H, et al. (2015) A randomized controlled trial of treatments for co-occurring substance use disorders and post-traumatic stress disorder. Addiction 110(7), 1194-204

Nakamura 2017

Nakamura Y, Lipschitz DL, Donaldson GW, et al. (2017) Investigating Clinical Benefits of a Novel Sleep-Focused Mind-Body Program on Gulf War Illness Symptoms: A Randomized Controlled Trial. Psychosomatic medicine 79(6), 706-18

Talbot 2014

Talbot LS, Maguen S, Metzler TJ, et al. (2014) Cognitive behavioral therapy for insomnia in posttraumatic stress disorder: a randomized controlled trial. Sleep 37(2), 327-41

Zlotnick 1997

Zlotnick C, Shea TM, Rosen K, et al. (1997) An affect-management group for women with posttraumatic stress disorder and histories of childhood sexual abuse. Journal of Traumatic Stress 10, 425-436

Present-centered therapy

Johnson 2011

Johnson DM, Zlotnick C and Perez S (2011) Cognitive behavioral treatment of PTSD in residents of battered women's shelters: results of a randomized clinical trial. Journal of consulting and clinical psychology 79(4), 542

Johnson 2016

Johnson DM, Johnson NL, Perez SK, et al. (2016) Comparison of adding treatment of PTSD during and after shelter stay to standard care in residents of battered women's shelters: results of a randomized clinical trial. Journal of traumatic stress 29(4), 365-73

Ford 2011

Ford JD, Steinberg KL and Zhang W (2011) A randomized clinical trial comparing affect regulation and social problem-solving psychotherapies for mothers with victimization-related PTSD. Behavior Therapy 42(4), 560-78

McDonagh 2005

McDonagh A, Friedman M, McHugo G, et al. (2005) Randomized trial of cognitive-behavioral therapy for chronic posttraumatic stress disorder in adult female survivors of childhood sexual abuse. Journal of consulting and clinical psychology 73(3), 515

Cognitive therapies

Wells 2012

Wells A and Colbear JS (2012) Treating posttraumatic stress disorder with metacognitive therapy: A preliminary controlled trial. Journal of Clinical Psychology 68(4), 373-81

Wells 2015

Wells A, Walton D, Lovell K and Proctor D (2015) Metacognitive therapy versus prolonged exposure in adults with chronic post-traumatic stress disorder: A parallel randomized controlled trial. Cognitive Therapy and Research 39(1), 70-80

Behavioural therapies

Basoglu 2005

Basoglu M, Salcioglu E and Livanou M (2005) Single-session behavioural treatment of earthquake-related posttraumatic stress disorder: a randomised waiting list controlled trial, Journal of Traumatic Stress 18, 1-11

Basoglu 2007

Başoğlu M, Şalcioğlu E and Livanou M (2007) A randomized controlled study of single-session behavioural treatment of earthquake-related post-traumatic stress disorder using an earthquake simulator. Psychological medicine 37(2), 203-13

Problem solving

Sahler 2013

Sahler OJ, Dolgin MJ, Phipps S, et al. (2013) Specificity of problem-solving skills training in mothers of children newly diagnosed with cancer: results of a multisite randomized clinical trial. Journal of Clinical Oncology 31(10), 1329-35

Eye movement desensitisation and reprocessing

Acarturk 2015

Acarturk C, Konuk E, Cetinkaya M et al. (2015) EMDR for Syrian refugees with posttraumatic stress disorder symptoms: Results of a pilot randomized controlled trial. European Journal of Psychotraumatology 6(1), 27414

Acarturk 2016

Acarturk C, Konuk E, Cetinkaya M, et al. (2016) The efficacy of eye movement desensitization and reprocessing for post-traumatic stress disorder and depression among Syrian refugees: Results of a randomized controlled trial. Psychological medicine 46(12), 2583-93

Aldahadha 2012

Aldahadha B, Al-Harthy H and Sulaiman S (2012) The efficacy of eye movement desensitization reprocessing in resolving the trauma caused by the road accidents in the Sultanate of Oman. Journal of Instructional Psychology 39(3/4), 146

Carletto 2016

Carletto S, Borghi M, Bertino G, et al. (2016) Treating post-traumatic stress disorder in patients with multiple sclerosis: a randomized controlled trial comparing the efficacy of eye movement desensitization and reprocessing and relaxation therapy. Frontiers in psychology 7

Carlson 1998

Carlson JG, Chemtob CM, Rusnak K, et al. (1998) Eye movement desensitization and reprocessing (EDMR) treatment for combat-related posttraumatic stress disorder. Journal of Traumatic Stress 11(1), 3-24

Edmond 1999/2004

Edmond T, Rubin A and Wambach K (1999) The effectiveness of EMDR with adult female survivors of childhood sexual abuse. Social Work Research 23, 103-116

Edmond T and Rubin A (2004) Assessing the long-term effects of EMDR: Results from an 18-month follow-up study with adult female survivors of CSA. Journal of child sexual abuse 13(1), 69-86

Himmerich 2016

Himmerich HD, Willmund G, Zimmermann P, et al. (2016) Serum concentrations of Tnf-A and its soluble receptors during psychotherapy in German soldiers suffering from combat-related PTSD. Psychiatria Danubina 28(3), 293-8

Jarero 2013

Jarero I, Amaya C, Givaudan M and Miranda A. (2013) EMDR individual protocol for paraprofessional use: A randomized controlled trial with first responders. Journal of EMDR Practice and Research 7(2), 55-64

Jensen 1994

Jensen JA (1994) An investigation of eye movement desensitization and reprocessing (EMD/R) as a treatment for posttraumatic stress disorder (PTSD) symptoms of Vietnam combat veterans. Behavior Therapy 25, 311-325

Karatzias 2011

Karatzias T, Power K, Brown K, et al. (2011) A controlled comparison of the effectiveness and efficiency of two psychological therapies for posttraumatic stress disorder: eye movement desensitization and reprocessing vs. emotional freedom techniques. The Journal of nervous and mental disease 199(6), 372-8

Power 2002

Power K, McGoldrick T, Brown K, et al. (2002) A controlled comparison of Eye Movement Desensitization and Reprocessing versus exposure plus cognitive restructuring versus waiting list in the treatment of Posttraumatic Stress Disorder. Clinical Psychology and Psychotherapy 9, 299-318

Rothbaum 2005

Rothbaum B, Astin M and Marsteller F (2005) Prolonged exposure versus eye movement desensitization and reprocessing (EMDR) for PTSD rape victims. Journal of Traumatic Stress 18, 607–616

Scheck 1998

Scheck MM, Schaeffer JA and Gillette C (1998) Brief psychological intervention with traumatized young women: The efficacy of eye movement desensitization and reprocessing. Journal of traumatic stress 11(1), 25-44

Taylor 2003

Taylor S, Thordarson DS, Maxfield L, et al. (2003) Comparative efficacy, speed, and adverse effects of three PTSD treatments: exposure therapy, EMDR and relaxation training. Journal of Consulting & Clinical Psychology 71(2), 330-338

Ter Heide 2016

Ter Heide FJ, Mooren TM, van de Schoot R, et al. (2016) Eye movement desensitisation and reprocessing therapy v. stabilisation as usual for refugees: Randomised controlled trial. The British Journal of Psychiatry 209(4), 311-318

van der Kolk 2007

Van der Kolk B, Spinazzola J, Blaustein M, et al. (2007) A randomized clinical trial of EMDR, fluoxetine and pill placebo in the treatment of PTSD: Treatment effects and long-term maintenance. Journal of Clinical Psychiatry 68(1), 37-46

Hypnotherapy

Abramowitz 2008

Abramowitz EG, Barak Y, Ben-Avi I, et al. (2008) Hypnotherapy in the treatment of chronic combat-related PTSD patients suffering from insomnia: a randomized, zolpidem-controlled clinical trial. Intl. Journal of Clinical and Experimental Hypnosis 56(3), 270-80

Brom 1989

Brom D, Kleber RJ and Defares PB (1989) Brief psychotherapy for posttraumatic stress disorders. Journal of consulting and clinical psychology 57(5), 607

Galovski 2008/2016

Galovski T (2008) Sleep-directed Hypnosis As A Complement To CPT In Treating PTSD [NCT00725192]. Available from: https://clinicaltrials.gov/ct2/show/NCT00725192 [accessed 02.08.2017]

Galovski TE, Harik JM, Blain LM, et al. (2016) Augmenting cognitive processing therapy to improve sleep impairment in PTSD: A randomized controlled trial. Journal of consulting and clinical psychology 84(2), 167

Interpersonal psychotherapy

Krupnick 2008

Krupnick JL, Green BL, Stockton P, et al. (2008) Group interpersonal psychotherapy for low-income women with posttraumatic stress disorder. Psychotherapy Research 18(5), 497-507

Markowitz 2015a

Markowitz JC, Petkova E, Neria Y, et al. (2015) Is exposure necessary? A randomized clinical trial of interpersonal psychotherapy for PTSD. American Journal of Psychiatry 172(5), 430-40

Psychodynamic therapies

Brom 1989

Brom D, Kleber RJ and Defares PB (1989) Brief psychotherapy for posttraumatic stress disorders. Journal of consulting and clinical psychology 57(5), 607

Steinert 2017

Steinert C, Bumke PJ, Hollekamp RL, et al. (2017) Resource activation for treating post-traumatic stress disorder, co-morbid symptoms and impaired functioning: a randomized controlled trial in Cambodia. Psychological medicine 47(3), 553-64

Counselling

Bass 2016

Bass J, Murray SM, Mohammed TA, et al. (2016) A randomized controlled trial of a trauma-informed support, skills, and psychoeducation intervention for survivors of torture and related trauma in Kurdistan, Northern Iraq. Global Health: Science and Practice 4(3), 452-66

Blanchard 2002/2003/2004

Blanchard EB (2002) Treatment-related changes in cardiovascular reactivity to trauma cues in motor vehicle accident-related PTSD. Behaviour Therapy 33, 417-426

Blanchard EB, Hickling EJ, Devineni T, et al. (2003) A controlled evaluation of cognitive behaviorial therapy for posttraumatic stress in motor vehicle accident survivors. Behaviour Research & Therapy 41, 79-96

Blanchard EB, Hickling EJ, Malta LS, et al. (2004) One-and two-year prospective follow-up of cognitive behavior therapy or supportive psychotherapy. Behaviour research and therapy 42(7), 745-59

Ehlers 2014

Ehlers A, Hackmann A, Grey N, et al. (2014) A randomized controlled trial of 7-day intensive and standard weekly cognitive therapy for PTSD and emotion-focused supportive therapy. American Journal of Psychiatry 171(3), 294-304

Neuner 2004

Neuner F, Schauer M, Klaschik C, et al. (2004) A Comparison of Narrative Exposure Therapy, Supportive Counseling, and Psychoeducation for Treating Posttraumatic Stress Disorder in an African Refugee Settlement. Journal of Consulting & Clinical Psychology 72(4), 579-587

Neuner 2008

Neuner F, Onyut PL, Ertl V, et al. (2008) Treatment of posttraumatic stress disorder by trained lay counselors in an African refugee settlement. A randomized controlled trial. J Consult Clin Psychol 76, 686-694

Yeomans 2010

Yeomans PD, Forman EM, Herbert JD and Yuen E (2010) A randomized trial of a reconciliation workshop with and without PTSD psychoeducation in Burundian sample. Journal of traumatic stress 23(3), 305-12

Combined somatic and cognitive therapies

Brom 2017

Brom D, Stokar Y, Lawi C, et al. (2017) Somatic Experiencing for Posttraumatic Stress Disorder: A Randomized Controlled Outcome Study. Journal of traumatic stress 30(3), 304-12

Church 2013/2014

Church D, Hawk C, Brooks AJ, et al. (2013) Psychological trauma symptom improvement in veterans using emotional freedom techniques: a randomized controlled trial. The Journal of nervous and mental disease 201(2), 153-60

Church D (2014) Reductions in pain, depression, and anxiety symptoms after PTSD remediation in veterans. Explore: The Journal of Science and Healing 10(3), 162-9

Connolly 2011

Connolly S and Sakai C (2011) Brief trauma intervention with Rwandan genocide-survivors using Thought Field Therapy. International Journal of Emergency Mental Health 13(3), 161

Geronilla 2016

Geronilla L, Minewiser L, Sacramento CA and McWilliams M (2016) EFT (emotional freedom techniques) remediates PTSD and psychological symptoms in veterans: a randomized controlled replication trial. Energy 8(2), 29

Robson 2016

Robson R, Robson P, Ludwig R, et al. (2016) Effectiveness of Thought Field Therapy Provided by Newly Instructed Community Workers to a Traumatized Population in Uganda: A Randomized Trial. Current Research in Psychology 1, 1-11

Resilience-oriented treatment

Kent 2011

Kent M, Davis MC, Stark SL and Stewart LA (2011) A resilience-oriented treatment for posttraumatic stress disorder: Results of a preliminary randomized clinical trial. Journal of traumatic stress 24(5), 591-5

Attention bias modification

Bar-Haim 2011/Badura-Brack 2015 study 1

Bar-Haim Y and Fruchter E (2011) Attention Bias Modification Treatment for Patients With Post Traumatic Stress Disorder (PTSD) [NCT01368302]. Available from: https://clinicaltrials.gov/ct2/show/NCT01368302 [accessed 26.07.2017]

Badura-Brack AS, Naim R, Ryan TJ, et al. (2015) Effect of attention training on attention bias variability and PTSD symptoms: randomized controlled trials in Israeli and US combat veterans. American journal of psychiatry 172(12), 1233-41

Bar-Haim 2011/Badura-Brack 2015 study 2

Bar-Haim Y and Fruchter E (2011) Attention Bias Modification Treatment for Patients With Post Traumatic Stress Disorder (PTSD) [NCT01368302]. Available from: https://clinicaltrials.gov/ct2/show/NCT01368302 [accessed 26.07.2017]

Badura-Brack AS, Naim R, Ryan TJ, et al. (2015) Effect of attention training on attention bias variability and PTSD symptoms: randomized controlled trials in Israeli and US combat veterans. American journal of psychiatry 172(12), 1233-41

Schoorl 2013

Schoorl M, Putman P and van Der Does W (2013) Attentional bias modification in posttraumatic stress disorder: a randomized controlled trial. Psychotherapy and psychosomatics 82(2), 99-105

Couple intervention

Monson 2008/2012

Monson CM and Vorstenbosch V (2008) Cognitive-behavioral couples therapy for posttraumatic stress disorder [NCT00669981]. Available from: https://clinicaltrials.gov/ct2/show/NCT00669981 [accessed 08.08.2017]

Monson CM, Fredman SJ, Macdonald A, et al. (2012) Effect of cognitive-behavioral couple therapy for PTSD: A randomized controlled trial. Jama 308(7), 700-9

Sautter 2015

Sautter FJ, Glynn SM, Cretu JB, et al. (2015) Efficacy of structured approach therapy in reducing PTSD in returning veterans: A randomized clinical trial. Psychological services12(3), 199

Parent training/Family intervention

Kazak 2004

Kazak AE, Alderfer MA, Streisand R, et al (2004) Treatment of posttraumatic stress symptoms in adolescent survivors of childhood cancer and their families: A randomized clinical trial. Journal of Family Psychology 18(3), 493-504

Lieberman 2005/2006/Ghosh Ippen 2011

Lieberman AF, Van Horn P and Ippen CG (2005) Toward evidence-based treatment: child-parent psychotherapy with preschoolers exposed to marital violence. J Am Acad Child Adolesc Psychiatry 44(12), 1241-8

Lieberman AF, Ippen CG and van Horn P (2006) Child-parent psychotherapy: 6-month follow-up of a randomized controlled trial. Journal of the American Academy of Child & Adolescent Psychiatry 45(8), 913-8

Self-help with support

Ivarsson 2014

Ivarsson D, Blom M, Hesser H, et al. (2014) Guided internet-delivered cognitive behavior therapy for post-traumatic stress disorder: a randomized controlled trial. Internet interventions 1(1), 33-40

Knaevelsrud 2007

Knaevelsrud C and Maercker A (2007) Internet-based treatment for PTSD reduces distress and facilitates the development of a strong therapeutic alliance: a randomized controlled clinical trial. BMC psychiatry 7(1), 13

Knaevelsrud 2015

Knaevelsrud C, Brand J, Lange A, et al. (2015) Web-based psychotherapy for posttraumatic stress disorder in war-traumatized Arab patients: randomized controlled trial. Journal of medical Internet research17(3)

Knaevelsrud 2017

Knaevelsrud C, Böttche M, Pietrzak RH, et al. (2017) Efficacy and Feasibility of a Therapist-Guided Internet-Based Intervention for Older Persons with Childhood Traumatization: A Randomized Controlled Trial. The American Journal of Geriatric Psychiatry

Lange 2003

Lange A, Rietdijk D, Hudcovicova M, et al. (2003) Interapy: a controlled randomized trial of the standardized treatment of posttraumatic stress through the internet. J.Consult.Clin.Psychol 71, 901-909

Lewis 2017

Lewis CE, Farewell D, Groves V, et al. (2017) Internet-based guided self-help for posttraumatic stress disorder (ptsd): Randomized controlled trial. Depression and anxiety 34(6), 555-65

Littleton 2016

Littleton H, Grills AE, Kline KD, et al. (2016) The From Survivor to Thriver program: RCT of an online therapist-facilitated program for rape-related PTSD. Journal of anxiety disorders 43, 41-51

van Dam 2013

van Dam D, Ehring T, et al. (2013) Trauma-focused treatment for posttraumatic stress disorder combined with CBT for severe substance use disorder: a randomized controlled trial. BMC psychiatry 13(1), 172

van Emmerik 2008

Van Emmerik AA, Kamphuis JH and Emmelkamp PM (2008) Treating acute stress disorder and posttraumatic stress disorder with cognitive behavioral therapy or structured writing therapy: a randomized controlled trial. Psychotherapy and psychosomatics 77(2), 93-100

Self-help (without support)

Ehlers 2003

Ehlers A, Clark DM, Hackmann A, et al. (2003) A randomized controlled trial of cognitive therapy, a self-help booklet, and repeated assessments as early interventions for posttraumatic stress disorder. Arch.Gen.Psychiatry 60(10), 1024-1032

Henderson 2007

Henderson P, Rosen D and Mascaro N (2007) Empirical study on the healing nature of mandalas. Psychology of Aesthetics, Creativity, and the Arts 1(3), 148

Hirai 2005

Hirai M and Clum GA (2005) An Internet-based self-change program for traumatic event related fear, distress, and maladaptive coping. Journal of traumatic stress 2005 18(6), 631-6

Kuhn 2017

Kuhn E, Kanuri N, Hoffman JE, et al. (2017) A randomized controlled trial of a smartphone app for posttraumatic stress disorder symptoms. Journal of consulting and clinical psychology 85(3), 267

Meshberg-Cohen 2014

Meshberg-Cohen S, Svikis D and McMahon TJ (2014) Expressive writing as a therapeutic process for drug-dependent women. Substance abuse 35(1), 80-8

Miner 2016

Miner A, Kuhn E, Hoffman JE, et al. (2016) Feasibility, acceptability, and potential efficacy of the PTSD Coach app: A pilot randomized controlled trial with community trauma survivors. Psychological Trauma: Theory, Research, Practice, and Policy 8(3), 384

Sloan 2004

Sloan DM and Marx BP (2004) A closer examination of the structured written disclosure procedure. Journal of consulting and clinical psychology 72(2), 165

Sloan 2007

Sloan DM, Marx BP and Epstein EM. (2007) Does altering the writing instructions influence outcome associated with written disclosure? Behavior therapy 38(2), 155-68

Sloan 2011

Sloan DM, Marx BP and Greenberg EM (2011) A test of written emotional disclosure as an intervention for posttraumatic stress disorder. Behaviour Research and Therapy 49(4), 299-304

Sloan 2012

Sloan DM, Marx BP, Bovin MJ, et al. (2012) Written exposure as an intervention for PTSD: A randomized clinical trial with motor vehicle accident survivors. Behaviour research and therapy 50(10), 627-35

Spence 2011

Spence J, Titov N, Dear BF, et al. (2011) Randomized controlled trial of Internet-delivered cognitive behavioral therapy for posttraumatic stress disorder. Depression and anxiety 28(7), 541-50

Truijens 2014

Truijens FL and van Emmerik AA (2014) Visual feedback in written imaginal exposure for posttraumatic stress: a preliminary study. Journal of Loss and Trauma 19(5), 403-15

Xu 2016

Xu W, Wang J, Wang Z, et al. (2016) Web-based intervention improves social acknowledgement and disclosure of trauma, leading to a reduction in posttraumatic stress disorder symptoms. Journal of health psychology 21(11), 2695-708

Psychosocial interventions for the treatment of PTSD in adults

Introduction to the clinical evidence

Psychosocial interventions will be considered as classes of intervention (animal-assisted therapy; art therapy; meditation or mindfulness-based stress reduction [MBSR]; supported employment; practical support; psychoeducational interventions; relaxation; peer support; mentoring, nature-assisted therapies and spiritual interventions) and form the subsections below.

Animal-assisted therapy: clinical evidence

Included studies

Two studies of animal-assisted therapy for the treatment of PTSD in adults were identified for full-text review. Neither of these studies were included.

Excluded studies

Two studies were reviewed at full text and excluded from this review because the population was outside the scope (trial of people without PTSD), or a cross-over study where the first phase data were not available.

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

Art therapy: clinical evidence

Included studies

Two studies of art therapy for the treatment of PTSD in adults were identified for full-text review. Neither of these studies were included.

Excluded studies

Two studies were reviewed at full text and excluded from this review because they were systematic reviews with no new useable data and any meta-analysis results were not appropriate to extract.

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

Meditation or mindfulness-based stress reduction (MBSR): clinical evidence

Included studies

Twenty-five studies of meditation or mindfulness based stress reduction (MBSR) for the treatment of PTSD in adults were identified for full-text review. Of these 25 studies, 9 RCTs (N=680) were included. There were 3 comparisons for meditation/MBSR (one study was in two comparisons).

There were no studies for early treatment (intervention initiated 1-3 months post-trauma) of PTSD symptoms.

For delayed treatment (intervention initiated more than 3 months post-trauma) of PTSD symptoms, 8 RCTs (N=564) compared meditation/MBSR (alone or in addition to TAU) with TAU, attention-placebo or waitlist (Bormann et al. 2008; Bormann et al. 2012/2013 [one study reported across two papers]; Bränström et al. 2010/2012 [one study reported across two papers]; Kearney et al. 2013; Kearney et al. 2016; Levine et al. 2005; Possemato et al. 2016; Wahbeh et al. 2016/Colgan et al. 2016 [one study reported across two papers]). 1 RCT (N=114) compared meditation (in addition to TAU) with relaxation (in addition to TAU) (Wahbeh et al. 2016/Colgan et al. 2016 [one study reported across two papers]), and 1 RCT (N=116) compared MBSR (in addition to TAU) with present-centered therapy (in addition to TAU) (Polusny et al. 2015).

Sub-analyses were possible for the delayed treatment meditation/MBSR (alone or in addition to TAU) versus TAU/attention-placebo/waitlist comparison, comparing effects by multiplicity of trauma, specific comparison, diagnostic status at baseline, and trauma type.

Excluded studies

Sixteen studies were reviewed at full text and excluded from this review. The most common reasons for exclusion were systematic review with no new useable data and any meta-analysis results not appropriate to extract, or efficacy or safety data could not be extracted.

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

Summary of clinical studies included in the evidence review

Table 89 provides brief summaries of the included studies and evidence from these are summarised in the clinical GRADE evidence profiles below (Table 90, Table 91 and Table 92).

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

Table 89: Summary of included studies: Meditation or mindfulness-based stress reduction (MBSR) for delayed treatment (>3 months)

Comparison	Meditation/MBSR (+/- TAU) versus TAU/attention-placebo/waitlist	Meditation (+ TAU) versus relaxation (+ TAU)	MBSR (+ TAU) versus present-centered therapy (+ TAU)
Total no. of studies (N randomised)	8 (564)	1 (114)	1 (116)
Study ID	Bormann 2008[1] Bormann 2012/2013[2] Branstrom 2010/2012[3] Kearney 2013[4] Kearney 2016[5] Levine 2005[6] Possemato 2016[7] Wahbeh 2016/Colgan 2016[8]	Wahbeh 2016/Colgan 2016	Polusny 2015
Country	US[1,2,4,5,6,7,8] Sweden[3]	US	US
Diagnostic status	PTSD diagnosis according to ICD/DSM criteria[1,2,4,8] Clinically important PTSD symptoms (scoring above a threshold on validated scale) [3,5,6,7]	PTSD diagnosis according to ICD/DSM criteria	PTSD diagnosis according to ICD/DSM criteria
Mean months since onset of PTSD	NR[1,3,5,6,7] 411.6[2] NR ('chronic') [4,8]	NR ('chronic')	NR
Mean age (range)	56 (40-76) [1] 57.3 (25-84) [2] 51.8 (range NR) [3] 52 (range NR) [4] 49.9 (range NR) [5] 45 (range NR) [6] 46.4 (21-71) [7] 52.2 (range NR) [8]	52.2 (range NR)	58.5 (range NR)
Sex (% female)	0[1] 3[2] 99[3] 21[4] 15[5] 100[6] 13[7] 6[8]	6	16
Ethnicity (% BME)	34[1] 42[2] NR[3] 32[4] 38[5] 33[6]	14	16

Comparison	Meditation/MBSR (+/- TAU) versus TAU/attention-placebo/waitlist	Meditation (+ TAU) versus relaxation (+ TAU)	MBSR (+ TAU) versus present-centered therapy (+ TAU)
	18[7] 14[8]		
Coexisting conditions	NR[1,3,4,6,7,8] 80% Current Major Depressive Episode; 62% Dysthymic Disorder; 34% Obsessive–Compulsive Disorder; 56% Generalized Anxiety Disorder[2] All participants had Gulf War Illness[5]	NR	42% mood disorder
Mean months since traumatic event	NR[1,2,4,5,7] NR (14% had received their diagnosis within the last year, 55% between 1 and 2 years ago, and 31% had been diagnosed with cancer more than 2 years ago)[3] NR (within 18 months of cancer diagnosis)[6] 341.8[8]	341.8	NR
Type of traumatic event	Military combat: All participants had served in the Vietnam, Korean or first Gulf War[1] Military combat: 97% served during Vietnam, Korea, or Iraq (Operation Desert Storm), and 3% served during the wars in Iraq or Afghanistan (Operations Iraqi Freedom, New Dawn, and Enduring Freedom). Veterans were asked to identify the worst traumatic event that occurred during their military duty, and these included war zone or combat (71%), accident or explosion (13%), death of someone close (8%), or other illness, injury, or captivity (8%)[2] Diagnosis of life-threatening condition: People with cancer (who were not undergoing current radiation or chemotherapy treatment). 76% breast cancer; 14%	Military combat: 54% Vietnam; 34% OEF/OIF; 12% Other combat	Military combat: 74% combat exposure. 75% Vietnam War; 15% Gulf War; 10% OEF/OIF; 1% Other

Comparison	Meditation/MBSR (+/- TAU) versus TAU/attention-placebo/waitlist	Meditation (+ TAU) versus relaxation (+ TAU)	MBSR (+ TAU) versus present-centered therapy (+ TAU)
	gynecological cancer; 7% lymphatic cancer; 1% pancreatic cancer; 1% cancer in the neck[3] Military combat: 'Veterans' (no further detail reported) [4] Military combat: Veterans with Gulf war illness[5] Diagnosis of life-threatening condition: Diagnosis of primary metastatic breast cancer[6] Military combat: 42% Iraq or Afghanistan War Veterans; 32% Vietnam War Veterans; 13% Gulf War I Veterans; 16% deployed to other conflicts[7] Military combat: 54% Vietnam; 34% OEF/OIF; 12% Other combat[8]		
Single or multiple incident index trauma	Multiple[1,2,4,5,7,8] Single[3,6]	Multiple	Multiple
Lifetime experience of trauma	NR[1,2,3,6,7,8] Mean number of categories of lifetime trauma: 10[4] Mean number of traumas: 4.5 (3.3) [5]	NR	Mean number of lifetime traumatic events 7.7 (SD=3.1). Event type (other than combat exposure): Sexual trauma (28%); Physical assault (66%); Disaster exposure (43%); Serious injury event (64%); Life-threatening illness or injury (58%); Other traumatic event, eg, sudden, unexpected death of someone close (95%)
Intervention details	Meditation-based mantram + TAU[1,2] Mindfulness-based stress reduction (MBSR), following modified protocol of Kabat-Zinn 1990[3]+ TAU[4,5]	Mindfulness meditation (two arms combined: body scan mindfulness meditation [MM] and mindful awareness of the breath with an intention to slow the	Mindfulness-based stress reduction (MBSR) + TAU (90% taking psychoactive medication)

Comparison	Meditation/MBSR (+/- TAU) versus TAU/attention-placebo/waitlist	Meditation (+ TAU) versus relaxation (+ TAU)	MBSR (+ TAU) versus present-centered therapy (+ TAU)
	Complementary/alternative (CAM) oriented intervention + TAU[6] Primary Care Brief Mindfulness Training + TAU[7] Mindfulness meditation (two arms combined: body scan mindfulness meditation [MM] and mindful awareness of the breath with an intention to slow the breath [MM+SB]) + TAU[8]	breath [MM+SB]) + TAU (other medications or therapies permitted)	
Intervention format	Group[1,2,3,4,5,6,7] Individual[8]	Individual	Group
Intervention intensity	6 x weekly 90-min session (9 hours) [1] 6 x weekly 90-min session (9 hours). Mean number of attended sessions 5.65 (SD=0.63; range 3-6). 98% attended four or more sessions + mean number of case management visits 4.59 (SD=4.16; range 0-18) [2] 8x weekly 2-hour sessions (16 hours). 25% completed all 8 group sessions, 22% participated in 7 sessions, 25% in 6 sessions, 6% in 5 sessions, 6% in 4 sessions, 9% in 3 sessions, and 6% participants did not attend any of the sessions[3] 8x weekly 2.5-hour sessions + 1x 7-hour session on a Saturday (27 hours) + homework practice (45-min a day, 6 days a week). Mean number of sessions attended 7 (SD=2) [4] 8x weekly 2.5-hour sessions + 1x 7-hour session on a Saturday (27 hours) + homework practice (30-45 min a day, 6 days a week). Median number of sessions	6x weekly 20-min sessions (2 hours) + home practice (20-min per day between sessions). Mean 50.3 hours (SD=17.6; supervised + home practice)	9x sessions: 8x weekly 2.5 hour sessions + a daylong (6.5 hour) retreat (26.5 hours). Mean number of sessions attended 6.96 (SD=2.56)

Comparison	Meditation/MBSR (+/- TAU) versus TAU/attention-placebo/waitlist	Meditation (+ TAU) versus relaxation (+ TAU)	MBSR (+ TAU) versus present-centered therapy (+ TAU)
	attended=7 (range: 0-9 sessions) [5] 24x twice-weekly sessions (length of sessions not reported) [6] 4x weekly 1.5-hour sessions (6 hours). 44% attended ≥3/4 sessions; 56% attended ≥1 session[7] 6x weekly 20-min sessions (2 hours) + home practice (20-min per day between sessions). Mean 50.3 hours (SD=17.6; supervised + home practice) [8]		
Comparator	TAU (weekly or monthly primary care visits, medication management) [1] TAU (case management + 87% were prescribed antidepressants) [2] Waitlist[3] TAU (64% antidepressants; 45% benzodiazepines; 14% antipsychotics; 23% prazosin; 5% carbamazapine; 50% supportive individual therapy; 36% supportive group; 9% CBT individual therapy; 5% CBT group) [4] TAU (48% antidepressants; 17% opiates; 14% benzodiazapines; 10% amphetamines; 4% CBT; 7% ACT; 3% CPT; 35% psychaitric medication management; 38% other mental health treatment) [5] TAU (unstructured psychoeducational support group + 77% receiving other treatment) [6] TAU (42% medication; 19% therapy) [7] TAU (other medications or therapies permitted) [8]	Biofeedback-assisted relaxation + TAU	TAU (86% taking psychoactive medication)
Intervention length (weeks)	6[1,2,8] 8[3,4,5]	6	9

Comparison	Meditation/MBSR (+/- TAU) versus TAU/attention-placebo/waitlist	Meditation (+ TAU) versus relaxation (+ TAU)	MBSR (+ TAU) versus present-centered therapy (+ TAU)
	12[6] 4[7]		

Note. [1]Bormann 2008; [2]Bormann 2012/2013; [3]Branstrom 2010/2012; [4]Kearney 2013; [5]Kearney 2016; [6]Levine 2005; [7]Possemato 2016; [8]Wahbeh 2016/Colgan 2016

See appendix G for full evidence tables.

Quality assessment of clinical studies included in the evidence review

The clinical evidence profiles for this review (meditation/MBSR for the treatment of PTSD in adults) are presented in Table 90, Table 91 and Table 92.

Table 90: Summary clinical evidence profile: Meditation/Mindfulness-based stress reduction (MBSR; +/- TAU) versus TAU/attention-placebo/waitlist for delayed treatment (>3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk TAU/attention-placebo/waitlist	Corresponding risk Meditation/Mindfulness-based stress reduction (MBSR; +/- TAU)			
PTSD symptomatology self-report at endpoint PCL change score Follow-up: 4-12 weeks		The mean ptsd symptomatology self-report at endpoint in the intervention groups was 0.23 standard deviations lower (0.47 lower to 0.02 higher)		387 (6 studies)	low[1,2]
PTSD symptomatology self-report at 1-4 month follow-up PCL change score Follow-up: 4-17 weeks		The mean ptsd symptomatology self-report at 1-4 month follow-up in the intervention groups was 0.04 standard deviations lower (0.48 lower to 0.4 higher)		109 (2 studies)	very low[1,2,3]
PTSD symptomatology clinician-rated at endpoint CAPS/PSS-I change score Follow-up: 4-8 weeks		The mean ptsd symptomatology clinician-rated at endpoint in the intervention groups was 0.43 standard deviations lower (0.7 to 0.16 lower)		284 (4 studies)	low[1,2]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk TAU/attention-placebo/wait list	Corresponding risk Meditation/Mindfulness-based stress reduction (MBSR; +/- TAU)			
PTSD symptomatology clinician-rated at 6-month follow-up PSS-I change score Follow-up: mean 26 weeks		The mean ptsd symptomatology clinician-rated at 6-month follow-up in the intervention groups was 0.6 standard deviations lower (1.2 lower to 0 higher)		45 (1 study)	very low[1,2]
Remission Number of people scoring below clinical threshold on a scale Follow-up: 6-12 weeks	174 per 1000	228 per 1000 (96 to 542)	RR 1.31 (0.55 to 3.11)	172 (2 studies)	very low[1,4,5]
Response at endpoint Number of people showing clinically significant improvement based on RCI ≥10/11 points on PCL-C Follow-up: 6-8 weeks	213 per 1000	291 per 1000 (151 to 564)	RR 1.37 (0.71 to 2.65)	124 (2 studies)	very low[1,3,5]
Response at 4-month follow-up Number of people showing clinically significant improvement based on RCI ≥10 points on PCL-C Follow-up: mean 17 weeks	227 per 1000	359 per 1000 (141 to 914)	RR 1.58 (0.62 to 4.02)	47 (1 study)	very low[1,5]
Anxiety symptoms at endpoint BSI Anxiety/HADS-A change score Follow-up: 6-8 weeks		The mean anxiety symptoms at endpoint in the intervention groups was 0.23 standard deviations lower (0.5 lower to 0.04 higher)		217 (2 studies)	very low[1,3,6]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk TAU/attention-placebo/wait list	Corresponding risk Meditation/Mindfulness-based stress reduction (MBSR; +/- TAU)			
Anxiety symptoms at 3-month follow-up HADS-A change score Follow-up: mean 13 weeks		The mean anxiety symptoms at 3-month follow-up in the intervention groups was 0.39 standard deviations lower (0.86 lower to 0.09 higher)		71 (1 study)	very low[1,3,6]
Depression symptoms at endpoint BDI/BSI Depression/HADS-D/PHQ-9 change score Follow-up: 4-8 weeks		The mean depression symptoms at endpoint in the intervention groups was 0.55 standard deviations lower (0.75 to 0.36 lower)		450 (6 studies)	moderate[1]
Depression symptoms at 1-6 month follow-up HADS-D/PHQ-9 change score Follow-up: 4-26 weeks		The mean depression symptoms at 1-6 month follow-up in the intervention groups was 0.56 standard deviations lower (0.86 to 0.26 lower)		225 (4 studies)	very low[1,2,3]
Sleeping difficulties PSQI change score Follow-up: mean 6 weeks		The mean sleeping difficulties in the intervention groups was 0.09 standard deviations lower (0.57 lower to 0.38 higher)		77 (1 study)	very low[1,3,6]
Emotional and behavioural problems STAXI-2 change score Follow-up: mean 6 weeks		The mean emotional and behavioural problems in the intervention groups was 0.53 standard deviations lower (1.27 lower to 0.21 higher)		29 (1 study)	very low[1,6]
Quality of life at endpoint Q-LES-Q-SF/SF-8/12 Mental Component summary (MCS)		The mean quality of life at endpoint in the intervention groups was 0.6 standard		222 (3 studies)	low[1,2]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk TAU/attention-placebo/wait list	Corresponding risk Meditation/Mindfulness-based stress reduction (MBSR; +/- TAU)			
change score Follow-up: 6-8 weeks Better indicated by higher values		deviations higher (0.33 to 0.87 higher)			
Quality of life at 4-month follow-up SF-8 Mental Component summary (MCS) change score Follow-up: mean 17 weeks Better indicated by higher values		The mean quality of life at 4-month follow-up in the intervention groups was 0.77 standard deviations higher (0.17 to 1.37 higher)		47 (1 study)	very low[1,2]
Discontinuation Number of participants lost to follow-up for any reason Follow-up: 4-8 weeks	108 per 1000	161 per 1000 (99 to 260)	RR 1.49 (0.92 to 2.41)	424 (6 studies)	low[1,6]

BDI= Beck Depression Inventory; BSI=Brief Symptom Inventory; CAPS= Clinician-administered PTSD scale; CI=confidence interval; HADS-A/D= Hospital Anxiety and Depression Scale-Anxiety/Depression; PCL-C= PTSD checklist-Civilian; PHQ-9=patient heatlth questionnaire for depression; PSS-I= PTSD symptom scale-interview; PSQI=Pittsburgh Sleep Quality Index; RR=risk ratio; SF-8/12=Short-form 8/12; SMD=standardised mean difference; STAXI= State-Trait Anger Experssion Inventory; TAU=Treatment as usual; Q-LES-Q-SF= Quality of Life Enjoyment and Satisfaction Questionnaire

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

[2] OIS not met (N<400)

[3] Data is not reported/cannot be extracted for all outcomes

[4] Substantial heterogeneity (I2=50-80%)

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

[6] 95% CI crosses both line of no effect and threshold for clinically important effect

Table 91: Summary clinical evidence profile: Meditation (+ TAU) versus relaxation (+ TAU) for delayed treatment (>3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Relaxation (+ TAU)	Corresponding risk Meditation (+ TAU)			
PTSD symptomatology self-report		The mean PTSD symptomatology self-report in the		77 (1 study)	very low[1,2,3]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Relaxation (+ TAU)	Corresponding risk Meditation (+ TAU)			
PCL change score Follow-up: mean 6 weeks		intervention groups was 0.68 standard deviations lower (1.17 to 0.19 lower)			
Response Number of people showing clinically significant improvement based on RCI ≥11 points on PCL-C Follow-up: mean 6 weeks	120 per 1000	269 per 1000 (85 to 852)	RR 2.24 (0.71 to 7.1)	77 (1 study)	very low[1,3,4]
Depression symptoms BDI change score Follow-up: mean 6 weeks		The mean depression symptoms in the intervention groups was 0.57 standard deviations lower (1.06 to 0.09 lower)		77 (1 study)	very low[1,2,3]
Sleeping difficulties PSQI change score Follow-up: mean 6 weeks		The mean sleeping difficulties in the intervention groups was 0.35 standard deviations lower (0.83 lower to 0.13 higher)		77 (1 study)	very low[1,3,5]

BDI= Beck Depression Inventory; CI=confidence interval; PCL-C= PTSD checklist-Civilian; PSQI=Pittsburgh Sleep Quality Index; RR=risk ratio; SMD=standardised mean difference; TAU=treatment as usual;

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

[2] OIS not met (N<400)

[3] Data is not reported/cannot be extracted for all outcomes

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

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

Table 92: Summary clinical evidence profile: Mindfulness-based stress reduction (MBSR; + TAU) versus present-centered therapy (+ TAU) for delayed treatment (>3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Present-centered therapy (+ TAU)	Corresponding risk Mindfulness-based stress reduction (MBSR; + TAU)			
PTSD symptomatology self-rated - Endpoint PCL change score Follow-up: mean 9 weeks		The mean PTSD symptomatology self-rated - endpoint in the intervention groups was 0.59 standard deviations lower (0.96 to 0.21 lower)		116 (1 study)	very low[1,2]
PTSD symptomatology self-rated - 2-month follow-up PCL change score Follow-up: mean 8 weeks		The mean PSTD symptomatology self-rated - 2-month follow-up in the intervention groups was 0.76 standard deviations lower (1.14 to 0.39 lower)		116 (1 study)	very low[1,2]
PTSD symptomatology clinician-rated - Endpoint CAPS change score Follow-up: mean 9 weeks		The mean PTSD symptomatology clinician-rated - endpoint in the intervention groups was 0.2 standard deviations lower (0.57 lower to 0.16 higher)		116 (1 study)	very low[1,3]
PTSD symptomatology clinician-rated - 2-month follow-up CAPS change score Follow-up: mean 8 weeks		The mean PTSD symptomatology clinician-rated - 2-month follow-up in the intervention groups was 0.59 standard deviations lower (0.96 to 0.21 lower)		116 (1 study)	very low[1,2]
Remission - Endpoint Number of people no longer meeting diagnostic criteria for PTSD	431 per 1000	431 per 1000 (284 to 655)	RR 1 (0.66 to 1.52)	116 (1 study)	very low[1,4]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Present-centered therapy (+ TAU)	Corresponding risk Mindfulness-based stress reduction (MBSR; + TAU)			
Follow-up: mean 9 weeks					
Remission - 2-month follow-up Number of people no longer meeting diagnostic criteria for PTSD Follow-up: mean 8 weeks	466 per 1000	535 per 1000 (372 to 773)	RR 1.15 (0.8 to 1.66)	116 (1 study)	very low[1,3]
Response self-rated - Endpoint Number of people showing improvement of at least 10 points on PCL Follow-up: mean 9 weeks	231 per 1000	369 per 1000 (115 to 1000)	RR 1.6 (0.5 to 5.06)	32 (1 study)	very low[1,4]
Response self-rated - 2-month follow-up Number of people showing improvement of at least 10 points on PCL Follow-up: mean 8 weeks	250 per 1000	478 per 1000 (185 to 1000)	RR 1.91 (0.74 to 4.95)	39 (1 study)	very low[1,4]
Response clinician-rated - Endpoint Number of people showing improvement of at least 10 points on CAPS Follow-up: mean 9 weeks	500 per 1000	635 per 1000 (405 to 1000)	RR 1.27 (0.81 to 2)	61 (1 study)	very low[1,3]
Response clinician-rated - 2-month follow-up Number of people showing improvement of at least 10 points on CAPS Follow-up: mean 8 weeks	533 per 1000	667 per 1000 (437 to 1000)	RR 1.25 (0.82 to 1.9)	60 (1 study)	very low[1,3]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Present-centered therapy (+ TAU)	Corresponding risk Mindfulness-based stress reduction (MBSR; + TAU)			
Depression symptoms - Endpoint PHQ-9 change score Follow-up: mean 9 weeks		The mean depression symptoms - endpoint in the intervention groups was 0.29 standard deviations lower (0.65 lower to 0.08 higher)		116 (1 study)	very low[1,3]
Depression symptoms - 2-month follow-up PHQ-9 change score Follow-up: mean 8 weeks		The mean depression symptoms - 2-month follow-up in the intervention groups was 0.33 standard deviations lower (0.69 lower to 0.04 higher)		116 (1 study)	very low[1,3]
Quality of life - Endpoint WHO-QoL-BREF change score Follow-up: mean 9 weeks Better indicated by higher values		The mean quality of life - endpoint in the intervention groups was 0.27 standard deviations higher (0.09 lower to 0.64 higher)		116 (1 study)	very low[1,3]
Quality of life - 2-month follow-up WHO-QoL-BREF change score Follow-up: mean 8 weeks Better indicated by higher values		The mean quality of life - 2-month follow-up in the intervention groups was 0.47 standard deviations higher (0.1 to 0.84 higher)		116 (1 study)	very low[1,2]
Discontinuation Number of participants lost to follow-up for any reason Follow-up: mean 9 weeks	17 per 1000	103 per 1000 (13 to 833)	RR 6 (0.75 to 48.29)	116 (1 study)	very low[1,4]

CAPS= Clinician-administered PTSD scale; CI=confidence interval; PCL= PTSD checklist; PHQ-9= Patient health questionnaire-9 item; RR=risk ratio; SMD=standardised mean difference; TAU=treatment as usual; WHO-QoL-BREF=an instrument World Health Organisation Quality of Life Measure, brief version;

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

[2] OIS not met (N<400)

[3] *95% CI crosses both line of no effect and threshold for clinically important effect*
[4] *95% CI crosses line of no effect and threshold for both clinically important benefit and clinically important harm*

See appendix I for full GRADE tables.

Sensitivity and subgroup analysis

Sub-analysis of the comparison, meditation/MBSR (alone or in addition to TAU) versus TAU/attention-placebo/waitlist, by multiplicity of trauma and trauma type revealed a statistically significant subgroup difference for self-rated PTSD symptomatology (K=6; N= 387; Chi² = 4.25, p = 0.04), with a small but statistically significant benefit observed for those who had experience multiple incident index trauma/military combat (SMD -0.30 [-0.51, -0.09]), and a clinically important (but not statistically significant) harm for single incident index trauma/diagnosis of life-threatening condition (SMD 0.57 [-0.23, 1.36]). However, there is only a single study in the single incident index trauma/diagnosis of life-threatening condition subgroup and it is possible that effects are spurious. The test for subgroup differences is not possible for clinician-rated PTSD symptomatology (single subgroup). The test for subgroup differences for discontinuation revealed a non-statistically significant difference (K=6; N=424; Chi² = 0.00, p = 0.98).

Sub-analysis by specific comparison revealed no statistically significant subgroup difference for self-rated PTSD symptomatology (Chi² = 5.29, p = 0.15), clinician-rated PTSD symptomatology (Chi² = 0.08, p = 0.78), or discontinuation (Chi² = 0.47, p = 0.79).

Sub-analysis by diagnostic status at baseline revealed no statistically significant subgroup difference for self-rated PTSD symptomatology (Chi² = 2.90, p = 0.09), clinician-rated PTSD symptomatology (Chi² = 0.08, p = 0.78), or discontinuation (Chi² = 0.24, p = 0.62).

Supported employment: clinical evidence

Included studies

One study of supported employment for the treatment of PTSD in adults was identified for full-text review. This RCT (N=85) was included in a single comparison for supported employment.

There were no studies for early treatment (intervention initiated 1-3 months post-trauma) of PTSD symptoms.

For delayed treatment (intervention initiated more than 3 months post-trauma) of PTSD symptoms, 1 RCT (N=85) compared individual placement and support (IPS) supported employment with standard VA vocational rehabilitation programme (TAU).

Excluded studies

There were no studies that met criteria for full-text review that were excluded.

Summary of clinical studies included in the evidence review

Table 93 provides a brief summary of the included study and evidence from this study is summarised in the clinical GRADE evidence profile below (Table 94).

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

Table 93: Summary of included studies: Supported employment for delayed treatment (>3 months)

Comparison	Individual placement and support (IPS) supported employment versus standard VA vocational rehabilitation programme (TAU)
Total no. of studies (N randomised)	1 (85)
Study ID	Davis 2012
Country	US
Diagnostic status	PTSD diagnosis according to ICD/DSM criteria
Mean months since onset of PTSD	NR
Mean age (range)	40.2 (range NR)
Sex (% female)	12
Ethnicity (% BME)	73
Coexisting conditions	89% major depressive disorder; 20% dysthymia; 54% agoraphobia; 59% panic disorder; 28% social phobia; 42% alcohol dependence; 21% alcohol abuse; 37% drug dependence; 18% drug abuse
Mean months since traumatic event	NR
Type of traumatic event	Military combat: 'Veterans'. Mean length of military service 7.1 years (SD=5.6)
Single or multiple incident index trauma	Multiple
Lifetime experience of trauma	NR
Intervention details	Individual placement and support (IPS) supported employment (following protocols of Becker & Drake 2001 and Supported Employment Evidence-Based Practices [EBP] KIT 2009). IPS involved rapid job search and individualized placement in diverse competitive jobs, with ongoing work-based vocational assessment and assistance in finding subsequent jobs, if needed
Intervention format	Individual
Intervention intensity	NR
Comparator	Veterans Health Administration Vocational Rehabilitation Program (VRP) treatment as usual
Intervention length (weeks)	52
Note. None	

See appendix G for full evidence tables.

Quality assessment of clinical studies included in the evidence review

The clinical evidence profile for this review (supported employment for the treatment of PTSD in adults) is presented in Table 94.

Table 94: Summary clinical evidence profile: Individual placement and support (IPS) supported employment versus standard VA vocational rehabilitation programme (TAU) for delayed treatment (>3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Standard VA vocational rehabilitation programme (TAU)	Corresponding risk Individual placement and support (IPS) supported employment			
PTSD symptomatology clinician-rated CAPS change score Follow-up: mean 52 weeks		The mean PTSD symptomatology clinician-rated in the intervention groups was 0.44 standard deviations lower (0.97 lower to 0.09 higher)		57 (1 study)	low[1,2]
PTSD symptomatology self-rated DTS change score Follow-up: mean 52 weeks		The mean PTSD symptomatology self-rated in the intervention groups was 0.21 standard deviations lower (0.71 lower to 0.28 higher)		64 (1 study)	low[1,2]
Response Number of people rated as 'much' or 'very much' improved on CGI-I Follow-up: mean 52 weeks	116 per 1000	166 per 1000 (57 to 484)	RR 1.43 (0.49 to 4.16)	85 (1 study)	very low[1,3]
Depression symptoms QIDS change score Follow-up: mean 52 weeks		The mean depression symptoms in the intervention groups was 0.25 standard deviations lower (0.76 lower to 0.25 higher)		62 (1 study)	low[1,2]
Competitive employment Number of people who gained competitive employment Follow-up: mean 52 weeks	279 per 1000	762 per 1000 (458 to 1000)	RR 2.73 (1.64 to 4.54)	85 (1 study)	low[1,4]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Standard VA vocational rehabilitation programme (TAU)	Corresponding risk Individual placement and support (IPS) supported employment			
Competitive employment Weeks competitively employed Follow-up: mean 52 weeks Better indicated by higher values		The mean competitive employment in the intervention groups was 0.93 standard deviations higher (0.48 to 1.37 higher)		85 (1 study)	low[1,5]
Discontinuation Number of participants lost to follow-up for any reason Follow-up: mean 52 weeks	186 per 1000	143 per 1000 (54 to 376)	RR 0.77 (0.29 to 2.02)	85 (1 study)	very low[1,3]

CAPS= Clinician-administered PTSD scale; CI=confidence interval; DTS=Davidson Trauma Scale; QIDS= Quick Inventory of Depressive Symptomatology; RR=risk ratio; SMD=standardised mean difference; TAU=treatment as usual

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

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

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

[4] OIS not met (events<300)

[5] OIS not met (N<400)

See appendix F for full GRADE tables.

Practical support: clinical evidence

Included studies

Two studies of practical support for the treatment of PTSD in adults were identified for full-text review. Of these 2 studies, 1 RCT (N=41) was included in a single comparison for practical support.

There were no studies for early treatment (intervention initiated 1-3 months post-trauma) of PTSD symptoms.

For delayed treatment (intervention initiated more than 3 months post-trauma) of PTSD symptoms, 1 RCT (N=41) compared practical support with treatment as usual (Weinstein et al. 2016).

Excluded studies

One study was reviewed at full text and excluded from this review because the outcomes were not of interest.

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

Summary of clinical studies included in the evidence review

Table 95 provides a brief summary of the included study and evidence from this study is summarised in the clinical GRADE evidence profile below (Table 96).

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

Table 95: Summary of included studies: Practical support for delayed treatment (>3 months)

Comparison	Practical support versus TAU
Total no. of studies (N randomised)	1 (41)
Study ID	Weinstein 2016
Country	Jordan
Diagnostic status	Clinically important PTSD symptoms (scoring above a threshold on validated scale)
Mean months since onset of PTSD	NR
Mean age (range)	28.8 (15-68)
Sex (% female)	49
Ethnicity (% BME)	NR
Coexisting conditions	NR
Mean months since traumatic event	NR (fled Syria during the past 24 months)
Type of traumatic event	Witnessing war as a civilian: Syrian refugees currently residing in Jordan
Single or multiple incident index trauma	Multiple
Lifetime experience of trauma	NR
Intervention details	Need satisfaction intervention. Participants in the intervention condition were asked to engage in a week-long effort to try a variety of daily activities
Intervention format	Individual
Intervention intensity	4x 10-15 min sessions (40 mins-1 hour)
Comparator	TAU (participants visited by members of the volunteer organization as they typically would be)
Intervention length (weeks)	1

Note. None

See appendix G for full evidence tables.

Quality assessment of clinical studies included in the evidence review

The clinical evidence profile for this review (practical support for the treatment of PTSD in adults) is presented in Table 96.

Table 96: Summary clinical evidence profile: Practical support versus TAU for delayed treatment (>3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk TAU	Corresponding risk Practical support			
PTSD symptomatology self-rated PDS change score Follow-up: mean 1 weeks		The mean ptsd symptomatology self-rated in the intervention groups was 1.12 standard deviations lower (1.79 to 0.45 lower)		41 (1 study)	very low[1,2,3]
Depression symptoms CES-D change score Follow-up: mean 1 weeks		The mean depression symptoms in the intervention groups was 8.69 standard deviations lower (10.76 to 6.61 lower)		41 (1 study)	very low[1,2,3]

CES-D= Centre of Epidemiological Studies-Depression; CI=confidence interval; PDS= Post-traumatic Diagnositic Scale; RR=risk ratio; SMD=standardised mean difference; TAU=treatment as usual

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

[2] *OIS not met (N<400)*

[3] *Data is not reported/cannot be extracted for all outcomes*

Psychoeducational interventions: clinical evidence

Included studies

Ten studies of psychoeducation for the treatment of PTSD in adults were identified for full-text review. Of these 10 studies, 3 RCTs (N=689) were included. There were 2 comparisons for psychoeducation.

For early treatment (intervention initiated 1-3 months post-trauma) of PTSD symptoms, 1 RCT (N=386) compared psychoeducation in addition to treatment as usual with treatment as usual-only (Jensen et al. 2016).

For delayed treatment (intervention initiated more than 3 months post-trauma) of PTSD symptoms, 2 RCTs (N=303) compared psychoeducation (alone or in addition to TAU) with waitlist or TAU (Ghafoori et al. 2016; Kaslow et al. 2010).

Excluded studies

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

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

Summary of clinical studies included in the evidence review

Table 97 and Table 98 provide brief summaries of the included studies and evidence from these are summarised in the clinical GRADE evidence profiles below (Table 99 and Table 100).

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

Table 97: Summary of included studies: Psychoeducation for early treatment (1-3 months)

Comparison	Psychoeducation (+ TAU) versus TAU
Total no. of studies (N randomised)	1 (386)
Study ID	Jensen 2016
Country	Denmark
Diagnostic status	Clinically important PTSD symptoms (scoring above a threshold on validated scale)
Mean months since onset of PTSD	NR
Mean age (range)	Medians: 66-67.5 (mean and range NR)
Sex (% female)	41
Ethnicity (% BME)	NR
Coexisting conditions	NR
Mean months since traumatic event	NR (intervention initiated 1-3 months post-ICU)
Type of traumatic event	Unintentional injury/illness/medical emergency: Adults who had been mechanically ventilated ≥48 h in the ICU. Diagnosis at ICU admission: Neurological (5%); Respiratory (36%); Cardiovascular (15%); Gastrointestinal (10%); Renal (1%); Sepsis (29%); Trauma and intoxications (3%). Median hours ventilated 172 (intervention) and 159.1 (control). Median length of ICU stay 9-10 days
Single or multiple incident index trauma	Single
Lifetime experience of trauma	NR
Intervention details	Psychoeducation sessions: Individualized ICU recovery program
Intervention format	Individual
Intervention intensity	3 sessions (length of sessions NR)
Comparator	TAU: Standard care included light sedation, early mobilization, daily CAM-ICU delirium assessment, written information for visitors, and ICU discharge without follow-up. ICU diaries were not used, but unplanned ICU visits and access to the medical record after discharge were permitted. Physical training was initiated in the ICU and physical rehabilitation was offered to all patients
Intervention length (weeks)	43

Note. None

Table 98: Summary of included studies: Psychoeducation for delayed treatment (>3 months)

Comparison	Psychoeducation (+/- TAU) versus waitlist/TAU
Total no. of studies (N randomised)	2 (303)
Study ID	Ghafoori 2016[1] Kaslow 2010[2]
Country	US
Diagnostic status	Clinically important PTSD symptoms (scoring above a threshold on validated scale)
Mean months since onset of PTSD	NR
Mean age (range)	NR[1] 34.7 (18-64) [2]
Sex (% female)	45[1] 100[2]
Ethnicity (% BME)	73[1] 100[2]
Coexisting conditions	NR[1] All participants had attempted suicide in the past year[2]
Mean months since traumatic event	NR[1] NR (experienced interpersonal violence within the past year) [2]
Type of traumatic event	Unclear (no details reported) [1] Domestic violence[2]
Single or multiple incident index trauma	Unclear[1] Multiple[2]
Lifetime experience of trauma	Mean number of lifetime traumas 8.3 (SD=3.6) [1] NR[2]
Intervention details	Single psychoeducation session[1] Culturally informed, empowerment-focused psychoeducational group intervention (Nia; following the protocol by Davis et al. 2009) + TAU[2]
Intervention format	Individual[1] Group[2]
Intervention intensity	1x 90-min session (1.5 hours) [1] 10x 90-min sessions (15 hours). Mean number of sessions attended 9.0 (SD=1.0) [2]
Comparator	Waitlist[1] TAU: referred for standard psychiatric and medical care offered by the hospital, including free weekly suicide and IPV support groups. Other forms of treatment received by participants during intervention interval: Mental health emergency service (43%); Psychiatric hospitalization (21%); Day treatment or intensive outpatient treatment (36%); Psychiatric medication (57%); Individual counseling or therapy (59%); Crisis hotline (30%); Medical emergency service (52%); Medical hospitalization (32%); Women's or domestic violence shelter (25%); Self-help group (36%); Al-Anon/Adult Children of Alcoholics (2%); Other support group, e.g., church, HIV/AIDS (40%)[2]

Comparison	Psychoeducation (+/- TAU) versus waitlist/TAU
Intervention length (weeks)	0.1[1] NR[2]
Note. [1]Ghafoori 2016; [2]Kaslow 2010	

See appendix F for full evidence tables.

Quality assessment of clinical studies included in the evidence review

The clinical evidence profiles for this review (psychoeducation for the treatment of PTSD in adults) are presented in Table 99 and Table 100.

Table 99: Summary clinical evidence profile: Psychoeducation (+ TAU) versus TAU for early treatment (1-3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk TAU	Corresponding risk Psychoeducation (+ TAU)			
PTSD symptomatology self-rated at 2-month follow-up HTQ-IV change score Follow-up: mean 8 weeks		The mean PTSD symptomatology self-rated at 2-month follow-up in the intervention groups was 0.05 standard deviations higher (0.21 lower to 0.31 higher)		225 (1 study)	low[1,2]
Anxiety symptoms at 2-month follow-up HADS-A endpoint score Follow-up: mean 8 weeks		The mean anxiety symptoms at 2-month follow-up in the intervention groups was 0.05 standard deviations higher (0.19 lower to 0.29 higher)		261 (1 study)	low[1,2]
Depression symptoms at 2-month follow-up HADS-D endpoint score Follow-up: mean 8 weeks		The mean depression symptoms at 2-month follow-up in the intervention groups was 0.05 standard deviations higher (0.19 lower to 0.3 higher)		260 (1 study)	low[1,2]
Quality of life at 2-month follow-up SF-12 MCS Follow-up: mean 8 weeks Better indicated by higher values		The mean quality of life at 2-month follow-up in the intervention groups was 0.17 standard deviations lower		231 (1 study)	low[1,2]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk TAU	Corresponding risk Psychoeducation (+ TAU)			
		(0.42 lower to 0.09 higher)			
Discontinuation Number of participants lost to follow-up for any reason Follow-up: mean 8 weeks	393 per 1000	389 per 1000 (302 to 499)	RR 0.99 (0.77 to 1.27)	386 (1 study)	very low[1,3]

CI=confidence interval; HADS-A/D= Hospital Anxiety and Depression Scale-Anxiety/Depression; HTQ-IV= Harvard Trauma Questionnaire-IV; RR=risk ratio; SF-12 MCS= Short Form-12; Mental Component Summary; SMD=standardised mean difference; TAU=treatment as usual
[1] Risk of bias is high or unclear across multiple domains
[2] OIS not met (N<400)
[3] 95% CI crosses line of no effect and threshold for both clinically important benefit and clinically important harm

Table 100: Summary clinical evidence profile: Psychoeducation (+/- TAU) versus waitlist or TAU for delayed treatment (>3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist or TAU	Corresponding risk Psychoeducation (+/- TAU)			
PTSD symptomatology self-rated at endpoint DTS change score		The mean PTSD symptomatology self-rated at endpoint in the intervention groups was 0.23 standard deviations lower (0.65 lower to 0.19 higher)		89 (1 study)	low[1,2]
PTSD symptomatology self-rated at 1-month follow-up PCL change score Follow-up: mean 4 weeks		The mean PTSD symptomatology self-rated at 1-month follow-up in the intervention groups was 0.23 standard deviations lower (0.74 lower to 0.28 higher)		59 (1 study)	very low[1,2,3]
PTSD symptomatology self-rated at 6-month follow-up DTS change score		The mean PTSD symptomatology self-rated at 6-month follow-up in the intervention groups was		69 (1 study)	low[1,2]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist or TAU	Corresponding risk Psychoeducation (+/- TAU)			
Follow-up: mean 26 weeks		0.3 standard deviations lower (0.78 lower to 0.17 higher)			
PTSD symptomatology self-rated at 12-month follow-up DTS change score Follow-up: mean 52 weeks		The mean PTSD symptomatology self-rated at 12-month follow-up in the intervention groups was 0.15 standard deviations lower (0.65 lower to 0.35 higher)		62 (1 study)	low[1,2]
Anxiety symptoms at 1-month follow-up BSI Anxiety change score Follow-up: mean 4 weeks		The mean anxiety symptoms at 1-month follow-up in the intervention groups was 0.34 standard deviations lower (0.85 lower to 0.18 higher)		59 (1 study)	very low[1,2,3]
Depression symptoms at endpoint BDI-II change score		The mean depression symptoms at endpoint in the intervention groups was 0.75 standard deviations lower (1.19 to 0.32 lower)		89 (1 study)	low[1,4]
Depression symptoms at 1-month follow-up BSI Depression change score Follow-up: mean 4 weeks		The mean depression symptoms at 1-month follow-up in the intervention groups was 1.1 standard deviations lower (1.65 to 0.55 lower)		59 (1 study)	very low[1,3,4]
Depression symptoms at 6-month follow-up BDI-II change score Follow-up: mean 26 weeks		The mean depression symptoms at 6-month follow-up in the intervention groups was 0.51 standard deviations lower		69 (1 study)	low[1,4]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist or TAU	Corresponding risk Psychoeducation (+/- TAU)			
		(0.99 to 0.03 lower)			
Depression symptoms at 12-month follow-up BDI-II change score Follow-up: mean 52 weeks		The mean depression symptoms at 12-month follow-up in the intervention groups was 0.51 standard deviations lower (1.02 lower to 0 higher)		62 (1 study)	low[1,4]
Suicide - Endpoint BSS change score		The mean suicide - endpoint in the intervention groups was 0.39 standard deviations lower (0.81 lower to 0.03 higher)		89 (1 study)	low[1,2]
Suicide - 6-month follow-up BSS change score Follow-up: mean 26 weeks		The mean suicide - 6-month follow-up in the intervention groups was 0.44 standard deviations lower (0.92 lower to 0.04 higher)		69 (1 study)	low[1,2]
Suicide - 12-month follow-up BSS change score Follow-up: mean 52 weeks		The mean suicide - 12-month follow-up in the intervention groups was 0.11 standard deviations lower (0.61 lower to 0.39 higher)		62 (1 study)	low[1,2]
Discontinuation Number of participants lost to follow-up for any reason	444 per 1000	307 per 1000 (227 to 409)	RR 0.69 (0.51 to 0.92)	303 (2 studies)	low[1,5]

BDI= Beck Depression Inventory; BSI=Brief Symptom Inventory; BSS=Beck Scale for Suicidal Ideation; CI=confidence interval; DTS=; PCL= PTSD checklist; RR=risk ratio; SMD=standardised mean difference; TAU=treatment as usual

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

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

[3] Data is not reported/cannot be extracted for all outcomes

[4] OIS not met (N<400)

[5] OIS not met (events<300)

See appendix F for full GRADE tables.

Relaxation: clinical evidence

Included studies

Six studies of relaxation for the treatment of PTSD in adults were identified for full-text review. None of these studies were included.

Comparisons with trauma-focused CBT are presented in the Trauma-focused CBT section above.

Excluded studies

Six studies were reviewed at full text and excluded from this review because the comparison were outside the protocol (within-class comparison) or outcomes were not of interest, there was non-randomised group assignment, a small sample size (N<10 per arm), or the population was outside the scope (trial of soldiers on active service).

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

Peer support: clinical evidence

Included studies

Two studies of peer support for the treatment of PTSD in adults were identified for full-text review. Neither of these studies were included.

Excluded studies

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

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

Mentoring: clinical evidence

Included studies

One study of mentoring for the treatment of PTSD in adults was identified for full-text review. This study was not included.

Excluded studies

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

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

Nature-assisted therapies: clinical evidence

Included studies

Two studies of nature-assisted therapies for the treatment of PTSD in adults were identified for full-text review. Neither of these studies were included.

Excluded studies

Two studies were reviewed at full text and excluded from this review because of small sample size (N<10 per arm) or non-validated outcome measures.

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

Spiritual intervention: clinical evidence

Included studies

One study of spiritual intervention for the treatment of PTSD in adults was identified for full-text review. This study was not included.

Excluded studies

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

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

Economic evidence

Included studies

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

Excluded studies

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

Economic model

No separate economic modelling on psychosocial interventions for the treatment of PTSD in adults was undertaken. However, psychoeducation was included in the economic analysis conducted for psychological interventions for the treatment of PTSD in adults as an intervention of potential interest, as it had been compared with psychological interventions and was part of the network of evidence. Relaxation was also included in the analysis although it was of no interest per se, because it allowed indirect comparisons between psychological interventions of interest. Other psychosocial interventions were not considered as they were not part of the decision problem and they did not provide additional connections between interventions of interest in the network. Results of the economic analysis are reported in the

economic modelling section for psychological interventions in this report. Full details of the economic analysis are provided in Appendix J.

Resource impact

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

Clinical evidence statements

Meditation/Mindfulness-based stress reduction (MBSR) for delayed treatment (>3 months)

- Low quality evidence from 4 RCTs (N=284) suggests a small but statistically significant benefit of meditation/MBSR (alone or in addition to TAU) relative to TAU, attention-placebo or waitlist on improving clinician-rated PTSD symptomatology at endpoint, and very low quality single-RCT (N=45) evidence suggests this benefit is maintained at 6-month follow-up, in adults with PTSD over 3 months after trauma. Moderate to very low quality evidence from 1-6 RCTs (N=47-450) suggests moderate and statistically significant benefits of meditation/MBSR on depression symptoms at endpoint and 1-6 month follow-up, and quality of life at endpoint and 4-month follow-up. However, low to very low quality evidence from 1-6 RCTs (N=29-387) suggests non-significant effects on self-rated PTSD symptomatology at endpoint or 1-4 month follow-up, the rate of remission, sleeping difficulties and emotional and behavioural problems at endpoint, the rate of response at endpoint or 4-month follow-up, and anxiety symptoms at endpoint or 3-month follow-up. Low quality evidence from 6 RCTs (N=424) suggests there may be higher drop-out associated with meditation/MBSR, however, this effect is not statistically significant.
- Very low quality single-RCT (N=77) evidence suggests moderate and statistically significant benefits of meditation (in addition to TAU) relative to relaxation (in addition to TAU) on improving self-rated PTSD symptomatology and depression symptoms, and a clinically important but not statistically significant benefit on the rate of response, in adults with PTSD over 3 months after trauma. However, evidence from the same RCT suggests a non-significant effect on sleeping difficulties. No discontinuation evidence is available.
- Very low quality single-RCT (N=116) evidence suggests a moderate to large and statistically significant benefit of MBSR (in addition to TAU) relative to present-centered therapy (in addition to TAU) on improving self-rated PTSD symptomatology at endpoint and 2-month follow-up, and a delayed benefit on clinician-rated PTSD symptomatology at 2-month follow-up (non-significant at endpoint), in adults with PTSD over 3 months after trauma. However, evidence from the same RCT suggests non-significant differences between MBSR and present-centered therapy on the rate of remission and response (based on self-rated and clinician-rated measures), depression symptoms, and quality of life at endpoint and 2-month follow-up. Evidence from this RCT suggests higher drop-out may be associated with MBSR, however, this effect is not statistically significant.

Supported employment for delayed treatment (>3 months)

- Low quality single-RCT (N=85) evidence suggests a large and statistically significant benefit of individual placement and support (IPS) supported employment relative to standard VA vocational rehabilitation programme (TAU) on competitive employment (as measured by number of people who gained

competitive employment and weeks competitively employed), in adults with PTSD over 3 months after trauma. However, low to very low quality evidence from this same RCT (N=57-85) suggests non-significant effects of IPS on PTSD symptomatology (self-rated or clinician-rated), the rate of response, depression symptoms and discontinuation.

Practical support for delayed treatment (>3 months)

- Very low quality single-RCT (N=41) evidence suggests large and statistically significant benefits of practical support relative to TAU on improving self-rated PTSD symptomatology and depression symptoms, in adults with PTSD over 3 months after trauma. No evidence for other outcomes is available.

Psychoeducational interventions for early treatment (1-3 months)

- Low to very low quality single-RCT (N=225-386) evidence suggests non-significant effects of psychoeducation in addition to TAU relative to TAU-only for the early treatment of PTSD (initiated within 1-3 months of trauma) on self-rated PTSD symptomatology, anxiety symptoms, depression symptoms, and quality of life at 2-month follow-up (endpoint data not available), or discontinuation.

Psychoeducational interventions for delayed treatment (>3 months)

- Low to very low quality evidence from single-RCT analyses (N=59-89) suggests a moderate to large and statistically significant benefit of psychoeducation (alone or in addition to TAU) relative to waitlist or TAU on depression symptoms (at endpoint, and 1-, 6- and 12-month follow-up), in adults with PTSD over 3 months after trauma. However, evidence from single-RCT analyses suggests non-significant effects of psychoeducation on self-rated PTSD symptomatology (at endpoint, and 1-, 6- and 12-month follow-up), anxiety symptoms at 1-month follow-up, and suicide (at endpoint, 6-month and 1-year follow-up). Low quality evidence from 2 RCTs (N=303) suggests a moderate and statistically significant benefit on discontinuation, with lower drop-out associated with psychoeducation.

Economic evidence statements

- Evidence from the guideline economic analysis suggests that psychoeducation is more cost-effective than psychological interventions in the treatment of adults with clinically important symptoms of PTSD, with the exception of brief trauma-focused CBT. This finding should be interpreted with great caution due to the limitations in the evidence for psychoeducation. The economic analysis is directly applicable to the NICE decision-making context and is characterised by minor limitations, mainly relating to the NMA that informed the analysis.

Recommendations

No recommendations were made on psychosocial interventions for the treatment of PTSD.

Rationale and impact

Why the committee didn't make any recommendations

There was some evidence for benefits of meditation or mindfulness-based stress reduction (MBSR) on improving PTSD symptoms. However, there was too much uncertainty in the evidence for the committee to make a recommendation.

Limited evidence showed no significant benefit or harm for psychoeducation or supported employment and thus the committee judged that no recommendation was warranted.

The guideline NMA and economic analysis of treatments for adults with clinically important symptoms of PTSD showed that, compared with psychological interventions, psychoeducation was highly clinically and cost-effective. However, the evidence base was very limited and highly uncertain, and did not warrant a recommendation for psychoeducation on its own.

There is very limited evidence suggesting that pratical support may be associated with potential benefit. However, this finding was based on a single study with very limited outcome data, and the committee concluded that it did not allow enough certainty for a recommendation to be made.

Impact of the recommendations on practice

No recommendations were made for psychosocial interventions for the treatment of PTSD, and as none of these interventions are in widespread use in routine clinical practice, the committee thought that there would be no change in practice.

The committee's discussion of the evidence

Interpreting the evidence

Outcomes that matter the most

Critical outcomes were measures of PTSD symptom improvement on validated scales, remission (as defined as a loss of diagnosis or scoring below threshold on a validated scale), and response (as measured by an agreed percentage improvement in symptoms and/or by a dichotomous rating of much or very much improved). Attrition from treatment (for any reason) was also considered an important outcome, as a proxy for the acceptability and/or tolerability of treatment. The committee considered dissociative symptoms, personal/social/occupational functioning (including global functioning/functional impairment, sleeping or relationship difficulties, and quality of life), and symptoms of a coexisting condition (including anxiety, depression and substance use disorder symptoms) as important but not critical outcomes. This distinction was based on the primacy of targeting the core PTSD symptoms, whilst acknowledging the influence that wider benefits may have on decision-making about the efficacy of a given intervention. Generally change scores were favoured over final scores as although in theory randomisation should balance out any differences at baseline, this assumption can be violated by small sample sizes. The committee also expressed a general preference for self-rated PTSD symptomatology, however, in considering psychosocial interventions (relative to pharmacological interventions) a greater emphasis was placed on triangulating effects on self-rated PTSD symptomatology with clinician-rated outcome measures, given that the latter but not the former could be blinded.

The quality of the evidence

With the exception of a single outcome of moderate quality, all the evidence reviewed was of low or very low quality, reflecting the high risk of bias associated with the studies (including for instance, high risk of bias associated with randomisation method as reflected by significant group differences at baseline, and lack of/unclear blinding of outcome assessment), the limited number of RCTs, the small numbers in

the trials and the imprecision of many of the results (in terms of both the width of the confidence intervals and the failure to meet the optimal information size).

Consideration of clinical benefits and harms

The committee discussed the evidence for meditation and MBSR. These interventions were initially considered separately, however, the committee judged that given the considerable overlap in techniques and proposed mechanisms, meta-analysis that combined the two might be more informative. This decision is supported by the non-significant test for subgroup differences in the sub-analysis by specific comparison. The committee discussed that the small but statistically significant benefit observed on blinded clinician-rated PTSD symptomatology that appeared to be maintained up to 6-month follow-up was encouraging. The larger evidence base for self-rated PTSD symptomatology suggests non-significant effects at endpoint and 1-4 month follow-up. The committee also discussed anecdotal evidence based on their experience that MBSR may be associated with potential harms, such as increasing the likelihood of intrusive thoughts. The effects on remission and response also failed to meet statistical significance. The committee judged the uncertainty in the evidence to be too high to warrant a recommendation.

No evidence was identified for animal-assisted therapy, art therapy, relaxation (except in comparison to trauma-focused therapies where relaxation was shown to be inferior), peer support, mentoring, nature-assisted therapies or spiritual intervention. There was limited evidence for neither significant benefits or harms for psychoeducation or supported employment. For practical support, there is limited evidence for efficacy but the evidence base was considered too small for the committee to be confident that the benefits observed are true effects and thus a recommendation could not be supported. Taken together the committee judged that the evidence for benefit was weak and given the concerns about potential harm, a recommendation was not appropriate.

Cost effectiveness and resource use

No evidence on the cost effectiveness of psychosocial interventions for the treatment of PTSD in adults was identified. The guideline economic analysis suggested that psychoeducation was more cost-effective than psychological interventions, with the exception of brief trauma-focused CBT. However, the committee noted that the result for psychoeducation should be interpreted with great caution due to the limited and uncertain evidence base, and decided not to recommend psychoeducation on its own, but as part of individual trauma-focused CBT. The committee did not make any recommendations on other psychosocial interventions for the treatment of PTSD in adults due to uncertain or limited evidence of their benefits. As none of these interventions are in widespread use in routine clinical practice, the committee expressed the view that there would be no impact on resources.

References for included studies

Meditation or Minfulness-based stress reduction (MBSR)

Bormann 2008

Bormann JE, Thorp S, Wetherell JL, et al. (2008) A spiritually based group intervention for combat veterans with posttraumatic stress disorder: feasibility study. Journal of Holistic Nursing 26(2), 109-16

Bormann 2012/2013

Bormann JE, Liu L, Thorp SR, et al. (2012) Spiritual wellbeing mediates PTSD change in veterans with military-related PTSD. International journal of behavioral medicine 19(4), 496-502

Bormann JE, Thorp SR, Wetherell JL, et al. (2013) Meditation-based mantram intervention for veterans with posttraumatic stress disorder: a randomized trial. Psychological Trauma: Theory, Research, Practice, and Policy 5(3), 259

Branstrom 2010/2012

Bränström R, Kvillemo P, Brandberg Y, et al. (2010) Self-report mindfulness as a mediator of psychological well-being in a stress reduction intervention for cancer patients—a randomized study. Annals of behavioral medicine 39(2), 151-61

Bränström R, Kvillemo P and Moskowitz JT (2012) A randomized study of the effects of mindfulness training on psychological well-being and symptoms of stress in patients treated for cancer at 6-month follow-up. International journal of behavioral medicine 19(4), 535-42

Kearney 2013

Kearney DJ, McDermott K, Malte C, et al. (2013) Effects of participation in a mindfulness program for veterans with posttraumatic stress disorder: a randomized controlled pilot study. Journal of clinical psychology 69(1), 14-27

Kearney 2016

Kearney DJ, Simpson TL, Malte CA, et al. (2016) Mindfulness-based stress reduction in addition to usual care is associated with improvements in pain, fatigue, and cognitive failures among veterans with gulf war illness. The American journal of medicine 129(2), 204-14

Levine 2005

Levine EG, Eckhardt J and Targ E (2005) Change in post-traumatic stress symptoms following psychosocial treatment for breast cancer. Psycho-Oncology 14(8), 618-35

Polusny 2015

Polusny MA, Erbes CR, Thuras P, et al. (2015) Mindfulness-based stress reduction for posttraumatic stress disorder among veterans: A randomized clinical trial. JAMA 314(5), 456-65

Possemato 2016

Possemato K, Bergen-Cico D, Treatman S, et al. (2016) A randomized clinical trial of primary care brief mindfulness training for veterans with PTSD. Journal of clinical psychology 72(3), 179-93

Wahbeh 2016/Colgan 2016

Wahbeh H, Goodrich E, Goy E and Oken BS (2016) Mechanistic pathways of mindfulness meditation in combat veterans with posttraumatic stress disorder. Journal of clinical psychology 72(4), 365-83

Colgan DD, Christopher M, Michael P and Wahbeh H (2016) The body scan and mindful breathing among veterans with PTSD: Type of intervention moderates the

relationship between changes in mindfulness and post-treatment depression. Mindfulness 7(2), 372-83

Individual placement and support (IPS) supported employment

Davis 2012

Davis LL, Leon AC, Toscano R, et al. (2012) A randomized controlled trial of supported employment among veterans with posttraumatic stress disorder. Psychiatric Services 63(5), 464-70

Weinstein 2016

Weinstein N, Khabbaz F and Legate N (2016) Enhancing need satisfaction to reduce psychological distress in Syrian refugees. Journal of consulting and clinical psychology 84(7), 645

Psychoeducation

Ghafoori 2016

Ghafoori B, Fisher D, Korosteleva O and Hong M (2016) A Randomized, Controlled Pilot Study of a Single-Session Psychoeducation Treatment for Urban, Culturally Diverse, Trauma-Exposed Adults. The Journal of nervous and mental disease 204(6), 421-30

Jensen 2016

Jensen JF, Egerod I, Bestle MH, et al. (2016) A recovery program to improve quality of life, sense of coherence and psychological health in ICU survivors: a multicenter randomized controlled trial, the RAPIT study. Intensive Care Medicine 42, 1733-1743

Kaslow 2010

Kaslow NJ, Leiner AS, Reviere S, et al. (2010) Suicidal, abused African American women's response to a culturally informed intervention. Journal of consulting and clinical psychology 78(4), 449

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

Introduction to the clinical evidence

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

Acupuncture: clinical evidence

Included studies

Ten studies of acupuncture for the treatment of PTSD in adults were identified for full-text review. Of these 10 studies, 2 RCTs (N=222) were included. There were 2 comparisons for acupuncture.

There were no studies for early treatment (intervention initiated 1-3 months post-trauma) of PTSD symptoms.

For delayed treatment (intervention initiated more than 3 months post-trauma) of PTSD symptoms, 1 RCT (N=84) compared acupuncture with waitlist (Hollifield et al. 2007), and 1 RCT (N=138) compared acupuncture with paroxetine (Wang et al. 2012).

Comparisons with trauma-focused CBT are presented in the Trauma-focused CBT section above.

Excluded studies

Eight studies were reviewed at full text and excluded from this review. The most common reasons for exclusion were small sample size (N<10 per arm) or systematic review with no new useable data and any meta-analysis results not appropriate to extract.

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

Summary of clinical studies included in the evidence review

Table 101 provides brief summaries of the included studies and evidence from these are summarised in the clinical GRADE evidence profiles below (Table 102 and Table 103).

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

Table 101: Summary of included studies: Acupuncture for delayed treatment (>3 months)

Comparison	Acupuncture versus waitlist	Acupuncture versus paroxetine
Total no. of studies (N randomised)	1 (84)	1 (138)
Study ID	Hollifield 2007	Wang 2012
Country	US	China
Diagnostic status	PTSD diagnosis according to ICD/DSM criteria	PTSD diagnosis according to ICD/DSM criteria
Mean months since onset of PTSD	NR	NR
Mean age (range)	42.2 (range NR)	49.3 (range NR)
Sex (% female)	66	58
Ethnicity (% BME)	36	NR
Coexisting conditions	NR	NR
Mean months since traumatic event	NR (traumatic experience occurred before age 12 for 62%; between age 12 and 17 for 21%; 17% of	NR

Comparison	Acupuncture versus waitlist	Acupuncture versus paroxetine
	participants experienced trauma only as an adult)	
Type of traumatic event	Unclear: 38% reported experiencing ≥3 events; 33% identified ≥5 years of ongoing childhood abuse	Natural disaster: Wenchuan earthquake
Single or multiple incident index trauma	Unclear	Single
Lifetime experience of trauma	NR	NR
Intervention details	Manual acupuncture (needles without electrical stimulation)	Electroacupuncture to acupoints on head and neck
Intervention format	Individual	Individual
Intervention intensity	24x twice-weekly 1-hour sessions (24 hours)	36x alternate-day 30-min sessions (18 hours)
Comparator	Waitlist	Paroxetine (20mg/day)
Intervention length (weeks)	12	12
Note. None		

See appendix G for full evidence tables.

Quality assessment of clinical studies included in the evidence review

The clinical evidence profiles for this review (acupuncture for the treatment of PTSD in adults) are presented in Table 102 and Table 103.

Table 102: Summary clinical evidence profile: Acupuncture versus waitlist for delayed treatment (>3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist	Corresponding risk Acupuncture			
PTSD symptomatology self-rated PSS-SR change score Follow-up: mean 12 weeks		The mean PTSD symptomatology self-rated in the intervention groups was 1.45 standard deviations lower (2.09 to 0.81 lower)		48 (1 study)	very low[1,2]
Remission Number of people scoring <16 on	148 per 1000	517 per 1000 (196 to 1000)	RR 3.49 (1.32 to 9.21)	56 (1 study)	very low[1,3]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Waitlist	Corresponding risk Acupuncture			
PSS-SR Follow-up: mean 12 weeks					
Depression symptoms HSCL-25 Depression change score Follow-up: mean 12 weeks		The mean depression symptoms in the intervention groups was 1.05 standard deviations lower (1.66 to 0.44 lower)		48 (1 study)	very low[1,2]
Anxiety symptoms HSCL-25 Anxiety change score Follow-up: mean 12 weeks		The mean anxiety symptoms in the intervention groups was 1.38 standard deviations lower (2.02 to 0.75 lower)		48 (1 study)	very low[1,2]
Functional impairment SDS change score Follow-up: mean 12 weeks		The mean functional impairment in the intervention groups was 0.95 standard deviations lower (1.55 to 0.35 lower)		48 (1 study)	very low[1,2]
Discontinuation Number of participants lost to follow-up for any reason Follow-up: mean 12 weeks	222 per 1000	344 per 1000 (144 to 820)	RR 1.55 (0.65 to 3.69)	56 (1 study)	very low[1,4]

CI=confidence interval; HSCL-25= Hopkins Symptom Checklist-25; PSS-SR PTSD symptom scale-self-report =; RR=risk ratio; SDS= Sheehan Disability Scale; SMD=standardised mean difference

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

[2] OIS not met (N<400)

[3] OIS not met (events<300)

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

Table 103: Summary clinical evidence profile: Acupuncture versus paroxetine for delayed treatment (>3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Paroxetine	Corresponding risk Acupuncture			
PTSD symptomatology clinician-rated - Endpoint CAPS change score Follow-up: mean 12 weeks		The mean PTSD symptomatology clinician-rated - endpoint in the intervention groups was 0.21 standard deviations lower (0.56 lower to 0.14 higher)		127 (1 study)	low[1,2]
PTSD symptomatology clinician-rated - 3-month follow-up CAPS change score Follow-up: mean 13 weeks		The mean PTSD symptomatology clinician-rated - 3-month follow-up in the intervention groups was 0.35 standard deviations lower (0.7 lower to 0 higher)		127 (1 study)	low[1,3]
PTSD symptomatology clinician-rated - 6-month follow-up CAPS change score Follow-up: mean 26 weeks		The mean ptsd symptomatology clinician-rated - 6-month follow-up in the intervention groups was 0.36 standard deviations lower (0.71 lower to 0 higher)		127 (1 study)	low[1,3]
Anxiety symptoms - Endpoint HAM-A change score Follow-up: mean 12 weeks		The mean anxiety symptoms - endpoint in the intervention groups was 0.22 standard deviations lower (0.57 lower to 0.13 higher)		127 (1 study)	low[1,2]
Anxiety symptoms- 3-month follow-up HAM-A change score Follow-up: mean 13 weeks		The mean anxiety symptoms- 3-month follow-up in the intervention groups was 0.3 standard deviations lower (0.65 lower to 0.05 higher)		127 (1 study)	low[1,2]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Paroxetine	Corresponding risk Acupuncture			
Anxiety symptoms - 6-month follow-up HAM-A change score Follow-up: mean 26 weeks		The mean anxiety symptoms - 6-month follow-up in the intervention groups was 0.21 standard deviations lower (0.56 lower to 0.14 higher)		127 (1 study)	low[1,2]
Depression symptoms - Endpoint HAMD change score Follow-up: mean 12 weeks		The mean depression symptoms - endpoint in the intervention groups was 0.36 standard deviations lower (0.71 to 0.01 lower)		127 (1 study)	low[1,3]
Depression symptoms - 3-month follow-up HAMD change score Follow-up: mean 13 weeks		The mean depression symptoms - 3-month follow-up in the intervention groups was 0.43 standard deviations lower (0.79 to 0.08 lower)		127 (1 study)	low[1,3]
Depression symptoms - 6-month follow-up HAMD change score Follow-up: mean 26 weeks		The mean depression symptoms - 6-month follow-up in the intervention groups was 0.45 standard deviations lower (0.81 to 0.1 lower)		127 (1 study)	low[1,3]
Discontinuation Number of participants lost to follow-up for any reason Follow-up: mean 12 weeks	72 per 1000	87 per 1000 (28 to 272)	RR 1.2 (0.38 to 3.75)	138 (1 study)	very low[1,4]

CAPS= Clinician-administered PTSD scale; CI=confidence interval; HAM-A/D= Hospital Anxiety and Depression Scale-Anxiety/Depression; RR=risk ratio; SMD=standardised mean difference

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

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

[3] OIS not met (N<400)

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

See appendix I for full GRADE tables.

Exercise: clinical evidence

Included studies

Eleven studies of exercise for the treatment of PTSD in adults were identified for full-text review. Of these 11 studies, 2 RCTs (N=128) were included in a single comparison for exercise.

There were no studies for early treatment (intervention initiated 1-3 months post-trauma) of PTSD symptoms.

For delayed treatment (intervention initiated more than 3 months post-trauma) of PTSD symptoms, 2 RCTs (N=128) compared exercise in addition to treatment as usual with treatment as usual-only (Goldstein et al. 2018; Rosenbaum et al. 2011/Rosenbaum et al. 2015 [one study reported across two papers]).

Excluded studies

Nine studies were reviewed at full text and excluded from this review. The most common reason for exclusion was that the paper was a systematic review with no new useable data and any meta-analysis results not appropriate to extract.

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

Summary of clinical studies included in the evidence review

Table 104 provides brief summaries of the included studies and evidence from these are summarised in the clinical GRADE evidence profile below (Table 105).

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

Table 104: Summary of included studies: Exercise for delayed treatment (>3 months)

Comparison	Exercise (+ TAU) versus TAU
Total no. of studies (N randomised)	2 (128)
Study ID	Goldstein 2018[1] Rosenbaum 2011/2015[2]
Country	US[1] Australia[2]
Diagnostic status	PTSD diagnosis according to ICD/DSM criteria
Mean months since onset of PTSD	216[1] NR[2]
Mean age (range)	46.8 (24-69) [1] 47.8 (23-73) [2]
Sex (% female)	19[1] 16[2]
Ethnicity (% BME)	47[1] NR[2]

Comparison	Exercise (+ TAU) versus TAU
Coexisting conditions	Mean number of comorbidites 1.3 (SD=1.11). 35% current depression; 59% other psychiatric comorbidity[1] NR[2]
Mean months since traumatic event	NR
Type of traumatic event	Military combat: 'Veterans' (no further detail reported) [1] Unclear: 88% had experienced the PTSD-related traumatic event during the course of their occupation[2]
Single or multiple incident index trauma	Multiple
Lifetime experience of trauma	NR
Intervention details	Integrative Exercise (IE) program. Exercise sessions included aerobic exercise, strength training with weights and resistance bands, and yoga movements and poses presented within a framework of mindfulness principles, with one principle presented in each session as the focus of the week + TAU (38% taking psychiatric medication) [1] Aerobic (supervised) exercise, involved a weekly supervised 30-min resistance-training session and two unsupervised home-based exercise sessions, and a pedometer-based walking programme (encouraged to aim for a daily target of 10,000 steps) + TAU (usual inpatient care in a specialized unit for the treatment of PTSD) [2]
Intervention format	Group
Intervention intensity	36x thrice-weekly 1-hour sessions (36 hours). Mean number of sessions attended 28 (SD=11; range 10-52) [1] 12x weekly 30-min supervised sessions (6 hours) + 24x unsupervised home sessions and walking programme. Mean attended 7 supervised exercise sessions (SD = 2, 58% mean attendance) [2]
Comparator	TAU (42% taking psychiatric medication) [1] TAU (usual inpatient care in a specialized unit for the treatment of PTSD involved psychotherapy, pharmaceutical interventions, and group therapy) [2]
Intervention length (weeks)	12

Note. [1]Goldstein 2018; [2]Rosenbaum 2011/2015

See appendix F for full evidence tables.

Quality assessment of clinical studies included in the evidence review

The clinical evidence profile for this review (exercise for the treatment of PTSD in adults) is presented in Table 105.

Table 105: Summary clinical evidence profile: Exercise (+ TAU) versus TAU for delayed treatment (>3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk TAU	Corresponding risk Exercise (+ TAU)			
PTSD symptomatology self-report PCL change score Follow-up: mean 12 weeks		The mean PTSD symptomatology self-report in the intervention groups was 0.47 standard deviations lower (0.99 lower to 0.06 higher)		58 (1 study)	low[1,2]
PTSD symptomatology clinician-rated CAPS change score Follow-up: mean 12 weeks		The mean PTSD symptomatology clinician-rated in the intervention groups was 1.01 standard deviations lower (1.7 to 0.32 lower)		38 (1 study)	low[1,3]
Anxiety symptoms DASS Anxiety change score Follow-up: mean 12 weeks		The mean anxiety symptoms in the intervention groups was 0.75 standard deviations lower (1.28 to 0.22 lower)		58 (1 study)	low[1,3]
Depression symptoms DASS Depression change score Follow-up: mean 12 weeks		The mean depression symptoms in the intervention groups was 0.49 standard deviations lower (1.01 lower to 0.04 higher)		58 (1 study)	low[1,2]
Sleeping difficulties PSQI change score Follow-up: mean 12 weeks		The mean sleeping difficulties in the intervention groups was 0.72 standard deviations lower (1.25 to 0.19 lower)		58 (1 study)	low[1,3]
Discontinuation Number of participants lost to follow-up for any reason Follow-up: mean 12 weeks	265 per 1000	230 per 1000 (127 to 421)	RR 0.87 (0.48 to 1.59)	128 (2 studies)	low[4]

CAPS= Clinician-administered PTSD scale; CI=confidence interval; DASS= Depression Anxiety Stress Scales; PCL= PTSD checklist; PSQI=Pittsburgh Sleep Quality Index; RR=risk ratio; SMD=standardised mean difference; TAU=treatment as usual

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

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

[3] OIS not met (N<400)

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

See appendix I for full GRADE tables.

Repetitive transcranial magnetic stimulation (rTMS): clinical evidence

Included studies

Seven studies of repetitive transcranial magnetic stimulation (rTMS) for the treatment of PTSD in adults were identified for full-text review. Of these 7 studies, 1 RCT (N=20) was included in a single comparison for rTMS.

There were no studies for early treatment (intervention initiated 1-3 months post-trauma) of PTSD symptoms.

For delayed treatment (intervention initiated more than 3 months post-trauma) of PTSD symptoms, 1 RCT (N=20) compared rTMS with sham stimulation (Watts et al. 2012).

Excluded studies

Six studies were reviewed at full text and excluded from this review. The most common reasons for exclusion were small sample size (N<10 per arm) or systematic review with no new useable data and any meta-analysis results not appropriate to extract.

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

Summary of clinical studies included in the evidence review

Table 106 provides a brief summary of the included study and evidence from this study is summarised in the clinical GRADE evidence profile below (Table 107).

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

Table 106: Summary of included studies: Repetitive transcranial magnetic stimulation (rTMS) for delayed treatment (>3 months)

Comparison	rTMS versus sham stimulation
Total no. of studies (N randomised)	1 (20)
Study ID	Watts 2012
Country	US
Diagnostic status	PTSD diagnosis according to ICD/DSM criteria
Mean months since onset of PTSD	NR
Mean age (range)	55.9 (range NR)

Comparison	rTMS versus sham stimulation
Sex (% female)	10
Ethnicity (% BME)	0
Coexisting conditions	80% major depression; 35% panic disorder; 20% OCD; 15% substance use disorder
Mean months since traumatic event	477
Type of traumatic event	Mixed: Military combat (40%); sexual trauma (5%); assault (5%); multiple (50%)
Single or multiple incident index trauma	Multiple
Lifetime experience of trauma	NR
Intervention details	Repetitive transcranial magnetic stimulation (rTMS) delivered at 1Hz to the right dorsolateral prefrontal cortex
Intervention format	Individual
Intervention intensity	10 x consecutive day 20 min sessions (3.3 hours)
Comparator	Sham stimulation to the same area using a sham magnetic coil that looks and sounds identical to the active coil
Intervention length (weeks)	1.4
Note. None	

See appendix F for full evidence tables.

Quality assessment of clinical studies included in the evidence review

The clinical evidence profile for this review (rTMS for the treatment of PTSD in adults) is presented in Table 107.

Table 107: Summary clinical evidence profile: Repetitive transcranial magnetic stimulation (rTMS) versus sham stimulation for delayed treatment (>3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Sham stimulation	Corresponding risk Repetitive transcranial magnetic stimulation (rTMS)			
PTSD symptomatology self-report PCL change score Follow-up: mean 1.4 weeks		The mean PTSD symptomatology self-report in the intervention groups was 2.51 standard deviations lower (3.74 to 1.28 lower)		20 (1 study)	very low[1,2,3]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk Sham stimulation	Corresponding risk Repetitive transcranial magnetic stimulation (rTMS)			
PTSD symptomatology clinician-rated CAPS change score Follow-up: mean 1.4 weeks		The mean PTSD symptomatology clinician-rated in the intervention groups was 1.75 standard deviations lower (2.81 to 0.68 lower)		20 (1 study)	very low[1,2,3]
Depression symptoms BDI change score Follow-up: mean 1.4 weeks		The mean depression symptoms in the intervention groups was 0.99 standard deviations lower (1.93 to 0.05 lower)		20 (1 study)	very low[1,2,3]

[1] *Risk of bias is high or unclear across multiple domains*
[2] *OIS not met (N<400)*
[3] *Data is not reported/cannot be extracted for all outcomes*

See appendix I for full GRADE tables.

Yoga: clinical evidence

Included studies

Fifteen studies of yoga for the treatment of PTSD in adults were identified for full-text review. Of these 15 studies, 3 RCTs (N=194) were included in a single comparison for yoga.

There were no studies for early treatment (intervention initiated 1-3 months post-trauma) of PTSD symptoms.

For delayed treatment (intervention initiated more than 3 months post-trauma) of PTSD symptoms, 3 RCTs (N=194) compared yoga (alone or in addition to TAU) with TAU or waitlist or attention-placebo (Jindani et al. 2015; Mitchell et al. 2014/Dick et al. 2014/Reddy et al. 2014 [one study reported across three papers]; van der Kolk et al. 2014).

Excluded studies

Twelve studies were reviewed at full text and excluded from this review. The most common reasons for exclusion were that the paper was a systematic review with no new useable data and any meta-analysis results not appropriate to extract, or efficacy or safety data could not be extracted.

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

Summary of clinical studies included in the evidence review

Table 108 provides brief summaries of the included studies and evidence from these are summarised in the clinical GRADE evidence profile below (Table 109).

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

Table 108: Summary of included studies: Yoga for delayed treatment (>3 months)

Comparison	Yoga (+/- TAU) versus TAU/waitlist/attention-placebo
Total no. of studies (N randomised)	3 (194)
Study ID	Jindani 2015[1] Mitchell 2014/Dick 2014/Reddy 2014[2] van der Kolk 2014[3]
Country	Canada[1] US[2,3]
Diagnostic status	Clinically important PTSD symptoms (scoring above a threshold on validated scale) [1,2] PTSD diagnosis according to ICD/DSM criteria[3]
Mean months since onset of PTSD	NR[1,2] NR (PTSD treatment for ≥3 years) [3]
Mean age (range)	Median: 41 (18-64) [1] 44.4 (range NR) [2] 42.9 (range NR) [3]
Sex (% female)	89[1] 100[2,3]
Ethnicity (% BME)	NR[1] 47[2] 22[3]
Coexisting conditions	NR[1,3] 34% major depression[2]
Mean months since traumatic event	NR[1,2] NR (≥12 years) [3]
Type of traumatic event	Mixed: 23% Emotional abuse; 20% Complex multiple traumas (e.g., family, refugee, chronic illness); 16% Sexual abuse (including childhood sexual abuse); 15% Adverse life circumstances (e.g., employment, relationships); 11% Physical trauma (e.g., illness, motor vehicle accidents); 9% Domestic violence; 4% Systemic discrimination (e.g., racism, heterosexism); 3% Compassion fatigue (e.g., vicarious trauma, secondary trauma) [1] Multiple traumatic events, including: childhood physical abuse (47.4%), physical assault by romantic partner (59.5%), sexual abuse before the age of 13 (52.6%), sexual abuse between the ages of 13 and 18 (35.1%), adulthood sexual assault (57.9%), and the unexpected death of a loved one (86.8%)[2]

Comparison	Yoga (+/- TAU) versus TAU/waitlist/attention-placebo
	Unclear (no details reported) [3]
Single or multiple incident index trauma	Multiple[1,2] Unclear[3]
Lifetime experience of trauma	NR
Intervention details	Kundalini Yoga (KY) + TAU (39% sought alternative treatment; 49% prescribed medication) [1] Kripalu-based yoga[2] Trauma-informed yoga class (following protocol of Emerson & Hopper 2011) + TAU (participants were required to be engaged in ongoing supportive therapy and to continue whatever pharmacologic treatment they were receiving) [3]
Intervention format	Group
Intervention intensity	8x weekly 90-minute sessions (12 hours) + 15-min a day of home practice[1] 12x weekly/twice-weekly 75-min sessions (15 hours) [2] 10x 1-hour sessions (10 hours) [3]
Comparator	TAU (57% sought alternative treatment; 43% prescribed medication) [1] Waitlist[2] Attention-placebo (supportive women's health education following protocol used in Hien et al. 2009) + TAU (participants were required to be engaged in ongoing supportive therapy and to continue whatever pharmacologic treatment they were receiving) [3]
Intervention length (weeks)	8[1] 6-12[2] 10[3]
Note. [1]Jindani 2015; [2]Mitchell 2014/Dick 2014/Reddy 2014; [3]van der Kolk 2014	

See appendix G for full evidence tables.

Quality assessment of clinical studies included in the evidence review

The clinical evidence profile for this review (yoga for the treatment of PTSD in adults) is presented in Table 109.

Table 109: Summary clinical evidence profile: Yoga (+/- TAU) versus TAU/waitlist/attention-placebo for delayed treatment (>3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk TAU/waitlist/attention-placebo	Corresponding risk Yoga (+/- TAU)			
PTSD symptomatology self-report at endpoint PCL/DTS change score		The mean PTSD symptomatology self-report at endpoint in the intervention		148 (3 studies)	very low[1,2,3]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk TAU/waitlist/attention-placebo	Corresponding risk Yoga (+/- TAU)			
Follow-up: 6-10 weeks		groups was 0.71 standard deviations lower (1.95 lower to 0.52 higher)			
PTSD symptomatology self-report at 1-month follow-up PCL change score Follow-up: mean 4 weeks		The mean PTSD symptomatology self-report at 1-month follow-up in the intervention groups was 0.02 standard deviations higher (0.62 lower to 0.66 higher)		38 (1 study)	very low[1,3]
PTSD symptomatology clinician-rated CAPS change score Follow-up: mean 10 weeks		The mean PTSD symptomatology clinician-rated in the intervention groups was 0.66 standard deviations lower (1.18 to 0.14 lower)		60 (1 study)	very low[1,4,5]
Remission Number of people no longer meeting diagnostic criteria for PTSD Follow-up: mean 10 weeks	207 per 1000	515 per 1000 (234 to 1000)	RR 2.49 (1.13 to 5.5)	60 (1 study)	very low[1,5,6]
Dissociative symptoms DES change score Follow-up: mean 10 weeks		The mean dissociative symptoms in the intervention groups was 0.5 standard deviations lower (1.01 lower to 0.02 higher)		60 (1 study)	very low[1,5,7]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk TAU/waitlist/attention-placebo	Corresponding risk Yoga (+/- TAU)			
Anxiety symptoms at endpoint DASS Anxiety/STAI State change score Follow-up: 6-12 weeks		The mean anxiety symptoms at endpoint in the intervention groups was 0.2 standard deviations lower (0.85 lower to 0.44 higher)		88 (2 studies)	very low[1,7,8]
Anxiety symptoms at 1-month follow-up STAI State change score Follow-up: mean 4 weeks		The mean anxiety symptoms at 1-month follow-up in the intervention groups was 0.43 standard deviations lower (1.07 lower to 0.22 higher)		38 (1 study)	low[1,7]
Depression symptoms at endpoint BDI-II/DASS Depression/CES-D change score Follow-up: 6-12 weeks		The mean depression symptoms at endpoint in the intervention groups was 0.04 standard deviations higher (0.34 lower to 0.41 higher)		148 (3 studies)	very low[1,4]
Depression symptoms at 1-month follow-up CES-D change score Follow-up: mean 4 weeks		The mean depression symptoms at 1-month follow-up in the intervention groups was 0.01 standard deviations higher (0.62 lower to 0.65 higher)		38 (1 study)	very low[1,3]
Symptoms of alcohol use disorder at endpoint AUDIT change		The mean symptoms of alcohol use disorder at endpoint in the		25 (1 study)	low[1,7]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk TAU/waitlist/attention-placebo	Corresponding risk Yoga (+/- TAU)			
score Follow-up: 6-12 weeks		intervention groups was 0.53 standard deviations lower (1.34 lower to 0.27 higher)			
Symptoms of alcohol use disorder at 1-month follow-up AUDIT change score Follow-up: mean 4 weeks		The mean symptoms of alcohol use disorder at 1-month follow-up in the intervention groups was 0.76 standard deviations lower (1.58 lower to 0.06 higher)		25 (1 study)	low[1,7]
Symptoms of drug use disorder at endpoint DUDIT change score Follow-up: 6-12 weeks		The mean symptoms of drug use disorder at endpoint in the intervention groups was 0.4 standard deviations lower (1.2 lower to 0.4 higher)		25 (1 study)	low[1,7]
Symptoms of drug use disorder at 1-month follow-up DUDIT change score Follow-up: mean 4 weeks		The mean symptoms of drug use disorder at 1-month follow-up in the intervention groups was 0.43 standard deviations lower (1.23 lower to 0.36 higher)		25 (1 study)	low[1,7]
Sleeping difficutlies ISI change score Follow-up: mean 8 weeks		The mean sleeping difficutlies in the intervention groups was 0.76 standard		50 (1 study)	very low[1,4]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk TAU/waitlist/attention-placebo	Corresponding risk Yoga (+/- TAU)			
		deviations lower (1.34 to 0.18 lower)			
Discontinuation Number of participants lost to follow-up for any reason Follow-up: 6-12 weeks	154 per 1000	597 per 1000 (8 to 1000)	RR 3.88 (0.05 to 282.52)	118 (2 studies)	very low[1,2,3]

AUDIT= Alcohol Use Disorders Identification Test (AUDIT; change score); BDI= Beck Depression Inventory; CAPS= Clinician-administered PTSD scale; CES-D= Centre of Epidemiological Studies-Depression; CI=confidence interval; DASS= Depression Anxiety Stress Scales; DES= Dissociative Experiences Scales; DTS= Davidson Trauma Scale; DUDIT= Drug Use Disorders Identification Test; ISI= Insomnia Severity Index; PCL= PTSD checklist; RR=risk ratio; SMD=standardised mean difference; STAI=; TAU=treatment as usual

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

[2] Considerable heterogeneity (I2>80%)

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

[4] OIS not met (N<400)

[5] Data is not reported/cannot be extracted for all outcomes

[6] OIS not met (events<300)

[7] 95% CI crosses both line of no effect and threshold for clinically important effect

[8] Substantial heterogeneity (I2=50-80%)

See appendix F for full GRADE tables.

Bio-/neuro-feedback: clinical evidence

Included studies

Five studies of biofeedback or neurofeedback for the treatment of PTSD in adults were identified for full-text review. Of these 5 studies, 3 RCTs (N=102) were included in a single comparison for bio-/neuro-feedback.

There were no studies for early treatment (intervention initiated 1-3 months post-trauma) of PTSD symptoms.

For delayed treatment (intervention initiated more than 3 months post-trauma) of PTSD symptoms, 3 RCTs (N=102) compared biofeedback or neurofeedback (alone or in addition to TAU) with TAU or no treatment (Noohi et al. 2017; Tan et al. 2011; van der Kolk et al. 2016).

Excluded studies

Two studies were reviewed at full text and excluded from this review due to outcomes not being of interest (no validated PTSD scale) or the paper was a systematic review with no new useable data and any meta-analysis results not appropriate to extract.

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

Summary of clinical studies included in the evidence review

Table 110 provides brief summaries of the included studies and evidence from these are summarised in the clinical GRADE evidence profile below (Table 111).

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

Table 110: Summary of included studies: Bio-/neuro- feedback for delayed treatment (>3 months)

Comparison	Bio-/neuro-feedback (+/- TAU) versus TAU or no treatment
Total no. of studies (N randomised)	3 (102)
Study ID	Noohi 2017[1] Tan 2011[2] van der Kolk 2016[3]
Country	Iran[1] US[2,3]
Diagnostic status	PTSD diagnosis according to ICD/DSM criteria
Mean months since onset of PTSD	NR[1,2] NR ('chronic')[3]
Mean age (range)	Mean NR (25-60)[1] 40.7 (24-62)[2] 44.4 (range NR)[3]
Sex (% female)	0[1,2] 76[3]
Ethnicity (% BME)	NR[1] 72[2] 24[3]
Coexisting conditions	NR
Mean months since traumatic event	NR
Type of traumatic event	Military combat (no further detail reported)[1] Military combat: 65% OEF/OIF veterans; 35% Vietnam veterans[2] Mixed: The most frequently endorsed events were childhood caregiver emotional abuse (79%), sexual abuse (69%) and domestic violence (62%)[3]
Single or multiple incident index trauma	Multiple
Lifetime experience of trauma	NR[1,2] Mean number of traumatic events exposed to: 9.29 (SD = 2.90)[3]
Intervention details	Neurofeedback according to alpha/theta protocol, with aim to increase theta waves (4-8 Hz) in mid and frontal areas of the brain relative to alpha waves (8-12 Hz)[1]

Comparison	Bio-/neuro-feedback (+/- TAU) versus TAU or no treatment
	Biofeedback (heart rate variability) following protocol of Lehrer et al. 2000 + TAU[2] Neurofeedback training + TAU (57% on psychotropic medication: 25% SSRIs; 14% stimulants; 11% antipsychotics; 18% benzodiazapines; 11% buproprion)[3]
Intervention format	Individual
Intervention intensity	25x 30-40 min sessions, 4 times a week (12.5-17.5 hours)[1] 8x weekly 30-min sessions (4 hours) + 20-min twice daily home practice[2] 24x twice-weekly sessions[3]
Comparator	No treatment[1] TAU (noo further detail reported)[2] TAU (42% on psychotropic medication: 25% SSRIs; 13% benzodiazepines; 8% anxiolytics; 8% buproprion; 8% SSNRI; 4% TCA)[3]
Intervention length (weeks)	6[1] 8[2] 12[3]
Note. [1]Noohi 2017; [2]Tan 2011; [3]van der Kolk 2016	

See appendix G for full evidence tables.

Quality assessment of clinical studies included in the evidence review

The clinical evidence profile for this review (bio-/neuro- feedback for the treatment of PTSD in adults) is presented in Table 111.

Table 111: Summary clinical evidence profile: Bio-/neuro-feedback (+/- TAU) versus TAU or no treatment for delayed treatment (>3 months)

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk TAU or no treatment	Corresponding risk Bio-/neuro-feedback (+/- TAU)			
PTSD symptomatology self-rated at endpoint PCL/DTS/IES-R change score Follow-up: 6-12 weeks		The mean PTSD symptomatology self-rated at endpoint in the intervention groups was 1.73 standard deviations lower (3.15 to 0.3 lower)		94 (3 studies)	very low[1,2,3]
PTSD symptomatology self-rated at 4-6		The mean PTSD symptomatology self-rated at 4-6		68 (2 studies)	very low[1,2,3]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk TAU or no treatment	Corresponding risk Bio-/neuro-feedback (+/- TAU)			
week follow-up DTS/IES-R change score Follow-up: 4-6 weeks		week follow-up in the intervention groups was 2.49 standard deviations lower (4.41 to 0.57 lower)			
PTSD symptomatology clinician-rated at endpoint CAPS change score Follow-up: 8-12 weeks		The mean PTSD symptomatology clinician-rated at endpoint in the intervention groups was 1.25 standard deviations lower (2.67 lower to 0.18 higher)		64 (2 studies)	very low[1,2,4]
PTSD symptomatology clinician-rated at 1-month follow-up CAPS change score Follow-up: mean 4 weeks		The mean PTSD symptomatology clinician-rated at 1-month follow-up in the intervention groups was 2.21 standard deviations lower (3.03 to 1.38 lower)		38 (1 study)	low[1,3]
Remission at endpoint Number of people no longer meeting diagnostic criteria Follow-up: mean 12 weeks	292 per 1000	572 per 1000 (283 to 1000)	RR 1.96 (0.97 to 3.95)	52 (1 study)	low[1,4]
Remission at 1-month follow-up Number of people no longer meeting diagnostic criteria Follow-up: mean 4 weeks	83 per 1000	392 per 1000 (97 to 1000)	RR 4.71 (1.16 to 19.2)	52 (1 study)	low[1,5]
Depression symptoms at endpoint BDI change score Follow-up: mean 6 weeks		The mean depression symptoms at endpoint in the intervention groups was 1.92 standard deviations lower		30 (1 study)	very low[1,3,6]

Outcomes	Illustrative comparative risks* (95% CI)		Relative effect (95% CI)	No of Participants (studies)	Quality of the evidence (GRADE)
	Assumed risk TAU or no treatment	Corresponding risk Bio-/neuro-feedback (+/- TAU)			
		(2.81 to 1.04 lower)			
Depression symptoms at 6-week follow-up BDI change score Follow-up: mean 6 weeks		The mean depression symptoms at 6-week follow-up in the intervention groups was 2.08 standard deviations lower (2.99 to 1.17 lower)		30 (1 study)	very low[1,3,6]
Discontinuation Number of participants lost to follow-up for any reason Follow-up: 8-12 weeks	59 per 1000	151 per 1000 (34 to 681)	RR 2.57 (0.57 to 11.58)	72 (2 studies)	very low[1,7]

BDI= Beck Depression Inventory; CAPS= Clinician-administered PTSD scale; CI=confidence interval; DTS=Davidson Trauma Scale; IES-R= Impact of Event Scale-Revised; PCL= PTSD checklist; RR=risk ratio; SMD=standardised mean difference; TAU=treatment as usual

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

[2] Considerable heterogeneity (I2>80%)

[3] OIS not met (N<400)

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

[5] OIS not met (events<300)

[6] Data is not reported/cannot be extracted for all outcomes

[7] 95% CI crosses line of no effect and threshold for both clinically important benefit and clinically important harm

See appendix F for full GRADE tables.

Economic evidence

Included studies

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

Excluded studies

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

Economic model

No economic modelling on other non-pharmacological interventions for the treatment of PTSD in adults was undertaken, as other areas were identified as higher priorities for economic evaluation.

Resource impact

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

Clinical evidence statements

Acupuncture for delayed treatment (>3 months)

- Very low quality single-RCT (N=48) evidence suggests large and statistically significant benefits of acupuncture relative to waitlist on improving self-rated PTSD symptomatology, the rate of remission, anxiety and depression symptoms, and functional impairment in adults with PTSD over 3 months after trauma. Evidence from this same RCT (N=56) suggests there may be higher drop-out associated with acupuncture, however, this effect is not statistically significant.
- Low to very low quality single-RCT (N=127) evidence suggests non-significant differences between acupuncture and paroxetine on clinician-rated PTSD symptomatology, anxiety and depression symptoms at endpoint, 3-month and 6-month follow-up, and discontinuation in adults with PTSD over 3 months after trauma.

Exercise for delayed treatment (>3 months)

- Low quality single-RCT (N=58) evidence suggests moderate to large and statistically significant benefits of exercise in addition to TAU relative to TAU-only on improving clinician-rated PTSD symptomatology, anxiety symptoms and sleeping difficulties, in adults with PTSD over 3 months after trauma. However, evidence from the same study suggests non-significant effects of exercise on self-rated PTSD symptomatology, depression symptoms or discontinuation.

Repetitive transcranial magnetic stimulation (rTMS) for delayed treatment (>3 months)

- Very low quality single-RCT (N=20) evidence suggests large and statistically significant benefits of repetitive transcranial magnetic stimulation (rTMS) relative to sham stimulation on improving PTSD symptomatology (self-rated and clinician-rated) and depression symptoms, in adults with PTSD over 3 months after trauma. No evidence is available for discontinuation.

Yoga for delayed treatment (>3 months)

- Very low quality single-RCT analyses (N=50-60) suggests moderate and statistically significant benefits of yoga (in addition to TAU) relative to TAU or attention-placebo (in addition to TAU) on improving clinician-rated PTSD symptomatology, the rate of remission and sleeping difficulties in adults with PTSD over 3 months after trauma. Low to very low quality evidence from 1-3 RCTs (N=25-148) suggests clinically important, but not statistically significant benefits of yoga (alone or in addition to TAU) relative to TAU, attention-placebo or waitlist on self-rated PTSD symptomatology, dissociative symptoms at endpoint, and symptoms of alcohol use disorder at endpoint and 1-month follow-up. However, single-RCT (N=38) evidence suggests the effect on self-rated PTSD

symptomatology is not maintained at 1-month follow-up, and there is no follow-up data available for dissociative symptoms. Low to very low quality evidence from 1-3 RCTs (N=38-148) suggests non-significant effects of yoga on anxiety and depression symptoms and symptoms of drug use disorder (at endpoint and 1-month follow-up). Very low quality evidence from 2 RCTs (N=118) suggests there may be higher drop-out associated with yoga, however, this effect is not statistically significant.

Bio-/neuro-feedback for delayed treatment (>3 months)

- Low to very low quality evidence from 1-3 RCTs (N=30-94) suggests large and statistically significant benefits of bio-/neuro-feedback (alone or in addition to TAU) relative to TAU or no treatment on improving self-rated PTSD symptomatology at endpoint and 4-6 week follow-up, clinician-rated PTSD symptomatology at 1-month follow-up (clinically important but not statistically significant at endpoint), remission at 1-month follow-up (clinically important but not statistically significant at endpoint) and depression symptoms at endpoint and 6-week follow-up, in adults with PTSD over 3 months after trauma. Very low quality evidence from 2 RCTs (N=72) suggests there may be higher drop-out associated with bio-/neuro-feedback, however, this effect is not statistically significant.

Economic evidence statements

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

Recommendations

No recommendations were made on other non-pharmacological interventions for the treatment of PTSD.

Rationale and impact

Why the committee didn't make any recommendations

Limited evidence from a small number of RCTs showed some potential benefits of yoga relative to waitlist, treatment as usual or attention-placebo. However, the only PTSD outcome that included more than one study (self-rated PTSD symptomatology) showed non-statistically significant effects, benefits did not extend to anxiety or depression symptoms, effects appeared to be short-term, and there was a trend for higher discontinuation with yoga. Given this uncertainty in the evidence, the committee agreed not to make a recommendation for yoga.

Limited evidence from a small number of RCTs also showed some potential benefits on self-rated PTSD symptomatology associated with biofeedback or neurofeedback. However, effects on other primary PTSD outcomes failed to reach statistical significance, there was no evidence for long-term follow-up, and there were concerns about the generalisabilty of results. Given these uncertainties in the evidence, the committee did not judge it appropriate to make a recommendation.

The evidence for acupuncture, exercise, and repetitive transcranial magnetic stimulation (rTMS) was too limited to allow any certainty in the findings, and thus the committee judged that no recommendation could be made.

Impact of the recommendations on practice

No recommendations were made for other non-pharmacological interventions for the treatment of PTSD, and as none of these interventions are in widespread use in routine clinical practice, the committee thought that there would be no change in practice.

The committee's discussion of the evidence

Interpreting the evidence

Relative value placed on the outcomes considered

Critical outcomes were measures of PTSD symptom improvement on validated scales, remission (as defined as a loss of diagnosis or scoring below threshold on a validated scale), and response (as measured by an agreed percentage improvement in symptoms and/or by a dichotomous rating of much or very much improved). Attrition from treatment (for any reason) was also considered an important outcome, as a proxy for the acceptability and/or tolerability of treatment. The committee considered dissociative symptoms, personal/social/occupational functioning (including global functioning/functional impairment, sleeping or relationship difficulties, and quality of life), and symptoms of a coexisting condition (including anxiety, depression and substance use disorder symptoms) as important but not critical outcomes. This distinction was based on the primacy of targeting the core PTSD symptoms, whilst acknowledging the influence that wider benefits may have on decision-making about the efficacy of a given intervention. Generally change scores were favoured over final scores as although in theory randomisation should balance out any differences at baseline, this assumption can be violated by small sample sizes. The committee also expressed a general preference for self-rated PTSD symptomatology, however, in considering other non-pharmacological interventions (relative to pharmacological interventions) a greater emphasis was placed on triangulating effects on self-rated PTSD symptomatology with clinician-rated outcome measures, given that the latter but not the former could be blinded.

The quality of the evidence

All the evidence reviewed was of low or very low quality, reflecting the high risk of bias associated with the studies (including for instance, high risk of bias associated with randomisation method as reflected by significant group differences at baseline, and lack of/unclear blinding of outcome assessment), the limited number of RCTs, the small numbers in the trials and the imprecision of many of the results (in terms of both the width of the confidence intervals and the failure to meet the optimal information size).

Consideration of clinical benefits and harms

The committee discussed the evidence for yoga and noted that although the benefits observed on blinded clinician-rated PTSD symptomatology and remission were encouraging, the larger evidence base for self-rated PTSD symptomatology failed to meet statistical significance. The effects also failed to extend to anxiety or depression symptoms, and were non-significant at 1-month follow-up. Considered in the round the committee judged the uncertainty in the evidence to be too high to warrant a recommendation.

The committee discussed the evidence for biofeedback and neurofeedback and noted that benefits observed for self-rated PTSD symptomatology did not reach

statistical significance for clinician-rated PTSD symptomatology or remission. Furthermore, there was no evidence for long-term follow-up and concerns about the generalisabilty of results (all multiple incident index trauma, predominantly military combat-related). Taking into account these limitations of the evidence, and bearing in mind that such interventions are not in routine clinical practice and would require significant resources and training, the tommittee did not think that a recommendation was appropriate.

There was limited evidence for benefits associated with acupuncture, exercise, and repetitive transcranial magnetic stimulation (rTMS) however, the evidence base was composed of only small single studies, and thus was not sufficient for the committee to be confident that the benefits observed are true effects. On this basis, the committee concluded that a recommendation could not be supported.

The committee discussed the potential benefits associated with yoga and biofeedback/neurofeedback. However, the potential for clinical benefit was somewhat unclear given the equivocal results. The committee also discussed the higher drop-out associated with these interventions, which although not statistically significant was above the threshold for clinical importance and sufficient to raise concerns about the acceptability of these interventions, particularly for yoga where attrition was 46% compared with15% attrition for control. Taken together the committee judged that the evidence for benefit was weak and given the concerns about acceptability, a recommendation for yoga or biofeedback/neurofeedback was not appropriate.

Cost effectiveness and resource use

No evidence on the cost effectiveness of other non-pharmacological interventions for the treatment of PTSD in adults was identified and no economic modelling was undertaken. The committee did not make any recommendations on other non-pharmacological interventions for the treatment of PTSD in adults due to uncertain or limited evidence of their benefits. As none of these interventions are in widespread use in routine clinical practice, the committee expressed the view that there would be no impact on resources.

References for included studies

Acupuncture

Hollifield 2007

Hollifield M, Sinclair-Lian N, Warner TD and Hammerschlag R (2007) Acupuncture for posttraumatic stress disorder: a randomized controlled pilot trial. The Journal of nervous and mental disease 195(6), 504-13

Wang 2012

Wang Y, Hu YP, Wang WC, et al. (2012) Clinical studies on treatment of earthquake-caused posttraumatic stress disorder using electroacupuncture. Evidence-Based Complementary and Alternative Medicine 2012 [ID: 431279]

Exercise

Goldstein 2018

Goldstein LA, Mehling WE, Metzler TJ, et al. (2018) Veterans Group Exercise: A randomized pilot trial of an Integrative Exercise program for veterans with posttraumatic stress. Journal of affective disorders 227, 345-52

Rosenbaum 2011/2015

Rosenbaum S, Nguyen D, Lenehan T, et al. (2011) Exercise augmentation compared to usual care for Post Traumatic Stress Disorder: A Randomised Controlled Trial (The REAP study: R andomised E xercise A ugmentation for P TSD). BMC psychiatry 11(1), 115

Rosenbaum S, Sherrington C and Tiedemann A (2015) Exercise augmentation compared with usual care for post-traumatic stress disorder: a randomized controlled trial. Acta Psychiatrica Scandinavica 131(5), 350-9

Repetetive transcranial magnetic stimulation (rTMS)

Watts 2012

Watts BV, Landon B, Groft A and Young-Xu Y (2012) A sham controlled study of repetitive transcranial magnetic stimulation for posttraumatic stress disorder. Brain stimulation 5(1), 38-43

Yoga

Jindani 2015

Jindani F, Turner N and Khalsa SB (2015) A yoga intervention for posttraumatic stress: A preliminary randomized control trial. Evidence-Based Complementary and Alternative Medicine 2015

Mitchell 2014/Dick 2014/Reddy 2014

Mitchell KS, Dick AM, DiMartino DM, et al. (2014) A pilot study of a randomized controlled trial of yoga as an intervention for PTSD symptoms in women. Journal of Traumatic Stress 27(2), 121-8

Dick AM, Niles BL, Street AE, et al. (2014) Examining mechanisms of change in a yoga intervention for women: the influence of mindfulness, psychological flexibility, and emotion regulation on PTSD symptoms. Journal of clinical psychology 70(12), 1170-82

Reddy S, Dick AM, Gerber MR and Mitchell K (2014) The effect of a yoga intervention on alcohol and drug abuse risk in veteran and civilian women with posttraumatic stress disorder. The Journal of Alternative and Complementary Medicine 20(10), 750-6

van der Kolk 2014

van der Kolk BA, Stone L, West J, et al. (2014) Yoga as an adjunctive treatment for posttraumatic stress disorder: A randomized controlled trial. J Clin Psychiatry 75(6), e559-65

Bio-/neuro-feedback

Noohi 2017

Noohi S, Miraghaie AM, Arabi A and Nooripour R (2017) Effectiveness of neuro-feedback treatment with alpha/theta method on PTSD symptoms and their executing function. Biomedical Research 28(5)

Tan 2011

Tan G, Dao TK, Farmer L, et al. (2011) Heart rate variability (HRV) and posttraumatic stress disorder (PTSD): A pilot study. Applied Psychophysiology and Biofeedback 36, 27–35

van der Kolk 2016

van der Kolk BA, Hodgdon H, Gapen M, et al. (2016) A Randomized Controlled Study of Neurofeedback for Chronic PTSD. PloS one 11(12), e0166752

Appendices

Appendix A – Review protocols

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

Topic	**Pharmacological interventions for the treatment of PTSD in adults**
Review question(s)	Review questions 2.2 For adults with clinically important post-traumatic stress symptoms, what are the relative benefits and harms of psychological, psychosocial or other non-pharmacological interventions targeted at PTSD symptoms?
Sub-question(s)	Where evidence exists, consideration will be given to the specific needs of: • women who have been exposed to sexual abuse or assault, or domestic violence • lesbian, gay, bisexual, transsexual or transgender people • people from black and minority ethnic groups • people who are homeless or in insecure accommodation • asylum seekers or refugees or other immigrants who are entitled to NHS treatment • people who have been trafficked • people who are socially isolated (and who are not captured by any other subgroup listed) • people with complex PTSD • people with neurodevelopmental disorders (including autism) • people with coexisting conditions (drug and alcohol misuse, common mental health disorders, eating disorders, personality disorders, acquired brain injury, physical disabilities and sensory impairments) • people who are critically ill or injured (for instance after a vehicle crash)
Objectives	To identify the most effective psychological, psychosocial or other non-pharmacological interventions for the treatment of PTSD in adults

Topic	**Pharmacological interventions for the treatment of PTSD in adults**
Population	Adults with PTSD (as defined by a diagnosis of PTSD according to DSM, ICD or similar criteria, or clinically-significant PTSD symptoms as indicated by baseline scores above threshold on a validated scale more than one month after the traumatic event [see PTSD scales listed under outcomes]) For mixed adult and children populations, where possible disaggregated data will be obtained. If this is not possible then the study will be categorised according to the mean age of the population (<18 years as children and young people and ≥18 years as adult). If some, but not all, of a study's participants are eligible for the review, where possible disaggregated data will be obtained. If this is not possible then the study will be included if at least 80% of its participants are eligible for this review.
Exclude	Trials of people with adjustment disorders Trials of people with traumatic grief Trials of people with psychosis as a coexisting condition Trials of people with learning disabilities Trials of women with PTSD during pregnancy or in the first year following childbirth Trials of adults in contact with the criminal justice system (not solely as a result of being a witness or victim)
Intervention	Psychological interventions (psychological interventions listed below are examples of interventions which may be included either alone or in combination in an individual or group format): • Trauma-focused cognitive behavioural therapies (CBT), including cognitive therapy, cognitive processing therapy, compassion focused therapy, exposure therapy/prolonged exposure (PE), virtual reality exposure therapy (VRET), imagery rehearsal therapy, mindfulness-based cognitive therapy (MBCT) and narrative exposure therapy (NET) • Non-trauma-focused CBT, including stress inoculation training (SIT) • Psychologically-focused debriefing (including single session debriefing) • Eye movement desensitisation and reprocessing (EMDR) • Hypnotherapy • Psychodynamic therapies, including traumatic incident reduction (TIR) • Counselling, including non-directive/supportive/person-centred counselling

Topic	**Pharmacological interventions for the treatment of PTSD in adults**
	• Human givens therapy • Combined somatic and cognitive therapies, including thought field therapy (TFT) and emotional freedom technique (EFT) • Couple interventions, including cognitive-behavioural conjoint therapy • Parent training/family interventions, including behavioural family therapy Psychosocial interventions (psychosocial interventions listed below are examples of interventions which may be included either alone or in combination): • Meditation • Mindfulness-based stress reduction (MBSR) • Supported employment (including individual placement and support [IPS] supported employment and Veterans Health Administration Vocational Rehabilitation Programme [VRP]) • Practical support (including financial and housing) • Psychoeducational interventions • Peer support (including (including self-help groups and support groups and Trauma Risk Management [TRiM]) Other non-pharmacological interventions (other non-pharmacological interventions listed below are examples of interventions which may be included either alone or in combination): • Acupuncture (including classical acupuncture, electroacupuncture, auricular acupuncture, laser acupuncture and acupoint stimulation [such as acupressure, moxibustion and tapping]) • Exercise (including anaerobic [such as heavy weight training, sprinting, high-intensity interval training] and aerobic [such as running/jogging, swimming, cycling and walking] exercise, both supervised and unsupervised) • Repetitive transcranial magnetic stimulation (rTMS) • Yoga (including all types of yoga) Combination interventions, such as combined psychological plus pharmacological versus pharmacological alone, will also be considered here.

Topic	**Pharmacological interventions for the treatment of PTSD in adults**
	A distinction will be made between early interventions (delivered within 3 months of the traumatic event) and delayed interventions (delivered more than 3 months after the traumatic event) Exclude: Inoculation interventions for people who may be at risk of experiencing but have not experienced, a traumatic event Interventions that are not targeted at PTSD symptoms
Comparison	Any other intervention Treatment as usual Waitlist Placebo
Critical outcomes	Efficacy PTSD symptomology (mean endpoint score or change in PTSD score from baseline) Diagnosis of PTSD (number of people meeting diagnostic criteria for PTSD according to DSM, ICD or similar criteria) Recovery from PTSD/Remission (number of people no longer meeting diagnostic criteria for PTSD according to DSM, ICD or similar criteria at endpoint, or endpoint scores below threshold on a validated scale) Response (as measured by an agreed percentage improvement in symptoms and/or by a dichotomous rating of much or very much improved on Clinical Global Impressions [CGI] scale) Relapse (number of people who remitted at endpoint but at follow-up either met diagnostic criteria for PTSD according to DSM, ICD or similar criteria, or whose follow-up scores were above threshold on a validated scale) The following PTSD scales will be included: Assessor-rated PTSD symptom scales: • Clinician-Administered PTSD Scale for DSM–IV (CAPS) or DSM-V (CAPS-5) • Anxiety Disorders Interview Schedule for DSM-IV: Lifetime version (ADIS-IV-L) or DSM-5 (ADIS-5) - Adult and Lifetime Version • PTSD Symptom Scale – Interview Version (PSS-I) • Number of symptoms on the Structured Clinical Interview for DSM-IV (SCID)

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

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

Topic	**Pharmacological interventions for the treatment of PTSD in adults**
	If existing systematic reviews are found, the GC will assess their quality, completeness, and applicability to the NHS and to the scope of the guideline. If the GC agrees that a systematic review appropriately addresses a review question, a search for studies published since the review will be conducted. Data Extraction (selection and coding) Citations from each search will be downloaded into EndNote and duplicates removed. Titles and abstracts of identified studies will be screened by two reviewers for inclusion against criteria, until a good inter-rater reliability has been observed (percentage agreement =>90% or Kappa statistics, K>0.60). Initially 10% of references will be double-screened. If inter-rater agreement is good then the remaining references will be screened by one reviewer. All primary-level studies included after the first scan of citations will be acquired in full and re-evaluated for eligibility at the time they are being entered into a study database (standardised template created in Microsoft Excel). At least 10% of data extraction will be double-coded. Discrepancies or difficulties with coding will be resolved through discussion between reviewers or the opinion of a third reviewer will be sought. Non-English-language papers will be excluded (unless data can be obtained from an existing review). Data Analysis Where data is available, meta-analysis using a fixed-effects model will be used to combine results from similar studies. Heterogeneity will be considered and if a random-effects model is considered more appropriate it will be conducted. For risk of bias, outcomes will be downgraded if the randomisation and/or allocation concealment methods are unclear or inadequate. Outcomes will also be downgraded if no attempts are made to blind the assessors or participants in some way, i.e. by either not knowing the aim of the study or the result from other tests. Outcomes will also be downgraded if there is considerable missing data (see below). Handling missing data: Where possible an intention to treat approach will be used. Outcomes will be downgraded if there is a dropout of more than 20%, or if there was a difference of >20% between the groups. For heterogeneity: outcomes will be downgraded once if I2>50%, twice if I2 >80%

Topic	**Pharmacological interventions for the treatment of PTSD in adults**
	For imprecision: outcomes will be downgraded if: • Step 1: If the 95% CI is imprecise i.e. crosses 0.8 or 1.25 (dichotomous) or -0.5 or 0.5 (for continuous). Outcomes will be downgraded one or two levels depending on how many lines it crosses. • Step 2: If the clinical decision threshold is not crossed, we will consider whether the criterion for Optimal Information Size is met, if not we will downgrade one level for the following: - for dichotomous outcomes: <300 events - for continuous outcomes: <400 participants For clinical effectiveness, if studies report outcomes using the same scale mean differences will be considered, if not standardized mean differences (SMDs) will be considered and the following criteria will be used: • SMD <0.2 too small to likely show an effect • SMD 0.2 small effect • SMD 0.5 moderate effect • SMD 0.8 large effect • RR <0.8 or >1.25 clinical benefit Anything less (RR >0.8 and <1.25), the absolute numbers will be looked at to make a decision on whether there may be a clinical effect.
Heterogeneity (sensitivity analysis and subgroups)	Where substantial heterogeneity exists, sensitivity analyses will be considered, for instance: • Studies with <50% completion data (drop out of >50%) will be excluded, Where possible, the influence of subgroups will be considered, including subgroup analyses giving specific consideration to the groups outlined in the sub-question section and to the following groups: • Trauma type (including single incident relative to chronic exposure) • Duration of intervention (for instance, short-term [≤12 weeks] relative to long-term [>12 weeks]) • Intensity of intervention (for instance, low intensity [≤15 sessions] relative to high intensity [>15 sessions]) • Format of intervention (individual relative to group) • Mode of intervention delivery (including digital relative to face-to-face) • First-line treatment relative to second-line treatment and treatment-resistant PTSD (≥2 inadequate treatments) • Acute PTSD symptoms (clinically important PTSD symptoms for less than 3 months) relative to chronic PTSD symptoms (clinically important PTSD symptoms for 3 months or more)

Topic	**Pharmacological interventions for the treatment of PTSD in adults**
Notes	Practical and social support (area of scope) is covered quantitatively by interventions listed under psychosocial interventions: • Supported employment (including individual placement and support [IPS] supported employment and Veterans Health Administration Vocational Rehabilitation Programme [VRP]) • Practical support (including financial and housing) • Peer support (including self-help groups and support groups)

Appendix B – Literature search strategies

Literature search strategies for "For adults with clinically important post-traumatic stress symptoms, what are the relative benefits and harms of psychological, psychosocial or other non-pharmacological interventions targeted at PTSD symptoms?"

Clinical evidence

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

Date of last search: 29 January 2018

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

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

#	Searches
49	couples therapy/ or family therapy/ or marital therapy/ or exp parents/ed
50	49 use mesz, prem
51	couples therapy/ or family intervention/ or exp family therapy/ or exp marriage counseling/ or parent training/
52	51 use psyh
53	(((con?joint or couple* or family or families or husband* or marriage* or marital* or partner* or relations* or spous* or wife or wives* or (child* adj5 parent*)) adj6 (counsel* or intervention* or program* or support* or therap* or treat*)) or ((couples* or family* or relations*) adj (based or focused or led)) or ecological therap* or expressed emotion or family dynamics or family relationships).tw.
54	((child* adj2 family traumatic stress intervention) or cftsi).ti,ab.
55	play therapy.sh.
56	(doll therap* or ((play or playful) adj3 (intervention* or program* or therap* or treat*)) or sandplay or sand play).ti,ab.
57	meditation.sh. or meditat*.ti,ab.
58	mindfulness.sh. or (mbsr or mindful*).ti,ab.
59	exp horticulture/ or occupational therapy/ or recreational therapy/
60	59 use emez
61	horticultural therapy/ or occupational therapy/ or recreation therapy/
62	61 use mesz, prem
63	exp "nature (environment)"/ or horticulture therapy/ or recreation therapy/ or occupational therapy/
64	63 use psyh
65	((nature adj (assisted or based)) or (nature adj3 (intervention* or program* or therap* or treat*)) or ecotherap* or e cotherap* or gardening or horticult* or leisure activit* or naturopath* or occupational therap*).ti,ab. or exp animal assisted therapy/ use emez, mesz or animal assisted therapy/ use psyh or (((animal* or dog* or equine* or horse* or pet or pets) adj2(assist* or based or facilitat*)) or ((animal* or dog* or equine* or horse* or pet or pets) adj3(intervention* or therap* or treat* or program*))).ti,ab.
66	psychoeducation.sh. or (psychoed* or psycho ed*).ti,ab.
67	exp acupuncture/ use emez or exp alternative medicine/ use emez or biofeedback/ or massage/ use emez or meditation/ use emez or acupressure/ use mesz, prem or massage/ use mesz, prem or acupuncture/ use mesz, prem or exp complementary therapies/ use mesz, prem or exp alternative medicine/ use psyh or biofeedback/ use psyh or massage/ use psyh or mind body therapy/ use psyh
68	(chinese medicine or medicine, chinese traditional or (moxibustion or electroacupuncture)).sh,id. or ((alternative or complementary) adj2 (medicine* or therap*)).ti,ab,sh. or (acu point* or acupoint* or acupressur* or acupunctur* or (ching adj2 lo) or cizhen or dianzhen or electroacupunctur* or (jing adj2 luo) or jingluo or massag* or needle therap* or tapping or zhenjiu or zhenci).tw.
69	exp *exercise/ use emez or exp *kinesiotherapy/ use emez or exp exercise/ use mesz, prem or exercise therapy/ use mesz, prem or exp exercise/ use psyh (physiotherap* or physio therap* or rehab*).ti,ab,hw.
70	(((balance or flexibility or resistance or sitting* or strenth*) adj2 (exercise* or train*)) or aerobic* or anaerobic* or bowls or dancing or dance or cycling or cycle* or elliptical train* or jogging or low impact activit* or running or swimming or sprinting or swim*1 or walking or

#	Searches
	yoga or tai chi or weight train* or (weight and brain* and (change* or increas* or volum*))).ti,ab.
71	friendship/ or peer counseling/ or peer group/ or self help/ or self care/ or social network/ or social support/ or support group/
72	71 use emez
73	community networks/ or friends/ or exp peer group/ or self care/ or self-help groups/ or social networking/ or social support/
74	73 use mesz, prem
75	friendship/ or network therapy/ or exp social networks/ or peer relations/ or peers/ or peer counseling/ or self care skills/ or exp self help techniques/ or social support/ or exp support groups/
76	75 use psyh
77	((self adj (administer* or assess* or attribut* or care or change or directed or efficacy or help* or guide* or instruct* or manag* or medicat* or monitor* or regulat* or reinforc* or re inforc* or support* or technique* or therap* or train* or treat*)) or selfadminister* or selfassess* or selfattribut* or selfcare or selfchange or selfdirected or selfefficacy or selfhelp* or selfguide* or selfinstruct* or selfmanag* or selfmedicat* or selfmonitor* or selfregulat* or selfreinforc* or self re inforc* or selfsupport* or selftechnique* or selftherap* or selftrain* or selftreat* or (wellness adj (therap* or train* or treat*))).ti,ab,sh.
78	(befriend* or be*1 friend* or buddy or buddies or ((community or lay or paid or support) adj (person or worker*))).ti,ab.
79	(((consumer* or famil* or friend* or lay or mutual* or peer* or social* or spous* or voluntary or volunteer*) adj3 (assist* or advice* or advis* or counsel* or educat* or forum* or help* or mentor* or network* or support* or visit*)) or ((consumer* or famil* or peer* or self help or social* or support* or voluntary or volunteer*) adj2 group*) or ((consumer* or famil* or friend* or lay or mutual* or peer* or self help or social* or spous* or support* or voluntary or volunteer*) adj3 (intervention* or program* or rehab* or therap* or service* or skill* or treat*)) or (((consumer* or famil* or friend* or lay* or peer* or spous* or user* or support* or voluntary or volunteer*) adj (based or counsel* or deliver* or interact* or led or mediat* or operated or provides or provider* or run*)) or ((consumer* or famil* or friend* or lay* or peer* or relation* or spous* or support*) adj3 trust*) or voluntary work*)).ti,ab.
80	(((lay or peer*) adj3 (advis* or consultant or educator* or expert* or facilitator* or instructor* or leader* or mentor* or person* or tutor* or worker*)) or expert patient* or mutual aid).ti,ab.
81	(peer* adj3 (assist* or counsel* or educat* or program* or rehab* or service* or supervis*)).ti,ab.
82	((psychoeducat* or psycho educat*) adj3 (group or network* or service*)).ti,ab.
83	((psychosocial or social) adj work*).ti,ab.
84	((ptsd or posttrauma* or post trauma* or trauma*) adj2 support*).ti,ab.
85	recovery support.ti,ab.
86	financial management/ use emez or financial support/ use mesz, prem or finance/ use psyh
87	((financ* or money) adj2 (assist* or educat* or guidance or intervention* or program* or support* or train*)).ti,ab.
88	assisted living facility/ or emergency shelter/ or halfway house/ or housing/ or independent living/ or residential home/ or residential home/
89	88 use emez
90	assisted living facilities/ or emergency shelter/ or group homes/ or halfway houses/ or housing/ or independent living/ or residential facilities/

#	Searches
91	90 use mesz, prem
92	assisted living / use psyh or shelters/ use psyh or group homes/ use psyh or halfway houses/ use psyh or housing/ use psyh or residential care institutions/ use psyh or ((resident* or hous* or accommod* or commun* or comu* or home*) adj5 (support* or support* or shelter* or outreach* or visit* or appointment*)).ti,ab.
93	(residential treatm* or residential facility* or supported hous* or public hous*).ti,ab.
94	(accomod* or assertive community treatment* or home* or housing* or outreach* or residential*).ti,ab.
95	absenteeism/ or daily life activity/ or employment/ or medical leave/ or mentoring/ or occupational health/ or occupational therapy/ or return to work/ or supported employment/ or unemployment/ or vocational guidance/ or vocational rehabilitation/ or work capacity/ or work/
96	95 use emez
97	absenteeism/ or "activities of daily living"/ or employment, supported/ or employment/ or mentoring/ or occupational health/ or occupational therapy/ or rehabilitation, vocational/ or return to work/ or sick leave/ or unemployment/ or vocational guidance/ or work/
98	97 use mesz, prem
99	"activities of daily living"/ or exp coaching/ or employee absenteeism/ or employment status/ or occupational guidance/ or occupational health/ or occupational therapy/ or reemployment/ or unemployment/ or vocational counselors/ or exp vocational rehabilitation/
100	99 use psyh
101	(((supp* or transitional*) adj5 (employ* or work*)) or individual placement or (placement* adj3 (employ* or work*))).ti,ab.
102	((employ* or placement* or psychosocial* or psycho-social* or occupation* or soc* or vocation* or work* or job* or counsel*) adj5 rehab*).ti,ab.
103	(sheltered work* or vocatio* or fountain house* or fountainhouse* or clubhouse* or club house* or work therap*).ti,ab.
104	(transitional employment or rehabilitation counsel* or (occupational adj (health or medicine)) or work* adjustment).ti,ab.
105	((performance adj (activit* or coach* or management or occupation*)) or coaching).ti,ab.
106	(((sheltered or permitted or voluntary or vocational or return* or rehabilitat*) adj3 work*) or work capacity or reemploy* or re employ* or job retention or work capacity).ti,ab.
107	((employ* or job or occupation* or vocation* or work*) adj5 (counsel* or educat* or guidance* or intervention* or program* or rehab* or reintegrat* or re integrat* or support* or therap* or train*)).ti,ab.
108	placement.ti,ab.
109	or/11-12,14-15,17-19,21-22,24,26,28-46,48,50,52-58,60,62,64-70,72,74,76-87,89,91-94,96,98,100-108
110	meta analysis/ or "meta analysis (topic)"/ or systematic review/
111	110 use emez
112	meta analysis.sh,pt. or "meta-analysis as topic"/ or "review literature as topic"/
113	112 use mesz, prem
114	(literature review or meta analysis).sh,id,md. or systematic review.id,md.
115	114 use psyh
116	(exp bibliographic database/ or (((electronic or computer* or online) adj database*) or bids or cochrane or embase or index medicus or isi citation or medline or psyclit or psychlit or

#	Searches
	scisearch or science citation or (web adj2 science)).ti,ab.) and (review*.ti,ab,sh,pt. or systematic*.ti,ab.)
117	116 use emez
118	(exp databases, bibliographic/ or (((electronic or computer* or online) adj database*) or bids or cochrane or embase or index medicus or isi citation or medline or psyclit or psychlit or scisearch or science citation or (web adj2 science)).ti,ab.) and (review*.ti,ab,sh,pt. or systematic*.ti,ab.)
119	118 use mesz, prem
120	(computer searching.sh,id. or (((electronic or computer* or online) adj database*) or bids or cochrane or embase or index medicus or isi citation or medline or psyclit or psychlit or scisearch or science citation or (web adj2 science)).ti,ab.) and (review*.ti,ab,pt. or systematic*.ti,ab.)
121	120 use psyh
122	((analy* or assessment* or evidence* or methodol* or quantativ* or systematic*) adj2 (overview* or review*)).tw. or ((analy* or assessment* or evidence* or methodol* or quantativ* or systematic*).ti. and review*.ti,pt.) or (systematic* adj2 search*).ti,ab.
123	(metaanal* or meta anal*).ti,ab.
124	(research adj (review* or integration)).ti,ab.
125	reference list*.ab.
126	bibliograph*.ab.
127	published studies.ab.
128	relevant journals.ab.
129	selection criteria.ab.
130	(data adj (extraction or synthesis)).ab.
131	(handsearch* or ((hand or manual) adj search*)).ti,ab.
132	(mantel haenszel or peto or dersimonian or der simonian).ti,ab.
133	(fixed effect* or random effect*).ti,ab.
134	((pool* or combined or combining) adj2 (data or trials or studies or results)).ti,ab.
135	or/111,113,115,117,119,121-134
136	exp "clinical trial (topic)"/ or exp clinical trial/ or crossover procedure/ or double blind procedure/ or placebo/ or randomization/ or random sample/ or single blind procedure/
137	136 use emez
138	exp clinical trial/ or exp "clinical trials as topic"/ or cross-over studies/ or double-blind method/ or placebos/ or random allocation/ or single-blind method/
139	138 use mesz, prem
140	(clinical trials or placebo or random sampling).sh,id.
141	140 use psyh
142	(clinical adj2 trial*).ti,ab.
143	(crossover or cross over).ti,ab.
144	(((single* or doubl* or trebl* or tripl*) adj2 blind*) or mask* or dummy or doubleblind* or singleblind* or trebleblind* or tripleblind*).ti,ab.
145	(placebo* or random*).ti,ab.
146	treatment outcome*.md. use psyh

#	Searches
147	animals/ not human*.mp. use emez
148	animal*/ not human*/ use mesz, prem
149	(animal not human).po. use psyh
150	or/137,139,141-146
151	150 not (or/147-149)
152	or/135,151
153	10 and 109 and 152

Database: **CDSR, DARE, HTA, CENTRAL**

Date of last search: 29 January 2018

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

Database: **CDSR, DARE, HTA, CENTRAL**

Date of last search: 29 January 2018

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

Database: **CINAHL PLUS**

Date of last search: 29 January 2018

#	Searches
s52	s6 and s51
s51	s40 or s50
s50	s48 not s49
s49	(mh "animals") not (mh "human")
s48	s41 or s42 or s43 or s44 or s45 or s46 or s47
s47	ti (placebo* or random*) or ab (placebo* or random*)
s46	ti (single blind* or double blind* or treble blind* or mask* or dummy* or singleblind* or doubleblind* or trebleblind* or tripleblind*) or ab (single blind* or double blind* or treble blind* or mask* or dummy* or singleblind* or doubleblind* or trebleblind* or tripleblind*)
s45	ti (crossover or cross over) or ab (crossover or cross over)
s44	ti clinical n2 trial* or ab clinical n2 trial*

#	Searches
s43	(mh "crossover design") or (mh "placebos") or (mh "random assignment") or (mh "random sample")
s42	mw double blind* or single blind* or triple blind*
s41	(mh "clinical trials+")
s40	s7 or s8 or s9 or s10 or s11 or s12 or s13 or s14 or s15 or s16 or s17 or s18 or s19 or s20 or s21 or s22 or s23 or s29 or s30 or s31 or s34 or s35 or s36 or s37 or s38 or s39
s39	ti (analy* n5 review* or evidence* n5 review* or methodol* n5 review* or quantativ* n5 review* or systematic* n5 review*) or ab (analy* n5 review* or assessment* n5 review* or evidence* n5 review* or methodol* n5 review* or qualitativ* n5 review* or quantativ* n5 review* or systematic* n5 review*)
s38	ti (pool* n2 results or combined n2 results or combining n2 results) or ab (pool* n2 results or combined n2 results or combining n2 results)
s37	ti (pool* n2 studies or combined n2 studies or combining n2 studies) or ab (pool* n2 studies or combined n2 studies or combining n2 studies)
s36	ti (pool* n2 trials or combined n2 trials or combining n2 trials) or ab (pool* n2 trials or combined n2 trials or combining n2 trials)
s35	ti (pool* n2 data or combined n2 data or combining n2 data) or ab (pool* n2 data or combined n2 data or combining n2 data)
s34	s32 and s33
s33	ti review* or pt review*
s32	ti analy* or assessment* or evidence* or methodol* or quantativ* or qualitativ* or systematic*
s31	ti “systematic* n5 search*” or ab “systematic* n5 search*”
s30	ti “systematic* n5 review*” or ab “systematic* n5 review*”
s29	(s24 or s25 or s26) and (s27 or s28)
s28	ti systematic* or ab systematic*
s27	tx review* or mw review* or pt review*
s26	(mh "cochrane library")
s25	ti (bids or cochrane or embase or “index medicus” or “isi citation” or medline or psyclit or psychlit or scisearch or “science citation” or web n2 science) or ab (bids or cochrane or “index medicus” or “isi citation” or psyclit or psychlit or scisearch or “science citation” or web n2 science)
s24	ti (“electronic database*” or “bibliographic database*” or “computeri?ed database*” or “online database*”) or ab (“electronic database*” or “bibliographic database*” or “computeri?ed database*” or “online database*”)
s23	(mh "literature review")
s22	pt systematic* or pt meta*
s21	ti (“fixed effect*” or “random effect*”) or ab (“fixed effect*” or “random effect*”)
s20	ti (“mantel haenszel” or peto or dersimonian or “der simonian”) or ab (“mantel haenszel” or peto or dersimonian or “der simonian”)
s19	ti (handsearch* or "hand search*" or "manual search*") or ab (handsearch* or "hand search*" or "manual search*")
s18	ab "data extraction" or "data synthesis"
s17	ab "selection criteria"
s16	ab "relevant journals"

#	Searches
s15	ab "published studies"
s14	ab bibliograph*
s13	ti "reference list*"
s12	ab "reference list*"
s11	ti (“research review*” or “research integration”) or ab (“research review*” or “research integration”)
s10	ti (metaanal* or “meta anal*” or metasynthes* or “meta synethes*”) or ab (metaanal* or “meta anal*” or metasynthes* or “meta synethes*”)
s9	(mh "meta analysis")
s8	(mh "systematic review")
s7	(mh "literature searching+")
s6	s1 or s2 or s3 or s4 or s5
s5	ti ((posttraumatic* or "post traumatic*" or "stress disorder*" or "acute stress" or ptsd or asd or desnos or ("combat neuros*" or "combat syndrome" or "concentration camp syndrome" or "extreme stress" or flashback* or "flash back*" or hypervigilan* or hypervigilen* or "psych* stress" or "psych* trauma*" or psychotrauma* or psychotrauma*) or (posttrauma* or traumagenic* or "traumatic stress*"))) or ab ((posttraumatic* or "post traumatic*" or "stress disorder*" or "acute stress" or ptsd or asd or desnos or ("combat neuros*" or "combat syndrome" or "concentration camp syndrome" or "extreme stress" or flashback* or "flash back*" or hypervigilan* or hypervigilen* or "psych* stress" or "psych* trauma*" or psychotrauma* or psychotrauma*) or (posttrauma* or traumagenic* or "traumatic stress*")))
s4	ti ((trauma* and (avoidance or grief or horror or death* or nightmare* or "night mare*" or emotion*))) or ab ((trauma* and (avoidance or grief or horror or death* or nightmare* or "night mare*" or emotion*)))
s3	ti (("railway spine" or (rape near/2 trauma*) or reexperienc* or "re experienc*" or "torture syndrome" or "traumatic neuros*" or "traumatic stress")) or ab (("railway spine" or (rape near/2 trauma*) or reexperienc* or "re experienc*" or "torture syndrome" or "traumatic neuros*" or "traumatic stress"))
s2	(mh "stress, psychological")
s1	(mh "stress disorders, post-traumatic")

Health economic evidence

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

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

Date of last search: 1 March 2018

#	Searches
1	*acute stress/ or *behavioural stress/ or *emotional stress/ or *critical incident stress/ or *mental stress/ or *posttraumatic stress disorder/ or *psychotrauma/

#	Searches
1	*acute stress/ or *behavioural stress/ or *emotional stress/ or *critical incident stress/ or *mental stress/ or *posttraumatic stress disorder/ or *psychotrauma/
2	1 use emez
3	stress disorders, traumatic/ or combat disorders/ or psychological trauma/ or stress disorders, post-traumatic/ or stress disorders, traumatic, acute/ or stress, psychological/
4	3 use mesz, prem
5	exp posttraumatic stress disorder/ or acute stress disorder/ or combat experience/ or "debriefing (psychological)"/ or emotional trauma/ or post-traumatic stress/ or traumatic neurosis/ or "trauma"/ or stress reactions/ or psychological stress/ or chronic stress/
6	5 use psyh
7	(railway spine or (rape adj2 trauma*) or reexperienc* or re experienc* or torture syndrome or traumatic neuros* or traumatic stress).ti,ab.
8	(trauma* and (avoidance or grief or horror or death* or nightmare* or night mare* or emotion*)).ti,ab.
9	(posttraumatic* or post traumatic* or stress disorder* or acute stress or ptsd or asd or desnos or (combat neuros* or combat syndrome or concentration camp syndrome or extreme stress or flashback* or flash back* or hypervigilan* or hypervigilen* or psych* stress or psych* trauma* or psycho?trauma* or psychotrauma*)).ti,ab.
10	or/2,4,6-9
11	budget/ or exp economic evaluation/ or exp fee/ or funding/ or exp health care cost/ or health economics/ or exp pharmacoeconomics/ or resource allocation/
12	151 use emez
13	exp budgets/ or exp "costs and cost analysis"/ or economics/ or exp economics, hospital/ or exp economics, medical/ or economics, nursing/ or economics, pharmaceutical/ or exp "fees and charges"/ or value of life/
14	153 use mesz, prem
15	exp "costs and cost analysis"/ or cost containment/ or economics/ or finance/ or funding/ or "health care economics"/ or pharmacoeconomics/ or exp professional fees/ or resource allocation/
16	155 use psyh
17	(cost* or economic* or pharmacoeconomic* or pharmaco economic*).ti. or (cost* adj2 (effective* or utilit* or benefit* or minimi*)).ab. or (budget* or fee or fees or financ* or price or prices or pricing or resource* allocat* or (value adj2 (monetary or money))).ti,ab.
18	or/12,14,16-17
19	decision theory/ or decision tree/ or monte carlo method/ or nonbiological model/ or (statistical model/ and exp economic aspect/) or stochastic model/ or theoretical model/
20	159 use emez
21	exp decision theory/ or markov chains/ or exp models, economic/ or models, organizational/ or models, theoretical/ or monte carlo method/
22	161 use mesz, prem
23	exp decision theory/ or exp stochastic modeling/
24	163 use psyh
25	((decision adj (analy* or model* or tree*)) or economic model* or markov).ti,ab.
26	or/20,22,24-25

#	Searches
27	quality adjusted life year/ or "quality of life index"/ or short form 12/ or short form 20/ or short form 36/ or short form 8/ or sickness impact profile/
28	167 use emez
29	quality-adjusted life years/ or sickness impact profile/
30	169 use mesz, prem
31	(((disability or quality) adj adjusted) or (adjusted adj2 life)).ti,ab.
32	(disutili* or dis utili* or (utilit* adj1 (health or score* or value* or weigh*))).ti,ab.
33	(health year equivalent* or hye or hyes).ti,ab.
34	(daly or qal or qald or qale or qaly or qtime* or qwb*).ti,ab.
35	discrete choice.ti,ab.
36	(euroqol* or euro qol* or eq5d* or eq 5d*).ti,ab.
37	(hui or hui1 or hui2 or hui3).ti,ab.
38	(((general or quality) adj2 (wellbeing or well being)) or quality adjusted life or qwb or (value adj2 (money or monetary))).ti,ab.
39	(qol or hql* or hqol* or hrqol or hr ql or hrql).ti,ab.
40	rosser.ti,ab.
41	sickness impact profile.ti,ab.
42	(standard gamble or time trade* or tto or willingness to pay or wtp).ti,ab.
43	(sf36 or sf 36 or short form 36 or shortform 36 or shortform36).ti,ab.
44	(sf6 or sf 6 or short form 6 or shortform 6 or shortform6).ti,ab.
45	(sf12 or sf 12 or short form 12 or shortform 12 or shortform12).ti,ab.
46	(sf16 or sf 16 or short form 16 or shortform 16 or shortform16).ti,ab.
47	(sf20 or sf 20 or short form 20 or shortform 20 or shortform20).ti,ab.
48	(sf8 or sf 8 or short form 8 or shortform 8 or shortform8).ti,ab.
49	or/28,30-48
50	or/18,26,49

Database: **HTA, NHS EED**

Date of last search: 1 March 2018

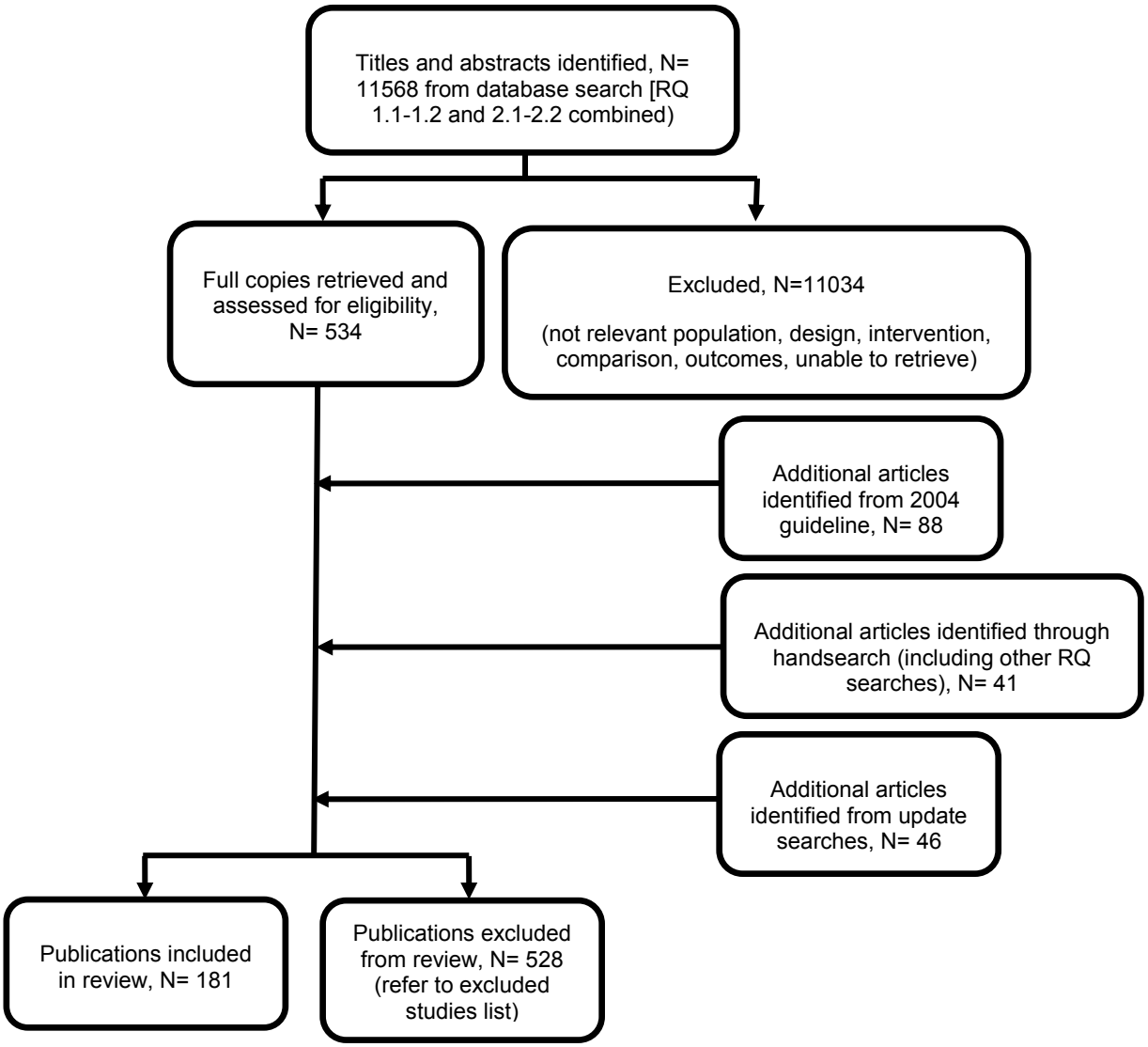
#	Searches
#1	MeSH descriptor: Stress Disorders, Traumatic this term only
#2	MeSH descriptor: Combat Disorders this term only
#3	MeSH descriptor: Psychological Trauma this term only
#4	MeSH descriptor: Stress Disorders, Post-Traumatic this term only
#5	MeSH descriptor: Stress Disorders, Traumatic, Acute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

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

Appendix C – Clinical evidence study selection

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

Figure 1: Flow diagram of clinical article selection for review "For adults with clinically important post-traumatic stress symptoms, what are the relative benefits and harms of psychological, psychosocial or other non-pharmacological interventions targeted at PTSD symptoms?"



Appendix D – Clinical evidence tables

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

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
Abramowitz 2008	Hypnotherapy: Hypnotherapy	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Military combat (no further detail reported)	33	Age range (mean): 21-40 (31.7) Gender (% female): 0 BME (% non-white): NR Country: Israel Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Multiple	Inclusion: suffering from chronic difficulties in initiating and maintaining sleep, night terrors, and nightmares, despite maintenance treatment by selective serotonin re-uptake inhibitor (SSRI) antidepressants and supportive psychotherapy, diagnosis of PTSD according to DSM-IV criteria, aged 21-40 years, and competent to endorse informed consent. Exclusion: evidence of traumatic brain injury, prescription of hypnotics for the last 4 weeks, regular alcohol and cannabis consumption, prominent depressive symptoms, and chronic pain
Acarturk 2015	EMDR: EMDR	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	Witnessing war as a civilian (Syrian refugees)	29	Age range (mean): 19-63 (36.6) Gender (% female): 76 BME (% non-white): Country: NR	Inclusion criteria: adult Syrian refugees (aged at least 18 years) in Kilis Refugee Camp (located at border between Turkey and Syria); with PTSD symptoms (IES-R score≥33). Exclusion criteria: having mental retardation; being pregnant; using psychiatric medication

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					Coexisting conditions: Turkey Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Multiple	
Acarturk 2016	EMDR: EMDR	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Witnessing war as a civilian (Syrian refugees. Traumatic events included: death of family members; threatened death to self or others; serious injury to self or loved ones; husband being at war; arrested family members; not being able to bury significant others who have died in Syria; lack of shelter)	98	Age range (mean): 17-64 Gender (% female): 74 BME (% non-white): NR Country: Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Multiple	Inclusion criteria were: diagnosis of PTSD according to the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV); age 18 years and older. Exclusion criteria were: diagnosis of psychotic disorder or substance abuse according to DSM-IV; being pregnant; any psychotherapy during the trial; concurrent use of any psychotropic medication during the trial.
Akbarian 2015	Trauma-focused CBT (combined):	PTSD diagnosis according to ICD/DSM	Mixed (Accident related injury, cancer, domestic	40	Age range (mean): NR (31.6)	Inclusion criteria: aged 18-45 years; met DSM-V criteria for a diagnosis of PTSD. Exclusion criteria: coexisting psychiatric conditions such as

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
	Cognitive therapy (+SSRI, neuroleptics, benzodiazepines)	criteria (including self-report of diagnosis)	violence (% for each not reported))		Gender (% female): 79 BME (% non-white): NR Country: Iran Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Unclear	major depressive disorder, anxiety disorders, substance abuse (alcohol, drugs), psychosis, and personality disorders; women who were pregnant or intending to get pregnant or who were breast-feeding; known physical illness such as heart disease; patients already undergoing a psychotherapeutic treatment
Aldahadha 2012	EMDR: EMDR	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Motor Vehicle Collisions (no further details reported)	51	Age range (mean): 19-37 (26.4) Gender (% female): 53 BME (% non-white): NR Country: Oman Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR	Inclusions: people with PTSD secondary to motor vehicle collisions. Exclusions: a high score on the Dissociative Experiences Scale

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					Single or multiple incident index trauma: Single	
Alghamdi 2015	Trauma-focused CBT: Narrative exposure therapy (NET)	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Being an emergency responder in a traumatic event (Firefighters exposed to traumatic events: 9% for one time, 18% for 2-3 times and 74%for over 3 times)	34	Age range (mean): 22-41 (30.4) Gender (% female): 0 BME (% non-white): NR Country: Japan Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Multiple	Inclusion criteria: Firefighters aged 19 or above; met DSM-IV criteria for PTSD. Exclusion criteria: an inability to finish the treatment due to any circumstance.
Asukai 2010	Trauma-focused CBT: Exposure therapy/prolonged exposure (PE)	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Exposure to sexual abuse or assault (Sexual assault (54%); physical assault (17%); accidents (29%))	24	Age range (mean): NR (29.3) Gender (% female): 88 BME (% non-white): NR Country: Japan Coexisting conditions: 88% comorbid major depression; 38%	Inclusion criteria: aged at least 18 years; primary diagnosis of PTSD diagnosis (assessed using MINI and CAPS); CAPS score ≥45; involved in single incident traumatic experience at least 3 months prior to study. Exclusion criteria: history of psychosis; organic brain syndrome; current substance dependence; serious risk of suicidal behavior; severe dissociation; people whose index trauma was domestic violence or abuse in childhood

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					panic disorder; 13% generalised anxiety disorder; 4% social anxiety disorder Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Single	
Bar-Haim 2011/Badura-Brack 2015 study 1	ABM: ABM	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Military combat (Israel Defence Forces veterans)	52	Age range (mean): 22-65 (36.1) Gender (% female): 0 BME (% non-white): NR Country: Isreal Coexisting conditions: 55% depression; 39% GAD; 15% Personality Disorder- Cluster B Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR	Inclusions: Male combat veterans with diagnosable PTSD (according to CAPS criteria) resulting from events at least 3 years prior. Exclusions: psychotic or bipolar disorder, nonfluent Hebrew,inability to use a computer keyboard, current psychotherapy or use of psychotropic medication commencing within the past year.

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					Single or multiple incident index trauma: Multiple	
Bar-Haim 2011/Badura-Brack 2015 study 2	ABM: ABM	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Military combat (US military veterans who served in recent conflicts in Iraq and Afghanistan)	46	Age range (mean): NR (36.3) Gender (% female): 0 BME (% non-white): NR Country: US Coexisting conditions: 59% depression; 8% GAD; 16% panic disorder; 4% social phobia; 4% Personality Disorder- Cluster B Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Multiple	Inclusions: US Armed Forces veterans with combat-related PTSD (according to CAPS criteria) who had served at any time in a war zone with the US military since March 2003. Exclusions: psychotic, bipolar or obsessive-compulsive disorder; current substance dependence; significant head injury; current psychotherapy; use of psychotropic medication commencing within the past 6 months prior to study recruitment
Basoglu 2005	Behavioural therapies: Imaginal exposure	PTSD diagnosis according to ICD/DSM criteria (including self-	Natural disasters (such as severe floods, earthquakes or tsunamis) – Survivors of earthquake in Turkey on August 17,	59	Age range (mean): NR (36.3) Gender (% female): 85 BME (% non-white):	Inclusion criteria: score>20 on TSCC, literate, 16-65 years of age, met DSM IV criteria for PTSD. Exclusion criteria: alcohol or drug dependence, severe depression with suicidal intent, psychotic illness, predominating grief, use

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
		report of diagnosis)	1999: 20% survivors were trapped under rubble; 39% suffered varying degrees of physical injury; 5% lost at least one first-degree relative and 70% lost at least a second-degree relative or a friend; 19% survivors participated in rescue work		NR Country: Turkey Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): 63% previous trauma (MVCs, fire, floods) Single or multiple incident index trauma: Single	of benzodiazepines, use of a stable dose of antidepressants for less than 2 months at the time of assessment, and previous CBT for earthquake-related traumatic stress problems
Basoglu 2007	Behavioural therapies: In vivo exposure	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Natural disasters (such as severe floods, earthquakes or tsunamis) – Survivors of earthquake in Turkey on August 17, 1999: 20% survivors were trapped under rubble; 39% suffered varying degrees of physical injury; 5% lost at least one first-degree relative and 70% lost at least a second-degree relative or a friend; 19% survivors participated in rescue work	31	Age range (mean): NR (34) Gender (% female): 87 BME (% non-white): NR Country: Coexisting conditions: Major depression: 36%, Panic disorder: 10%, panic disorder with agoraphobia: 19% Lifetime experience of trauma (mean number of prior traumas/% with	Inclusion criteria: earthquake survivors who had scored >25 on the TSCC, were literate, aged 18-65, DSM-IV diagnosis of PTSD and availability for follow-up. Exclusion criteria: predominant depression with suicidal ideas or grief, psychotic illness, history of cardiovascular problems, pregnancy, history of conversional fainting, use of benzodiazepines, use of antidepressants for less than 2 months at assessment, and previous CBT for earthquake-related PTSD.

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					previous trauma): NR Single or multiple incident index trauma: Single	
Bass 2013	Trauma-focused CBT: Cognitive processing therapy	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	Exposure to sexual abuse or assault (Women who had experienced or witnessed sexual violence)	434	Age range (mean): NR (35) Gender (% female): 100 BME (% non-white): NR Country: Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Multiple	Inclusion criteria: women aged 18-90 years; who had experienced or witnessed sexual violence; had a total symptom score of 55 (an average score of 1 for each of 55 symptoms, comprising the HSCL-25 items, the HTQ items, and additional locally relevant symptoms), and a functional impairment score of at least 10 (dysfunction on at least half the activities). Exclusion criteria: active suicidality (judged by clinical staff to require immediate treatment); not living in the study site.
Bass 2016	Counselling: Supportive counselling	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	Witnessing war as a civilian - Experiencing torture (defined as personally experiencing or witnessing physical torture, imprisonment, and/or military attacks)	209	Age range (mean): 18-82 (40.4) Gender (% female): 33 BME (% non-white): NR Country: Iraq Coexisting conditions: NR	Inclusion criteria: aged at least 18 years; residing in the Dohuk governorate; reporting experiences of torture; presenting with significant depressive symptoms (HSCL depression score ≥20); being mentally competent to give consent. Exclusion criteria: currently psychotic; actively suicidal

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Multiple	
Beck 2009	Trauma-focused CBT: CBT group	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Motor Vehicle Collisions (Serious motor vehicle accidents)	44	Age range (mean): 22-69 (43.3) Gender (% female): 82 BME (% non-white): 11 Country: US Coexisting conditions: 80% reported ongoing pain complaints from injuries sustained during the MVA Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): 45% of the participants had also previously experienced other traumas including natural disasters,	Inclusion criteria: experienced a motor vehicle accident involving actual or threatened death or serious injury at least 6 months prior to assessment; their emotional response included intense fear, helplessness, horror, or the perception that they would die (PTSD Criterion A; assessed using the MVA Interview). Exclusion criteria: Neurological problems, substance dependence/abuse, psychosis, suicidal ideation, medical problems preventing from participation in study, traumatic events < 6 months, did not meet PTSD criteria.

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					non-motor accident trauma, sexual assault, witnessing a violent death Single or multiple incident index trauma: Single	
Bisson 2004	Trauma-focused CBT: Brief individual CBT	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	Motor Vehicle Collisions - Physical injury (56% were injured from a motor vehicle accident, 35% from assault, 9% other injuries [included an electrocution, partial amputation of fingertips, falls and a variety of industrial injuries])	152	Age range (mean): NR (NR) Gender (% female): 57 BME (% non-white): NR Country: UK Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): 36% had previous trauma history Single or multiple incident index trauma: Single	Inclusion criteria: Physically injured (e.g. in a motor vehicle accident, assault or industrial accident); had a local home address; aged 16-70 years; showed evidence of acute psychological distress on the three self-report questionnaires as determined by fulfilment of DSM–IV PTSD symptom criteria on the PTSD Diagnostic Scale (PDS), a score >15 on the anxiety or depression sub-scale of the Hospital Anxiety and Depression Scale (HADS) or a score >35 on the Impact of Event Scale (IES). Exclusion criteria: pre-existing major psychiatric disorder; major physical disability or illness reported; evidence of cognitive deficit
Blanchard 2002/2003/ 2004	Trauma-focused CBT: CBT individual	PTSD diagnosis according to ICD/DSM criteria (including self-	Motor Vehicle Collisions (Not reported in details)	98	Age range (mean): NR (39.7) Gender (% female): 73 BME (% non-white): 10	Inclusion criteria: met DSM-IV criteria for chronic (greater than 6 months but not more than 24 months) PTSD or severely symptomatic sub-syndromal PTSD (meets criterion A, E and F for PTSD and two of criteria B, C, or D, with a CAPS score ≥30); injured in a motor vehicle

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
		report of diagnosis)			Country: US Coexisting conditions: 49% major depressive disorder (MDD); 35% generalized anxiety disorder (GAD) Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Single	accident and sought medical attention within 48 hours of the MVA. Exclusion criteria: co-morbid diagnoses (including delusional disorder, bipolar disorder, alcohol/drug abuse, cognitive impairment secondary to MVA)
Bohus 2013	Trauma-focused CBT: Dialectical behaviour therapy (DBT)	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Childhood sexual abuse - Sexual abuse may have been a singular event (13%) lasted up to 5 years (39%) or longer than 5 years (46%). Mean reported age at the time of the first sexual abuse was 7.6 years (range 2–17 years)	82	Age range (mean): NR (36) Gender (% female): 100 BME (% non-white): NR Country: Germany Coexisting conditions: Mean number of current Axis I disorders: 3.01 (1.09). 80% major depressive disorder; 45% met DSM-IV criteria for	Inclusion criteria: women aged 17-65 years; met DSM-IV criteria for a diagnosis of PTSD, related to childhood sexual abuse (defined as a sesxual assault that had to occur under the age of 18, and met PTSD A criterion); had been referred by their local psychiatrists for residential treatment due to treatment-resistant PTSD; have at least one of the following coexisting conditons: eating disorder, major depression, substance abuse, or score ≥ 4 or above on borderline personality disorder DSM-IV scale). Exclusion criteria: a lifetime diagnosis of schizophreni;, current substance dependence; BMI ≥16.5; intellectual disability; medical conditions contradicting the exposure protocol (e.g. severe cardiovascular disorders); those who had evidenced life-

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					borderline personality disorder Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): Single or multiple incident index trauma: Multiple	threatening behaviour in the last four months (assessed using Severe Behaviour Dyscontrol Interview [SBD-I]).
Bolton 2014a	Trauma-focused CBT: Cognitive processing therapy	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	Witnessing war as a civilian- 'Survivor of systematic violence' (defined as experiencing and/or witnessing physical torture [44% experienced personally; 45% witnessed], imprisonment where torture and other abuse were frequent [58% experienced personally; 52% witnessed], gas attacks [16% experienced personally; 15% witnessed] and/or other military attacks [71% experienced personally; 60% witnessed])	167	Age range (mean): NR (41.8) Gender (% female): 59 BME (% non-white): NR Country: Iraq Coexisting conditions: Significant depression symptomatology was an inclusion criterion Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR	Inclusion criteria: Survivors of systemic violence living in governorates of Erbil or Sulaimaniyah, Kurdistan; aged at least 18 years; fluent in Sorani Kurdish; currently has significant depression symptomatology (score of 2 or 3 on HSCL-25 [equivalent to experiencing a symptoms often or always] on at least one of the DSM-IV A Criteria related to presence of depressive symptoms or anhedonia and a total symptoms score ≥20). Exclusion criteria: current psychotic symptoms or active suicidality, not mentally competent to provide informed consent; already receiving treatment from the treatment provider

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					Single or multiple incident index trauma: Multiple	
Bormann 2008	Meditation: Mantram intervention group	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Military combat - All participants had served in the Vietnam, Korean or first Gulf War	29	Age range (mean): 40-76 (56) Gender (% female): 0 BME (% non-white): 34 Country: US Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Multiple	Inclusion criteria: at least 18 years age, fluent in English, enrolled in the VA health care system, assigned a health care provider, diagnosis of combat related PTSD, and ≥50 on PCL (self-rated). Exclusion criteria: Psychotic symptoms, severe suicidality, not able to participate in a group.
Bormann 2012/2013	Meditation: Mantram intervention group	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Military combat - 7% served during Vietnam, Korea, or Iraq (Operation Desert Storm), and 3% served during the wars in Iraq or Afghanistan (Operations Iraqi Freedom, New Dawn, and Enduring Freedom). Veterans were asked to identify the worst traumatic event that	146	Age range (mean): 25-84 (57.3) Gender (% female): 3 BME (% non-white): 42 Country: US Coexisting conditions: 80% Current Major Depressive Episode;	Inclusion criteria: outpatient veterans who reported having experienced trauma during military duty and who had sought care at one of the VA clinics; aged at least 18 years; met criteria for PTSD diagnosis (confirmed by the medical record and the Clinician Administered PTSD Scale [CAPS]); had achieved sobriety for at least two months (assessed with self-report that was confirmed by PTSD clinicians); had been on stable types and doses of psychotropic medications for at least two months before

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
			occurred during their military duty, and these included war zone or combat (71%), accident or explosion (13%), death of someone close (8%), or other illness, injury, or captivity (8%)		62% Dysthymic Disorder; 34% Obsessive–Compulsive Disorder; 56% Generalized Anxiety Disorder Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Multiple	joining the study. Exclusion criteria: unmanaged psychotic or bipolar disorder (during past year), dementia, or severe suicidal ideation assessed by the Mini-International Neuropsychiatric Interview (MINI)
Branstrom 2010/2012	MBSR: MBSR	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	Diagnosis of life-threatening condition - People with cancer (who were not undergoing current radiation or chemotherapy treatment): 76% breast cancer; 14% gynecological cancer; 7% lymphatic cancer; 1% pancreatic cancer; 1% cancer in the neck	85	Age range (mean): NR (51.8) Gender (% female): 99 BME (% non-white): NR Country: Sweden Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR	Inclusion criteria: patients with varying cancer diagnoses who were not undergoing current radiation or chemotherapy treatment

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					Single or multiple incident index trauma: Single	
Brom 1989	Trauma-focused CBT: CBT individual	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Mixed - Loss of a loved one as a result of murder/suicide, traffic accidents, acute or chronic illness (74%); violent crime (17%); traffic accident (4%); other (5%)	112	Age range (mean): 18-73 (42) Gender (% female): 79 BME (% non-white): NR Country: Netherlands Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Single	Inclusion criteria: met DSM-III criteria for PTSD; no more than 5 years had elapsed since the incurring event
Brom 2017	Combined somatic and cognitive therapies: Somatic experiencing (SE)	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Mixed - Vehicle accidents (44%); assault (13%); terrorist attacks (13%); other types of accidents (18%); death or injury of a family member (8%); medical trauma (6%); combat (3%); threat (2%)	63	Age range (mean): NR (40.5) Gender (% female): 51 BME (% non-white): NR Country: Coexisting conditions: NR	Inclusion criteria: aged over 18 years; met DSM-IV-TR criteria for full PTSD resulting from one or more single traumatic events; fluent in either Hebrew or English. Exclusion criteria: a history of psychosis; brain damage; active suicidal tendencies; substance use; psychiatric comorbidity apart from depression; complex traumatic situations that are characterized by prolonged situations of extreme stress

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Single	
Bryant 2003a	Trauma-focused CBT: Exposure therapy/prolonged exposure (PE)	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Exposure to non-sexual violence - Non-sexual assault (53%); motor vehicle accident (47%)	58	Age range (mean): NR (35.2) Gender (% female): 52 BME (% non-white): NR Country: Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Single	Inclusion criteria: civilian trauma survivors aged 18-60 years; met DSM-IV criteria for PTSD; met criteria for diagnosis for at least 3 months. Exclusion criteria: history of psychosis, organic brain syndrome, or substance dependence; current suicidal inclination; history of childhood sexual abuse
Buhmann 2016	Trauma-focused CBT: Cognitive therapy	PTSD diagnosis according to ICD/DSM criteria (including self-	Mixed - 43% torture; 28% refugee camp; 63% Danish asylum centre; 24% ex-combatant	280	Age range (mean): NR (45) Gender (% female): 41 BME (% non-white):	Inclusion criteria: aged at least 18 years; (refugees and persons based in Denmark because of family reunification with a refugee; had PTSD according to the ICD-10 diagnostic criteria; had a history of war-related

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
		report of diagnosis)			NR Country: Denmark Coexisting conditions: Patients were not excluded solely based on psychotic symptoms (9% psychotic during treatment). 94% depression according to ICD-10. 27% Personality change after catastrophic events (ICD-10 code F62.0). 25% report traumatic brain injury Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Multiple	psychological trauma such as imprisonment, torture, inhuman and degrading treatment or punishment, organised violence, prolonged political persecution and harassment or war; were motivated to receive treatment; gave written, voluntary informed consent. Exclusion criteria: severe personality disorder (ICD-10 diagnosis F2x and F30.1-F31.9); addiction to psychoactive substances (ICD-10 F1x.24-F1x.26); needed somatic or psychiatric hospitalisation; pregnant or lactating women
Capezzani 2013	Trauma-focused CBT: CBT individual	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Diagnosis of life-threatening condition - Participants in follow-up treatment for cancer (breast, colon, uterus, thyroid, melanoma, lung, stomach)	21	Age range (mean): NR (51.7) Gender (% female): 90 BME (% non-white): NR Country: Italy	Inclusion criteria: met DSM-IV criteria for a diagnosis of PTSD; were not receiving psychopharmacological therapy. Exclusion criteria: participants already receiving psychotherapy; psychopathological disturbances preexisting to the cancer diagnosis

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Single	
Carletto 2016	EMDR: EMDR	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Diagnosis of life-threatening condition (multiple sclerosis)	50	Age range (mean): NR(40.1) Gender (% female): 81 BME (% non-white): NR Country: Italy Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): Mean number of previous traumas: 4.3 (6.5) Single or multiple incident index trauma: Single	Inclusion criteria were as follows: (1) definite diagnosis of a relapsing-remitting and primary or secondary progressive MS disease (McDonald Criteria) (Polman et al., 2011); (2) age between 18 and 65 years; (3) clinically inactive phase of the disease; (4) fluent Italian speaker; (5) legal capacity to consent to the treatment; (6) diagnosis of PTSD; (7) Post-traumatic symptoms present for at least 3 months; (8) willingness to suspend all concomitant psychological treatment; (9) suspension of all psychotropic medications at least 1 month before the treatment or maintenance at baseline level throughout the study. Exclusion criteria were as follows: (1) presence of severe psychiatric disorders such as psychosis or bipolar disorder; (2) presence of severe medical conditions other than MS, such as diabetes, strokes or traumatic brain injuries; (3) drug or alcohol abuse; (4) suicide attempts;

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
						(5) overt dementia; (6) corticosteroid treatment during the previous 30 days
Carlson 1998	EMDR: EMDR	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Military combat (97% Vietnam veterans, 3% other combat theatre)	35	Age range (mean): Gender (% female): BME (% non-white): Country: Coexisting conditions: Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): Single or multiple incident index trauma:	Inclusions: male veterans who met DSM-IV criteria for PTSD. Exclusions: history of psychosis, DSM-IV diagnosis of antisocial personality disorder, self-reported substance abuse or dependence in past 30 days
Castillo 2016	Trauma-focused CBT: Imaginal exposure	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Military combat - OEF (Afganistan)/OIF (Iraq) service members (served active duty after September 11th 2001)	86	Age range (mean): NR (35.9) Gender (% female): 100 BME (% non-white): 69 Country: US Coexisting conditions: 62% mood disorder; 60% anxiety disorder; 3% substance use/abuse Lifetime experience of trauma (mean number of prior	Inclusion criteria: met DSM-IV criteria for PTSD diagnosis; had one clear trauma memory (regardless of type); agreement not to participate in other PTSD treatments during the study. Exclusion criteria: ; active drug or alcohol dependence or less than 3 months in remission from alcohol/drug dependence; presence of psychotic/bipolar/manic symptoms in the past month; cognitive impairment; suicidal/hoicidal ideation; current involvement in a violent relationship; engagement in self-mutilation; change in prescribed psychiatric medications in past month prior to stduy entry

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					traumas/% with previous trauma): 70% 8–17 trauma types; 66% ≥25 trauma incidents Single or multiple incident index trauma: Multiple	
Chambers 2014	Trauma-focused CBT: CBT individual	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	Unintentional injury/illness/medical emergency - Caregivers of patients with cancer (breast (31%), colorectal (9%), prostate (9%), hematologic (8%), lung (8%), and gynaecologic (7%))	690	Age range (mean): NR (52.5) Gender (% female): 88 BME (% non-white): NR Country: Australia Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Single	Inclusion criteria: Adult patients or caregivers who called cancer information and support cancer helplines (independent callers so not a dyad; only caregivers included in this RQ); Distress Thermometer (DT) score >4; able to read and speak English; no previous head injury or dementia. Exclusion criteria: people under current psychiatric care; those who presented with grief or bereavement.
Chard 2005	Trauma-focused CBT: Cognitive processing therapy	PTSD diagnosis according to ICD/DSM criteria (including self-	Childhood sexual abuse - Average age at onset of abuse was 6.4 years (SD=2.78); 21% indicated 1-5 incidents of abuse, 12% reported 6-10	71	Age range (mean): 18-56 (32.8) Gender (% female): 100 BME (% non-white): 19	Inclusion criteria: a diagnosis of PTSD; at least one incident of child sexual abuse as defined by state law; at least one memory of the abuse. Exclusion criteria: current trauma; current substance dependence (participants with a history of substance dependence were included

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
		report of diagnosis)	incidents, and 10% reported 11-30 incidents; 57% reported >100 abuse incidents		Country: US Coexisting conditions: Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): 62% mood disorder; 60% anxiety disorder; 3% substance use/abuse Single or multiple incident index trauma: Multiple	in the study if they maintained sobriety for 3 months following a detoxification treatment); suicidal intent; impeding medical conditions (e.g., undiagnosed seizure disorder); individuals taking prescription medication if was not stable medication for at least 3 months before treatment
Church 2013/2014	Combined somatic and cognitive therapies: Emotional freedom technique (EFT)	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	Military combat - 41% Gulf war era deployments; 58% other deployments. Mean number of tours 1.2 (sd=0.4)	59	Age range (mean): 24-86 (51.7) Gender (% female): 10 BME (% non-white): NR Country: US Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR	Inclusions: meet the clinical criterion for PTSD (score ≥ 50 on the PTSD Checklist-Military [PCL-M]), be under the care of a clinician from a VA or another licensed health care facility. Exclusions: scored 4 or higher on a 5-point scale on two questions on the Symptom Assessment-45 (SA-45) related to physical violence

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					Single or multiple incident index trauma: Multiple	
Cloitre 2002	Trauma-focused CBT: Exposure therapy/prolonged exposure (PE)	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Childhood sexual abuse - 48% had experienced both sexual and physical abuse, 39% had experienced sexual abuse only, and 13% had experienced physical abuse only	58	Age range (mean): NR (34) Gender (% female): 100 BME (% non-white): 54 Country: US Coexisting conditions: 45% current major depression; 79% anxiety disorder (generalized anxiety disorder [GAD] the most common [48%]) Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Multiple	Inclusion criteria: aged 18-65 years; met DSM–IV-criteria for a diagnosis of PTSD related to childhood sexual abuse (defined as ≥1 episode of sexual contact initiated by a caregiver or individual in a position of authority to the participant when she was under the age of 18 and the perpetrator must have been at least 5 years older than the participant, unless the participant experienced the sexual contact with this person as against her will), physical abuse (defined as an action by a parent or other adult in charge of the participant when she was under the age of 18 in which the adult purposefully hit, pushed, punched, or cut the participant leaving bruises, scratches, broken bones or teeth, or making her bleed), or both (DSM–IV); at least one clear memory of the abuse; plan on residing in the area for the duration of the treatment. Exclusion criteria: current diagnosis of organic or psychotic mental disorders, substance dependence; eating disorder, dissociative disorder, Bipolar I disorder or borderline personality disorder; suicide attempt or psychiatric hospitalization within the last 3 months
Cloitre 2010	Trauma-focused CBT: Exposure therapy/prolon	PTSD diagnosis according to ICD/DSM criteria	Childhood sexual abuse - Childhood sexual abuse (90%), childhood physical	71	Age range (mean): NR (35.3) Gender (% female): 100	Inclusion criteria: women aged 18-65 years; had a primary diagnosis of DSM-IV defined PTSD related to childhood sexual abuse and/or physical abuse by a caretaker or person in

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
	ged exposure (PE)	(including self-report of diagnosis)	abuse (79%), emotional abuse or neglect (82%)		BME (% non-white): 63 Country: US Coexisting conditions: Current Axis I comorbidity: 89% ≥1; 62% ≥2; 30% ≥3; 20% ≥4 Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): Mean number of lifetime traumas: 6.57 (SD=1.17). Experience of trauma as an adult: Domestic violence (63%); sexual assault (49%); physical assault (24%); other interpersonal victimization (61%) Single or multiple incident index trauma: Multiple	authority over them before the age of 18 years. Exclusion critera: substance dependence not in remission for at least 3 months; current psychotic symptoms; significant cognitive impairment; untreated bipolar disorder; acute suicidality in the previous 3 months requiring hospitalization or referral to the emergency room; initiated psychotherapy or pharmacological treatment during the study period or in the 3 months prior to study entry or psychotherapy was PTSD-focused
Coffey 2016	Trauma-focused CBT: Exposure therapy/prolon	PTSD diagnosis according to ICD/DSM criteria (including self-	Mixed - Any sexual assault occuring in adulthood or childhood (58%), attacked with a weapon (63%), attacked witout a weapon	126	Age range (mean): NR (34) Gender (% female): 46 BME (% non-white):	Inclusion criteria: aged 18-64 years; met DSM–IV–TR criteria for a diagnosis of both PTSD (stemming from any trauma except combat) and alcohol dependence (AD); one heavy drinking day in the past 60 days, as defined by

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
	ged exposure (PE)	report of diagnosis)	(56%), accident (60%), childhood physical abuse (41%), natural disaster (35%)		21 Country: US Coexisting conditions: All participants have co-occurring PTSD and substance dependence (inclusion criterion): 100% current alcohol dependence; 98% any current drug dependence. 80% current major depressive disorder, 69% additional anxiety disorder(s) Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Multiple	consumption of four standard drinks for women and five standard drinks for men. Exclusion criteria: an acute psychotic disorder; bipolar disorder with an active manic episode (but not simply the presence of bipolar disorder); imminent risk for suicide; prescription of craving reducing medications (e.g., naltrexone) or medications to reduce alcohol use (e.g., disulfiram); current self-reported use, or urine drug screen indicating use, of a benzodiazepine; judged to have a medical condition that might limit cooperation or compromise the integrity of the data (e.g., organic brain syndrome, dementia, head injury, neuropathy, etc.); illiteracy in English
Connolly 2011	Combined somatic and cognitive therapies: Thought field therapy (TFT)	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	Witnessing war as a civilian - Rwandan genocide (1994) survivors. Reported experiences during the 1994 genocide included: being beaten (60%), having been	171	Age range (mean): 18-73 (38) Gender (% female): 82 BME (% non-white): NR Country: Rwanda	Adult survivors of the Rwandan genocide aged 18-73 who met DSM-IV criterion A1 for PTSD by virtue of having been in Rwanda and survived the genocide of 1994

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
			abused (55.2%), witnessing others being beaten (80%), witnessing others being killed (85.5%), hearing others being hit or beaten (81.4%) and being forced to do things they were against (22.1%)		Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Multiple	
Cook 2010	Trauma-focused CBT: Imagery rehearsal therapy	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Military combat - Any sexual assault occuring in adulthood or childhood (58%), attacked with a weapon (63%), attacked witout a weapon (56%), accident (60%), childhood physical abuse (41%), natural disaster (35%)	124	Age range (mean): NR (59.4) Gender (% female): 0 BME (% non-white): 58 Country: US Coexisting conditions: All participants had regular nightmares (≥1 a week for ≥6 months) and global sleep disturbance (as rated by PSQI). 56% depressive disorder and 53% anxiety disorder (assessed with SCID) Lifetime experience of trauma (mean	Inclusion criteria: US male Vietnam War veterans receiving mental health services at the Philadelphia VA Medical Center; met DSM-IV criteria for a current PTSD diagnosis due to combat in Vietnam (assessed with CAPS); combat-related nightmares at least once a week for no less than 6 months; global sleep disturbance indicated by a score ≥ 5 on the Pittsburgh Sleep Quality Index. Exclusion criteria: current or lifetime DSM-IV schizophrenia, other psychotic disorders, bipolar disorder; active substance abuse or dependence in the past 6 months; a medical disorder known to impact sleep (e.g., narcolepsy); untreated sleep apnea

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Multiple	
Cottraux 2008	Trauma-focused CBT: Exposure therapy/prolonged exposure (PE)	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Mixed - Car accidents (33%); physical assault victims (26%); rape (8%); miscellaneous experiences (8%); family violence (7%); witnessed extreme violence (7%); incest (5%); witnessed the death of a close relative (3%); painful and complicated surgery (2%)	60	Age range (mean): NR (39) Gender (% female): 70 BME (% non-white): NR Country: France Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): Mean number of traumatic episodes: 1.78 (0.9) Single or multiple incident index trauma: Single	Inclusion criteria: adults aged 18-65 years; met DSM-IV criteria for chronic PTSD (symptoms had persisted for at least 3 months); had a PCLS score≥44. Exclusion criteria: Drug or alcohol addiction; schizophrenia or paranoia; antisocial personality; unsigned informed consent; noncooperation; home too far from the centre; currently undergoing other therapy; chronic use of neuroleptic drugs, mood stabilizers or antidepressants.
Davis 2007	Non-trauma-focused CBT: CBT for insomnia (CBT-I)	Clinically important PTSD symptoms (scoring above	Mixed - Most frequently reported types of trauma: car accidents (59%); unwanted sexual contact	43	Age range (mean): Gender (% female): BME (% non-white): Country:	Inclusion criteria: adults experiencing a traumatic event; having nightmares at least once a week for the previous 3 months. Exclusion criteria: apparent psychosis or mental retardation; active suicidality or recent

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
		a threshold on validated scale)	(59%); physical assault with a weapon (53%)		Coexisting conditions: Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): Single or multiple incident index trauma:	parasuicidal behaviours; current drug/alcohol dependence
Davis 2011	Non-trauma-focused CBT: CBT for insomnia (CBT-I)	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	Mixed - The most frequent types of trauma reported were unwanted sexual contact (60%), serious accidents (57%), physical assault with a weapon (57%), combat exposure (13%)	47	Age range (mean): NR (47) Gender (% female): 75 BME (% non-white): 19 Country: US Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): Mean 4.6 traumatic events (SD=2.0; range 1-9) Single or multiple incident index trauma: Single	Inclusion criteria: Adults aged at least 18 years; who had experienced a traumatic event; had nightmares at least once a week for the previous month). Exclusion criteria: apparent psychosis; mental retardation; active suicidality or recent parasuicidal behaviours; current drug/alcohol dependence
Davis 2012	Supported employment:	PTSD diagnosis according to	Military combat - 'Veterans'. Mean length of	85	Age range (mean): NR (40.2)	Inclusion criteria: veterans at the Tuscaloosa VA Medical Center (VAMC); aged 19-60 years; had

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
	Individual placement and support (IPS)	ICD/DSM criteria (including self-report of diagnosis)	military service 7.1 years (SD=5.6)		Gender (% female): 12 BME (% non-white): 73 Country: US Coexisting conditions: 89% major depressive disorder; 20% dysthymia; 54% agoraphobia; 59% panic disorder; 28% social phobia; 42% alcohol dependence; 21% alcohol abuse; 37% drug dependence; 18% drug abuse Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Multiple	a diagnosis of PTSD; had a medical clearance that they were able to participate in a work activity; were currently unemployed; were interested in competitive employment; were planning to remain in a 100-mile radius of the Tuscaloosa VAMC for the 12-month duration. Exclusion criteria: lifetime history of severe traumatic brain injury that resulted in severe cognitive disorder; a diagnosis of schizophrenia, schizoaffective disorder, or bipolar I disorder; a diagnosis of dementia; immediate need of detoxification from alcohol or drugs; pending active legal charges with expected incarceration
Difede 2007b	Trauma-focused CBT: Exposure therapy/prolonged exposure (PE)	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	Terrorist attacks - Disaster workers exposed to the World Trade Centre attack and/or its aftermath	31	Age range (mean): NR (45.77) Gender (% female): 3 BME (% non-white): 23	Inclusion criteria: Disaster workers exposed to the World Trade Center attack and/or its aftermath; met full DSM-IV TR PTSD diagnostic criteria or subthreshold PTSD criteria (i.e., met criteria for 2 of 3 symptom clusters and Clinician-Administered PTSD Scale (CAPS 30);

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					Country: US Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): 67% had trauma history Single or multiple incident index trauma: Single	aged 18-65-years; English fluency. Exclusion criteria: diagnosis of alcohol or substance dependence within the past 6 months; lifetime diagnosis of schizophrenia, schizoaffective, or bipolar disorder; head injury or medically unstable injuries; suicidal or homicidal intentions
Dorrepaal 2012	Trauma-focused CBT: CBT group	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Childhood sexual abuse - Childhood abuse (100%) including sexual (94%) or physical (63%) abuse	71	Age range (mean): NR (38.8) Gender (% female): NR BME (% non-white): NR Country: Netherlands Coexisting conditions: Mean number of current comorbidity DSM-IV axis I: 2.8 (1.9). Depressive disorder (55%). Mean number of anxiety disorders: 1.6 (1.2); social phobia (43%); panic disorder (42%). 19%	Inclusion criteria: met DSM-IV criteria for PTSD diagnosis (assessed with SCID) and met criteria for complex PTSD according to the Structured Interview of Disorders of Extreme Stress (SIDES); sexual and/or physical abuse before the age of 16. Exclusion criteria: antisocial personality disorder; current psychotic episode; dissociative identity disorder; severe alcohol or drug dependence or abuse; currently receiving or seeking exposure treatment

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					substance abuse and/or dependence. Mean number of current comorbidity SIDP-IV axis II disorders: 1.4 (1.2); borderline personality disorder (53%); avoidant personality disorder (25%) Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): Experience of adult abuse (63%): physical (43%) or sexual (49%) Single or multiple incident index trauma: Multiple	
Duffy 2007	Trauma-focused CBT: Cognitive therapy	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Terrorist attacks - Multiple traumas (81% experienced multiple traumatic events; median=3) mostly linked to terrorism and other civil conflict in Northern Ireland (60% civilian; 40% police, soldier, or other profession with active involvement). Characteristics of index	58	Age range (mean): NR (43.9) Gender (% female): 40 BME (% non-white): NR Country: UK Coexisting conditions: 72% any axis I comorbidity:	Inclusion criteria: adults aged 18-70 years; meeting DSM-IV criteria for PTSD; have experienced trauma in the context of civil conflict in Northern Ireland or elsewhere; PTSD considered to be the patient's main problem; willing to accept ransom allocation. Exclusion criteria: unable to travel to Northern Ireland Centre for Trauma and Transformation (NICTT) for regular treatment sessions; PTSD mainly related to childhood sexual abuse; other severe

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
			trauma event: Related to Northern Ireland “troubles” (84%); terrorist events outside Northern Ireland (5%); bombings (40%); shootings and killings (22%); taken hostage (14%); physical assault (14%); road injuries (9%); riots (1%). 74% experienced event (19% injured in event); 26% witnessed event		64% major depression; 21% panic disorder; 10% specific phobias; 14% alcohol or substance use diorder; 5% generalised anxiety disorder; 3% social phobia; 3% other anxiety disorder; 2% bulimia nervosa Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Multiple	psychiatric or physical disorder that requires immediate treatment in its own right
Dunn 2007	Non-trauma-focused CBT: Self-management therapy	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Military combat (Veterans)	111	Age range (mean): NR (54.9) Gender (% female): 0 BME (% non-white): 45 Country: US Coexisting conditions: All had comorbid depression (MDD [78% + 14% MDD in partial	Inclusion criteria: met DSM-IV criteria for chronic combat-related PTSD and major depressive disorder or dysthymia, MMSE score >=24. Exclusion criteria: active suicidal intent, current or past DSM-IV psychotic or bipolar disorder.

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					remission only] or dysthymia [0.01%], or both [0.07%]), 43.5% had an anxiety disorder, 0.08% had another Axis I disorder Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Multiple	
Dunne 2012	Trauma-focused CBT: CBT individual	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Motor Vehicle Collisions (Participants were diagnosed with chronic Whiplash-associated disorders, grade II or III)	26	Age range (mean): 20-49 (32.5) Gender (% female): 50 BME (% non-white): 27 Country: Australia Coexisting conditions: 54% met the DSM-IV criteria for comorbid depression and 31% met the criteria for current alcohol use disorder Lifetime experience of trauma (mean	Inclusion criteria: Chronic whiplash-associated disorder grade II or III and met the diagnostic criteria for current motor vehicle collision-related PTSD. Exclusion criteria: Cervical spine fractures, serious head injury or burns, previous history of neck pain or headaches requiring treatment, insufficient comprehension of English to complete measures, were receiving current treatment for a major psychiatric disorder.

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Single	
Echiverri-Cohen 2016	Trauma-focused CBT: Exposure therapy/prolonged exposure (PE)	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Mixed - Sexual assault (31%); physical assault (27%); child sexual assault (22%); child physical assault (8%); motor vehicle accident (6%); natural disaster (4%); death of loved one (2%)	49	Age range (mean): NR (37.7) Gender (% female): 75 BME (% non-white): 33 Country: US Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Unclear	Inclusion criteria: met DSM-IV criteria for current chronic PTSD; aged 18-65 years. Exclusion criteria: current diagnosis of schizophrenia or delusional disorder; medically unstable bipolar disorder; depression with psychotic features; depression severe enough to require immediate psychiatric treatment (e.g., actively suicidal); a current diagnosis of alcohol or substance dependence (within the previous three months); an ongoing intimate relationship with the perpetrator (in assault cases); unwilling to discontinue current psychotherapy or antidepressant medication; had a medical contraindication for the initiation of sertraline (e.g., pregnancy)
Edmond 1999/2004	EMDR: EMDR	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	Childhood sexual abuse - lasted for mean of 6.5 years (the mean age at which abuse began was 6.5 years, and the mean age at which it stopped was 13 years)	59	Age range (mean): NR (35) Gender (% female): 100 BME (% non-white): 15 Country: US	Inclusions: adult female survivors of childhood sexual abuse who had no previous exposure to EMDR. Exclusions: Ocular problems, active suicidal ideation, serious medical condition, inadequate ego strength, or severe mental disorders such as psychosis, and who were receiving any concurrent therapy.

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): 58% of participants also experienced childhood physical abuse and 66% some form of adult revictimization, such as domestic violence and rape Single or multiple incident index trauma: Multiple	
Ehlers 2003	Trauma-focused CBT: Cognitive therapy	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Motor Vehicle Collisions (Involvement in a MVC that required A & E attendance)	85	Age range (mean): 18-65 (NR) Gender (% female): NR BME (% non-white): NR Country: UK Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with	Inclusion criteria: aged 18-65 years; met DSM-IV criteria for primary diagnosis of PTSD (assessed with SCID); PDS score ≥20; intervention starting within 6 months of the traumatic event. Exclusion criteria: unconsciousness for >15 minutes after accident; no memory of the accident; history of psychosis; current alcohol or other substance dependence; borderline personality disorder; severe depression requiring immediate treatment in its own right (suicide risk); treatment or assessments that could not be conducted without the aid of an interpreter; score <14 on the PDS after the 3-week self-monitoring phase prior to randomisation

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					previous trauma): NR Single or multiple incident index trauma: Single	
Ehlers 2005	Trauma-focused CBT: Cognitive therapy	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Mixed - Accident (54%), assault (32%), witnessing death (14%)	28	Age range (mean): NR (36.6) Gender (% female): 54 BME (% non-white): 4 Country: UK Coexisting conditions: 39% current major depression; 21% comorbid anxiety disorders Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): Half of the participants reported an earlier trauma meeting the A criterion of DSM-IV (but these events were not addressed in treatment)	Inclusion criteria: aged 18–65 years old; met DSM-IV criteria for PTSD as determined by the SCID; the current episode of PTSD was linked to discrete traumatic events in adulthood; PTSD was the main problem; time since the trauma was at least 6 months. Exclusion criteria: unconsciousness for more than 15 min or no memory for the trauma; history of psychosis; current alcohol or drug dependence; borderline personality disorder; severe depression needing immediate treatment in its own right (i.e., suicide risk); assessment and treatment could not be conducted without the aid of an interpreter

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					Single or multiple incident index trauma: Single	
Ehlers 2014	Trauma-focused CBT: Cognitive therapy	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Mixed - Interpersonal violence (36%); Accidents/disaster (38%); Death/harm to others (8%); Other (18%)	91	Age range (mean): Gender (% female): BME (% non-white): Country: Coexisting conditions: Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): Single or multiple incident index trauma:	Inclusion criteria: aged 18-65 years; met DSM-IV criteria for chronic PTSD as determined by the SCID; their intrusive memories were linked to one or two discrete traumatic events in adulthood; PTSD was the main problem. Exclusion criteria: history of psychosis; current substance dependence; borderline personality disorder; acute serious suicide risk; if treatment could not be conducted without the aid of an interpreter
Falsetti 2008	Trauma-focused CBT: Exposure therapy/prolonged exposure (PE)	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Mixed - A mean of 6 traumatic events reported (SD=2.03, range=2–10). The most frequently reported traumatic events included unwanted or forced sexual contact (76%), physical assault without a weapon (71%), unwanted sexual contact before age 18 (69%), natural disaster (65%), and physical assault	60	Age range (mean): NR (35) Gender (% female): 100 BME (% non-white): 31 Country: US Coexisting conditions: 100% panic attacks (inclusion criterion). 89% met DSM-IV criteria for panic disorder (based on ADIS-R)	Inclusion criteria: met DSM-IV criteria for PTSD; reported experiencing panic attacks; experienced a traumatic event at least 3 months prior to study entry. Exclusion criteria: active psychosis; mental retardation; current suicidal or parasuicidal behaviour; current drug or alcohol dependency; illiteracy

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
			with a weapon (58%). Physical injury during a traumatic event was reported by 97% of the participants.		Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR trauma: Multiple	
Fecteau 1999	Trauma-focused CBT: Brief individual CBT	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Motor Vehicle Collisions (Motor vehicle accidents resulting in physical injury)	24	Age range (mean): 25-63 (41.3) Gender (% female): 70 BME (% non-white): NR Country: Canada Coexisting conditions: 85% had ongoing pain and physical complaints from their MVC Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Single	Inclusion criteria: involvement in a motor vehicle accident that necessitated at least outpatient medical attention; met diagnostic criteria for PTSD. Exclusion criteria: moderate or severe head injury; alcohol or substance abuse problems; severe-chronic pre-injury mental health difficulties
Foa 1991	Trauma-focused CBT: Exposure therapy/prolon	PTSD diagnosis according to ICD/DSM criteria (including self-	Exposure to sexual abuse or assault (Rape or attempted rape. 54% perpetrator was a stranger; 46% perpetrator	55	Age range (mean): NR (31.8) Gender (% female): 100 BME (% non-white):	Inclusion criteria: female victims of rape or attempted rape; met DSM-III- R criteria for PTSD; had been raped at least 3 months prior to study entry. Exclusion criteria: current or previous DSM-III-R diagnosis of organic mental

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
	ged exposure (PE)	report of diagnosis)	was an acquaintance. 60% weapon used)		26 Country: US Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Single	disorder, schizophrenia, or paranoid disorders; depression severe enough to require immediate psychiatric treatment; bipolar depression, or depression accompanied by delusions, hallucinations, or bizarre behavior; current alcohol or drug abuse; assault by spouse or other family member; illiteracy in English
Foa 2005	Trauma-focused CBT: Exposure therapy/prolonged exposure (PE)	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Exposure to sexual abuse or assault - Sexual assault (69%); nonsexual assault (14%); childhood sexual abuse (17%)	179	Age range (mean): 23-85 (50) Gender (% female): 12 BME (% non-white): NR Country: Unclear (US and/or UK) Coexisting conditions: 67% had coxisting Axis I condition: 41% major depression; 20% social anxiety disorder; 20% specific phobias; 14% generalised anxiety disorder and 12% panic disorder.	Inclusion criteria: adult women with a primary diagnosis of PTSD related to a sexual or nonsexual assault that occurred at least 3 months prior to the evaluation or to childhood sexual abuse (i.e., the index trauma). Exclusion criteria: being in an abusive relationship; current diagnosis of organic mental disorder, schizophrenia, or psychotic disorder; unmedicated, symptomatic bipolar disorder; substance dependence; and illiteracy in English; high risk for suicidal behavior (i.e., with intent or plan or both) or with recent history of serious self-injurious behavior (i.e., cutting); those taking psychiatric medication (e.g., antidepressants) if dose not stable for at least 3 months prior to study entry and not maintained during treatment

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): 97% witnessed or experienced other (nonindex) traumatic event; 83% experienced other interpersonal violence Single or multiple incident index trauma: Unclear	
Foa 2013b	Trauma-focused CBT (combined): Exposure therapy/prolonged exposure (PE) (+ naltrexone)	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Mixed - Physical assault (41%); sexual assault (28%); combat (10%); other (21%)	82	Age range (mean): 36-47 (42.7) Gender (% female): 35 BME (% non-white): 66 Country: US Coexisting conditions: 100% alcohol dependence (inclusion criterion) Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR	Inclusion criteria: met DSM-IV criteria for current PTSD and alcohol dependence; clinically significant trauma-related symptoms, as indicated by a score ≥15 on the PTSD Symptom Severity Interview (PSS-I); heavy drinking in the past 30 days, defined as an average of more than 12 standard alcohol drinks per week with at least 1 day of 4 or more drinks determined by the Timeline Follow-Back Interview (TFBI). Exclusion criteria: current substance dependence other than nicotine or cannabis; current psychotic disorder (eg, schizophrenia, bipolar disorder); clinically significant suicidal or homicidal ideation; opiate use in the month prior to study entry; medical illnesses that could interfere with treatment (eg, AIDS, active hepatitis); pregnancy or nursing

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					Single or multiple incident index trauma: Unclear	
Forbes 2012	Trauma-focused CBT: Cognitive processing therapy	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	Military combat - Service (of index trauma): 66% Vietnam; 14% Timor; 3% Iraq; 2% Afghanistan; 15% other	59	Age range (mean): NR (53.4) Gender (% female): 3 BME (% non-white): 0 Country: Australia Coexisting conditions: 80% current mood disorder; 73% other anxiety disorder; 44% substance abuse or dependence Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Multiple	Inclusion criteria: Veteran/former Australia Defence Force (ADF) member (irrespective of age [≥18 years] or theatre of conflict); diagnosis of PTSD or subsyndromal PTSD on Clinician Administered PTSD Scale (CAPS) (subsyndromal defined as at least one criterion in each symptom cluster plus full criterion in two of the three symptom clusters); stable medications for 4 weeks prior to trial entry, i.e. prescribed medication must have been the same for the last 4 weeks with no anticipated changes during the upcoming 12 weeks (if prescription has changed, or is under review, delay study enrolment until medications are stable); a reasonable comprehension of English (defined by proficiency to read and understand the participant information sheet and consent form). Exclusion criteria: current uncontrolled psychotic or bipolar disorder; prominent current suicidal or homicidal ideation; significant cognitive impairment; current substance dependence at a level likely to impede treatment; did not reside within the catchment area designated for treatment at the clinic
Ford 2011	Non-trauma-focused CBT: Affect regulation (individual)	PTSD diagnosis according to ICD/DSM criteria (including self-	Mixed (Exposure to victimization or incarceration)	146	Age range (mean): 18-45 (30.7) Gender (% female): 100 BME (% non-white):	Inclusion criteria were age 18–50 years old, mother or primary caregiver for a child 5 years old or younger, current full or partial PTSD, and past exposure to victimization or incarceration. Exclusion criteria included evidence of

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
		report of diagnosis)			59 Country: US Coexisting conditions: Most (72%) participants met Structured Clinical Interview for DSM-IV criteria for a current Axis I disorder other than PTSD. These included anxiety disorders (61%) and depressive (34%), bipolar (8%), or psychotic (9%) disorders Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): Single or multiple incident index trauma: Multiple	substantial cognitive impairment (i.e., score<16 on the Orientation, Attention, and Recall sections of the Mini Mental State Exam [MMSE), on one-to-one suicide watch (current or past suicidal ideation was not an exclusion), past-month psychiatric hospitalization, refused audiotaping, monolingual Spanish-speaking.
Galovski 2008/2016	Hynotherapy + trauma-focused CBT: Hypnotherapy + cognitive processing therapy	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Mixed - Interpersonal trauma including child sexual abuse (71%), child physical abuse (58%), adult sexual assault (63%), adult criminal victimization (32%), and domestic violence (56%)	108	Age range (mean): 18-70 (36.9) Gender (% female): 100 BME (% non-white): 50 Country: US	Inclusions: female gender, diagnosis of PTSD secondary to sexual or physical assault, clinically significant sleep impairment as indicated by a severity score of 3 or more on the CAPS sleep impairment symptom (item D-1), at least 3 months posttrauma at initial assessment and stable on any psychotropic medication for at least 1 month. Participants could continue

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Multiple	existing medications but were asked to keep medication usage stable. Exclusions: psychosis, mental retardation, active suicidality, parasuicidality, or current drug or alcohol dependence, currently being in an abusive relationship or being stalked. Participants could have received prior therapy, with the exception of CPT, and could receive concurrent therapy provided that it was not trauma or sleep focused. Before randomization, participants were asked to maintain the following standards throughout treatment: limit alcohol consumption to 14 servings per week with no more than 5 servings a day; limit caffeine consumption to 500 mg a day and to refrain from caffeine after 6pm; and try not to vary bed and rise times by more than 1 hour.
Geronilla 2016	Combined somatic and cognitive therapies: Emotional freedom technique (EFT)	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	Military combat - Veterans (33% Vietnam war)	58	Age range (mean): 23-85 (50) Gender (% female): 12 BME (% non-white): NR Country: Unclear (US and/or UK) Coexisting conditions: 91% have some insomnia (41% severe and 34% moderately severe) Lifetime experience of trauma (mean	Inclusion criteria: veterans; with clinically signficant PTSD symptoms (PCL-M score ≥50)

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Multiple	
Gersons 2000	Trauma-focused CBT: Brief eclectic psychotherapy	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Being an emergency responder in a traumatic event - Police officers exposed to trauma in the course of their work. Mean number of traumas in police work 17.1 (SD=8.2)	42	Age range (mean): NR (36.4) Gender (% female): 12 BME (% non-white): 0 Country: Netherlands Coexisting conditions: 86% any other comorbid psychiatric disorder (DSM-III-R): 40% Major Depression; 12% Dysthymia; 26% Alcohol Dependence; 10% Generalized Anxiety; 9% Agoraphobia; 7% Social Phobia; 7% Phobic Disorder; 7% OCD; 5% Panic Disorder Lifetime experience of trauma (mean number of prior	Inclusion criteria: Police officers requesting outpatient treatment following exposure to a PTSD Criterion A event in the course of their work; met DSM-III-R criteria for PTSD; medication-free (could not be on psychotropics) for at least 4 weeks before study entry. Exclusion criteria: current or past organic mental disorders, psychoactive substance-use disorders, schizophrenia or other psychotic disorders; severe depression (suicidal)

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					traumas/% with previous trauma): Mean number of traumas outside police work 3.5 (SD=2.5) Single or multiple incident index trauma: Multiple	
Ghafoori 2016	Psychoeducation: Single psychoeducation session	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	Unclear (not reported in details)	86	Age range (mean): NR (NR) Gender (% female): 45 BME (% non-white): 73 Country: US Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): Mean number of lifetime traumas 8.3 (SD=3.6) Single or multiple incident index trauma: Unclear	Inclusion criteria: aged at least 18 years; English speaking; experienced or witnessed any lifetime traumatic event that involved actual or threatened death or serious injury or threat to the physical integrity of others; experienced a traumatic event and responded to the traumatic event with fear, helplessness, or horror (DSM-IV-R Criterion A1 and A2 of PTSD). Exclusion criteria: medicated for bipolar disorder; diagnosis of schizophrenia; suicidal or homicidal ideation within one year of study participation; had been hospitalized in the previous year for psychiatric issues; had issues with substance abuse or dependence within three months of study participation; reported cognitive impairment
Ghafoori 2017	Trauma-focused CBT: Exposure	PTSD diagnosis according to ICD/DSM	Mixed - Experienced or witnessed a lifetime traumatic event that	71	Age range (mean): 18-71 (35.2)	Inclusion criteria: aged at least 18 years; English speaking; had experienced or witnessed a lifetime traumatic event that involved actual or

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
	therapy/prolonged exposure (PE)	criteria (including self-report of diagnosis)	involved actual or threatened death, serious injury or threat to the physical integrity of others		Gender (% female): 83 BME (% non-white): 72 Country: US Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): Single or multiple incident index trauma: Mean number of traumas experienced 6.49 (SD=3.45). Traumas reported: Natural disaster (47%); fire or explosion (28%); transportation accident (59%); serious accident at work, home or during a recreational activity (38%); exposure to toxic substance (11%); physical assault (82%); assault with a weapon (52%); sexual assault	threatened death, serious injury or threat to the physical integrity of others; met DSM-5 criteria for PTSD; had a score ≥33 on PCL-5. Exclusion criteria: displayed or reported acute psychosis; had suicidal or homicidal ideation within 1 year of study participation; were hospitalized in the previous year for psychiatric issues; identified issues with substance dependence within 3 months of study participation; reported cognitive impairment or traumatic brain injury; reported active self-harm/injury behaviors at the time of screening; indicated they were pregnant

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					(49%); other unwanted or uncomfortable sexual experience (61%); combat (9%); captivity (25%); life threatening illness or injury (44%); severe human suffering (28%); sudden violent death (32%); sudden accidental death (18%); serious injury, harm or death you caused to someone else (10%); any other stressful event or experience (56%) Single or multiple incident index trauma: Single	
Goldstein 2018	Exercise: Aerobic (supervised)	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Military combat (Veterans)	47	Age range (mean): 24-69 (46.8) Gender (% female): 19 BME (% non-white): 47 Country: US Coexisting conditions: Mean number of comorbidites 1.3	Inclusion criteria: veterans aged 18-69 years; met DSM-IV criteria for current PTSD or partial PTSD. Exclusion criteria: lifetime history of any psychiatric disorder with psychotic features, bipolar disorder, or mania; alcohol or substance dependence in past year; prominent suicidal or homicidal ideation; pregnancy; clinically significant neurological disorder or systemic illness affecting CNS function; history of seizure disorder; asthma; physical disabilities precluding use of exercise equipment; myocardial infarction

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					(SD=1.11). 35% current depression; 59% other psychiatric comorbidity Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Multiple	in past 6 months; moderate to severe traumatic brain injury; deemed otherwise unsuitable for the study by the principal investigator
Henderson 2007	Self-help (without support): Mandalas (expressive drawing)	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	Mixed - Assault (8%); motor vehicle accident (11%); death or suicide of a family member or close friend (19%), physical abuse (11%); separation of parents or other family stressor (11%); serious health concern of family or self (11%); sexual abuse (11%); verbal abuse (6%); witness to a traumatic event (11%)	36	Age range (mean): 18-23 (18.4) Gender (% female): 78 BME (% non-white): NR Country: US Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Single	Inclusions: those who reported experiencing one or more traumatic stressor(s) (determined by responses drawn from a checklist contained in the PDS); who showed at least moderate levels of PTSD symptom severity (>10 on the PDS). Exclusions: currently in psychotherapy; currently taking psychotropic medication

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
Hensel-Dittmann 2011	Trauma-focused CBT: Narrative exposure therapy (NET)	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Witnessing war as a civilian - 93% asylum seekers who had fled from their countries of origin after experiencing organized violence. 76% reported experinces of torture and >70% had been in detention	28	Age range (mean): NR (NR) Gender (% female): NR BME (% non-white): NR Country: Germany Coexisting conditions: 82% major depression, 18% dysthymia, 54% anxiety disorder/OCD, 11% substance abuse, and 4% psychotic disorder Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Multiple	Inclusion criteria: a history of experiencing organized violence; a current PTSD diagnosis. Exclusion criteria: substance dependence; strong suicidal intentions requiring inpatient treatment; schizophrenia; pregnancy
Hermenau 2013	Trauma-focused CBT: Narrative exposure therapy (NET)	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	Child soldiers - Male former combatants and child soldiers who reported combat experience. Participants joined the first armed group at mean age of 12.40 years (SD = 2.65, range = 5–18) and stayed	38	Age range (mean): 16-25 (19) Gender (% female): 0 BME (% non-white): NR Country: Democratic	Inclusion criteria: male former combatants and child soldiers who reported combat experience

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
			on average 3.60 years with armed groups (SD = 3.98, range = less than 1 year–10 years). They joined one to four (M = 1.83, SD = 0.87) armed groups belonging to a wide range of militia and self-defense groups, including the Forces démocratique pour la libération du Rwanda (FDLR [Democratic Forces for the Liberation of Rwanda]), Congès nationale du peuple (CNDP [National Congress of the People]), and several local Mai-Mai militia groups		Replic of Congo Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Multiple	
Hien 2009	Non-trauma-focused CBT: Seeking Safety	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Mixed - The majority of participants had experienced physical abuse (84.8%) or sexual abuse (67.6%) during adulthood. Many of the participants reported other traumatic experiences, including transportation accidents (72.7%) and a life-threatening illness (39.8%)	353	Age range (mean): NR (39.2) Gender (% female): 100 BME (% non-white): 55 Country: US Coexisting conditions: All participants had co-occurring PTSD (full [80.4%] or subthreshold PTSD [19.6%]) and	Inclusion criteria: enrolled in one of seven community-based substance abuse treatment programs (CTPs), had at least one traumatic event in their lifetime and to have met DSM-IV-TR (APA, 2000) criteria for either full or sub-threshold PTSD (met either criteria C or D, but not both), aged 18–65 years of age, used alcohol or an illicit substance within the past six months, have a current diagnosis of drug or alcohol abuse or dependence, capable of giving informed consent. Exclusion criteria were: advanced stage medical disease as indicated by global physical deterioration, impaired cognition as indicated by a Mini-Mental Status Exam

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					substance use. The most frequently diagnosed substance use disorder was cocaine dependence (70.5%), followed by alcohol (56.1%), marijuana (27.2%), and opioid dependence (25.6%). Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): Very high rates of childhood abuse histories (70.1% sexual and 58.7% physical abuse) were also reported Single or multiple incident index trauma: Multiple	score < 21, significant risk of suicidal/homicidal intent or behavior, history of schizophrenia-spectrum diagnosis, a history of active (past two months) psychosis, involvement in litigation related to PTSD, non English-speaking, refused to be video- or audio-taped.
Hijazi 2014	Trauma-focused CBT: Brief narrative exposure therapy (NET)	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	Witnessing war as a civilian - Iraqi and Syrian refugees: Racial/religious oppression (92%); exposure to combat situation (92%); witnessing murder (68%);	63	Age range (mean): NR (48.2) Gender (% female): 56 BME (% non-white): NR Country: US	Inclusion criteria: adult Iraqi refugees who had resettled in southeast Michigan; reported exposure to a violent or traumatic event related to being a refugee, to the war, or to sectarian strife; reported being bothered by the event, thought about it repeatedly, or felt like they had not overcome it. Exclusion criteria: currently

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
			murder/violent death of family/friends (65%); kidnapping of family/friends (59%); witnessing torture (41%); physically harmed (38%); imprisoned arbitrarily (29%); witnessing mass execution of civilians (27%); kidnapped (27%); tortured (25%); taken hostage (18%); sexually abused/raped (6%). Most participants experienced multiple events (mean 19.8; SD=6.4)		Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Multiple	received exposure therapy for PTSD; planning to leave area in next 4 months
Himmerich 2016	EMDR: EMDR	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Military combat - German soldiers who had served deployments abroad	38	Age range (mean): NR (28.5) Gender (% female): 0 BME (% non-white): NR Country: Germany Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR	Inclusion criteria: male German soldiers who had served deployments abroad; met ICD-10 criteria for combat-related PTSD; the event leading to PTSD had to be no more than 24 months ago

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					Single or multiple incident index trauma: Multiple	
Hinton 2005	Trauma-focused CBT: CBT individual	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Witnessing war as a civilian - Participants had passed through the Cambodian genocide (1975-1979) where they may have been subjected to slave labour, physical and sexual violence, threat of death by illness, starvation or execution.	40	Age range (mean): NR (51.8) Gender (% female): 60 BME (% non-white): NR Country: US Coexisting conditions: 100% met criteria for generlalised anxiety disorder Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Multiple	Inclusion criteria: having passed through the Cambodian genocide (1975–1979); having been at least 6 years of age at the beginning of the genocide; meeting criteria for treatment-resistance, defined as still meeting PTSD criteria (as assessed by the SCID module for PTSD) despite receiving supportive counseling and an adequate trial of a selective serotonin reuptake inhibitor (SSRI) (i.e., at least 1 year on the maximally tolerated dosage). Exclusion criteria: inability to give informed consent; psychosis in the last year
Hinton 2009	Trauma-focused CBT: CBT individual	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Witnessing war as a civilian - Participants were exposed to the Cambodian genocide (1975-1979)	24	Age range (mean): NR (49.5) Gender (% female): 60 BME (% non-white): NR Country: US Coexisting	Inclusion criteria: having passed through the Cambodian genocide (1975–1979); having been at least 6 years old at the beginning of the genocide; having pharmacology-resistant PTSD as defined by continued presence of PTSD (as assessed by the SCID module for PTSD) despite receiving supportive counseling and an adequate trial of a selective serotonin reuptake

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					conditions: 100% had comorbid orthostatic panic Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Multiple	inhibitor at the maximally tolerated dose for a minimum of 6 months; having current (in the last month) orthostatic panic, as determined by the Orthostatic PA Interview. Exclusion criteria: inability to give informed consent; organic mental disorder, psychotic spectrum disorder, bipolar disorder, or active substance abuse or dependence; serious suicide ideation currently or in the last 6 months; pregnancy
Hinton 2011	Trauma-focused CBT: CBT group	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Unclear (No details reported)	24	Age range (mean): NR (49.5) Gender (% female): 100 BME (% non-white): 100 Country: US Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Unclear	Inclusion criteria: Latino women who were considered to be treatment-resistant, defined as still meeting PTSD criteria (as assessed by a Spanish-speaking social worker using the PTSD module of the SCID) despite receiving both supportive counseling for at least six months and an adequate trial of a selective serotonin reuptake inhibitor (SSRI), that is, at least six months on the maximally tolerated dosage. Exclusion criteria: inability to give informed consent; psychosis in the last year; not having Spanish as the preferred language of communication; active substance abuse; male gender
Hirai 2005	Self-help (without	Clinically important PTSD	Mixed - MVCs (33%), interpersonal violence	36	Age range (mean): NR (29.4)	Inclusion criteria: 18 years or older and had experienced a traumatic event, and met the

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
	support): Computerised trauma-focused CBT	symptoms (scoring above a threshold on validated scale)	(22%), eye-witnessed traumatic events (11%), life-threatening disease (11%), illness or traumatic loss (22%)		Gender (% female): 78 BME (% non-white): 22 Country: US Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Single	DSM-IV reexperiencing and avoidance criteria. Exclusion criteria were a history of combat or childhood sexual abuse.
Hollifield 2007	Trauma-focused CBT: CBT group	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Unclear - 38% reported experiencing ≥3 events; 33% identified ≥5 years of ongoing childhood abuse	84	Age range (mean): NR (42.2) Gender (% female): 66 BME (% non-white): 36 Country: US Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR	Inclusion criteria: met DSM-IV criteria for a diagnosis of PTSD (assessed using the SCID); PSS-SR score ≥16; a commitment to accept randomization. Exclusion criteria: active substance abuse or psychosis; current active treatment specifically for PTSD

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					Single or multiple incident index trauma: Unclear	
Ivarsson 2014	Self-help with support: Computerised trauma-focused CBT with support	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Mixed - Sexual, physical, and/or psychological abuse by partner (23%); life-threatening disease (13%); severe offense by significant other (perceived as threatening to integrity) (10%); life-threatening accident (8%); non-sexual assault by stranger (8%); murder of close relative (6%); non-sexual assault by family member (5%); death of close relative (5%); severe maltreatment in health care (5%); multiple stressors (5%); life-threatening disease of close relative (3%); military combat (3%); torture (2%); rape by stranger (2%); rape by family member (2%); tsunami disaster (2%)	62	Age range (mean): 21-67 (46) Gender (% female): 82 BME (% non-white): NR Country: Sweden Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): 41% had experienced more than one traumatic event Single or multiple incident index trauma: Single	Inclusion criteria: to be a resident of Sweden; to be at least 18 years of age; to have access to a computer and internet; to able to read and understand the Swedish language; to be on a current stable dose of medication (for at least the last 3 months) or medication-free; to fulfill the DSM-IV diagnostic criteria for a primary diagnosis of chronic PTSD according to the screening questionnaires. Exclusion criteria: imminent suicide risk as assessed by item 9 on the Beck Depression Inventory (BDI-II), followed by a telephone interview regarding suicidal ideation; concurrent psychological treatment; presence of alcohol abuse (scoring 19 or higher on Alcohol Use Disorders Identification Test, AUDIT), on-going trauma or trauma of more recent origin than 3 months; individuals who reported symptoms following childhood abuse as their main reason for participating
Jacob 2014	Trauma-focused CBT: Narrative exposure therapy (NET)	PTSD diagnosis according to ICD/DSM criteria (including self-	Witnessing war as a civilian - Widowed or orphaned survivors of Rwandan (1994) genocide. Among the 43 widows, the most	76	Age range (mean): NR (37.6) Gender (% female): 84 BME (% non-white): 100	Inclusion criteria: survivors of Rwandan genocide who were made orphans or widows; met DSM-IV-TR criteria for PTSD. Exclusion criteria: mental retardation; psychotic symptoms; current drug or alcohol

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
		report of diagnosis)	frequently reported worst life experiences were sexual abuse (21%), the genocide in general (21%), and witnessing a massacre (14%). Among the 33 orphans, the most frequently reported worst life experiences were sexual abuse (21%), witnessing the killing of a parent (15.2%), and the genocide in general (12%)		Country: Rwanda Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): Mean number of traumatic event types ever experienced: 14.4 (SD=3.8) Single or multiple incident index trauma: Multiple	
Jarero 2013	EMDR: EMDR	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	Being an emergency responder in a traumatic event (First responders)	39	Age range (mean): 18-60 (NR) Gender (% female): 49 BME (% non-white): NR Country: Mexico Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): Active duty first responders (38% Red Cross	Inclusion criteria included the following: (a) to be first responders, (b) to be on active duty, and (c) aged 18–60 years. Exclusion criteria included (a) current suicidal ideation; (b) a diagnosis of psychotic or bipolar disorder, organic mental disorder, or substance abuse; (c) current suicidal or homicidal ideation; and (d) significant cognitive impairment.

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					paramedics; 38% emergency line operators; 23% firefighters) Single or multiple incident index trauma: Multiple	
Jensen 1994	EMDR: EMDR	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	Military combat (Vietnam veterans)	29	Age range (mean): 40-55 (43.1) Gender (% female): 0 BME (% non-white): NR Country: US Coexisting conditions: 40% had a recent VA diagnosis of alcohol abuse or alcohol dependence and were receiving inpatient treatment for these disorders Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Multiple	Inclusions: male Vietnam combat veterans who were concurrently receiving, or were eligible to receive, health and mental health services at a VA Medical Center; clinically important PTSD symptoms according to Structured Interview for PTSD (SI-PTSD). Exclusions: current unstable psychological condition (e.g. psychosis, or suspected organic brain damage), questionable motivation for completing the study, questionable symptomatology, unclear military background.

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
Jindani 2015	Yoga: Yoga	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	Mixed - 23% Emotional abuse; 20% Complex multiple traumas (e.g., family, refugee, chronic illness); 16% Sexual abuse (including childhood sexual abuse); 15% Adverse life circumstances (e.g., employment, relationships); 11% Physical trauma (e.g., illness, motor vehicle accidents); 9% Domestic violence; 4% Systemic discrimination (e.g., racism, heterosexism); 3% Compassion fatigue (e.g., vicarious trauma, secondary trauma)	80	Age range (median): 18-64 (41) Gender (% female): 89 BME (% non-white): NR Country: Canada Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Multiple	Inclusion criteria: score>57 on the PCL-17 and >18 years of age. Exclusion criteria: regular contemplative practice; an inability to abstain fromalcohol or substance 24 hours prior to class; issues that would be a participant safety risk
Johnson 2011	Present-centered therapy: Present-centered therapy	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Domestic violence - Psychological (100%)/physical (93%)/sexual (67%) partner violence	70	Age range (mean): NR (32.6) Gender (% female): 100 BME (% non-white): 57 Country: US Coexisting conditions: 67% MDD, 18% anxiety disorders Lifetime experience of trauma (mean number of prior	Inclusion criteria: participants had to experience an incident of IPV on the Conflict Tactic Scales-Revised the month prior to shelter admission, and meet diagnostic criteria for IPV-related PTSD or subthreshold PTSD according to the Clinician Administered PTSD Scale. Exclusion criteria: symptoms of psychosis on the psychotic screen of the Structured Clinical Interview for Axis I disorders, met diagnostic criteria for lifetime Bipolar Disorder on the SCID-I/P, endorsed significant suicidal ideation with intent and plan, if on psychotropic medications, have had any change in medication dose or type

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					traumas/% with previous trauma): 6.31 types of prior trauma, aside from index IPV. 73% had experienced prior lifetime IPV Single or multiple incident index trauma: Multiple	in the last month, or were in concurrent individual therapy
Johnson 2016	Present-centered therapy: Present-centered therapy	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Domestic violence - Psychological (48%)/physical (37%)/sexual (3%) partner violence	60	Age range (mean): NR (33.3) Gender (% female): 100 BME (% non-white): 57 Country: US Coexisting conditions: 60% MDD, 43% other anxiety disorder Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): 3.6 prior trauma. 66% had experienced prior lifetime IPV	Inclusion criteria: participants had to be a resident of one of the four participating shelters at the time of the baseline assessment, report IPV the month prior to shelter, and meet Diagnostic and Statistical Manual of Mental Disorders diagnostic criteria for current PTSD or subthreshold PTSD from IPV using the Clinician-Administered PTSD Scale. Exclusion criteria: reported psychotic symptoms, met DSM-IV diagnostic criteria for lifetime bipolar disorder or current substance dependence on the Structured Clinical Interview for DSM-IV Axis I Disorders-Patient Version, endorsed significant suicidal ideation with intent and plan, reported concurrent individual therapy, or reported any change in medication dose or type in the last month

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					Single or multiple incident index trauma: Multiple	
Jung 2013	Trauma-focused CBT: Brief individual CBT	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Childhood sexual abuse - Participants had experienced childhood sexual abuse (mean reported age at time of first sexual abuse was 7.7 years [SD=4.3]) and also suffered from a feeling of being contaminated (FBC). The duration of abuse lasted 6.8 years (SD=5.2) on average, and the duration of FBC ranged from 2 to 46 years (mean 20 years). 71.4% of abuse was severe, and included penetration, 71.4% of abuse was inflicted by a relative	34	Age range (mean): 19-61 (37.2) Gender (% female): 100 BME (% non-white): 11 Country: Germany Coexisting conditions: Mean 3.4 (SD=1.06) DSM-IV Axis-I or Axis-II diagnoses: 57% major depressive disorder; 32% eating disorders; 32% borderline personality disorder; 25% social anxiety disorder Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Multiple	Inclusion criteria: female participants aged 17–65 years; met DSM-IV diagnosis for PTSD related to childhood sexual abuse (CSA); had the feeling of being contaminated, defind as meeting at least one of the following 3 criteria: 'feeling dirty' because of the CSA, disgusted by their own bodies, or being convinced that the perpetrator´s body fluids or cells remain in or on their bodies. Exclusion criteria: a lifetime diagnosis of psychotic or bipolar disorder; current drug dependency according to DSM-IV criteria; body mass index lower than 16.5; mental retardation; acute-severe suicidality with suicidal plans; were receiving simultaneous therapy during the study period

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
Karatzias 2011	EMDR: EMDR	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Mixed - Accident (37%), assault/murder (43%), 'other' (20%)	46	Age range (mean): Gender (% female): BME (% non-white): Country: Coexisting conditions: Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): Single or multiple incident index trauma:	Inclusions: met DSM-IV criteria for PTSD; if on medication, having been on a stable dose for at least 6 weeks; and aged 18-65 years. Exclusions: the presence of suicidal ideation or intent as assessed at a clinical interview; a history of psychotic illness, concurrent severe depressive illness, or substance use disorder; or receiving psychotherapy out of the study.
Kaslow 2010	Psychoeducation: Psychoeducational group	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	Domestic violence (No further details reported)	217	Age range (mean): 18-64 (34.7) Gender (% female): 100 BME (% non-white): 100 Country: US Coexisting conditions: All participants had attempted suicide in the past year Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR	Inclusion criteria: African-American women who had experienced both interpersonal violence (IPV) and made a suicide attempt within the past year. Exclusion criteria: inability to complete the pretreatment interview because of cognitive impairment, acute psychosis, or delirium

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					Single or multiple incident index trauma: Multiple	
Katz 2014	Trauma-focused CBT: Exposure therapy/prolonged exposure (PE)	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	Exposure to sexual abuse or assault - Female veterans who had a history of sexual trauma, including: military sexual trauma (88%); childhood sexual abuse (71%); adult sexual assault (44%); domestic violence (68%)	34	Age range (mean): 22-66 (42) Gender (% female): 100 BME (% non-white): 56 Country: US Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Multiple	Inclusion criteria: female veterans who had experienced a history of sexual trauma (e.g., childhood, adult, and/or military sexual assault, molestation, or domestic violence); had symptoms of psychological distress (such as anxiety, depression, and sleep difficulties) and were seeking psychotherapy treatment in a Department of Veterans Affairs medical center women's mental health clinic. Exclusion criteria: suicidal attempts or hospitalizations in the 6 months prior to treatment; psychotic symptoms or suffering from a psychotic-related disorder; actively using alcohol or drugs in the three months prior to study entry; had a strong tendency to dissociate to the point that it could interfere with their ability to participate in this study (e.g., difficulty concentrating during session, unable to tolerate negative emotions, and having periods of time of not being aware of current surroundings)
Kazak 2004	Family therapy: Family therapy group	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	Family member or carer of person with life-threatening illness or injury (Mothers of childhood cancer survivors)	146	Age range (median): 26-59 (42.9) Gender (% female): 100 BME (% non-white): 12 Country: US Coexisting conditions: NR	Mothers of child participants who were included if they were: (1) childhood cancer survivors aged 11-19 years; (2) had completed treatment 1–10 years previously; (3) on the oncology tumor registry. Participants were excluded if they: (1) experienced a relapse; (2) had mental retardation; (3) were not fluent in English; (4) resided more than 150 miles from the hospital

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Single	
Kearney 2013	MBSR: MBSR	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Military combat (Veterans)	47	Age range (mean): NR (52) Gender (% female): 21 BME (% non-white): 32 Country: US Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): Mean number of categories of lifetime trauma: 10 Single or multiple incident index trauma: Multiple	Inclusion criteria: veterans with an established diagnosis of chronic PTSD at VA Puget Sound Health Care System (PSHCS) in Seattle. Exclusion criteria (determined by review of the medical record): any past or present psychotic disorder; mania, or poorly controlled bipolar disorder; borderline or schizoaffective personality disorder; current suicidal or homicidal ideation; active substance abuse or dependence
Kearney 2016	MBSR: MBSR	Clinically important PTSD symptoms	Military combat (Veterans with Gulf war illness)	55	Age range (mean): NR (49.9)	Inclusion criteria: met criteria for Gulf War illness, defined as deployment to the Gulf War theater of operations between August 1990 and

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
		(scoring above a threshold on validated scale)			Gender (% female): 15 BME (% non-white): 38 Country: US Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): Mean number of traumas: 4.5 (3.3) Single or multiple incident index trauma: Multiple	August 1991 and self-report of at least 2 of the following symptoms that began after August 1990, lasted at least 6 months, and were present at the time of the interview: (1) fatigue that limits usual activity; (2) musculoskeletal pain involving 2 or more regions of the body; and (3) cognitive symptoms (memory, concentration, or attention difficulties). Exclusion criteria: history of psychosis; current mania; current suicidal or homicidal ideation; prior participation in mindfulness-based stress reduction; active substance/alcohol abuse that posed a safety threat (current drinking and a past year history of alcohol-related seizures or delirium tremens); inpatient psychiatric admission within the past month
Kent 2011	Resilience-oriented treatment: Resilience-oriented treatment	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	Mixed - All participants were veterans from the Vietnam war era up through the Gulf war. The traumas indexed by the CAPS were combat (31%), childhood sexual abuse (21%), childhood physical abuse (18%), violent unexpected death of another (14%), sexual assault (6%), physical assault (5%), and accident (5%)	39	Age range (mean): 34-66 (54) Gender (% female): 33 BME (% non-white): 24 Country: US Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR	Inclusions: United States veterans from the Vietnam war era up through the Gulf war, and scoring > 40 on the CAPS. Exclusions: active suicidality, active alcohol/substance abuse, psychosis, and life-threatening illness

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					Single or multiple incident index trauma: Multiple	
Knaevelsrud 2007	Self-help with support: Computerised trauma-focused CBT with support	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	Mixed - Sexual abuse/Rape (32%); Death of close person (42%); Accident (6%); Physical disease (9%)	96	Age range (mean): 18-68 (35) Gender (% female): 90 BME (% non-white): NR Country: Germany Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Single	Inclusion criteria: have experienced a traumatic event that occurred at least one month prior to treatment and that met the criteria specified in DSM-IV; be 18 years or older; be fluent in written German; not be receiving treatment elsewhere. Exclusion criteria: Severely depressed mood (score on the SCL-90 [Brief Symptom Inventory, BSI] exceeded the cut-off) or suicidal intentions (assessed using the Suicide Risk Assessment [SRT]); dissociative tendency (above cut-off score on Somatoform Dissociation Questionnaire [SDQ-5]); were at risk of psychosis (scored above cut-off point on the Dutch Screening Device for Psychotic Disorder); if they indicated heavy alcohol or drug abuse
Knaevelsrud 2015	Self-help with support: Computerised trauma-focused CBT with support	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	Witnessing war as a civilian - Sexual violence (war-related and sexual abuse; 40%); experienced the killing of a family member or close person (15%); being exposed to violence (eg, kidnapping, witnessing bomb attacks) and war or torture (19%); Others (eg, kidnapping,	159	Age range (mean): 18-56 (28.1) Gender (% female): 72 BME (% non-white): NR Country: Iraq Coexisting conditions: NR Lifetime experience of trauma (mean	Inclusion criteria: participants had to have a history of trauma according to the Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition; DSM-IV) criteria accompanied by posttraumatic stress symptoms (PDS score>11), knowledge of Arabic, and age between 18 and 65 years. Exclusion criteria: currently receiving treatment elsewhere, substance abuse or dependence, high risk of suicide, psychotic symptoms, and low symptom severity

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
			witnessing bomb attacks) (33%)		number of prior traumas/% with previous trauma): Mean 3.4 traumatic events Single or multiple incident index trauma: Multiple	
Knaevelsrud 2017	Self-help with support: Computerised trauma-focused CBT with support	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	Witnessing war as a civilian (World War II)	94	Age range (mean): 63-85 (71.4) Gender (% female): 65 BME (% non-white): NR Country: Germany Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Multiple	Inclusion criteria: have experienced a traumatic event as a child or adolescent during World War II that met the criterion A for PTSD as specified in DSM-IV (i.e., war traumatization); report at least a subsyndromal level of PTSD symptoms (participants met Criterion B and either Criterion C or D); be able to understand and write texts in German. Exclusion criteria: severe depression (i.e., Brief Symptom Inventory-18 [BSI-18] depression score >3); suicide risk (i.e., participant who indicated suicidal ideation on the BSI-18 was given a call to examine suicide risk using Suicide Risk Assessment); abuse of drugs or alcohol; receive psychological treatment elsewhere simultaneously
Krakow 2000	Non-trauma-focused CBT: Imagery rehearsal therapy for nightmares	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	Exposure to sexual abuse or assault - 97% reported history of sexual assault: 50% raped as adults; 54% raped as children; >60%	169	Age range (mean): NR (37) Gender (% female): 100 BME (% non-white): 3	Inclusion criteria: females aged at least 18 years; complaints of nightmares at least once a week for greater than 6-month duration; insomnia; PTSD or posttraumatic stress symptoms coupled with clear Criterion A trauma

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
			experienced multiple episodes of sexual assault		Country: US Coexisting conditions: All participants had regular nightmares (≥1 a week for >6 months) and insomnia Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): 68% experienced non-sexual violent assaults as adults and 72% as children. 78% reported other traumatic events including unexpected deaths in the family, witnessing violence, motor vehicle accidents, or natural disasters Single or multiple incident index trauma: Multiple	link(s). Exclusion criteria: acute intoxication; acute psychosis
Krupnick 2008	IPT: IPT (group)	PTSD diagnosis according to ICD/DSM	Mixed - Study participants had experienced multiple episodes of trauma,	48	Age range (mean): NR (32)	Inclusions: reported history of one or more interpersonal traumas (sexual or physical assault, abuse, molestation); current relationship

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
		criteria (including self-report of diagnosis)	usually beginning in childhood. 98% sexual assault (96% first assualted before age 12); 96% physical assault before age 12		Gender (% female): 100 BME (% non-white): 94 Country: US Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): Mean 6.4 prior traumas Single or multiple incident index trauma: Multiple	problem (defined as a score of 3 or higher on an IIP item); diagnosis of current PTSD, with symptoms that began after an interpersonal trauma; psychoactive medications had to be stable for at least 3 months before study entry. Exclusions: current diagnosis or history of schizophrenia or bipolar disorder; diagnosis of alcohol or drug abuse or dependence in the past month; score greater than 30 on the DES; antisocial personality disorder; women with serious, ongoing physical assault/abuse, or threat of abuse, from domestic partners; women more than 4 months pregnant
Kubany 2003	Trauma-focused CBT: CBT individual	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Domestic violence - All participants had been physically or emotionally abused by an intimate partner or a romantic partner. 73% had been physically hurt over five times by their partner, 51% had been phsyically hurt by more than one intimate partner.	37	Age range (mean): 22-62 (36.4) Gender (% female): 100 BME (% non-white): 51 Country: US Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): Mean 8.3 (SD=3.2)	Inclusion criteria: had been out of an abusive relationship for at least 30 days with no intention of reconciling; had not been physically or sexually abused or stalked by anyone for at least 30 days; met diagnostic criteria for partner-abuse-related PTSD; obtained a score on the Global Guilt Scale of the Trauma-Related Guilt Inventory reflecting at least moderate abuse-related guilt. Exclusion criteria: currently abusing alcohol or drugs; had schizophrenia or bipolar disorder

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					types of traumatic events. Types of trauma exposure (reported by >25%): Natural disaster (49%); Motor vehicle accident (32%); Sudden death friendlloved one (57%); Life-threatening/disabling event to loved one (35%); Assaulted by acquaintanc/strange r (30%); Witnessed severe assault to acquaintancdstrange r (32%); Threatened with deathlserious harm (78%); Growing up: witnessed family violence (46%); Growing up: physically punished (49%); Before 13: sexual contact-someone at least 5 years older (32%); As a teen: unwanted sexual contact (38%); As an adult: unwanted sexual	

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					contact (49%); Stalked (70%) Single or multiple incident index trauma: Multiple	
Kubany 2004	Trauma-focused CBT: CBT individual	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Domestic violence - All participants had been physically, sexually, and/or psychologically abused (e.g., threatened, stalked, badgered, humiliated) by an intimate or romantic partner. 68% reported having been physically hurt by intimate partners more than five times, and 51% had been physically hurt by more than one intimate partner. The mean period of time from the first to the last incident of abuse was 6.3 years (SD=6.9)	125	Age range (mean): 18-70 (42.2) Gender (% female): 100 BME (% non-white): 47 Country: US Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): Mean 9.0 (SD=4.2) types of traumatic events. Types of events (reported by >25%): Natural disaster (40%); Motor vehicle accident (36%); “Other” kind of accident (26%); Sudden death of friend or loved one (59%); Life-threatening/disabling	Inclusion criteria: had been out of an abusive relationship for at least 30 days with no intention of reconciling; had not been physically or sexually abused or stalked by anyone for at least 30 days; met diagnostic criteria for partner abuse-related PTSD; obtained a score on the Global Guilt Scale of the TRGI reflecting at least moderate abuse-related guilt. Exclusion criteria: currently abusing alcohol or drugs; have schizophrenia or bipolar disorder

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					event to loved one (44%); Life-threatening illness (26%); Witnessed severe assault to acquaintance or stranger (38%); Threatened with death or serious harm (80%); Growing up: witnessed family violence (44%); Growing up: physically abused (59%); Before age 13: sexual contact—someone at least 5 years older (48%); Before age 13: unwanted sexual contact—someone close in age (29%); As a teen: unwanted sexual contact (35%); As an adult: unwanted sexual contact (56%); Stalked (66%) Single or multiple incident index trauma: Multiple	

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
Kuhn 2017	Self-help (without support): Computerised non-trauma-focused CBT	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	Mixed - Physical assault (47%); sexual assault (14%); serious accident (21%); life-threatening illness or injury (6%); disaster exposure (3%); combat exposure (3%); other event (7%)	120	Age range (mean): NR (39.3) Gender (% female): 69 BME (% non-white): 33 Country: US Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): Mean number of traumatic event types 8.5 (SD=3.5). Lifetime trauma exposure: Physical assault (87%); Sexual assault (73%); Serious accident (79%); Life-threatening illness or injury (60%); Disaster exposure (74%); Combat exposure (7%); Other event (93%) Single or multiple incident index trauma: Single	Inclusion criteria: aged at least 18 years; being fluent in English; owning a mobile device capable of using PTSD Coach; having been exposed to a traumatic event more than 1 month ago; score ≥ 35 on the PCL–C; not currently being in PTSD treatment

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
Lange 2003	Self-help with support: Computerised trauma-focused CBT with support	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	Mixed - Traumatic loss, sexual abuse, physical abuse/robbery, abrupt change in personal circumstance, MVCs, divorce	184	Age range (mean): 19-71 (39) Gender (% female): 80 BME (% non-white): NR Country: Netherlands Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Single	Inclusion criteria: above threshold on the IES (Dutch version). Exclusion criteria: severely depressed mood, tendency to psychological dissociation, risk of psychosis, substance abuse, trauma within the past 3 months, incest, aged <18 years or being treated elsewhere.
Laugharne 2016	Trauma-focused CBT: Exposure therapy/prolonged exposure (PE)	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	Mixed - Adult sexual assault (20%); witnessing death or injury (25%); serious injury to self (10%); motor vehicle accident (10%); threat to physical safety (10%); sudden death of a loved one (10%); child sexual assault (5%); physical assault (5%); natural disaster (5%)	20	Age range (mean): NR (40.1) Gender (% female): 70 BME (% non-white): NR Country: Australia Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with	Inclusion criteria: aged 18-65 years; met CAPS criteria for PTSD; be willing to engage in psychological treatment and neuroimaging. Exclusion criteria: initiation of any new prescription medication within the previous month; current drug or alcohol dependence; diabetes; past history of psychotic illness; neurological disorders; evidence of a diagnosable cluster B personality disorder scored via SCID II; score >30 on the Dissociative Experiences Scale (DES)

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					previous trauma): NR Single or multiple incident index trauma: Single	
Levine 2005	Meditation: Complementary/alternative (CAM) oriented intervention	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	Diagnosis of life-threatening condition (Metastatic primary breast cancer)	26	Age range (mean): NR (45) Gender (% female): 100 BME (% non-white): 33 Country: US Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Single	Inclusion criteria: women within 18 months of initial diagnosis of primary metastatic breast cancer; [for this analysis] were classified as having significant PTSD symptoms (defined as PCL-C score ≥44 and endorsement of ≥1 reexperienceing symptoms, ≥3 avoidance symptoms and ≥2 hyperarousal symptoms)
Lewis 2017	Self-help with support: Computerised trauma-focused CBT with support	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Mixed - Transportation accidents (21%); witnessing a sudden, violent, or accidental death (21%); traumatic childbirth or stillbirth (19%); sexual assault or rape (12%); physical attack (10%); life threatening illness or injury	42	Age range (mean): 20-65 (39.3) Gender (% female): 60 BME (% non-white): BR Country: US Coexisting conditions: NR	Inclusion criteria: adults aged 18 or over, who continued to meet diagnostic criteria for DSM-5 PTSD of mild to moderate severity (CAPS-5 score of 55 or less) after a 2-week period of symptom monitoring. Exclusion criteria: psychosis, previous trauma-focused psychological therapy, DSM-5 severe major depressive episode, substance dependence, inability to read and write fluently in English,

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
			(7%); serious accident (2%); learning of the violent death of a loved one (2%); seeing a mutilated body (2%); and being held hostage/detained (2%)		Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Single	inability to access the internet, change in psychotropic medication within 1-month, concurrent psychological therapy, suicidal intent, and individuals who had symptoms linked to multiple traumas or a CAPS-5 score of over 55
Lieberman 2005/2006/ Ghosh Ippen 2011	Psychodynamic therapies: Child-Parent Psychotherapy using play	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	Domestic violence (Not reported in details)	75	Age range (mean): NR (NR) Gender (% female): 100 BME (% non-white): 76 Country: US Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): Most mothers reported multiple traumatic stressors in addition to marital violence (mean = 12.36, range 2–26). Maternal childhood trauma included witnessing marital violence (48%),	Child–mother dyads were recruited if the child was 3 to 5 years old, had been exposed to marital violence as confirmed by mother's report on the Conflict Tactics Scale 2 (Straus et al., 1996), and the perpetrator was not living in the home. Exclusionary criteria for the mothers were documented abuse of the target child, current substance abuse and homelessness, mental retardation, and psychosis. Children with mental retardation or autistic spectrum disorder were also excluded

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					physical abuse (49%), sexual molestation (42%), and the sudden/traumatic death of someone close (44%). Single or multiple incident index trauma: Multiple	
Lindauer 2005	Trauma-focused CBT: Brief eclectic psychotherapy	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Mixed (25% robbery/weapon used; 13% assaulted by strangers; 13% threatened with death/serious harm; 13% rape; 4% natural disaster; 4% motor vehicle accident; 21% 'other' kind of accident; 4% combat or warfare; 4% life-threatening/disabling event to a loved one)	24	Age range (mean): NR (39) Gender (% female): 54 BME (% non-white): NR Country: Netherlands Coexisting conditions: 13% had mild major depression (those with moderate or severe depression were excluded) Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): Mean number of prior traumas 3.7 (SD=3.4)	Inclusion criteria: met DSM-IV criteria for PTSD (assessed with SI-PTSD). Exclusion criteria: any current or past organic mental disorder; psychotic disorders; psychoactive substance use disorders; moderate and severe major depression; non-PTSD anxiety disorders; severe dissociative disorders; use of psychiatric medication; language mastery problems

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					Single or multiple incident index trauma: Single	
Lindauer 2008	Trauma-focused CBT: Brief eclectic psychotherapy	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Domestic violence (67% interpersonal violence; 33% accidents or disasters)	24	Age range (mean): NR (39.7) Gender (% female): 50 BME (% non-white): NR Country: Netherlands Coexisting conditions: 15% had mild major depression (those with moderate or severe depression were excluded) Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Multiple	Inclusion criteria: civilian Dutch outpatients who met DSM-IV criteria for PTSD (assessed using SI-PTSD). Exclusion criteria: organic mental disorder; head trauma with loss of consciousness; mental retardation; seizures; neurological disorders; schizophrenia; psychotic disorders; bipolar disorder; moderate and severe major depression; panic disorder; phobia; obsessive–compulsive disorder; dissociative disorders; lifetime or current alcohol or drug abuse or dependence; use of psychiatric medication; left-handedness
Littleton 2016	Self-help with support: Computerised trauma-	PTSD diagnosis according to ICD/DSM criteria (including self-	Exposure to sexual abuse or assault (Women who had experienced a completed rape since the age of 14)	87	Age range (mean): 18-42(22) Gender (% female): 100 BME (% non-white):	Inclusion criteria: currently enrolled in one of four university campuses, PTSD diagnosis (determined using PSS-I) secondary to a rape that occurred after the age of 14, regular access to a computer and a telephone number at which

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
	focused CBT with support	report of diagnosis)			54 Country: US Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): >50% had experienced some other form of interpersonal violence, with childhood/adolescent physical and/or sexual abuse being most commonly reported, followed by physical abuse by a romantic partner Single or multiple incident index trauma: Single	they could reliably be reached. Exclusion criteria: currently receiving psychotherapy,lack of stability on psychotropic medication (individual has not been on current medication/dosage for at least three months), active suicidality as determined by interview utilizing the Scale for Suicidal Ideation, or meeting DSM-IV criteria for current substance dependence as assessed with the substance use disorder module of the SCID-IV.
Maguen 2017	Trauma-focused CBT: CBT individual	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Military combat - 79% Vietnam; OIF (15%); OEF (6%); Gulf war (3%); Other (9%). 67% single service tour and 33% mutliple	33	Age range (mean): NR (NR) Gender (% female): 0 BME (% non-white): 29 Country: US Coexisting conditions: NR	Inclusion criteria: at least 18 years old; endorsed killing or being responsible for the death of another in a war zone and reported continued distress regarding these events; documented PTSD diagnosis; received prior exposure-based treatment for PTSD; if on a prescribed medication as part of current treatment for PTSD, dosage had to be constant for 1 month before enrollment; if receiving cognitive

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Multiple	processing therapy (CPT) or prolonged exposure (PE), must have completed and waited 2 weeks before enrollment. Exclusion criteria: current or lifetime diagnosis of a psychotic disorder; recent psychiatric hospitalizations; recent suicidal and/or homicidal behaviors; presence of untreated substance dependence
Margolies 2013	Non-trauma-focused CBT: CBT for insomnia (CBT-I)	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Military combat (Veterans from Operation Enduring Freedom (OEF) and Peration Iraqi Freedom (OIF))	40	Age range (mean): 21-54 (37.7) Gender (% female): 10 BME (% non-white): 60 Country: US Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): 65% of participants were receiving some form of treatment for PTSD Single or multiple incident index trauma: Multiple	Inclusion criteria: veteran of either OEF and/or OIF; diagnosis of PTSD as determined by the intake conducted through the PTSD Clinic and/or the Mental Health Service Clinic; current symptoms of sleep disturbance, defined as (1) self-report of at least three episodes of insomnia per week for at least 6 months (an episode is defined as taking at least 30 minutes to fall asleep, being awake for at least 60 minutes after falling asleep, or accumulating less than 6.5 hours of sleep per night) and (2) daytime consequences of insomnia, such as fatigue, irritability, or difficulty concentrating. Exclusion criteria: met criteria for current history (within the last 6 months) of alcohol or substance dependence or abuse; bipolar disorder; any psychotic disorder; severe, untreated major depression; previously diagnosed with sleep apnea that was not treated; diagnosed with a seizure disorder
Markowitz 2015a	Trauma-focused CBT:	PTSD diagnosis according to	Domestic violence - 93% reported interpersonal	110	Age range (mean): NR (40.1)	Inclusion criteria: aged 18-65 years; had a primary DSM-IV diagnosis of chronic PTSD;

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
	Exposure therapy/prolonged exposure (PE)	ICD/DSM criteria (including self-report of diagnosis)	trauma (42% acute; 58% chronic)		Gender (% female): 70 BME (% non-white): 35 Country: US Coexisting conditions: Current major depressive disorder (50%); recurrent major depressive disorder (34%); current generalised anxiety disorder (13%). Any axis II diagnosis (49%): 25% paranoid; 14% narcissistic; 5% borderline; 21% avoidant; 3% dependent; 25% obsessive-compulsive; 25% depressive; 15% passive-aggressive. Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): Mean number of traumas 2.8 (SD=1.8). 36%	CAPS score >50. Exclusion criteria: psychotic disorders; bipolar disorder; an unstable medical condition; substance dependence; active suicidal ideation; antisocial, schizotypal, or schizoid personality disorder; prior nonresponse to >8 weeks of a study therapy; ongoing psychiatric treatment including pharmacotherapy

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					reported trauma in childhood or adolescence Single or multiple incident index trauma: Multiple	
McDonagh 2005	Trauma-focused CBT: Exposure therapy/prolonged exposure (PE)	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Childhood sexual abuse (Childhood sexual abuse characteristics: 23% experienced life threat; 34% injured; 64% penetrated. Perpetrator of worst CSA event: 32% father or stepfather; 35% other male relative; 31% known male; 1% male stranger)	74	Age range (mean): NR (40.4) Gender (% female): 100 BME (% non-white): 7 Country: Coexisting conditions: 11% met criteria for borderline personality disorder Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): Mean number of trauma types 3.3 (SD=1.1). Trauma history: 80% childhood physical abuse; 62% adult physical abuse; 50% adult sexual trauma	Inclusion criteria: Women with histories of childhood sexual abuse (CSA), CSA defined as any sexual contact (including caressing, fondling, or stimulating the genitalia of a child; having the child stimulate the perpetrator's genitalia; and/or oral, anal, or vaginal rape) occurring with anyone 5 or more years older when the study participant was under the age of 16 years; met DSM-IV criteria for PTSD (assessed with SCID and CAPS); at least some of the participants' intrusive and avoidance symptoms of PTSD had to be clearly related to the history of CSA; have at least one clear, detailed memory of the CSA. Exclusion criteria: use of medication with significant autonomic nervous system effects (e.g., clonidine, beta blockers, or calcium-channel blockers); pregnancy; known cardiovascular disease; hypertension severe enough to require medication; current diagnosis of mania, hypomania, schizophrenia, schizoaffective disorder, schizophreniform disorder, brief reactive psychosis, psychotic disorder not otherwise specified, dissociative identity disorder, any organic psychiatric disorder, depression severe enough to require acute psychiatric treatment, bipolar depression, or

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					Single or multiple incident index trauma: Multiple	depression accompanied by delusions, hallucinations, or bizarre behavior; current alcohol or drug abuse; withdrawal from benzodiazepines, alcohol, heroin, or other opiates any time during the 3 months prior to consideration for entry into the study; presence of active suicidality or a history of two or more suicide gestures or attempts in the preceding year; presence of a relationship with an abusive partner
McGovern 2011	Non-trauma-focused CBT: Integrated CBT	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Childhood sexual abuse (68% experienced childhood sexual assault, 18% childhood physical assault, 9% adult sexual assault, 2% adult physical assault and 2% experienced trauma from an accident)	53	Age range (mean): NR (37.7) Gender (% female): 57 BME (% non-white): 9 Country: US Coexisting conditions: 100% had alcohol or drug dependence Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Multiple	Inclusion criteria: aged at least 18 years; actively enrolled in outpatient addiction services and met criteria for any substance use disorder; met criteria for diagnosis of PTSD verified by the Clinician Administered PTSD Scale (CAPS); CAPS score ≥44; medical and legal situations were stable such that ability to participate in the full duration of the study seemed likely. Exclusion criteria: acute psychotic symptoms (persons with a psychotic disorder were eligible if their symptoms were stable and they were receiving appropriate mental health services); psychiatric hospitalization or suicide attempt in the past month, unless the hospitalization or attempt was directly related to substance intoxication or detoxification and the person was currently stable
McGovern 2015	Non-trauma-focused CBT:	Clinically important PTSD	Mixed (Childhood sexual assault and adult physical	146	Age range (mean): NR (35)	Inclusion criteria: newly admitted patients meeting current diagnostic criteria for both

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
	Integrated CBT	symptoms (scoring above a threshold on validated scale)	assault but numbers for each trauma type were not reported)		Gender (% female): 60 BME (% non-white): 5 Country: US Coexisting conditions: Mean number of psychiatric disorders 3.8 (SD=1.7). All participants met criteria for substance use disorder (mean number of substance use disorders 3 [SD=2]): 54% prescription opioids; 48% cocaine; 42% cannabis; 34% heroin; 22% sedatives; 18% amphetamines; 9% hallucinogens; 9% other; 60% alcohol. 58% major depression; 43% generalized anxiety; 30% panic with agoraphobia; 28% social anxiety; 16% panic disorder; 15% OCD; 14%	PTSD and substance use disorder; PCL-C score≥44; intention to enter the intensive outpatient program; no current legal or impending relocation factors that could jeopardize timely protocol completion; informed consent. Exclusion criteria: acute psychotic symptoms; suicide attempt in the past 30 days

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					dysthymia; 13% agoraphobia; 9% bipolar type disorders Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Multiple	
Meshberg-Cohen 2014	Self-help (without support): Expressive writing	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	Unclear	149	Age range (mean): NR (36.3) Gender (% female): 100 BME (% non-white): 75 Country: US Coexisting conditions: All participants in a residential treatment facility for substance use disorder. DSM-IV substance dependence diagnosis (current): Alcohol (29%); Amphetamine/Stimulant (0.7%); Cannabis (10%);	Inclusion criteria: women in residential treatment for substance use disorder, at least 18 years old, meet DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition) criteria for a substance use disorder, have approval for 60 days of residential treatment from a third-party payer to help facilitate presence for the 1-month follow-up. Exclusion criteria: acute mental disorder (eg, current suicidality) that would make it difficult to provide informed consent and/or follow the study protocol, or had literacy problems that would prevent them from being able to complete the writing sessions or the research assessments

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					Cocaine (82%); Hallucinogen (0.7%); Opioid (45%); Sedative (5%); More than one drug (57%) Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): Mean number of different types of trauma events: 3.7 (sd=2.3) Single or multiple incident index trauma: Unclear	
Mills 2012	Trauma-focused CBT: Exposure therapy/prolonged exposure (PE)	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Mixed - Physical assault (93%); threatened or held captive (89%); witnessed death/injury (79%); sexual assault (78%); childhood sexual abuse (55%); accident/disaster (66%); torture (24%); military combat (2%); other (68%)	103	Age range (mean): NR (33.7) Gender (% female): 62 BME (% non-white): NR Country: Australia Coexisting conditions: All participants had a DSM-IV-TR diagnosis of substance dependence (inclusion criterion); participants using a	Inclusion criteria: past-month DSM-IV-TR diagnoses of PTSD and substance dependence; aged at least 18 years or older; fluency in English. Exclusion criteria: currently suicidal (expressed suicidal ideation accompanied by a plan and intent); had a recent history of self-harm (past 6 months); had current active symptoms of psychosis; experienced cognitive impairment severe enough to impede treatment

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					median of 4.0 different drug classes in the preceding month; most commonly reported main drug of concern was heroin (21%), cannabis (19%), amphetamines (18%), benzodiazepines (16%), alcohol (12%), cocaine (7%), other opiates (5%), and hallucinogens (1%). 73% screened positive for borderline personality disorder Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): Trauma types experienced median 6.0 (2-10); 77% experienced trauma during childhood	

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					Single or multiple incident index trauma: Multiple	
Miner 2016	Self-help (without support): Computerised trauma-focused CBT	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	Unclear	49	Age range (mean): NR (45.7) Gender (% female): 82 BME (% non-white): 43 Country: US Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Unclear	Inclusion criteria: at least 18 years old, fluency in English, not currently receiving treatment for PTSD, having an active e-mail address, and scoring≥25 on the PCL-C.
Mitchell 2014/Dick 2014/Reddy 2014	Yoga: Yoga	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	Mixed - Multiple traumatic events, including: childhood physical abuse (47.4%), physical assault by romantic partner (59.5%), sexual abuse before the age of 13 (52.6%), sexual abuse between the ages of 13 and 18 (35.1%), adulthood sexual assault (57.9%),	38	Age range (mean): NR (44.4) Gender (% female): 100 BME (% non-white): 47 Country: US Coexisting conditions: 34% major depression	Inclusion criteria: aged 18–65 years; a positive on the Primary Care PTSD screen (PC-PTSD); reported at least subthreshold PTSD during their diagnostic interview, as indicated by the presence of at least one symptom in each criterion cluster, or meeting criteria for at least two symptom clusters. Exclusion criteria: participation in a yoga class within the past 6 months; substance-dependence problem in the past 3 months; recent change of psychiatric

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
			and the unexpected death of a loved one (86.8%)		Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Multiple	medication; indication of current suicide or homicide risk
Monson 2006	Trauma-focused CBT: Cognitive processing therapy	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Military combat - 83% served in war zone index trauma: 78% combat, 17% sexual and 5% noncombat physical assault. 80% Vietnam War; 7% Post-Vietnam; 10% Gulf War I; 3% Korean War.	60	Age range (mean): NR (54) Gender (% female): 10 BME (% non-white): 7 Country: US Coexisting conditions: 73% current comorbid diagnosis: 55% mood disorder; 48% other anxiety disorder; 2% substance abuse or dependence Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR	Inclusion criteria: met DSM-IV-TR criteria for PTSD due to a military-related stressor; CAPS severity score ≥45. Exclusion criteria: current uncontrolled psychotic or bipolar disorder; substance dependence (those with substance abuse diagnoses were included); prominent current suicidal or homicidal ideation; significant cognitive impairment

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					Single or multiple incident index trauma: Multiple	
Monson 2008/2012	Couple interventions: Cognitive-behavioural conjoint therapy	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Mixed - Adult sexual trauma (20%); child sexual trauma (28%); noncombat physical assault (15%); motor vehicle collision (8%); witnessing/learning about death/illness (13%); combat (5%); other (13%)	40	Age range (mean): NR (37.1) Gender (% female): 75 BME (% non-white): 28 Country: US and Canada Coexisting conditions: 63% any comorbidity, 40% mood disorder, 30% anxiety disorder, 0% substance abuse, 10% 'other'. Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Unclear	Inclusion criteria: heterosexual and same-sex couples where one partner met criteria for PTSD (met the DSM-IV-TR symptom cluster criteria and a total CAPS severity score≥45), and both members of the couple were between 18 and 70 years old. Exclusion criteria: substance dependence that hadn't been in remission for at least 3 months, uncontrolled bipolar or psychotic disorder, acute suicidality or homicidality, severe cognitive impairment, severe IPV within the past year, receiving other couple therapy or individual therapy for PTSD during the study and unstable drug regimen within the 2 months prior to study entry.
Morath 2014	Trauma-focused CBT: Narrative exposure therapy (NET)	PTSD diagnosis according to ICD/DSM criteria (including self-	Witnessing war as a civilian - Refugees with a history of war and torture experiences (38% from Africa; 62% from Middle	34	Age range (mean): 16-47 (28) Gender (% female): 41 BME (% non-white):	Inclusion criteria: Refugees with a history of war and torture experiences; met DSM-IV criteria for PTSD (assessed with CAPS). Exclusion criteria: acute infections; chronic somatic illnesses (e.g., HIV, osteoarthrosis, autoimmune diseases);

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
		report of diagnosis)	East). Mean 9 war/torture events		NR Country: Germany Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): Trauma types experienced mean 7.0 (SD=2.0) Single or multiple incident index trauma: Multiple	glucocorticoid medication; met DSM-IV criteria for comorbid alcohol or substance abuse or dependence; current or past history of a psychosis (according to DSM-IV)
Mueser 2008	Trauma-focused CBT: CBT individual	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Mixed - 34% childhood sexual abuse; 17% childhood physical abuse; 15% sudden unexpected death of a loved one; 13% adult sexual assault; 11% adult physical assault; 4% other traumatic event; 2% sexual and physical assault; 2% witnessing violence; 1% motor vehicle accident; 1% combat	108	Age range (mean): NR (44.2) Gender (% female): 79 BME (% non-white): 16 Country: US Coexisting conditions: All participants met criteria for severe mental illness: 61% major depression; 23% bipolar disorder; 8% schizoaffective disorder; 7% schizophrenia. 25%	Inclusion criteria: aged at least 18 years; designation by the states of New Hampshire or Vermont as having a severe mental illness, defined as a DSM–IV Axis I disorder and persistent impairment in the areas of work, school, or ability to care for oneself; DSM–IV diagnosis of major depression, bipolar disorder, schizoaffective disorder, or schizophrenia; current DSM–IV diagnosis of PTSD; legal ability and willingness to provide informed consent to participate in the study. Exclusion criteria: psychiatric hospitalization or suicide attempt within the past 3 months; current DSM–IV substance dependence

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					borderline personality disorder; 41% substance use disorder Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Multiple	
Nacasch 2011	Trauma-focused CBT: Exposure therapy/prolonged exposure (PE)	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Military combat - Combat (63%); terror (37%)	30	Age range (mean): NR (34.3) Gender (% female): NR BME (% non-white): NR Country: Israel Coexisting conditions: 67% mood disorders; 43% anxiety disorders Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR	Inclusion criteria: diagnosed with PTSD related to combat or terror; traumatic event must have occurred at least 3 months before this diagnosis; PSS-I score ≥25. Exclusion criteria: current active substance dependence; current psychotic symptoms; bipolar disorder; severe dissociative disorder; those deemed to be at high risk for suicidal behaviour (i.e. with intent, plan, or both); had prior treatment with exposure therapy

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					Single or multiple incident index trauma: Multiple	
Nakamura 2017	Non-trauma-focused CBT: Mind-Body Bridging (MBB)	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	Military combat - Gulf War veterans (US military service members with sleep and physical health complaints who were deployed in 1990–1991). Mean months in Persian Gulf War 7.3 (SD=3.8); Mean months of service 7.5 (SD=3.3); Mean years in military 15.1 (SD=8.1)	60	Age range (mean): 39-69 (10) Gender (% female): 10 BME (% non-white): 12 Country: US Coexisting conditions: All paricipants had self-reported sleep disturbance and Gulf War Illness (inclusion criteria) Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Multiple	Inclusion criteria: US military service members who served in the Persian Gulf War from August 1990 to January 1991; self-reported sleep disturbance defined by MOS-Sleep Scale (score ≥35); at least two or more self-reported unrelieved symptoms typical of Gulf War Illness including unexplained fatigue, chronic headaches, joint or muscle pain, cognitive difficulties, memory and concentration problems, shortness of breath, and chronic GI symptoms typical of irritable bowel syndrome. Exclusion criteria: delayed sleep phase syndrome, advanced sleep phase syndrome, or narcolepsy; active suicidal ideation; a highly unstable medical or psychiatric condition (any condition requiring hospitalization imminently or within 3 months before study); Parkinson disease; dementia of any cause; frequent nocturia; severe cognitive difficulties or if they were terminally ill
Neuner 2004	Trauma-focused CBT: Narrative exposure therapy (NET)	PTSD diagnosis according to ICD/DSM criteria (including self-	Witnessing war as a civilian - Most refugees had experienced multiple traumatic events in the Sudanese civil war before they fled to Uganda.	43	Age range (mean): NR (33.2) Gender (% female): 60 BME (% non-white): NR	Inclusion criteria: refugees living in the Imvepi settlement in northern Uganda; met DSM-IV criteria for PTSD. Exclsuion criteria: mental retardation; psychosis

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
		report of diagnosis)	However, northern Uganda was not a safe exile for the refugees as the settlements were threatened and attacked by Sudanese and Ugandan rebel armies. The majority of participants (52%) reported the witnessing of people badly injured or killed as worst event type (which included the killing of relatives as well as massacres and mutilations); further worst event types were threats with weapons and kidnappings (17%), physical attacks (12%), torture (7%), combat experiences (7%), sexual assaults (5%) and natural disasters (2%)		Country: Uganda Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): Mean number of traumatic event types 10.1 (SD=6.5) Single or multiple incident index trauma: Multiple	
Neuner 2008	Trauma-focused CBT: Narrative exposure therapy (NET)	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Witnessing war as a civilian - Rwandan and Somalian refugees settled in a refugee camp in Uganda	277	Age range (mean): NR (35) Gender (% female): 51 BME (% non-white): NR Country: Uganda Coexisting conditions: NR	Inclusion criteria: PTSD diagnosis according to DSM IV, living in two villages closest to the research base in the settlement. Exclusion criteria: drug abuse, mental retardation, psychosis

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): Mean number of trauma event types 14.1 (SD=5.2)Single or multiple incident index trauma: Multiple	
Neuner 2010	Trauma-focused CBT: Narrative exposure therapy (NET)	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Witnessing war as a civilian - Asylum-seekers with a history of victimization by organized violence. The most common traumatic event types reported by the patients were witnessing a violent assault on a familiar person (91%), torture (88%), being in a war zone (72%), and experiencing a violent assault by a stranger (62%). Origin: Turkey (78%); Balkans (13%); Africa (9%)	32	Age range (mean): NR (31.4) Gender (% female): 31 BME (% non-white): NR Country: Germany Coexisting conditions: 19% drug abuse Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Multiple	Inclusion criteria: asylum-seeker status with a temporary leave to remain; a history of victimization by organized violence; met DSM-IV criteria for PTSD. Exclusion criteria: mental retardation; schizophrenia; severe brain lesions requiring immediate treatment
Nijdam 2012	Trauma-focused CBT:	PTSD diagnosis according to	Exposure to non-sexual violence (Physical and	140	Age range (mean): NR (37.8)	Inclusion criteria: aged 18-65 years; met DSM-IV criteria for PTSD diagnosis; experienced a

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
	Brief eclectic psychotherapy	ICD/DSM criteria (including self-report of diagnosis)	sexual abuse occurred repeatedly and/or over a longer period. The most common traumatic event types reported by the women in the both groups were assault by a family member or an acquaintance (82%) and sexual abuse or assault by a family member or an acquaintance (77%))		Gender (% female): 56 BME (% non-white): NR Country: Netherlands Coexisting conditions: 60% major depressive disorder; 16% anxiety disorder other than PTSD Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): 54% had earlier traumatic experiences Single or multiple incident index trauma: Single	single traumatic event (which had stopped at the time of inclusion) that led to the development of PTSD; mastery of the Dutch language. Exclusion criteria: acute suicidality; current severe major depressive disorder or current severe alcohol or substance dependence according to DSM-IV (patients were allowed to enter after initial treatment of these disorders); lifetime psychotic disorder according to DSM-IV; severe personality disorder according to the SCID and DSM-IV
Noohi 2017	Bio-/Neuro-feedback: Neurofeedback	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Military combat (Not reported in details)	30	Age range (mean): 25-60 (NR) Gender (% female): 0 BME (% non-white): NR Country: Iran Coexisting conditions: NR	Inclusion criteria: aged 30-50 years; met DSM-IV criteria for combat-related PTSD (based on psychiatrist's opinion and confirmed with SCID); lived in Kermanshah City; educated up to at least primary school; had sufficient physical and cognitive ability to participate in intervention sessions. Exclusion criteria: psychotic or bipolar disorder; serious limiting physical illness such as cancer or kidney problems

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Multiple	
Pabst 2014	Trauma-focused CBT: Narrative exposure therapy (NET)	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Mixed - Physical and sexual abuse occurred repeatedly and/or over a longer period. The most common traumatic event types reported by the women in the both groups were assault by a family member or an acquaintance (82%) and sexual abuse or assault by a family member or an acquaintance (77%)	22	Age range (mean): 19-54 (29.9) Gender (% female): 100 BME (% non-white): NR Country: Germany Coexisting conditions: All participants met DSM-IV-TR criteria for borderline personality disorder Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): Mean types of trauma 5 Single or multiple incident index trauma: Multiple	Inclusion criteria: females aged at least 18 years; met DSM-IV -TR criteria for both PTSD and borderline personality disorder; stable medication; legal competence; sufficient cognitive function; sufficient knowledge of the German or English language. Exclusion criteria: severe mental disorders (i.e., those with comorbidities such as drug abuse, psychoses); acute consumption of psychoactive substances (other than prescribed for medical purposes); simultaneous participation in other studies; pregnancy or breastfeeding; known severe internal, neurological, musculoskeletal, endocrinological or sleep disorders with organic origin (clinical examination during the screening visit, judged by the investigator); continuing and not interruptible exposure to sexual or physical abuse; acute suicidal behaviour (serious suicide attempts during the last 8 weeks); positive drug-screening in urine toxicology test; BMI<18

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
Pacella 2012	Trauma-focused CBT: Exposure therapy/prolonged exposure (PE)	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	Mixed (100% were living with HIV and 34% reported that their most distressing trauma was related to their HIV diagnosis. 97% reported experiencing both an HIV-and nonHIV-related trauma)	66	Age range (mean): 31-61 (46.4) Gender (% female): 37 BME (% non-white): 61 Country: US Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): Mean 4.91 (SD=1.78) different types of prior trauma Single or multiple incident index trauma: Unclear	Inclusion criteria: met criteria for a likely diagnosis of PTSD as assessed through the self-report PTSD Diagnostic Scale (PDS); were currently taking antiretroviral medications for HIV; fluent in English. Exclusion criteria: diagnosis of a psychotic disorder; current or previous diagnosis of schizophrenia; current suicidal ideation
Paunovic 2011	Trauma-focused CBT: Exposure inhibition therapy	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Unclear - Details of index trauma not reported (only lifetime experience of trauma)	29	Age range (mean): NR (37.2) Gender (% female): 59 BME (% non-white): NR Country: Sweden Coexisting conditions: NR Lifetime experience of trauma (mean number of prior	Inclusion criteria: aged 18-60 years; had experienced an interpersonal traumatic event according to the DSM- IV criteria for PTSD (APA, 1994) at least 12 months prior to screening; met DSM-IV criteria for a primary diagnosis of chronic PTSD; score ≥2 on the CAPS global severity rating scale (0 - 4). Exclusion criteria: organic brain disorder; psychotic disorder; current drug or alcohol abuse; serious suicide risk; currently ongoing psychotherapy

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					traumas/% with previous trauma): Traumatic events experienced, and/or witnessed: Severe assault (62%); rape (38%); childhood traumatic events (28%); manslaughter attempt (21%); assault (17%); sexual assault (14%); witnessed assault (10%); attempted rape(7%); armed robbery (3%); information about a friend's death (3%); rape by a group (3%); witnessed attempted murder (3%); witnessed suicide (3%); witnessed murder (3%); traffic accidents (3%); serious accidents (3%); other fatal accidents (3%); war trauma (3%) Single or multiple incident index trauma: Unclear	

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
Polusny 2015	MBSR: MBSR	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Military combat (74% combat exposure. 75% Vietnam War; 15% Gulf War; 10% OEF/OIF; 1% Other)	116	Age range (mean): NR (58.5) Gender (% female): 16 BME (% non-white): 16 Country: US Coexisting conditions: 42% mood disorder Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): Mean number of lifetime traumatic events 7.7 (SD=3.1). Event type (other than combat exposure): Sexual trauma (28%); Physical assault (66%); Disaster exposure (43%); Serious injury event (64%); Life-threatening illness or injury (58%); Other traumatic event, eg, sudden, unexpected death of someone close (95%)	Inclusion criteria: veterans; met DSM-IV criteria for full or subthreshold PTSD (defined as endorsement of DSM-IV criterion A1 and at least 1 symptom each from criteria B, C, and D with significant impairment); agreement to not receive other psychotherapy for PTSD during study. Exclusion criteria: current substance dependence (except nicotine or caffeine); current psychotic disorder (eg, schizophrenia, bipolar disorder); prominent current suicidal or homicidal ideation; cognitive impairment or medical illness that could interfere with treatment

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					Single or multiple incident index trauma: Multiple	
Popiel 2015	Trauma-focused CBT: Exposure therapy/prolonged exposure (PE)	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Motor Vehicle Collisions - Status during MVC: Driver (38%); Passenger (30%); Cyclist (5%); Pedestrian (14%); Found out about death (7%); Other (5%). Patient considered MVA perpetrator (11%)	228	Age range (mean): NR (37.7) Gender (% female): NR BME (% non-white): NR Country: Poland Coexisting conditions: 49% Comorbid Axis I disorder; 41% Comorbid personality disorder; 21% traumatic brain injury in MVA; 39% had no comorbid mental disorders; 48% still had ongoing medical sequelae (including chronic pain) related to the accident Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): Number of previous traumatic events (before current	Inclusion criteria: adult survivors of mototr vehicle accidents (MVAs); met DSM IV-TR criteria for PTSD. Exclusion criteria: life threats attributable to the study procedures (elevated suicide risk, unstable medical condition with contraindications for SSRI, pregnancy); coexisting medical conditions requiring psychotropic medication other than the study medication; a lack of commitment to maintaining the study regime (refusal of: random allocation; terminating existing treatments before beginning the treatment within the study; participation in weekly therapy sessions); previous treatment for PTSD with paroxetine or PE

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					MVA): 2.1 (sd=1.3). 5% childhood trauma Single or multiple incident index trauma: Single	
Possemato 2016	MBSR: MBSR	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	Military combat - '42% Iraq or Afghanistan War Veterans; 32% Vietnam War Veterans; 13% Gulf War I Veterans; 16% deployed to other conflicts	62	Age range (mean): 21-71 (46.4) Gender (% female): 13 BME (% non-white): 18 Country: US Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Multiple	Inclusion criteria: subthreshold or diagnostic-level PTSD related to military service as determined by the CAPS. Exclusion criteria: gross cognitive impairment, as assessed by a score ≥ 16 on the Blessed Orientation Memory and Concentration test; moderate to severe traumatic brain injury, as determined by review of the patient medical record; suicide attempt or intent to commit suicide in the last 2 months, as assessed by the Columbia Suicide Severity Rating Scale; receipt of mental healthcare (psychotherapy or medication) outside VA PC in the last 2 months; interest in enrolling in PTSD specialty care
Power 2002	Trauma-focused CBT: CBT individual	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Mixed - Motor vehicle collision (31%; 24% passenger, 7% pedestrian); occupational accident (22%); physical assault (18%); sexual assault (4%); traumatic death (4%); real/implied	105	Age range (mean): NR (39.2) Gender (% female): 42 BME (% non-white): NR Country: UK	Inclusion criteria: aged 18-65 years; met DSM-IV criteria for PTSD; if on medication, had been on a stable dose for at least 6 weeks, and were required to remain so for the duration of the trial. Exclusion criteria: concurrent severe depressive illness; past or present psychotic illness; history of alcoholism or drug abuse within the last 6 months as defined by DSM IV; suicidal ideation

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
			physical threat (13%); other (7%)		Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Single	or intent as assessed at clinical interview; physical illness of clinical significance; psychotherapy commitments outside the study
Rauch 2015	Trauma-focused CBT: Exposure therapy/prolonged exposure (PE)	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	Military combat (86% Iraq deployment; 22% Afghanistan)	36	Age range (mean): NR (31.9) Gender (% female): 8 BME (% non-white): Country: US Coexisting conditions: 47% major depressive episode; 14% panic disorder; 8% agoraphobia; 8% social phobia; 6% alcohol abuse; 6% generalized anxiety disorder Lifetime experience of trauma (mean number of prior traumas/% with	Inclusion criteria: military veterans; significant PTSD symptoms (defined as CAPS score ≥50); reported impairment of at least 3 months duration. Exclusion criteria: level of self-harm risk that requires immediate, focused intervention; unmanaged psychosis or bipolar disorder; alcohol or substance dependence in the past 3 months; working night-shifts; changes to psychoactive medications in the past 4 weeks; taking medication that makes HPA axis measures difficult to interpret

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					previous trauma): NR Single or multiple incident index trauma: Multiple	
Resick 2002	Trauma-focused CBT: CBT individual	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Exposure to sexual abuse or assault (Women who had experienced a discrete incident of completed rape (oral, anal or vaginal) in childhood (41%) or adulthood)	181	Age range (mean): NR (32) Gender (% female): 100 BME (% non-white): 29 Country: US Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): Mean 6.4 adult crime incidents (SD=4.9) in addition to the index rape. 86% had experienced at least one other major crime victimization in addition to the index rape: 48% had at least one additional rape; 14% serious physical assaults; 54% physical	Inclusion criteria: women who had experienced a discrete incident of completed rape (oral, anal, or vaginal) in childhood or adulthood; at least 3 months posttrauma (no upper limit). Exclusion criteria: current psychosis; developmental disabilities; suicidal intent; current parasuicidal behavior; current dependence on drugs or alcohol (within prior 6 months); illiteracy; currently in an abusive relationship or being stalked; in the case of marital rape, the participant had not been out of the relationship for at least 6 months

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					assaults with minor injuries; 22% kidnapped as part of a crime; 18% robbery victims; 36% attempted rapes; 26% criminal or vehicular homicide involving a friend or family member; 14% victim of attempted murder Single or multiple incident index trauma: Single	
Robson 2016	Combined somatic and cognitive therapies: Thought field therapy (TFT)	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	Witnessing war as a civilian (Western Uganda, where there had been intermittent conflict since Uganda gained independence in 1963)	256	Age range (mean): NR (44.7) Gender (% female): 85 BME (% non-white): NR Country: Uganda Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR	Inclusion criteria: aged at least 18 years; presenting with 'symptoms suggestive of PTSD'. Exclusion criteria: None

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					Single or multiple incident index trauma: Multiple	
Rosenbaum 2011/2015	Exercise: Aerobic (supervised)	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Unclear (88% had experienced the PTSD-related traumatic event during the course of their occupation)	81	Age range (mean): 23-73(47.8) Gender (% female): 16 BME (% non-white): NR Country: Australia Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Multiple	Inclusion criteria: men and women aged over 18 years; psychiatrist-confirmed DSM-IV-TR diagnosis of primary PTSD; medical clearance to participate in an exercise programme; cognitively able to provide consent to participate. Exclusion criteria: medically unfit to participate in an exercise programme (for example recent acute cardiac event, unstable angina, acute embolus or infarction, or acute systematic infection); pregnant or planning pregnancy in the proceeding 12 months; complex PTSD with trauma occurring in childhood only
Rothbaum 2005	Trauma-focused CBT: Exposure therapy/prolonged exposure (PE)	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Exposure to sexual abuse or assault - Rape in adulthood (12 or older) or a single incident of rape in childhood by either a family member or non-family member. Index assault experiences lasted an average of 88 min (SD = 144.63) and were perpetrated by one to	74	Age range (mean): NR (33.8) Gender (% female): 100 BME (% non-white): 32 Country: US Coexisting conditions: 40% had one comorbid diagnosis, 25% had	Inclusion criteria: female victims of a rape (defined as any form of unwanted genital penetration including vaginal, anal, oral, and digital penetration) at least 3 months prior to study entry; the index event must have been a rape in adulthood (i.e., age 12 or older) or a single incident of rape in childhood (ages 0–11) by either a family or a nonfamily member. Exclusion criteria: a history of schizophrenia or other psychoses; current suicidal risk or practiced self-mutilation; illiterate and thus

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
			three assailants, with the majority (90%) perpetrated by one assailant. Most assaults occurred in the residence of the victim (28%) or the perpetrator (22%), but also were perpetrated in other residences (7%), abandoned buildings (3%), vehicles (12%), outdoors (18%), or other settings (12%). The majority of assaults (43%) were perpetrated by friends, relatives, dates, and significant others; 33% by strangers; and 23% by acquaintances		two or more diagnoses in addition to PTSD Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): Including the index assault, participants experienced a mean of 6.0 traumas (SD = 4.1) prior to study entry Single or multiple incident index trauma: Single	unable to complete self-reports; met DSM-IV criteria for current alcohol or drug dependence as determined by the SCID; blind or had a history of serious eye disease (e.g., detached retina) that would cause risk with rapid eye movement; use of cocaine in any form within 60 days of treatment administration; or in an ongoing threatening situation (e.g., domestic violence)
Rothbaum 2006	Trauma-focused CBT (combined): Exposure therapy/prolonged exposure (PE) (+ sertraline)	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Mixed - Sexual assault (37%); non-sexual assaul (25%); death of another (22%); motor vehicle accident (9%); other (8%)	65	Age range (mean): NR (39.3) Gender (% female): 65 BME (% non-white): 20 Country: US Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with	Inclusion criteria for open-label treatment phase: aged at least 18 years; in general good health; met DSM-IV criteria for primary psychiatric diagnosis of chronic PTSD (minimum duration of 3 months) as determined by administration of the SCID. Inclusion criteria for open-label augmentation: partial responders (≥20% iimprovement in PTSD severity score) to 10-week open-label sertraline. Exclusion criteria: history of a psychotic or bipolar disorder; prior failure of an adequate trial of sertraline for PTSD; current administration of psychiatric medication; any medical contraindication to taking sertraline

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					previous trauma): NR Single or multiple incident index trauma: Single	
Ruglass 2017/Hien 2011	Trauma-focused CBT: Exposure therapy/prolonged exposure (PE)	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	Mixed - 70% multiple trauma: Physical assault (59%); sexual assault (38%); sudden injury or death of other (42%); accident or disaster (8%); other (10%)	110	Age range (mean): NR (44.6) Gender (% female): 36 BME (% non-white): 82 Country: US Coexisting conditions: 77% alcohol dependent, 66% drug dependent, 45% alcohol and drug dependent. Primary substance: alcohol (45%); cannabis (8%); cocaine (16%); alcohol and stimulants (25%); other polysubstance (6%). 37% anxiety, 28% major depressive disorder Lifetime experience of trauma (mean number of prior traumas/% with	Inclusion criteria: met DSM-IV-TR criteria for full PTSD, or subthreshold PTSD defined as meeting criterion A, B, either C or D, and E and F; met DSM-IV-TR criteria for either past or current alcohol or substance dependence and alcohol/substance use in the prior 90 days. Exclusion criteria: psychotic, schizoaffective or bipolar disorder; current severe depression (indicated by Beck Depression Inventory score ≥ 30) or suicide risk; currently in an abusive relationship; concurrent participation in PTSD-specific treatment; start or regimen change of any psychotropic medication 8 weeks before study participation; organic mental syndrome

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					previous trauma): NR Single or multiple incident index trauma: Multiple	
Sahler 2013	Problem solving: Problem-solving skills training	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	Family member or carer of person with life-threatening illness or injury (Parent of child newly diagnosed with cancer)	309	Age range (mean): NR (37.3) Gender (% female): 100 BME (% non-white): 43 Country: US Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Single	Inclusions: mothers whose child had been diagnosed with cancer at one of four sites 2-16 weeks earlier, able to speak and read English/Spanish and living within 50 miles of the center. Exclusions: child in medical crisis (as determined by the oncologist)
Sannibale 2013	Trauma-focused CBT: Exposure therapy/prolonged exposure (PE)	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Mixed - Violent crime (31%); child physical/sexual abuse (23%); witnessed injury/killing/mutilation (15%); news of someone close (11%); adult abusive relationship (7%); accident/fire/explosion	62	Age range (mean): NR (41.2) Gender (% female): 53 BME (% non-white): NR Country: Australia Coexisting conditions: 100%	Inclusion criteria: aged at least 18 years; consumed alcohol at hazardous levels (men ≥29 and women ≥15, 10-g ethanol drinks per week); met DSM-IV criteria for PTSD (assessed with CAPS); met DSM-IV criteria for alcohol use disorder (AUD; assessed with SCID). Exclusion criteria: current psychosis; severe suicide risk; significant cognitive impairment; limited English comprehension; severe substance dependence

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
			(7%); danger of losing life/other (8%)		met DSM-IV criteria for alcohol use disorder (AUD). 95% alcohol dependent, 15% had other substance dependency Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Single	
Sautter 2015	Couple interventions: Cognitive-behavioural conjoint therapy	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Military combat - Veterans of Operation Iraqi Freedom (OIF)/Operation Enduring Freedom (OEF)	57	Age range (mean): NR (33.1) Gender (% female): 2 BME (% non-white): 34 Country: US Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR	Inclusion criteria: veterans of Operation Iraqi Freedom (OIF)/Operation Enduring Freedom (OEF), who met Diagnostic and Statistical Manual of Mental Disorders (fourth edition, text revision; DSM–IV–TR) criteria for PTSD, and who had been cohabiting with an opposite-sex intimate partner for at least 6 consecutive months. Exclusion criteria for both partners included: physical aggression with injury to a partner during domestic violence as measured on the Physical Assault subscale of the Revised Conflict Tactic Scales), active substance dependence within the past 3months, current psychotic symptoms, imminent suicidality, and/orhomicidal behavior. Partners with a current diagnosis of PTSD were also excluded. Veterans were asked to not participate in

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					Single or multiple incident index trauma: Multiple	concurrent evidence based PTSD treatments, and couples were asked to refrain from participating in other concurrent couple therapies while in the trial. If prescribed psychotropic medications, then veterans were asked to communicate with their prescribing physicians the importance of maintaining a stable regimen during their study participation, to alert study staff to medication changes while in the study, and to avoid major changes in medication
Scheck 1998	EMDR: EMDR	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	Mixed - 90% childhood physical/emotional abuse, >50% traumatic sexual experiences, such as rape or child molestation	67	Age range (mean):16-25 (20.9) Gender (% female): 100 BME (% non-white): 38 Country: US Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Multiple	Inclusions: female gender, aged under 25 years, a recent history of at least two of eight dysfunctional behaviors assessed (arrests, sexual promiscuity, runaway behavior, and drug and alcohol abuse), and a self-reported traumatic memory. Exclusions: medical problems or conditions (heart problems, history of convulsions, pregnancy) or severe dissociation (as judged by the principal investigator)
Schnurr 2003	Trauma-focused CBT: CBT group	PTSD diagnosis according to ICD/DSM	Military combat (Vietnam veterans)	360	Age range (mean): NR (50.7)	Inclusion criteria: Male Vietnam vetrans with combat-related PTSD. Exclusion criteria: Current or lifetime DSM-IV psychotic disorder,

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
		criteria (including self-report of diagnosis)			Gender (% female): 0 BME (% non-white): 34 Country: US Coexisting conditions: 67% had any current psychiatric disorder: 56% had mood disorder; 32% anxiety disorder; 5% substance abuse Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Multiple	mania, or bipolar disorder; current major depression with psychotic features; current alcohol or drug dependency; unwillingness to refrain from substance abuse at treatment or work; significant cognitive impairment; severe cardiovascular disorder
Schnurr 2007/Haug 2004	Trauma-focused CBT: Exposure therapy/prolonged exposure (PE)	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Exposure to sexual abuse or assault - The type most commonly identified as the worst, or index, event was sexual trauma (68%), followed by physical assault (16%) and war-zone exposure (6%)	284	Age range (mean): NR (44.8) Gender (% female): 100 BME (% non-white): 45 Country: US Coexisting conditions: 78% any current comorbid psychiatric disorder:	Inclusion criteria: Female veterans; met DSM-IV criteria for PTSD; symptom severity score ≥45 on the CAPS; at least 3 months since experiencing the trauma; a clear memory of the trauma that caused PTSD; agreement to not receive other psychotherapy for PTSD during study treatment. Exclusion criteria: substance dependence not in remission for at least 3 months; current psychotic symptoms, mania, or bipolar disorder; prominent current suicidal or homicidal ideation; cognitive impairment

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					64% mood disorder; 48% anxiety disorder; 2% substance abuse Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): Lifetime trauma exposure mean event types 9.7: any sexual trauma (92%); military sexual trauma (73%); physical assault (88%); combat exposure (25%); disaster exposure (72%); serious accident (82%); life-threatening illness or injury (43%); other traumatic event (89%) Single or multiple incident index trauma: Multiple	indicated by chart diagnosis or observable cognitive difficulties; current involvement in a violent relationship (defined as more than casual contact; eg, dating or living with an abusive partner); or self-mutilation within the past 6 months
Schoorl 2013	ABM: ABM	PTSD diagnosis according to ICD/DSM criteria	Unclear	102	Age range (mean): NR (37.1) Gender (% female): 75	Inclusions: diagnosis of chronic PTSD (duration at least 3 months). Exclusions: a psychotic disorder (lifetime); alcohol or drug dependency (current); deficits in motor skills prohibiting the

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
		(including self-report of diagnosis)			BME (% non-white): NR Country: Netherlands Coexisting conditions: 2.7 additional diagnoses per patient. Depression: 70%, Dysthymia: 13%, Panic: 33%, Social anxiety: 36%, GAD: 38%, OCD: 16%, Somatization: 8% Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): 93% 2+ traumas. Most of the patients had experienced multiple traumas (93.1%). More than half (56.9%) of the patients had been traumatized in childhood and 40.6% had experienced both childhood trauma and more recent trauma	use of a computer keyboard, and color blindness; inability to complete the measurements in Dutch or English

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					Single or multiple incident index trauma: Multiple	
Sijbrandij 2007	Trauma-focused CBT: Brief individual CBT	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Mixed - Assault (66%); accidental injury (13%); sexual assault (6%); sudden death of a loved one (5%); witnessing assault (2%); other (7%)	143	Age range (mean): NR (37.6) Gender (% female): 60 BME (% non-white): NR Country: Netherlands Coexisting conditions: 44% major depression; 11% anxiety disorder other than PTSD Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): 59% prior trauma Single or multiple incident index trauma: Single	Inclusion: aged at least 18 years; met DSM-IV criteria for acute PTSD according to DSM-IV, ignoring the time criterion of duration of symptoms for at least 1 month; traumatic event occurred between 2 weeks and 3 months before inclusion; traumatic event is finished at the time of inclusion; proficient in Dutch. Exclusion criteria: suicidal ideation; fulfilling DSM-IV criteria for a psychotic disorder, organic disorder, substance abuse, or chronic PTSD
Sloan 2004	Self-help (without support): Expressive writing	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	Mixed - The types of traumatic events endorsed by the participants included rape, witness to murder, physical assault by stranger, life-	51	Age range (mean): NR (18.9) Gender (% female): 100 BME (% non-white): 51	Inclusion criteria: Women who reported that they had experienced one or more traumatic stressors (checklist drawn from the Posttraumatic Stress Diagnostic Scale [PDS]) and who showed at least moderate levels of PTSD symptom severity (i.e., greater than 10 on

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
			threatening car accident, and childhood sexual assault by family member		Country: US Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): 63% reported experiencing more than one traumatic event Single or multiple incident index trauma: Unclear	the PDS). Exclusion criteria: currently in psychotherapy or currently taking psychotropic medication (determined with the demographic questionnaire completed at the first session)
Sloan 2007	Self-help (without support): Expressive writing	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	Mixed - The most frequently reported traumatic events were sexual assault (65%), physical assault by stranger (48%), motor vehicle accident (43%), and witness to murder (15%)	85	Age range (mean): NR (18.7) Gender (% female): 80 BME (% non-white): 41 Country: US Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): 68% reported experiencing more	Inclusion criteria: individuals had to report a trauma history (occurring more than 3 months prior) and subsequent posttraumatic stress symptoms of at least moderate severity as defined by the PDS manual (e.g., scores of 10 or higher). Exclusion criteria: currently being in psychotherapy or the current use of psychotropic medication

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					than one traumatic event Single or multiple incident index trauma: Unclear	
Sloan 2011	Self-help (without support): Expressive writing	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Mixed - Index traumatic events included sexual assault (40%), physical assault by stranger (31%), motor vehicle accident (14%), witness to a murder (7%) and warzone experience (7%)	57	Age range (mean): NR (18.9) Gender (% female): NR BME (% non-white): 43 Country: US Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Single	Inclusion criteria: undergraduate students at a large, urban university who reported a PTSD criterion A (DSM-IV, APA, 1994) trauma event (occurring more than 3 months prior), related posttraumatic stress symptoms of at least moderate symptom severity as defined by the PDS manual, and met diagnostic criteria for PTSD
Sloan 2012	Self-help (without support): Expressive writing	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Motor Vehicle Collisions (Not reported in details)	46	Age range (mean): NR (40.7) Gender (% female): 65 BME (% non-white): 63 Country: US Coexisting conditions: 25%	Inclusion criteria: adults with a primary diagnosis of PTSD related to a MVA that occurred at least 3 months prior to the initial evaluation. Exclusion criteria: current diagnosis of organic mental disorder, schizophrenia, psychotic disorder, unmedicated and symptomatic bipolar disorder, substance dependence, illiteracy in English, those at high risk for suicidal behavior or with a history of two or more suicide gestures or

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					major depressive episode, 10% alcohol abuse Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): Median=10.0 events that met DSM-IV PTSD Criterion A for a traumatic stressor. Approximately 85% of the sample reported a history of physical assault and approximately 60% reported a history of sexual assault Single or multiple incident index trauma: Single	attempts in the preceding year, participants taking psychiatric medication that have not been on a stable dose for at least three months prior to study entry or plan to change the regimen during treatment, participants currently receiving psychotherapy
Sloan 2016a/2018	Trauma-focused CBT: Cognitive processing therapy	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Mixed - Adult non-sexual assault (19%); child sexual assault (16%); adult sexual assault (15%); combat related (13%); sudden death (noncombat) or violence to a friend or loved one (10%); child non-sexual assault (9%); motor vehicle accident	126	Age range (mean): NR (43.9) Gender (% female): 48 BME (% non-white): 45 Country: US Coexisting conditions: NR Lifetime experience of trauma (mean	Inclusion criteria: aged at least 18 years or older; met DSM-5 criteria for PTSD. Exclusion criteria: current high risk for suicide; active psychosis or mania; severe cognitive impairment; current diagnosis of substance dependence; concurrent psychosocial treatment for PTSD

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
			(8%); injury from other accidental causes (10%)		number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Single	
Sloan 2016b/unpublished	Trauma-focused CBT: CBT group	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Military combat - Combat (70%); accident (9%); death/trauma of a loved one/friend (7%); adult sexual assault (3%); adult non-sexual assaut (4%); childhood non-sexual assalut (4%); childhood sexual assault (1%); other (4%)	198	Age range (mean): NR (55.8) Gender (% female): 0 BME (% non-white): 26 Country: US Coexisting conditions: 55% major depressive disorder, 21% generalized anxiety disorder, 12% panic disorder, 9% binge eating disorder, 7% social anxiety disorder, 5% specific phobia, 3% obsessive compulsive disorder, 3% cannabis abuse, 1% alcohol abuse Lifetime experience of trauma (mean number of prior traumas/% with	Inclusion criteria: male veterans; met DSM-5 criteria for current PTSD (assessed with CAPS-5). Exclusion criteria: significant cognitive impairment; active psychosis/psychotic disorder; high risk for suicide; current substance dependence; currently engaged in psychotherapy for PTSD

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					previous trauma): NR Single or multiple incident index trauma: Multiple	
Spence 2011	Self-help (without support): Computerised trauma-focused CBT	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Mixed - Trauma types reported to have been experienced personally or witnessed by more than 50% of the treatment group: physical assault (74%), other unwanted sexual experience (70%), sexual assault (57%), transportation accidents (52%), and other stressful experiences (52%)	44	Age range (mean): 21-68 (42.6) Gender (% female): 81 BME (% non-white): NR Country: Australia Coexisting conditions: 57% reported taking medication for anxiety or depression at baseline Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): Mean number of traumatic events: 6.3. Most participants had experienced multiple types of trauma	Inclusion criteria: resident of Australia; at least 18 years of age; had access to a computer, the Internet, and use of a printer; met DSM-IV diagnostic criteria for a principal diagnosis (defined as the disorder the participant nominated as their most troubling disorder) of PTSD determined via a telephone-administered diagnostic interview (Mini International Neuropsychiatric Interview Version 5.0.0; MINI). Exclusion criteria: currently participating in CBT; currently experiencing a psychotic mental illness, severe symptoms of depression (defined as a total score >22 or responding >2 to Question 9 (suicidal ideation) on the Patient Health Questionnaire-9 Item (PHQ-9), or highly dissociative (defined as a total score above 40 on the Dissociative Experiences Scale (DES); taking medication and not been taking the same dose for at least 1 month or intended to change that dose during the course of the program

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					Single or multiple incident index trauma: Multiple	
Steinert 2017	Psychodynamic therapies: Resource activation	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Mixed - Domestic violence (23%), sexual abuse (15%), traffic accident (24%), other serious accident, e.g. stepping on a mine (7%), witnessing death of someone close (12%), assault (10%), 'other' such as combat or trafficking (10%)	86	Age range (mean): NR (27.5) Gender (% female): 61 BME (% non-white): NR Country: Cambodia Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Single	Inclusion critera: adults aged 18 or over seeking help from one of the professionals of the 'Mekong Project', who had a PCL-C score ≥44. Exclusion criteria: psychosis, organic brain disorder, cognitive impairment, dementia, acute suicidality, acute need for treatment, and severe impairment, ongoing therapy or therapy within the last 2 years and severe communication difficulties.
Stenmark 2013	Trauma-focused CBT: Narrative exposure therapy (NET)	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Witnessing war as a civilian - Refugees and asylum seekers. Region of origin: Afghanistan (15%); Iraq (27%); Middle East (remaining countries; 16%); Africa (26%); Other (15%)	81	Age range (mean): NR (35) Gender (% female): 31 BME (% non-white): NR Country: Norway Coexisting conditions: 40% with current major depressive episode	Inclusion criteria: Refugees and asylum seekers aged over 18 years; met DSM-IV criteria for PTSD. Exclusion criteria: psychotic disorders; current severe substance abuse; severe suicidal ideations

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): Mean number of traumatic event types: 8.2 (2.5) Single or multiple incident index trauma: Multiple	
Suris 2013	Trauma-focused CBT: Cognitive processing therapy	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Exposure to sexual abuse or assault (Participants were veterans who had PTSD related to military sexual assault)	129	Age range (mean): NR (46.1) Gender (% female): 85 BME (% non-white): 56 Country: US Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Unclear	Inclusion criteria: veterans with a current diagnosis of PTSD related to military sexual trauma (MST); the MST event occurred ≥3 months prior to study entry; MST was the veteran's lifetime trauma associated with the most severe current distress; the veteran had more than one clear memory of the trauma; any psychiatric medication regimen was stable for ≥6 weeks. Exclusion criteria: active substance dependence within the last 3 months; current psychotic symptoms; current unstable bipolar disorder; current prominent suicidal or homicidal intent; severe cognitive impairment; currently receiving other psychotherapy specifically for PTSD; current involvement in a violent relationship
Talbot 2014	Non-trauma-focused CBT: CBT for	PTSD diagnosis according to ICD/DSM	Unclear	45	Age range (mean): 22-59 (37.2)	Inclusions: aged 18-65 years, had chronic PTSD of at least 3 months duration based on DSM-IV diagnostic criteria or partial PTSD,

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
	insomnia (CBT-I)	criteria (including self-report of diagnosis)			Gender (% female): 69 BME (% non-white): 29 Country: US Coexisting conditions: 20% had comorbid depression and 51% had another psychiatric comorbidity. The mean (SD) number of comorbidities was 1.09 (0.19) Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Unclear	were currently in treatment for PTSD that could include medication therapy or enrollment in a specialized PTSD program or individual psychotherapy with a licensed clinician and had been in one of more of these treatments for at least 3 months; medication must have been stable for at least 1 month prior to baseline assessments and participants in psychotherapy needed to have no plans to discontinue psychotherapy or start new psychotherapy during the course of CBT-I, had persistent insomnia as defined by meeting research diagnostic criteria (RDC) for insomnia. Exclusions: presence of conditions or substances associated with comorbid insomnia independent to PTSD, including lifetime history of any psychiatric disorder with psychotic features and bipolar disorder and alcohol or substance abuse or dependence in the past year; current exposure to a recurrent trauma or exposure to a traumatic event within the past 3 months; pregnancy; diagnosis of sleep apnea, neurologic disorder, systemic illness affecting central nervous system function, and/or anemia; prominent suicidal or homicidal ideation; reports that insomnia began or worsened after starting selective serotonin reuptake inhibitor therapy; history of sleep restriction therapy or cognitive restructuring therapies of beliefs related to sleep; current prescriptions for benzodiazepine or benzodiazepine receptor agonists, opiates, or trazodone, or the use of over-the-counter sleep aids; termination of benzodiazepine or

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
						benzodiazepine receptor agonists, anticonvulsants, atypical antipsychotic medication, antidepressant medications in the past 2 weeks or plans to start these medications during the course of CBT-I; night shift work, in order to avoid the effect of circadian factors on evaluating insomnia; unstable housing; and nonclinically significant or sub-threshold insomnia, as indicated by a score of 0-14 on the Insomnia Severity Index (ISI)
Tan 2011	Bio-/Neuro-feedback: Biofeedback	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Military combat - 65% OEF/OIF veterans; 35% Vietnam veterans	20	Age range (mean): 24-62 (40.7) Gender (% female): 0 BME (% non-white): 72 Country: US Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Multiple	Inclusion criteria: a diagnosis of combat-related PTSD; agreement to adhere to protocol requirements. Exclusion criteria: presence of severe psychopathology that would preclude adherence to protocol procedures (e.g., actively psychotic, active substance abuse); significant cognitive deficits (i.e., Mini Mental State Examination score<17 or equivalent); previous participation in another study involving heart rate variability
Taylor 2003	Trauma-focused CBT: Exposure therapy/prolon	PTSD diagnosis according to ICD/DSM criteria	Mixed - The most common forms of traumatic event reported were sexual assault (45%),	60	Age range (mean): NR (37) Gender (% female): 75	Inclusion criteria: DSM–IV–TR diagnosis of PTSD as the primary (most severe) presenting problem; aged over 18 years and ability to provide written informed consent; willingness to

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
	ged exposure (PE)	(including self-report of diagnosis)	transportation accidents (43%), physical assault (43%), and being exposed to a sudden death (e.g., witnessing a homicide, 22%)		BME (% non-white): 23 Country: Canada Coexisting conditions: 42% major depression, 31% panic disorder, 12% social anxiety disorder Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): Most participants (65%) had experienced more than one type of traumatic event Single or multiple incident index trauma: Unclear	suspend any concomitant psychological treatment and to keep doses of any psychotropic medication constant throughout the course of the study. Exclusion criteria: mental retardation; current psychotic disorder; commencement or change in dose of psychotropic medication within the past 3 months
Ter Heide 2016	EMDR: EMDR	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Witnessing war as a civilian - Refugee sample, with most frequently reported traumatic events being close to death (83%), murder of family or friend (75%) and threatened with torture (72%)	74	Age range (mean): NR (41.5) Gender (% female): 28 BME (% non-white): NR Country: Netherlands Coexisting conditions: 74% comorbid depression	Inclusions: applied for treatment at Centrum '45, were at least 18 years of age, met the criteria for a PTSD diagnosis according to the DSM-IV-TR, and asked for individual therapy to diminish their PTSD symptoms, and were a refugee (had at some point claimed asylum in The Netherlands – irrespective of whether their claim had been met or rejected or was still under consideration). Exclusions: disorders that acutely threatened their mental or physical health (i.e. depression with high suicidal intent or psychotic features,

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): Mean number of types of traumatic events: 13.8 (sd=5.5) Single or multiple incident index trauma: Multiple	psychotic disorder, bipolar disorder and severe self-harm or eating disorders) or that interfered with their ability to participate (i.e. alcohol or substance dependence and cognitive disorders), receiving any other psychotherapeutic treatment during the study, and receiving psychotropic medication if not kept stable from 2 months before treatment until the post-treatment assessment
Truijens 2014	Self-help (without support): Expressive writing	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	Mixed - Traumatic events reported by the participants included having experienced or witnessed an accident (16.4%); physical, mental, or sexual abuse (34.5%); severe illness or death of a loved one (34.5%); and natural disaster or war (14.6%)	64	Age range (mean): NR (23.7) Gender (% female): 82 BME (% non-white): NR Country: Netherlands Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Single	Inclusion criteria: clinically elevated levels of posttraumatic stress, as evidenced by a score of 19 or higher on the Impact of Events Scale; sufficient fluency in Dutch to complete the study procedures; aged 18 years or older; willingness to provide written informed consent. Exclusion criteria: psychotic symptoms; suicidal ideation

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
van Dam 2013	Self-help with support: Structured writing therapy (SWT)	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	Unclear	36	Age range (mean): NR (42.3) Gender (% female): 32 BME (% non-white): NR Country: Netherlands Coexisting conditions: 88% Substance Dependence; 3% Substance Abuse. Primary SUD diagnosis: Alcohol, not in remission (44%); Drugs, not in remission (44%); Cannabis (12%); Cocaine (29%); Other (3%). 32% Depressive disorder; 9% Panic disorder; 6% Panic disorder with agoraphobia; 12% Social Phobia; 6% Specific phobia; 3% General anxiety disorder Lifetime experience of trauma (mean number of prior traumas/% with	Inclusion criteria: aged at least 18 years; met DSM-IV criteria for substance abuse or substance dependence; met DSM-IV criteria for full or partial PTSD (partial PTSD was defined as meeting symptom criteria for the reexperiencing cluster and for either the avoidance/numbing cluster or the hyperarousal cluster); already been allocated to ≥2 substance use disorder (SUD) therapies in the past 5 years; allocated to intensive SUD group treatment either as day treatment or as inpatient; sufficient understanding of the Dutch or English language. Exclusion criteria: diagnosis of Borderline Personality Disorder; other severe (psychiatric) problems that required immediate clinical care (e.g., psychotic symptoms, manic episode, current suicidal ideation, severe domestic violence); severe cognitive disorders; receiving concurrent psychotherapy for any kind of psychological disorder

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					previous trauma): NR Single or multiple incident index trauma: Unclear	
van der Kolk 2007	EMDR: EMDR	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Mixed - 28% child sexual abuse; 5% child physical abuse; 9% child sexual and physical abuse; 9% adult sexual assault; 6% adult physical assault; 8% domestic violence; 7% other adult victimization; 9% traumatic loss; 3% war/terrorism/violence; 16% injury/accident	88	Age range (mean): NR (36.1) Gender (% female): 83 BME (% non-white): 33 Country: US Coexisting conditions: Mean 3.2 comorbid Axis I/II diagnoses Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Multiple	Inclusions: aged 18-65 years with current PTSD and mixed trauma exposure at least 1 year prior to intake. Exclusions: unstable medical condition, contraindications to treatment (i..e pregnancy, glaucoma or detached retine, or history of severe allergies or multiple adverse drug reactions), inability to be weaned off current psychotropic medications, psychotic or bipolar disorder, current alcohol or substance abuse/dependence, sever dissociation, active suicidality or life threatening mutilation, prior exposure to active study interventions, concurrent trauma focussed treatment, unstable living situation, GAF score <40 and disability compensation for PTSD or pending trauma-related lawsuit.
van der Kolk 2014	Yoga: Yoga	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Unclear	76	Age range (mean): NR (42.9) Gender (% female): 100 BME (% non-white): 22 Country: US	Inclusion criteria: women aged 18-58 years; met DSM-IV criteria for PTSD; had chronic, treatment nonresponsive PTSD. Treatment unresponsiveness was determined by participants having had at least 3 years of prior therapy treatment that focused on the treatment of PTSD. Chronicity was based on meeting

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Unclear	criteria for PTSD in relation to an index trauma that occurred at least 12 years prior to intake. Exclusion criteria: unstable medical condition; pregnant or breastfeeding; alcohol or substance abuse/dependence in the past 6 months; active suicide risk or life-threatening mutilation; 5 or more prior yoga sessions; Global Assessment of Functioning (GAF) score < 40
van der Kolk 2016	Neurofeedback: Neurofeedback	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Mixed - The most frequently endorsed events were childhood caregiver emotional abuse (79%), sexual abuse (69%) and domestic violence (62%)	52	Age range (mean): NR (44.4) Gender (% female): 76 BME (% non-white): 24 Country: US Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): Mean number of traumatic events exposed to: 9.29 (SD = 2.90) Single or multiple incident index trauma: Multiple	Inclusion criteria: adults with multiple trauma exposures; who met DSM-IV criteria for PTSD per the Clinician Administered PTSD Scale (CAPS); who had received weekly trauma-focused psychotherapy for a minimum of six months; aged 18-58 years. Exclusion criteria: unstable medical condition; receiving disability benefits; active suicide risk or life-threatening self-mutilation; psychotic or bipolar disorder; traumatic brain injury (TBI); history of seizures; current substance or alcohol abuse; ongoing traumatic exposure (such as domestic violence); changing ongoing treatment during the course of the study; Global Assessment of Functioning (GAF) score <40.

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
van Emmerik 2008	Trauma-focused CBT: CBT individual	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Exposure to non-sexual violence - Nonsexual violence (50%); Traffic accident (23%); Sexual violence (11%); Other (16%)	125	Age range (mean): NR (40.2) Gender (% female): 67 BME (% non-white): NR Country: Netherlands Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Single	Inclusion criteria: aged at least 16 years; met DSM-IV criteria for a diagnosis of acute stress disorder (ASD) or PTSD; sufficient fluency in Dutch or English to complete treatment and research procedures. Exclusion criteria: psychiatric problems other than ASD or PTSD that were likely to hinder study participation or required clinical care that could be offered in the present study (e.g. dementia, psychotic symptoms, depression with suicidal ideation or severe substance abuse; of note, participants with moderate levels of depression or substance abuse secondary to the trauma were included); receiving concurrent psychotherapy
Wahbeh 2016/Colgan 2016	Meditation: Mindfulness meditation	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Military combat ('54% Vietnam; 34% OEF/OIF; 12% Other combat)	114	Age range (mean): NR (52.2) Gender (% female): 6 BME (% non-white): 14 Country: US Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with	Inclusion criteria: combat veteran (defined by a score of 7 on the Combat Exposure Scale); chronic PTSD diagnosis confirmed through clinician interview (CAPS); aged 25–65 years; good general medical health; stable dose of medications and therapy for duration of the study; willing and able to provide informed consent. Exclusion criteria: significant chronic medical illness in which symptoms and/or treatment precluded participation; psychiatric or behavioral illness such as schizophrenia, schizoaffective disorder, bipolar disorder, psychotic disorder (not including transient dissociative states or flashbacks associated with

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					previous trauma): NR Single or multiple incident index trauma: Multiple	PTSD reexperiencing symptoms), any DSM-IV cognitive disorder, current delirium, psychiatric instability or situational life crises, including evidence of being actively suicidal or homicidal, or any behavior that poses an immediate danger to the participant or others; substance dependence disorder within 3 months of the study or current substance use other than marijuana and alcohol (no more than 2 drinks/day by self-report); sexual assault as primary PTSD event(s) (to reduce heterogeneity from traumatic event); planning to move from the area in the next year; prior or current meditation practice defined as more than 5 minutes per day for 30 days over the last 6 months
Wang 2012	Acupuncture: Electroacupuncture	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Natural disasters (such as severe floods, earthquakes or tsunamis) – Wenchuan earthquake	138	Age range (mean): NR (49.3) Gender (% female): 58 BME (% non-white): NR Country: China Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Sinlge	Inclusion criteria: met criteria for DSM-IV-TR PTSD; Wenchuan earthquake-affected public, relief officers and volunteers; aged 18-65 years; signed informed consent; no loss of consciousness; no severe heart, liver, kidney disorders; able to participate in the examination and treatment. Exclusion criteria: those with depression or other mental disorders; those with learning disabilities; those who are taking anti-anxiety or antidepressant drugs; pregnant or lactating women

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
Watts 2012	rTMS: rTMS	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Mixed - Military combat (40%); sexual trauma (5%); assault (5%); multiple (50%)	NR	Age range (mean): NR (55.9) Gender (% female): 10 BME (% non-white): 0 Country: US Coexisting conditions: 80% major depression; 35% panic disorder; 20% OCD; 15% substance use disorder Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Multiple	Inclusion criteria: Primary diagnosis of PTSD assessed with SCID; CAPS score>50; no change in psychotropic medication, either dose or agent, for 2 months before rTMS; no change in psychosocial treatments for 2 months before rTMS; aged 20-70 years; competent to sign informed consent. Exclusion criteria: any metal object or implant in brain, skull, scalp, or neck; implantable devices, including cardiac pacemakers and defibrillators; seizure within the last year; substance abuse within the past 3 months; acute medical illness; any significant central nervous system disorders such as brain mass, stroke or epilepsy; treatment with a medication known to decrease the seizure threshold
Weinstein 2016	Practical support: Need satisfaction intervention	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	Witnessing war as a civilian - Syrian refugees currently residing in Jordan	41	Age range (mean): 15-68 (28.8) Gender (% female): 49 BME (% non-white): NR Country: Jordan Coexisting conditions: NR	Inclusion criteria: refugees who fled Syria during the past 24 months and resettled in Jordan. Exclusion criteria: not reported

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Multiple	
Weiss 2015 (study 1)	Trauma-focused CBT: CBT individual	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	Witnessing war as a civilian - Survivors of systematic violence (having experienced or witnessed physical torture or militant attacks) in Southern Iraq	149	Age range (mean): NR (42.8) Gender (% female): 31 BME (% non-white): NR Country: Iraq Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Multiple	Inclusion criteria: Survivors of systematic violence (having experienced or witnessed physical torture or militant attacks) in Southern Iraq; aged at least 18 years; score ≥36 on HTQ. Exclusion criteria: Clients identified by the CMHWs as currently being psychotic and/or those who were a danger to themselves or to others
Weiss 2015 (study 2)	Trauma-focused CBT: Cognitive processing therapy	Clinically important PTSD symptoms (scoring above	Witnessing war as a civilian - Survivors of systematic violence (having experienced or witnessed physical torture	193	Age range (mean): NR (40.3) Gender (% female): 34 BME (% non-white):	Inclusion criteria: Survivors of systematic violence (having experienced or witnessed physical torture or militant attacks) in Southern Iraq; aged at least 18 years; score ≥36 on HTQ. Exclusion criteria: Clients identified by the

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
		a threshold on validated scale)	or militant attacks) in Southern Iraq		NR Country: Iraq Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Multiple	CMHWs as currently being psychotic and/or those who were a danger to themselves or to others
Wells 2012	Cognitive therapies: Metacognitive therapy	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Mixed - Assault (35%), MVC (20%), robbery (10%), sexual assault (15%), witness (10%), work accident (10%)	20	Age range (mean): NR (37.4) Gender (% female): 55 BME (% non-white): NR Country: UK Coexisting conditions: 15% minor depressive disorder; 45% major depressive disorder; 15% GAD Lifetime experience of trauma (mean number of prior traumas/% with previous trauma):	Inclusion criteria: males and females aged 18 years or older, meeting Diagnostic and Statistical Manual of Mental Disorders, 4th Edition criteria for PTSD. A minimum of 3-months duration of symptoms was required. Exclusion criteria: current suicidality, psychosis, current alcohol, or substance dependence requiring prioritization, and/or required assessments and treatments that could not be conducted without the aid of an interpreter.

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					Median number of traumas=1/1.5 Single or multiple incident index trauma: Single	
Wells 2015	Trauma-focused CBT: Exposure therapy/prolonged exposure (PE)	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Mixed - Actual assault (28%); threatened assault (3%); sexual assault (9%); assaulted another (3%); road traffic accident (25%); witness (9%); fire (13%); war/combat (6%); armed robberry (3%)	32	Age range (mean): NR (41.2) Gender (% female): 38 BME (% non-white): NR Country: UK Coexisting conditions: 56% coexisting psychiatric diagnosis: 28% major depressive disorder; 22% panic disorder; 6% major depressive disorder and panic disorder Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): Total number of traumas median 2.0 (IQR 1.0-3.0)	Inclusion criteria: aged at least 18 years; met DSM-IV-TR criteria for a primary diagnosis of PTSD with symptom chronicity ≥3 months as determined by the SCID-I/P; no previous psychological intervention for their current PTSD; stability of pharmacological treatment for ≥3 months (if applicable). Exclusion criteria: current suicidal intent; overt self-harm; psychosis; evidence of drug/alcohol dependence requiring immediate treatment in its own right; those requiring the use of an interpreter

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
					Single or multiple incident index trauma: Single	
Xu 2016	Self-help (without support): Computerised trauma-focused CBT	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	Mixed - Witnessing others sudden death (37%); Physical abuse (30%), sexual abuse (17%), serious accident in workplace or at home (17%), fire or natural disasters (8%), traffic accidents (7%), hurting others seriously (4%)	82	Age range (mean): NR (NR) Gender (% female): 75 BME (% non-white): NR Country: China Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): NR Single or multiple incident index trauma: Multiple	Inclusion criteria: over 16 years old, have experienced at least one traumatic event more than 1 month ago, have suffered from posttraumatic stress symptoms (e.g. flashback, irritability, and insensitivity) for the past 1 month (these three symptoms were described in the screening questionnaires and participants should report at least one “yes” for them). Exclusion criteria: psychotic symptoms, received psychological treatment in the past 5 years.
Yeomans 2010	Counselling: Supportive psychotherapy group	Clinically important PTSD symptoms (scoring above a threshold on validated scale)	Witnessing war as a civilian - Almost all participants had been directly victimized by violence during or since the onset of conflict in Burundi in 1993. Frequency and types of events: Combat situation (99% experienced; 0.4% witnessed); Forced to hide	124	Age range (mean): NR (38.6) Gender (% female): 44 BME (% non-white): NR Country: Burundi Coexisting conditions: Lifetime experience of trauma (mean	Inclusion criteria: Participants recruited from among future participants of two trauma healing and reconciliation workshops, located near two Internally Displaced Persons camps in rural Burundi, and offered by a small nonprofit organization. These participants were referred to the workshop through a network of church elders who identified them as community members in psychological distress possibly as a result of experiences during the war. Exclusion critera: Not reported

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
			(97% experienced; 0.8% witnessed); Unnatural death of family member (97% experienced; 0.8% witnessed); Lack of food and water (95% experienced; 0.4% witnessed); Narrowly escaping death (92% experienced; 6% witnessed); Lack of shelter (90% experienced); Ill health and no medical care (86% experienced; 8% witnessed); Loss of personal property (82% experienced; 9% witnessed); Confined to indoors because of danger (80% experienced; 6% witnessed); Betrayed and placed at risk of death (42% experienced; 18% witnessed); Serious physical injury from combat (35% experienced; 45% witnessed); Forced to hide among the dead (28% experienced; 23% witnessed); Imprisonment (24% experienced; 18% witnessed); Sexual abuse/humiliation (10%		number of prior traumas/% with previous trauma): Mean number of types of events experienced was 9.9 (SD=2.1). The mean number of types of events experienced or witnessed was 12.6 (SD = 3.2) Single or multiple incident index trauma: Multiple	

Study ID	Intervention	PTSD details	Trauma type	N	Demographics	Inclusion/Exclusion criteria
			experienced; 25% witnessed); Forced to harm or kill a stranger (10% experienced; 25% witnessed); Forced to harm or kill a family member or friend (9% experienced; 24% witnessed); Disappearance/kidnapping of spouse (9% experienced; 18% witnessed); Rape (5% experienced; 25% witnessed); Disappearance/kidnapping of son or daughter (4% experienced; 20% witnessed)			

Zang 2014	Trauma-focused CBT: Narrative exposure therapy (NET)	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Natural disasters (such as severe floods, earthquakes or tsunamis) - Sichuan earthquake (2008). 27% injured in earthquake; 100% house damage. All participants reported seeing someone seriously injured and death during the earthquake	30	Age range (mean): 28-80 (53.6) Gender (% female): 90 BME (% non-white): NR Country: China Coexisting conditions: Lifetime experience of trauma (mean number of prior traumas/% with previous trauma): 20% prior trauma (7% 1 prior trauma; 13% 2-3) Single or multiple incident index trauma: Single	Inclusion criteria: survivors of Sichuan earthquake; aged at least 18 years; met DSM-IV criteria for PTSD. Exclusion criteria: participation in another psychological treatment programme; inability to finish treatment due to relocation; history of other mental illness
Zlotnick 1997	Non-trauma-focused CBT: Affect-management group	PTSD diagnosis according to ICD/DSM criteria (including self-report of diagnosis)	Childhood sexual abuse - 77% reported intrafamilial sexual abuse (abuse by a relative) and 35% reported parental sexual abuse	48	Age range (mean): NR (39) Gender (% female): 100 BME (% non-white): 0.02 Country: US Coexisting conditions: NR Lifetime experience of trauma (mean number of prior traumas/% with previous trauma):	Inclusions: met criteria for PTSD based on their past sexual abuse experiences, i.e., a history of sexual contact before the age of 17., received individual therapy for at least one month prior to the group, and reported no changes in their psychotropic medication in the month before the study. Exclusions: psychosis, current substance abuse, and/or dissociative identity disorder as determined by consultation with the subject's individual therapist

					77% had also experienced rape. Mean number of lifetime sexual abuse offenders reported was 3.71 (SD = 3.45) Single or multiple incident index trauma: Multiple	

OEF/OIF Operation Enduring Freedom (OEF) and Peration Iraqi Freedom (OIF))

Appendix E – Forest plots

Forest plots for "For adults with clinically important post-traumatic stress symptoms, what are the relative benefits and harms of psychological, psychosocial or other non-pharmacological interventions targeted at PTSD symptoms?"

Psychological interventions for the treatment of PTSD in adults

Trauma-focused CBT

Figure 2: Trauma-focused CBT versus waitlist or no treatment for early treatment (1-3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated (IES change score); single-incident index trauma

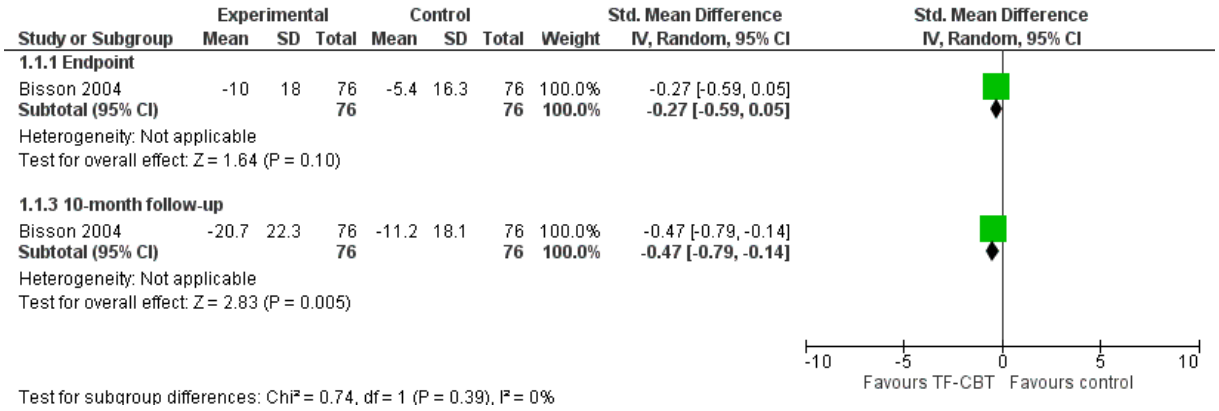


Figure 3: Trauma-focused CBT versus waitlist or no treatment for early treatment (1-3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated (CAPS change score); single-incident index trauma

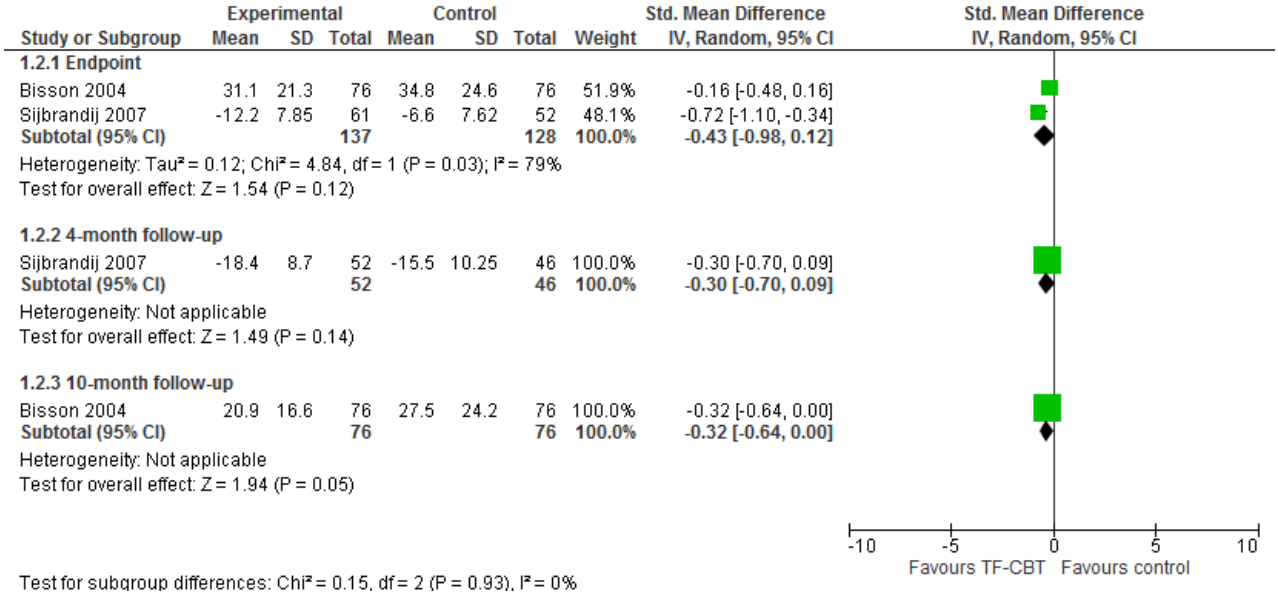


Figure 4: Trauma-focused CBT versus waitlist or no treatment for early treatment (1-3 months) of clinically important symptoms/PTSD: Remission (number of people no longer meeting diagnostic criteria for PTSD); Single incident index trauma

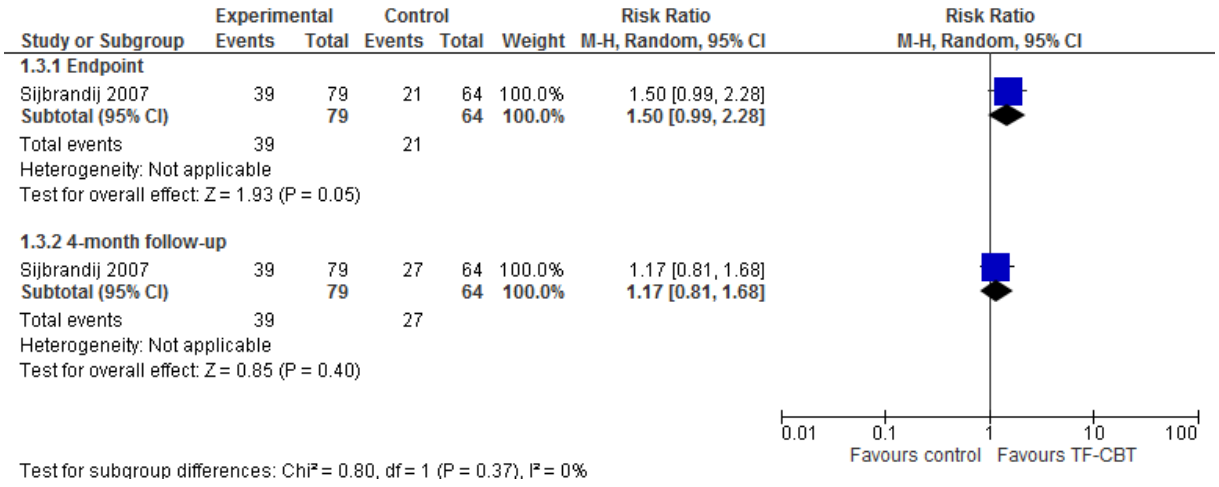


Figure 5: Trauma-focused CBT versus waitlist or no treatment for early treatment (1-3 months) of clinically important symptoms/PTSD: Response self-rated

(number of participants showing at least 50% improvement from baseline on IES); single-incident index trauma

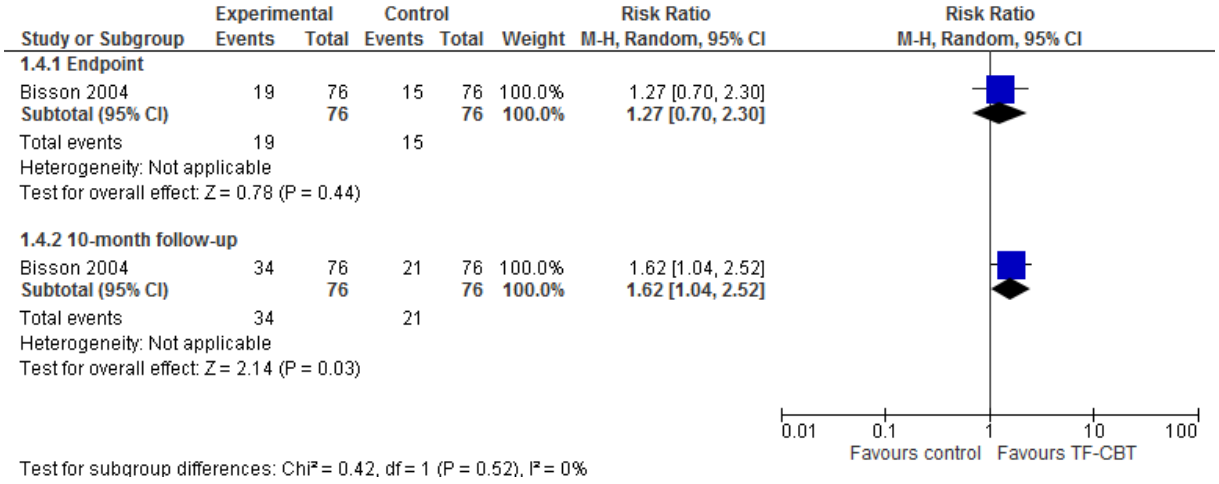


Figure 6: Trauma-focused CBT versus waitlist or no treatment for early treatment (1-3 months) of clinically important symptoms/PTSD: Anxiety symptoms (HADS-A change score); single-incident index trauma

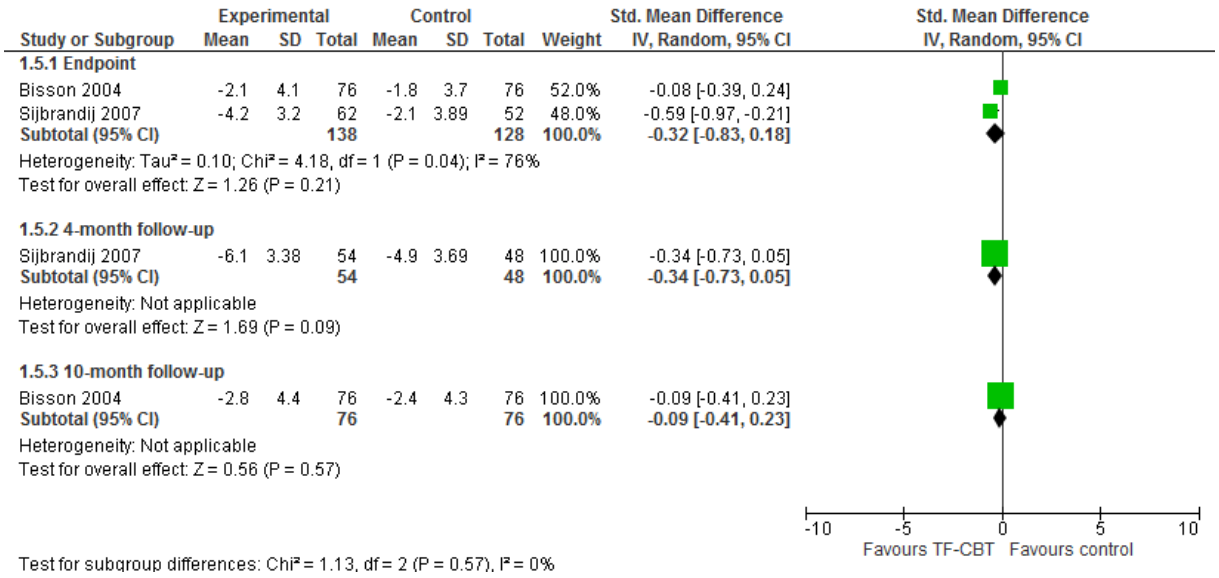


Figure 7: Trauma-focused CBT versus waitlist or no treatment for early treatment (1-3 months) of clinically important symptoms/PTSD: Depression symptoms (HADS-D change score); single-incident index trauma

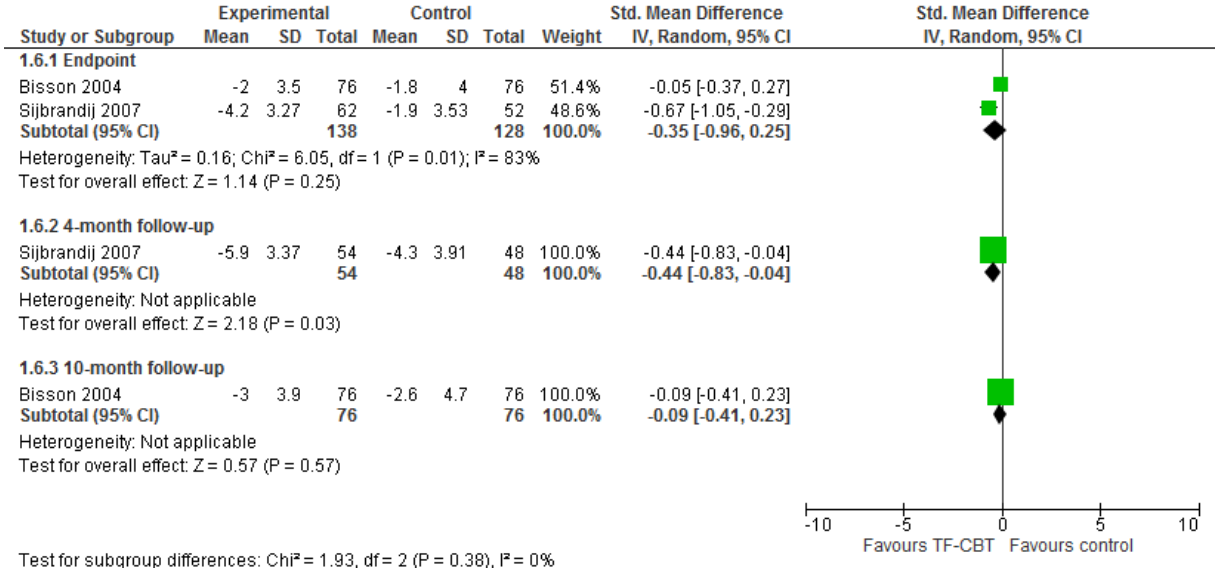


Figure 8: Trauma-focused CBT versus waitlist or no treatment for early treatment (1-3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)

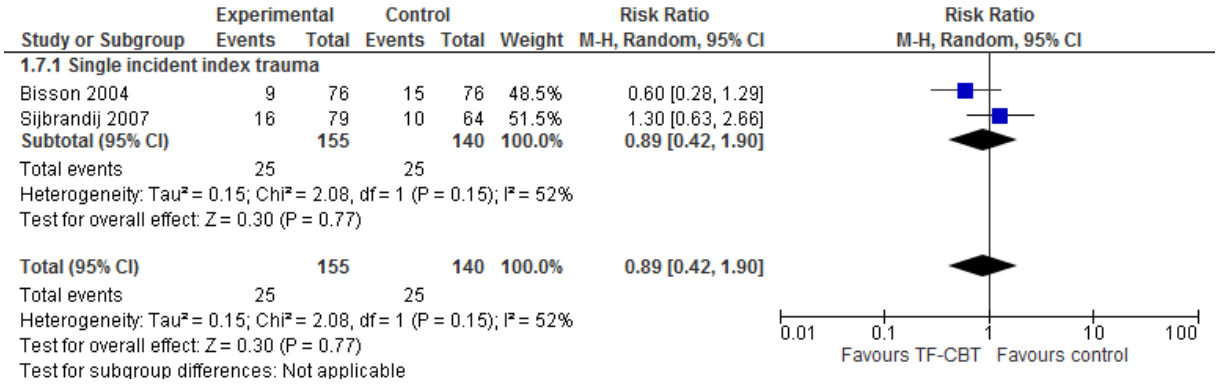


Figure 9: Trauma-focused CBT versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated at endpoint (PCL/SPTSS/HTQ/MPSS/PDS/PSS-SR/IES-R change score)

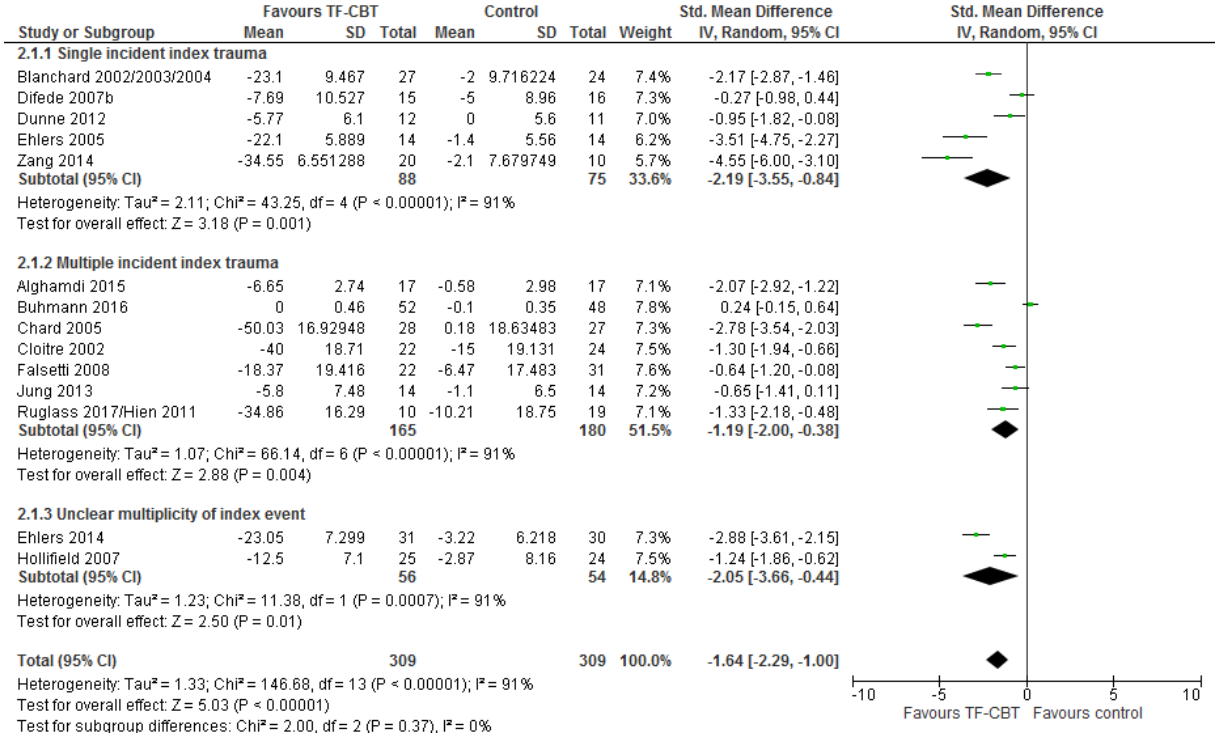


Figure 10: Trauma-focused CBT versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated at 6-7 week follow-up (IES/HTQ change score)

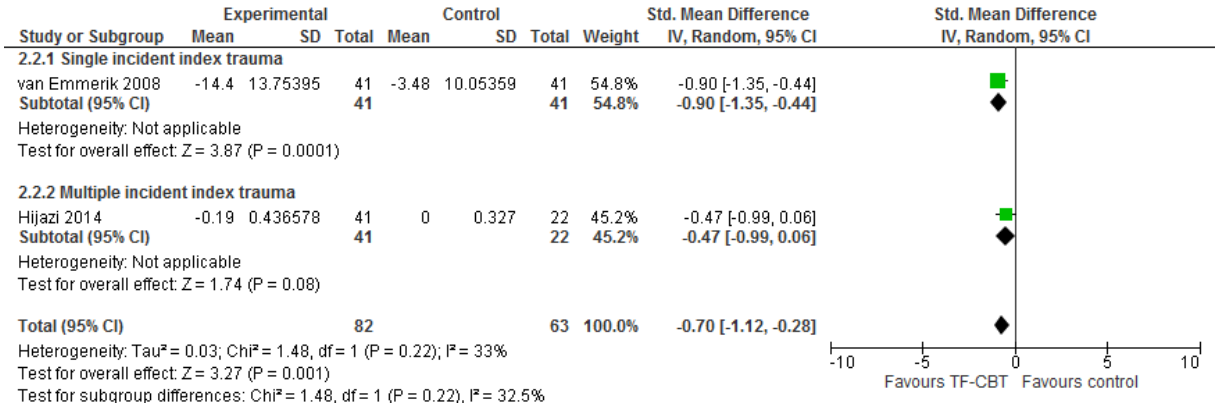


Figure 11: Trauma-focused CBT versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated at 3-month follow-up (HTQ change score)

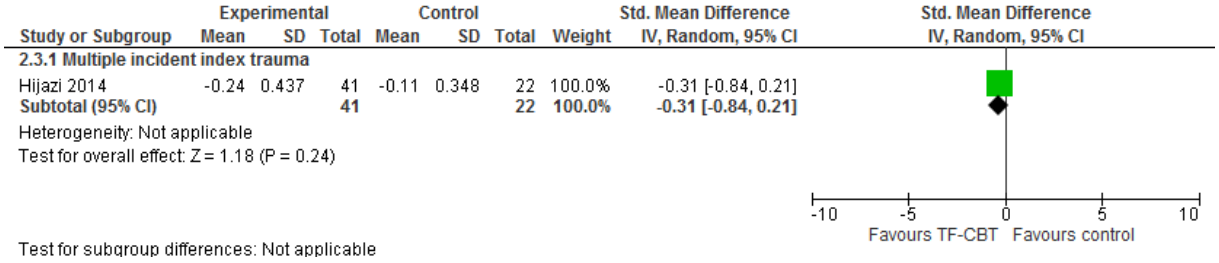


Figure 12: Trauma-focused CBT versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated at 8-month follow-up (PDS change score)

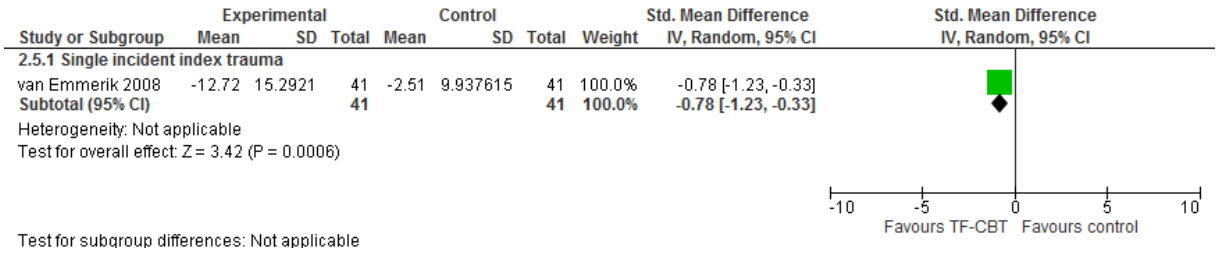


Figure 13: Trauma-focused CBT versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated at 1-year follow-up (IES change score)

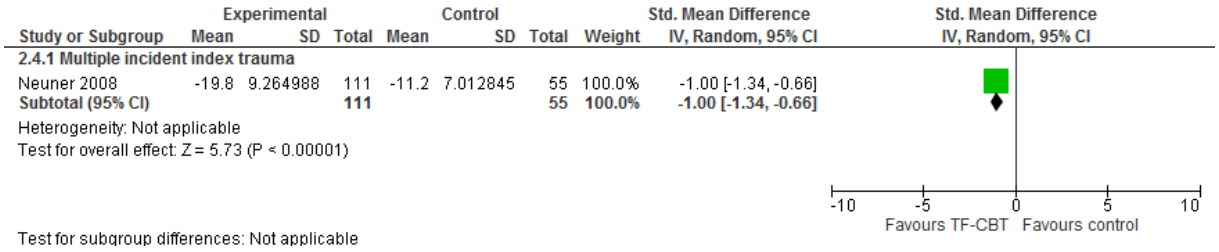


Figure 14: Trauma-focused CBT versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated at end-point (CAPS/HTQ/SI-PTSD/PSS-I change score)

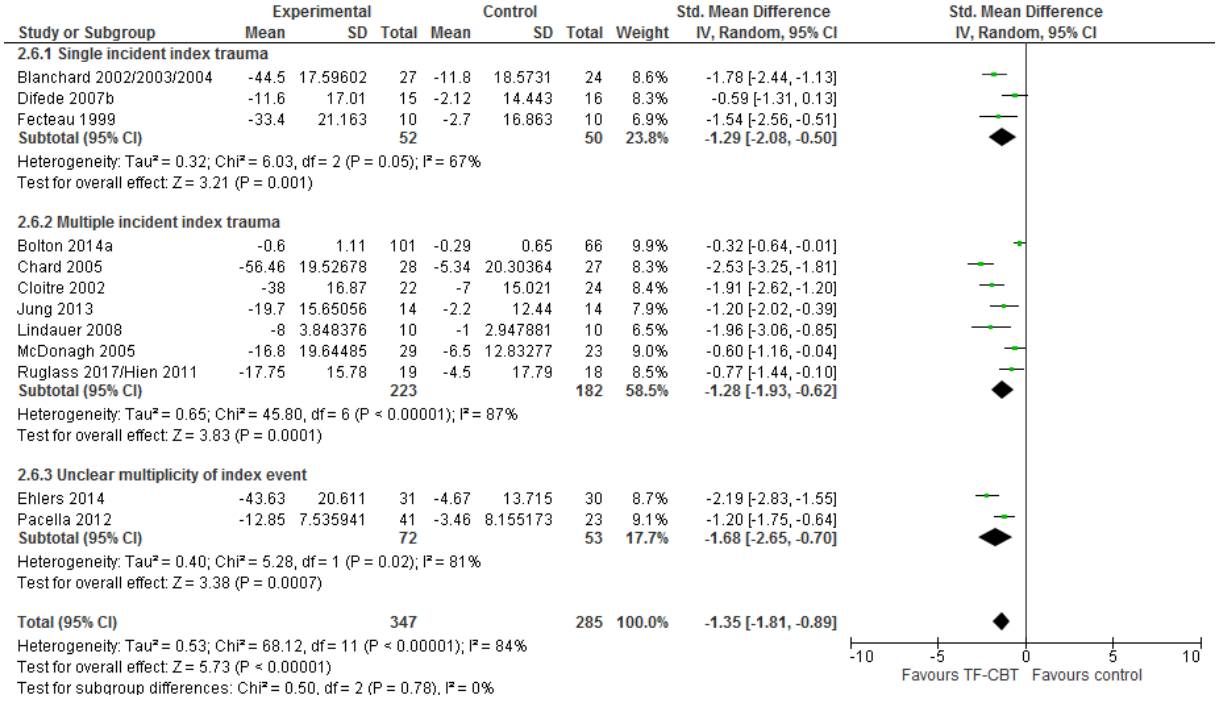


Figure 15: Trauma-focused CBT versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated at 3-5 month follow-up (CAPS/PSS-I/HTQ change score)

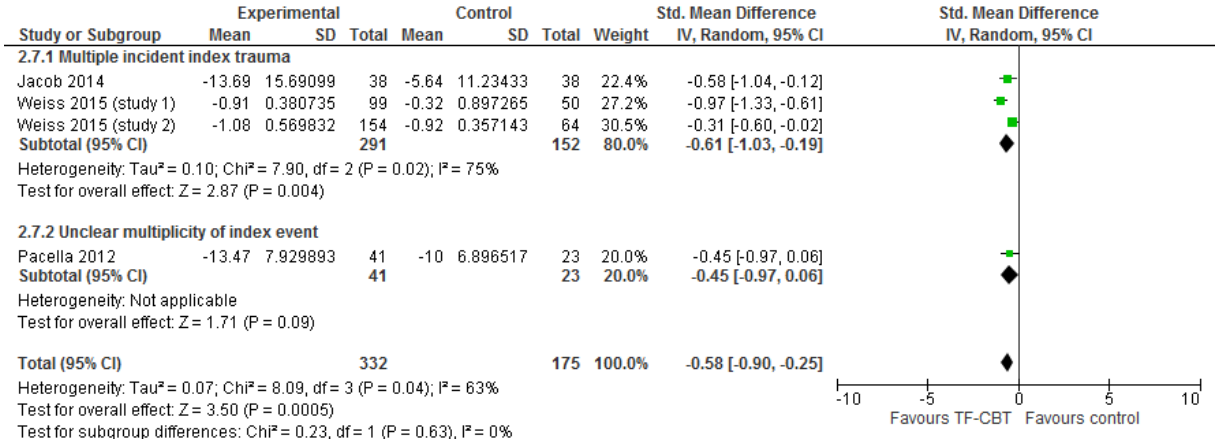


Figure 16: Trauma-focused CBT versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Remission at endpoint (number of

people no longer meeting diagnostic criteria for PTSD or no longer above clinical threshold on scale)

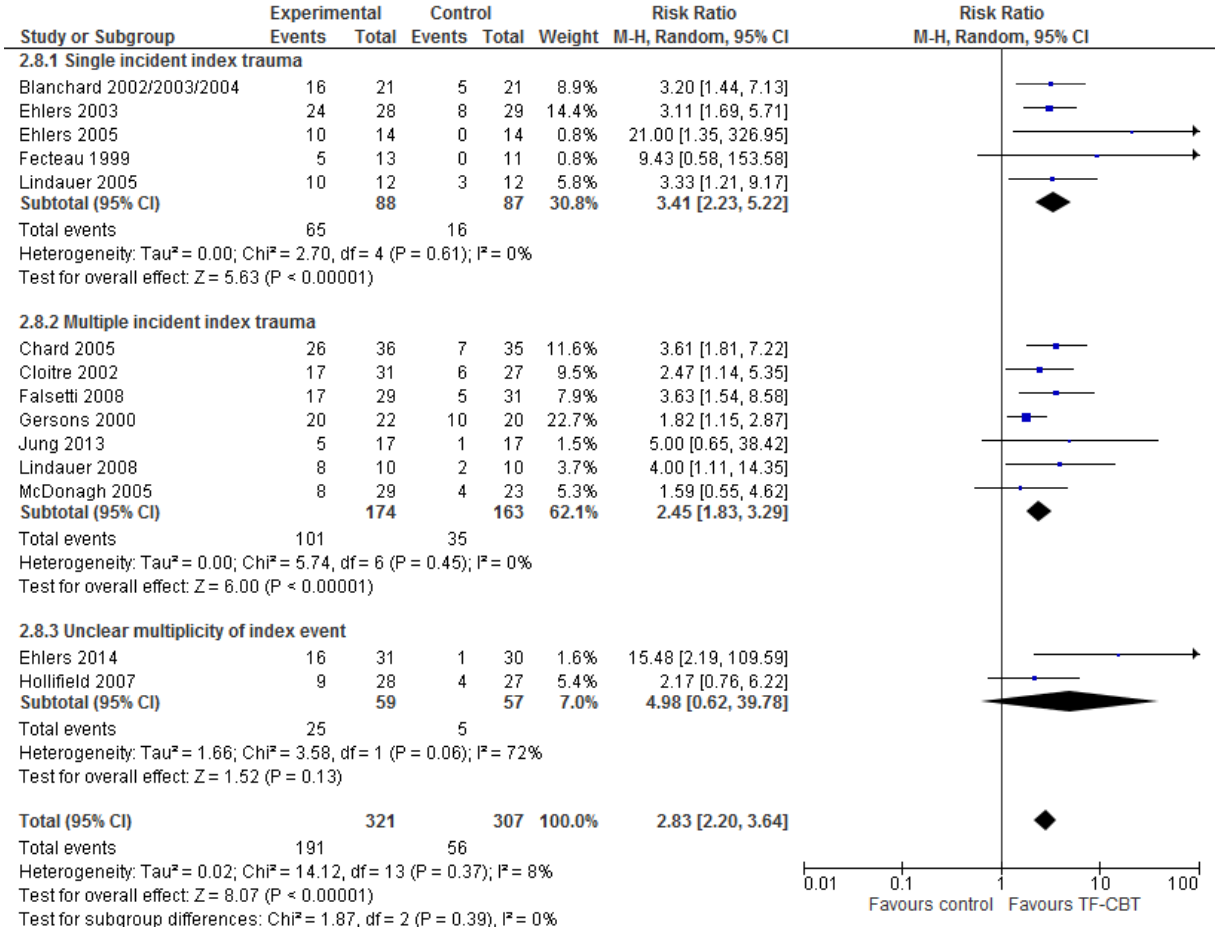


Figure 17: Trauma-focused CBT versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Remission at 3-6 month follow-up

(number of people no longer meeting diagnostic criteria for PTSD or no longer above clinical threshold on scale)

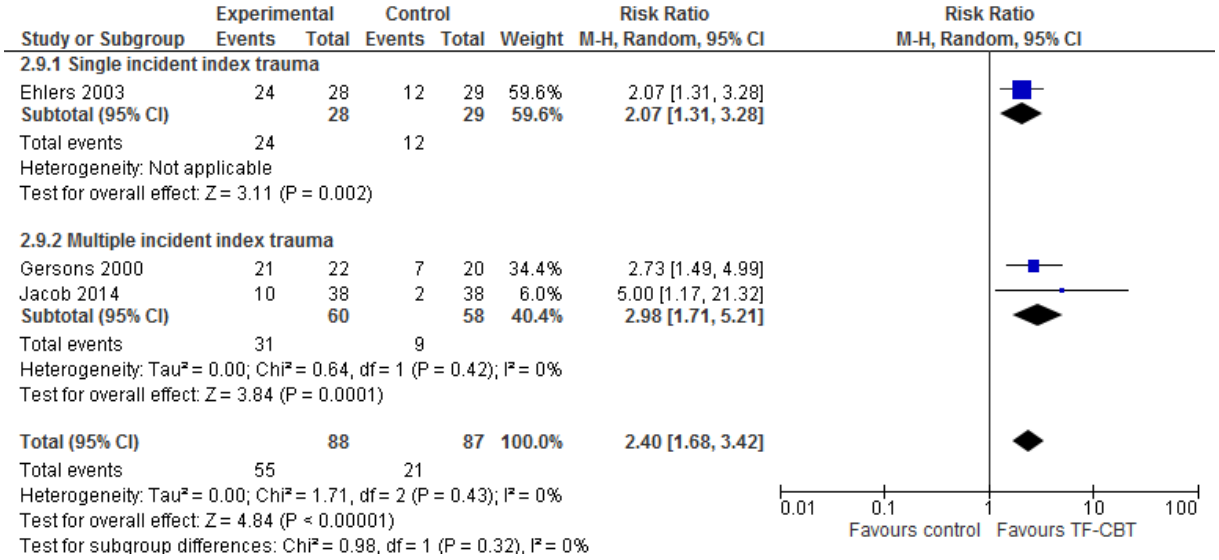


Figure 18: Trauma-focused CBT versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Remission at 8-month follow-up (number of people no longer meeting diagnostic criteria for PTSD)

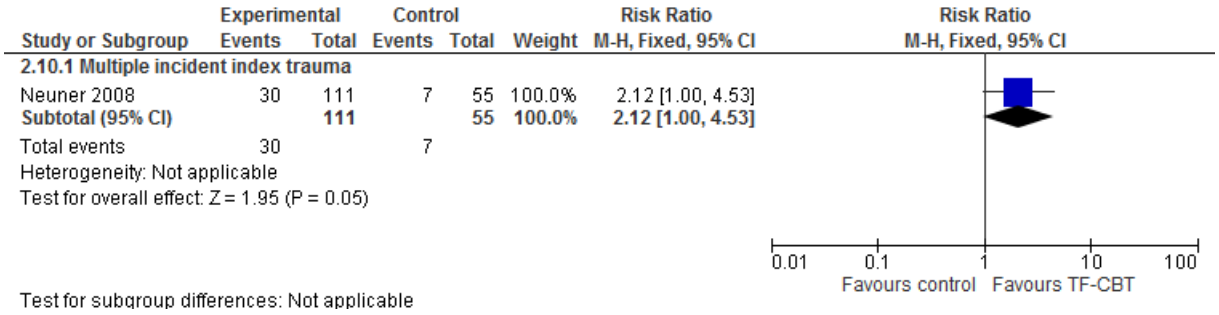


Figure 19: Trauma-focused CBT versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Response self-rated at endpoint

(number of people showing clinically significant improvement (based on reliable chage indices [RCI])≥50% improvement on PDS)

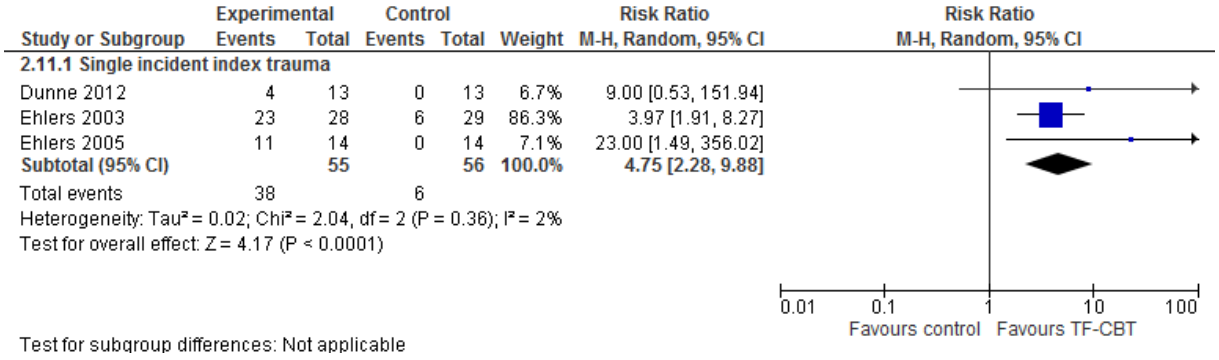


Figure 20: Trauma-focused CBT versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Response self-rated at 6-month follow-up (number of people showing ≥50% improvement on PDS)

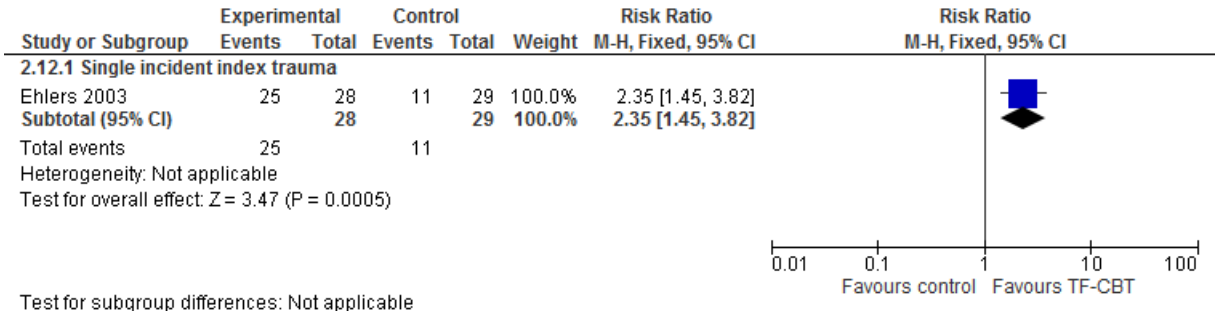


Figure 21: Trauma-focused CBT versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Response clinician-rated (number of

people showing improvement of at least 10 points on CAPS/clinically significant improvement on CAPS based on reliable change indices [RCI])

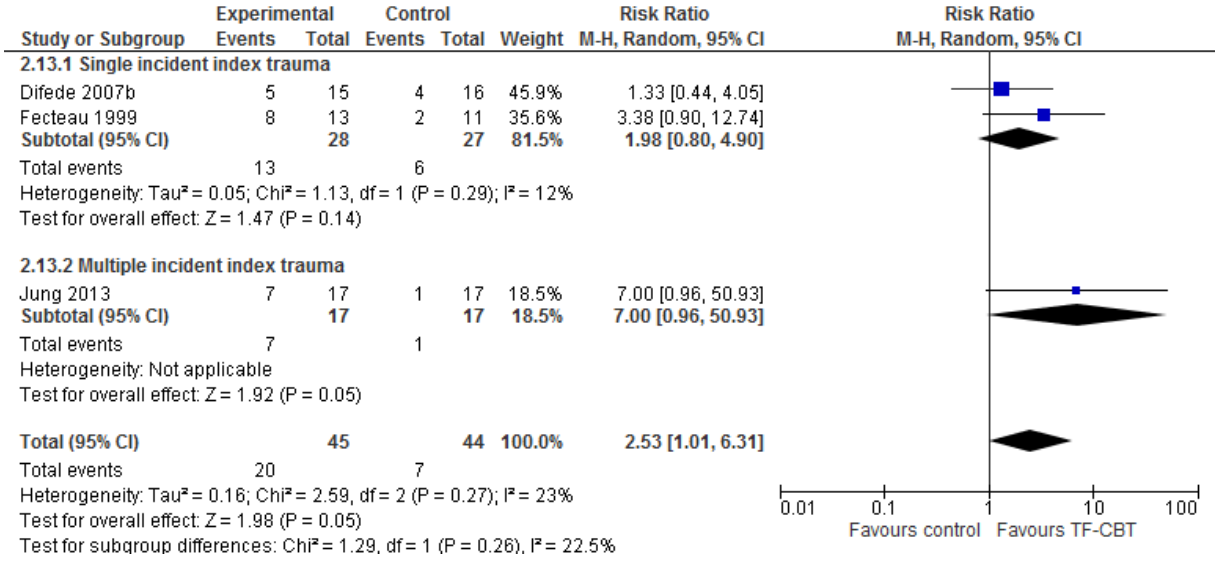


Figure 22: Trauma-focused CBT versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Anxiety symptoms at end-point (BAI/HADS-A/STAI State/HSCL-25 Anxiety/HAM-A change score)

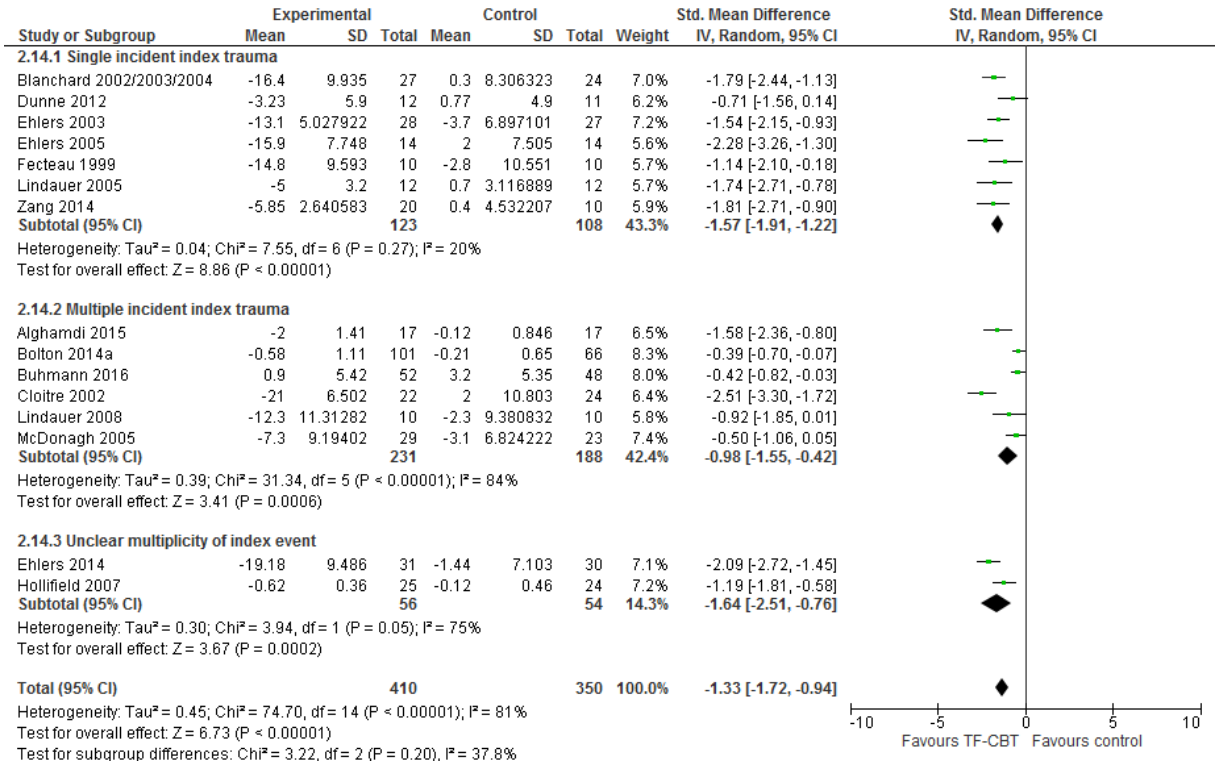


Figure 23: Trauma-focused CBT versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Anxiety symptoms at 2-month follow-up (STAI State change score)

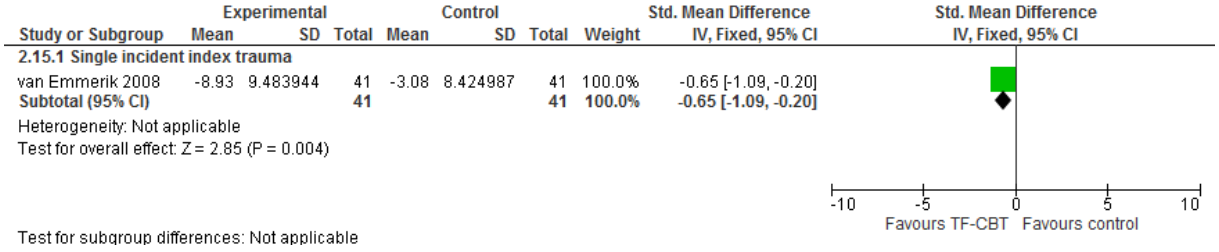


Figure 24: Trauma-focused CBT versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Anxiety symptoms at 5-6 month follow-up (BAI/HSCL-25 Anxiety change score)

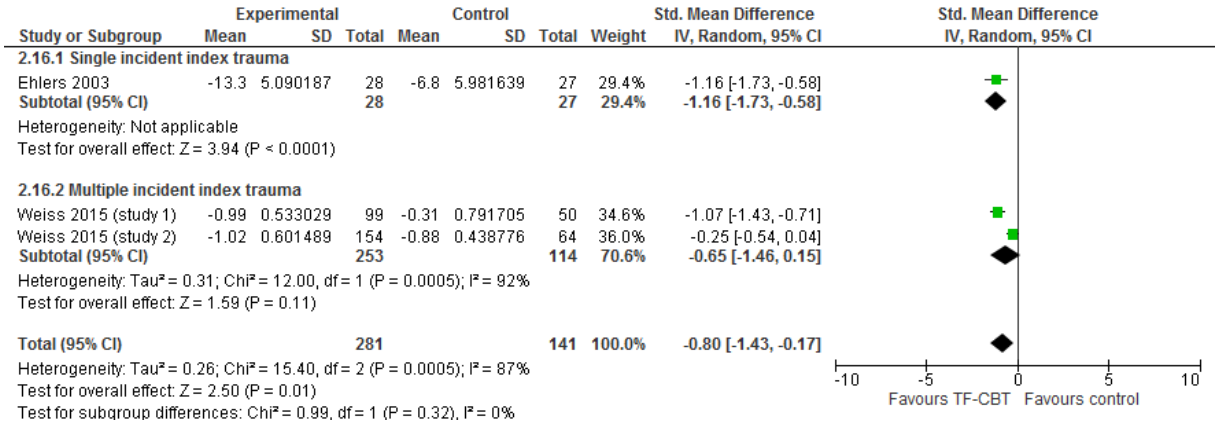


Figure 25: Trauma-focused CBT versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Anxiety symptoms at 1-year follow-up (STAI State change score)

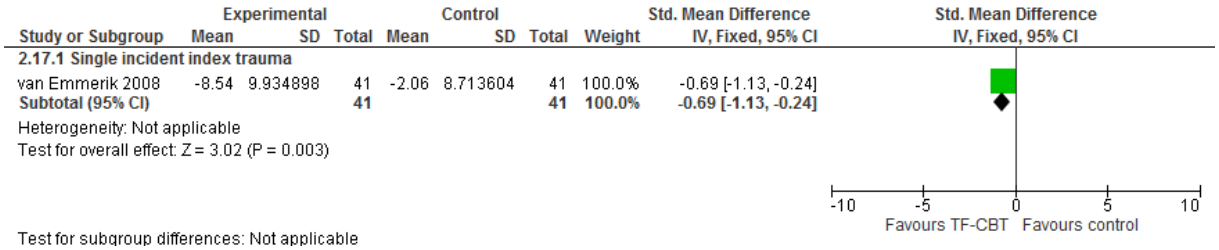


Figure 26: Trauma-focused CBT versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms at endpoint (BDI/BDI-II/CES-D/HADS-D/HSCL-25 Depression/HAMD change score)

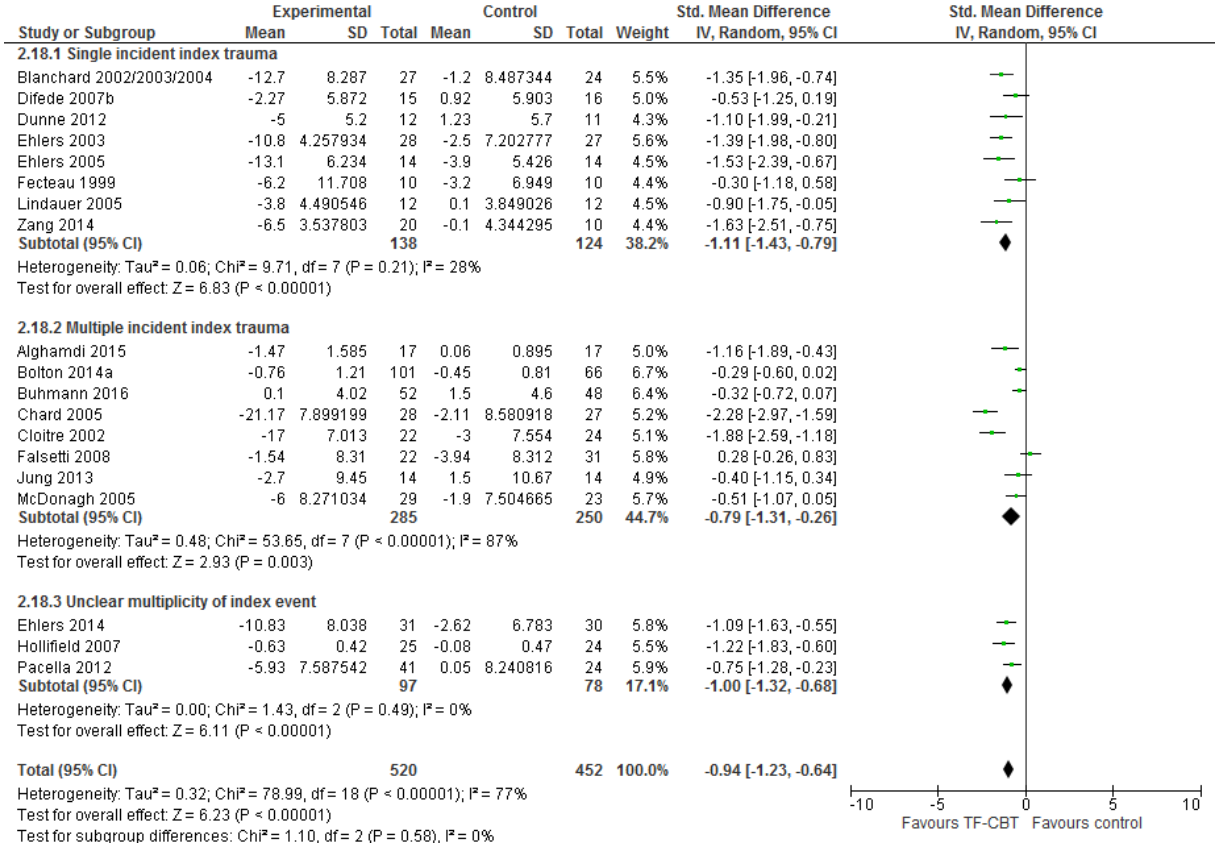


Figure 27: Trauma-focused CBT versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms at 6-7 week follow-up (BDI/BDI-II change score)

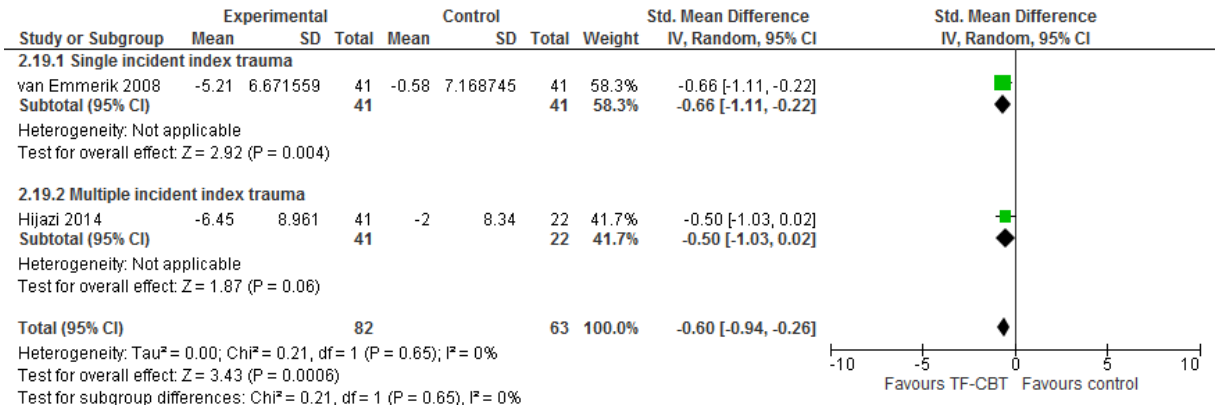


Figure 28: Trauma-focused CBT versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms at 3-6 month follow-up (BDI-II/CES-D/HSCL-25 Depression change score)

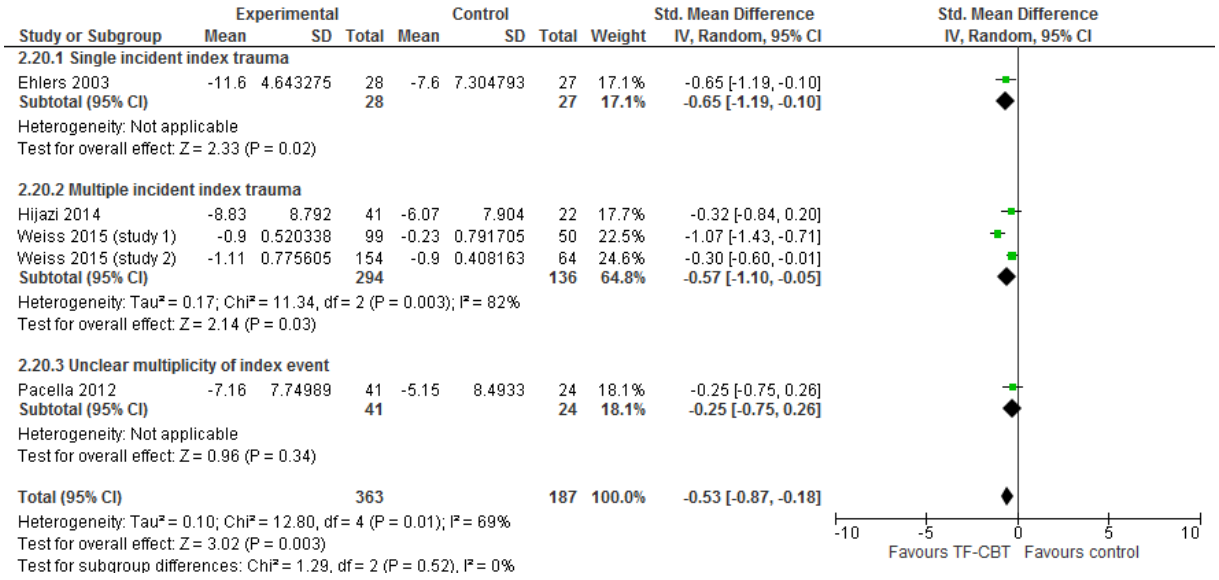


Figure 29: Trauma-focused CBT versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms at 1-year follow-up (BDI change score)

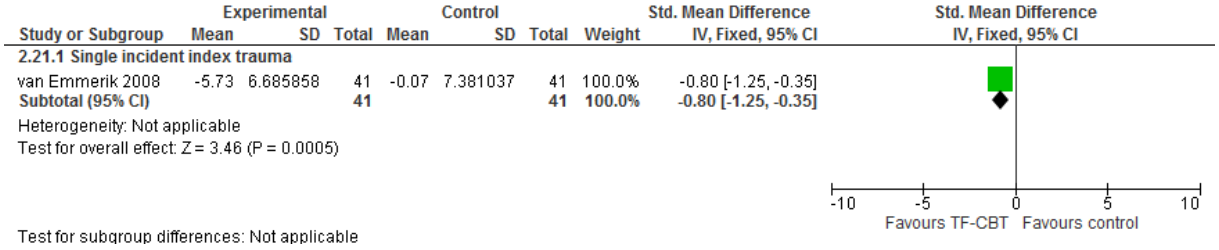


Figure 30: Trauma-focused CBT versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Dissociative symptoms at endpoint (DES change score)

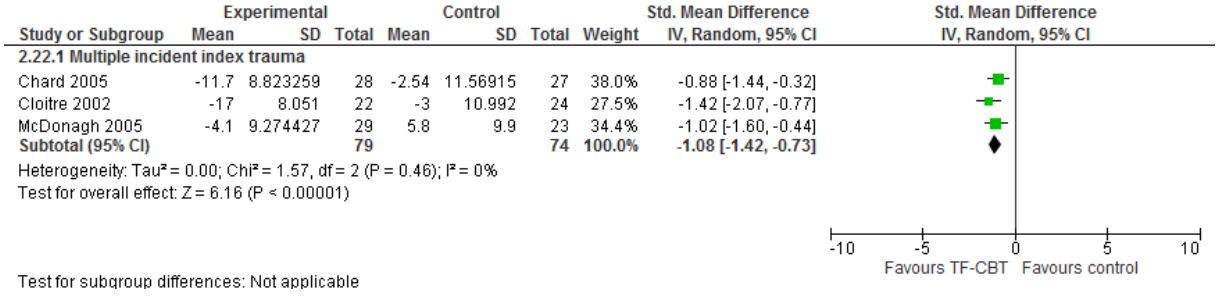


Figure 31: Trauma-focused CBT versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Dissociative symptoms at 2-month follow-up (DES change score)

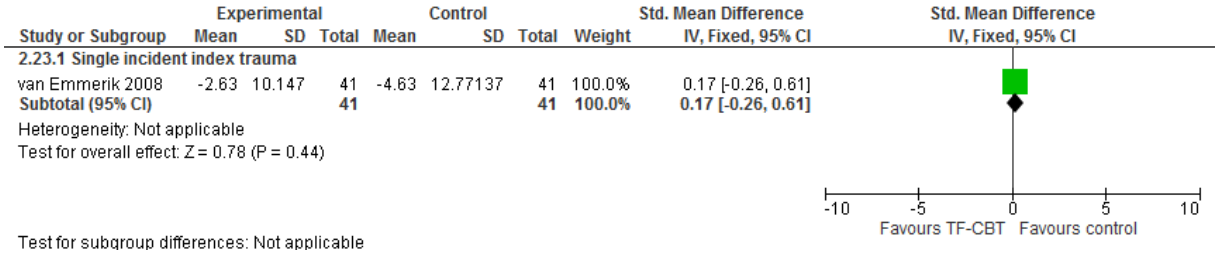


Figure 32: Trauma-focused CBT versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Dissociative symptoms at 1-year follow-up (DES change score)

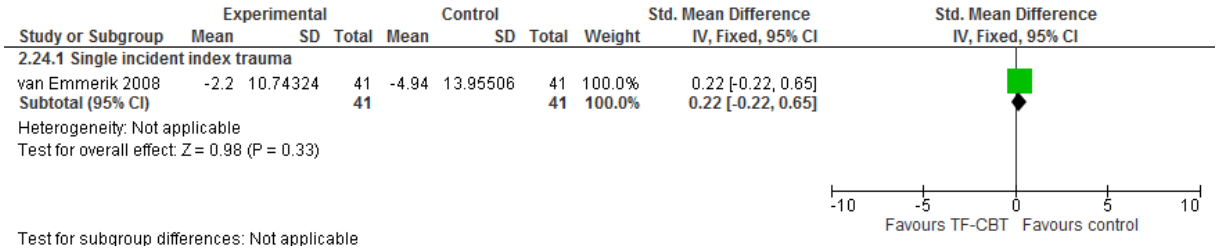


Figure 33: Trauma-focused CBT versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Emotional and behavioural problems: Anger (STAXI change score)

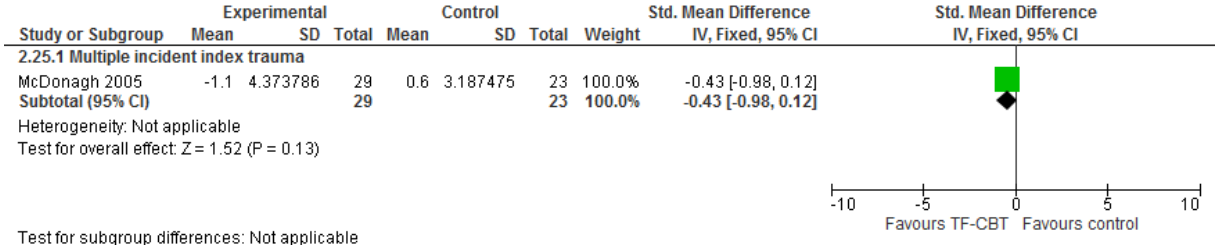


Figure 34: Trauma-focused CBT versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Substance abuse (number of days of primary substance use in past 30 days; ASI-Lite change score)

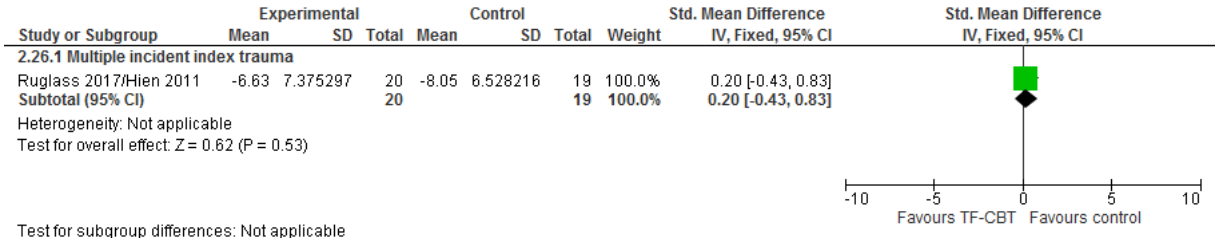


Figure 35: Trauma-focused CBT versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Global functioning (GAF change score)

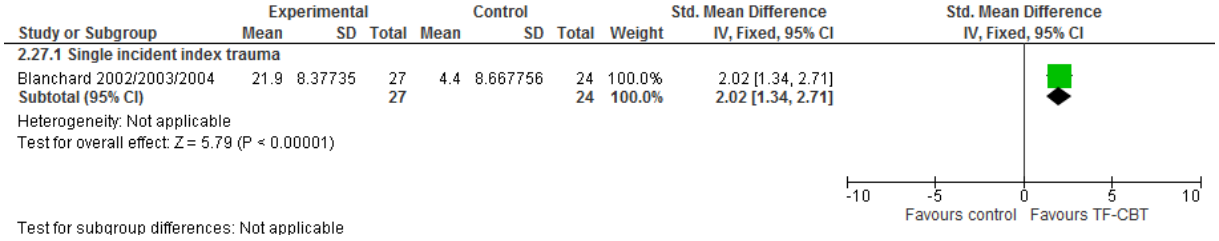


Figure 36: Trauma-focused CBT versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Functional impairment at endpoint (SDS/SAS-SR change score)

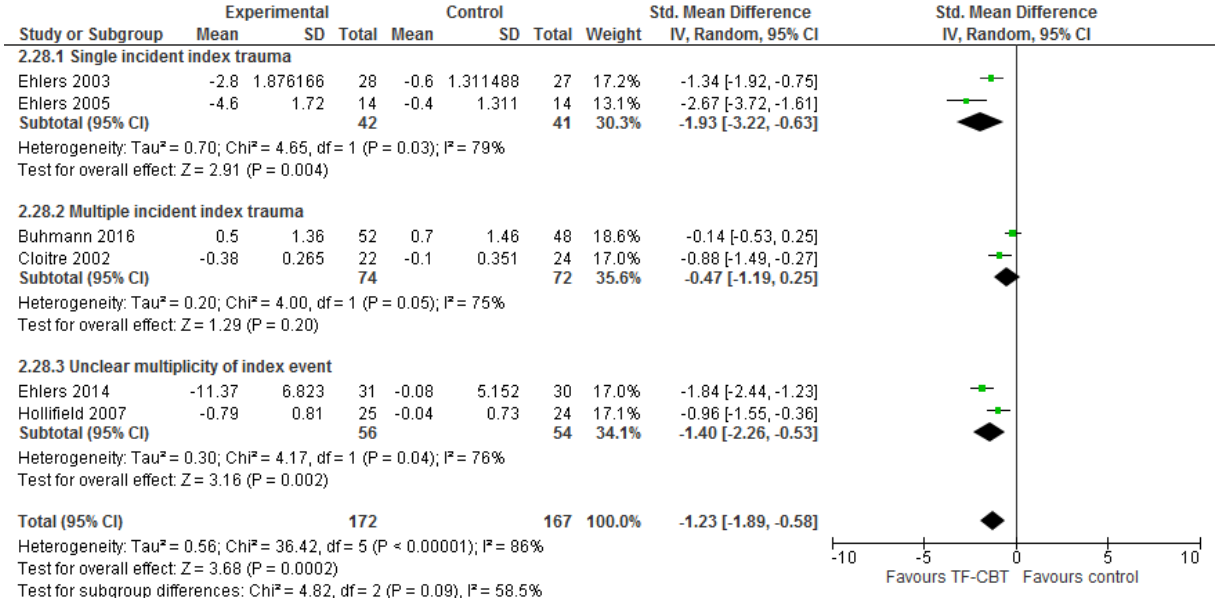


Figure 37: Trauma-focused CBT versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Functional impairment at 6-month follow-up (SDS change score)

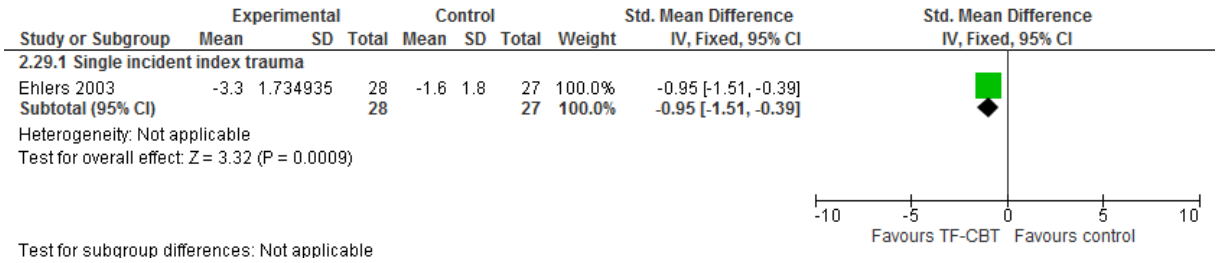


Figure 38: Trauma-focused CBT versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Relationship difficulties (IIP change score)

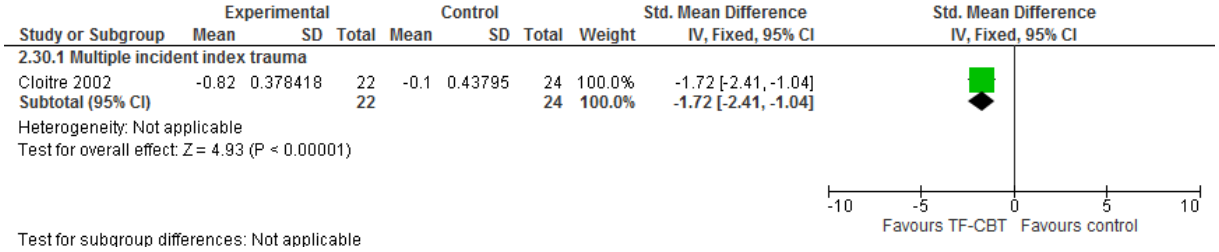


Figure 39: Trauma-focused CBT versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Quality of life at endpoint (WHO-5/SF-36 mental health/Q-LES-Q-SF/QOLI; change score)

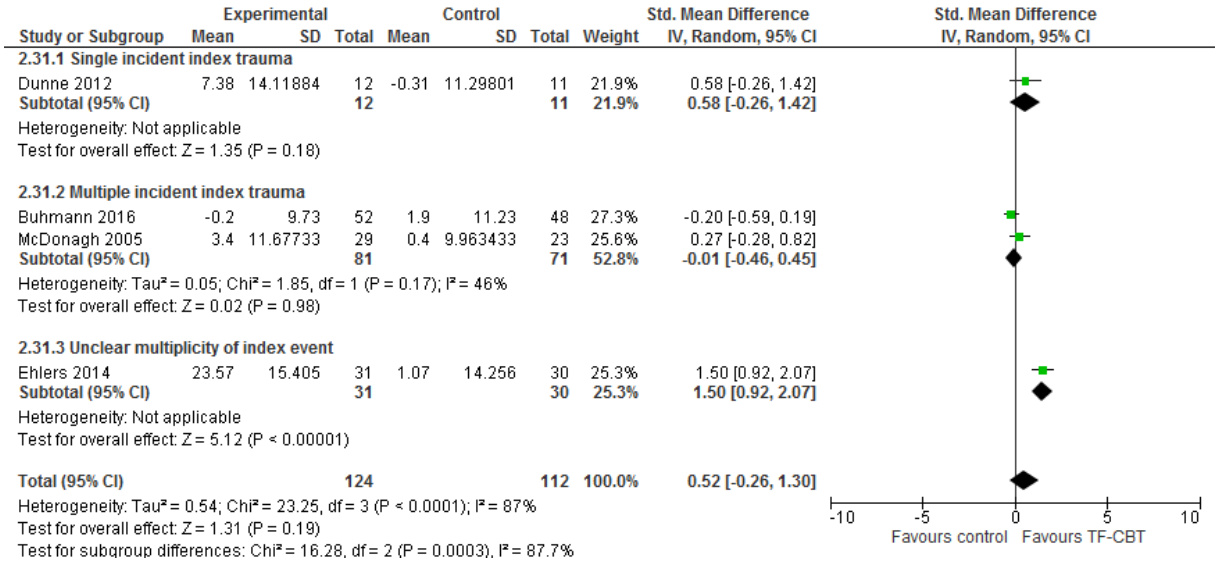


Figure 40: Trauma-focused CBT versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Quality of life at 6-week follow-up (WHO-5 change score)

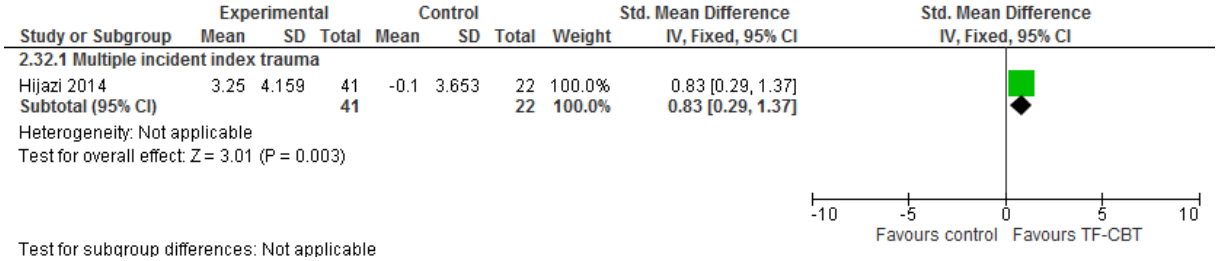


Figure 41: Trauma-focused CBT versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Quality of life at 3-month follow-up (WHO-5 change score)

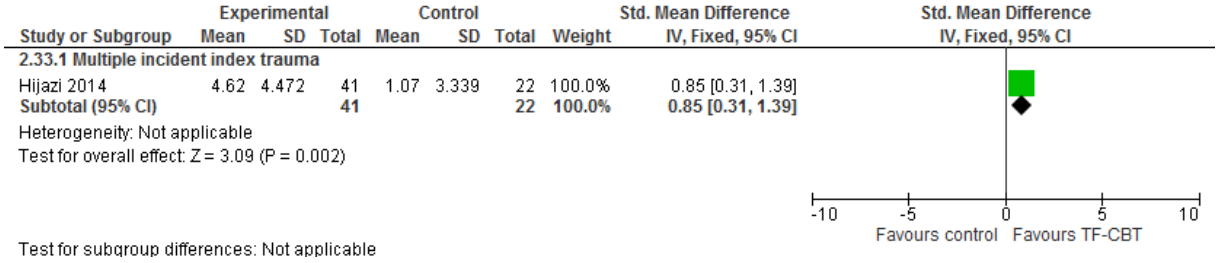
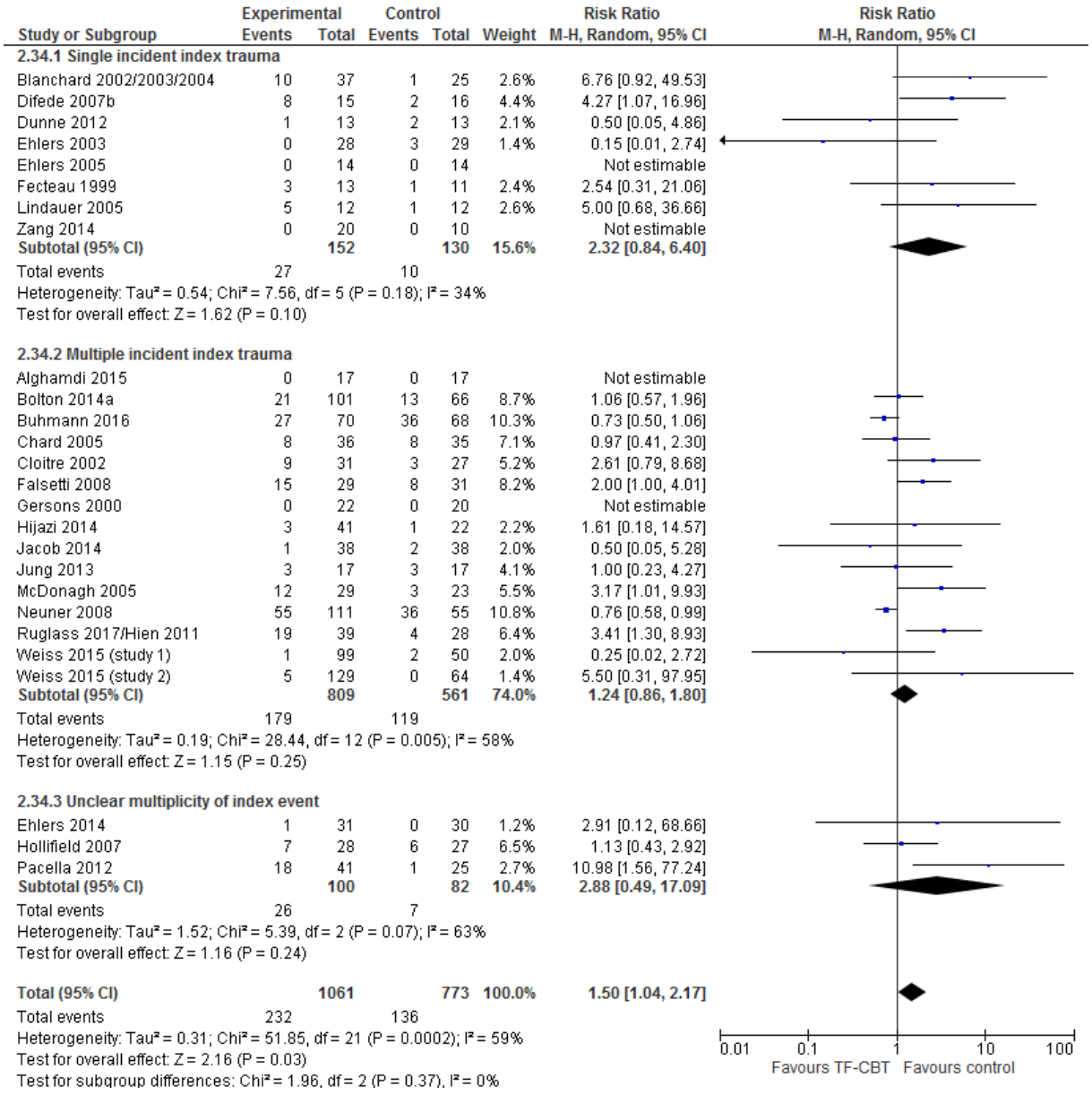


Figure 42: Trauma-focused CBT versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss of follow-up)



Sub-analysis by specific treatment: Trauma-focused CBT versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD

Figure 43: Trauma-focused CBT versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated at end-point (PCL/SPTSS/HTQ/MPSS/PDS/PSS-SR/IES-R change score)

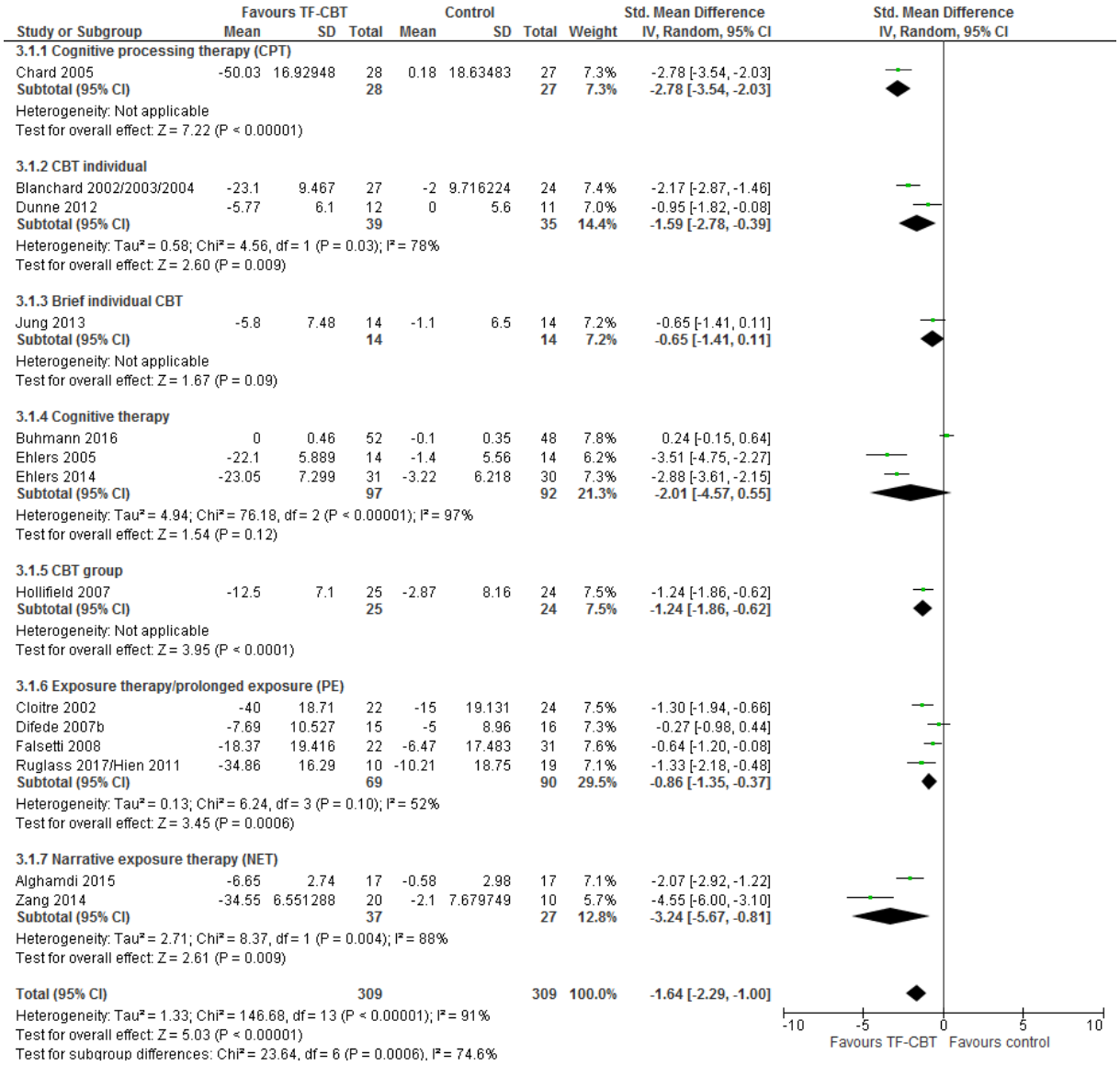


Figure 44: Trauma-focused CBT versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated at endpoint (CAPS/HTQ/SI-PTSD/PSS-I change score)

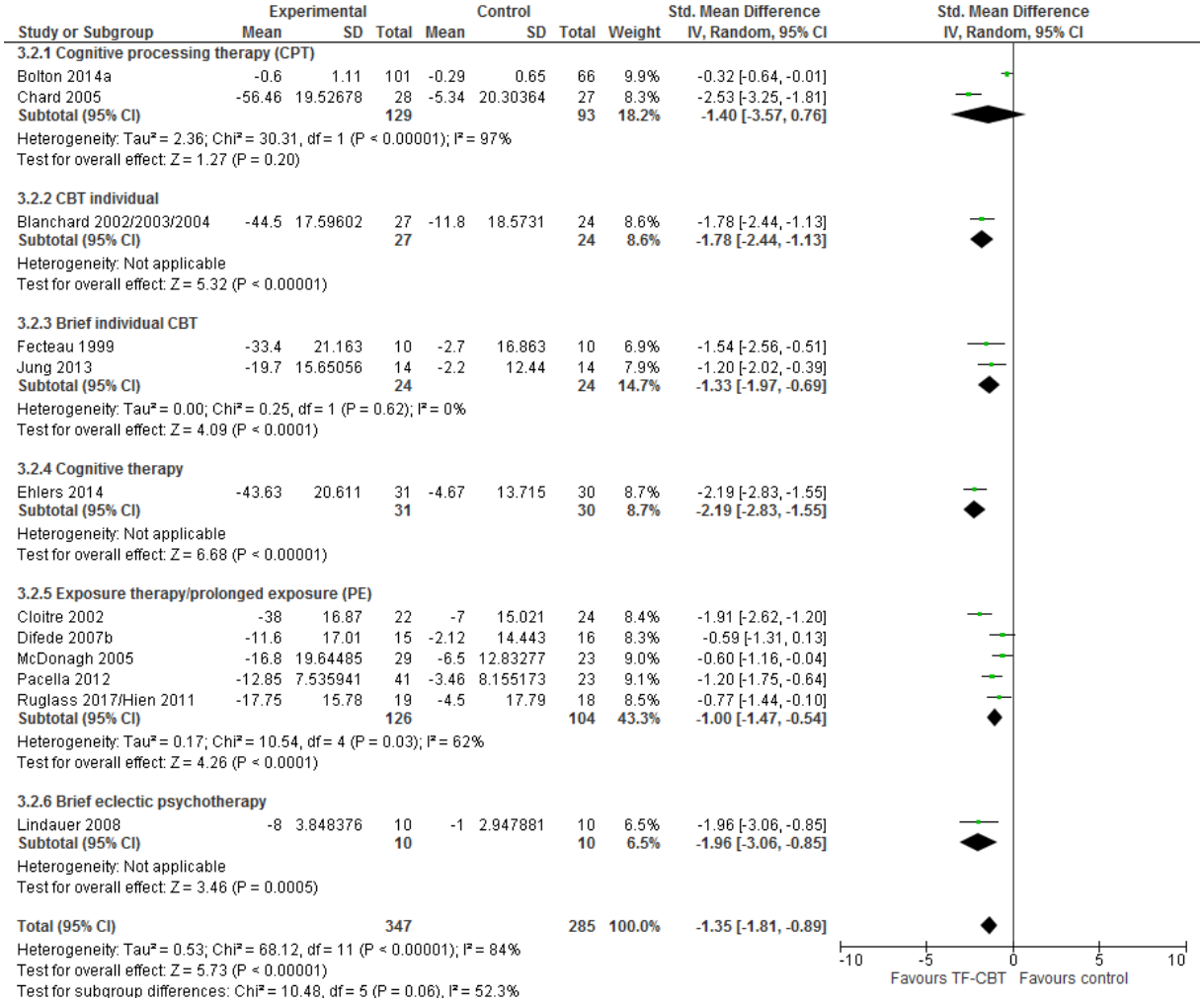
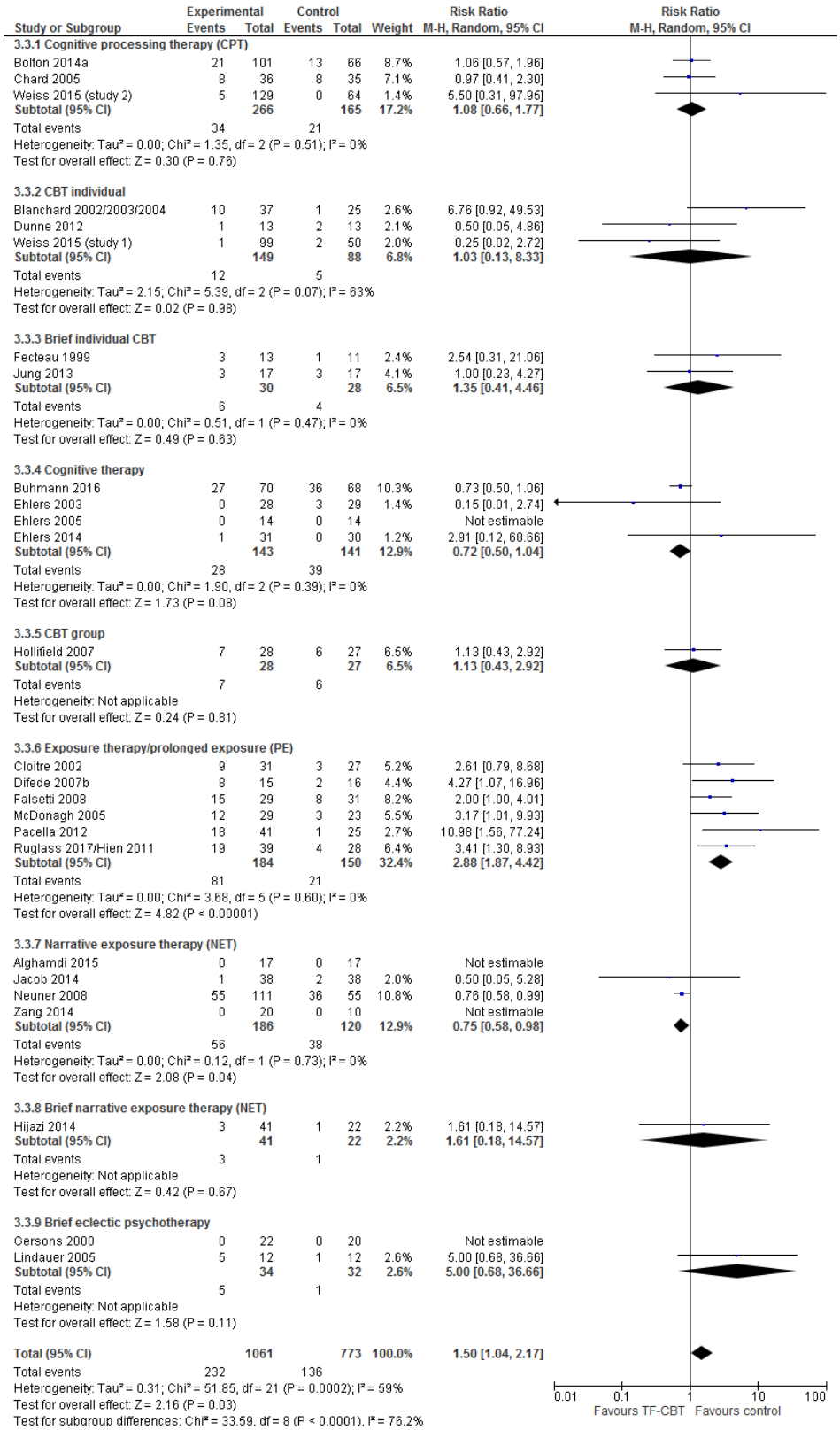


Figure 45: Trauma-focused CBT versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)


Experimental
Control
Risk Ratio
Risk Ratio
Study or Subgroup Events Total Events Total Weight M-H, Random, 95% CI
M-H, Random, 95% CI
3.3.1 Cognitive processing therapy (CPT)
Bolton 2014a 21 101 13 66 8.7% 1.06 [0.57, 1.96]
Chard 2005 8 36 8 35 7.1% 0.97 [0.41, 2.30]
Weiss 2015 (study 2) 5 129 0 64 1.4% 5.50 [0.31, 97.95]
Subtotal (95% CI) 266 165 17.2% 1.08 [0.66, 1.77]
Total events 34 21
Heterogeneity: Tau² = 0.00; Chi² = 1.35, df = 2 (P = 0.51); I² = 0%
Test for overall effect: Z = 0.30 (P = 0.76)
3.3.2 CBT individual
Blanchard 2002/2003/2004 10 37 1 25 2.6% 6.76 [0.92, 49.53]
Dunne 2012 1 13 2 13 2.1% 0.50 [0.05, 4.86]
Weiss 2015 (study 1) 1 99 2 50 2.0% 0.25 [0.02, 2.72]
Subtotal (95% CI) 149 88 6.8% 1.03 [0.13, 8.33]
Total events 12 5
Heterogeneity: Tau² = 2.15; Chi² = 5.39, df = 2 (P = 0.07); I² = 63%
Test for overall effect: Z = 0.02 (P = 0.98)
3.3.3 Brief individual CBT
Fecteau 1999 3 13 1 11 2.4% 2.54 [0.31, 21.06]
Jung 2013 3 17 3 17 4.1% 1.00 [0.23, 4.27]
Subtotal (95% CI) 30 28 6.5% 1.35 [0.41, 4.46]
Total events 6 4
Heterogeneity: Tau² = 0.00; Chi² = 0.51, df = 1 (P = 0.47); I² = 0%
Test for overall effect: Z = 0.49 (P = 0.63)
3.3.4 Cognitive therapy
Buhmann 2016 27 70 36 68 10.3% 0.73 [0.50, 1.06]
Ehlers 2003 0 28 3 29 1.4% 0.15 [0.01, 2.74]
Ehlers 2005 0 14 0 14 Not estimable
Ehlers 2014 1 31 0 30 1.2% 2.91 [0.12, 68.66]
Subtotal (95% CI) 143 141 12.9% 0.72 [0.50, 1.04]
Total events 28 39
Heterogeneity: Tau² = 0.00; Chi² = 1.90, df = 2 (P = 0.39); I² = 0%
Test for overall effect: Z = 1.73 (P = 0.08)
3.3.5 CBT group
Hollifield 2007 7 28 6 27 6.5% 1.13 [0.43, 2.92]
Subtotal (95% CI) 28 27 6.5% 1.13 [0.43, 2.92]
Total events 7 6
Heterogeneity: Not applicable
Test for overall effect: Z = 0.24 (P = 0.81)
3.3.6 Exposure therapy/prolonged exposure (PE)
Cloitre 2002 9 31 3 27 5.2% 2.61 [0.79, 8.68]
Difede 2007b 8 15 2 16 4.4% 4.27 [1.07, 16.96]
Falsetti 2008 15 29 8 31 8.2% 2.00 [1.00, 4.01]
McDonagh 2005 12 29 3 23 5.5% 3.17 [1.01, 9.93]
Pacella 2012 18 41 1 25 2.7% 10.98 [1.56, 77.24]
Ruglass 2017/Hien 2011 19 39 4 28 6.4% 3.41 [1.30, 8.93]
Subtotal (95% CI) 184 150 32.4% 2.88 [1.87, 4.42]
Total events 81 21
Heterogeneity: Tau² = 0.00; Chi² = 3.68, df = 5 (P = 0.60); I² = 0%
Test for overall effect: Z = 4.82 (P < 0.00001)
3.3.7 Narrative exposure therapy (NET)
Alghamdi 2015 0 17 0 17 Not estimable
Jacob 2014 1 38 2 38 2.0% 0.50 [0.05, 5.28]
Neuner 2008 55 111 36 55 10.8% 0.76 [0.58, 0.99]
Zang 2014 0 20 0 10 Not estimable
Subtotal (95% CI) 186 120 12.9% 0.75 [0.58, 0.98]
Total events 56 38
Heterogeneity: Tau² = 0.00; Chi² = 0.12, df = 1 (P = 0.73); I² = 0%
Test for overall effect: Z = 2.08 (P = 0.04)
3.3.8 Brief narrative exposure therapy (NET)
Hijazi 2014 3 41 1 22 2.2% 1.61 [0.18, 14.57]
Subtotal (95% CI) 41 22 2.2% 1.61 [0.18, 14.57]
Total events 3 1
Heterogeneity: Not applicable
Test for overall effect: Z = 0.42 (P = 0.67)
3.3.9 Brief eclectic psychotherapy
Gersons 2000 0 22 0 20 Not estimable
Lindauer 2005 5 12 1 12 2.6% 5.00 [0.68, 36.66]
Subtotal (95% CI) 34 32 2.6% 5.00 [0.68, 36.66]
Total events 5 1
Heterogeneity: Not applicable
Test for overall effect: Z = 1.58 (P = 0.11)
Total (95% CI) 1061 773 100.0% 1.50 [1.04, 2.17]
Total events 232 136
Heterogeneity: Tau² = 0.31; Chi² = 51.85, df = 21 (P = 0.0002); I² = 59%
Test for overall effect: Z = 2.16 (P = 0.03)
Test for subgroup differences: Chi² = 33.59, df = 8 (P < 0.0001), I² = 76.2%
0.01 0.1 1 10 100
Favours TF-CBT Favours control

Sub-analysis by diagnostic status at baseline: Trauma-focused CBT versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD

Figure 46: Trauma-focused CBT versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated at endpoint (PCL/SPTSS/HTQ/MPSS/PDS/PSS-SR/IES-R change score)

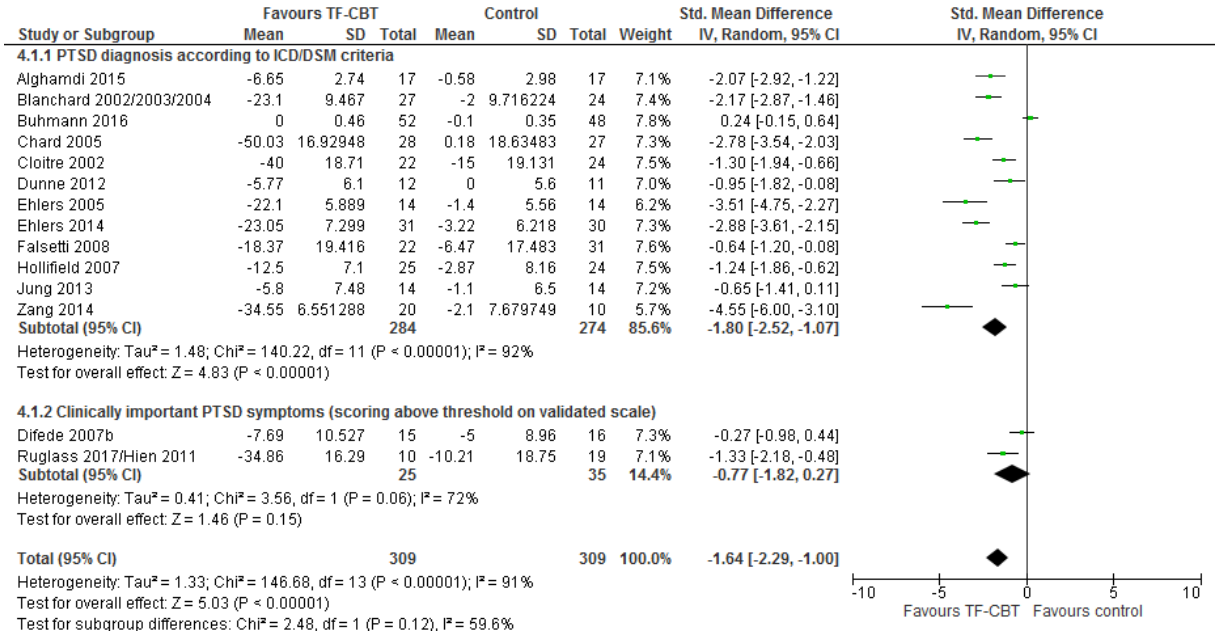


Figure 47: Trauma-focused CBT versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated at endpoint (CAPS/HTQ/SI-PTSD/PSS-I change score)

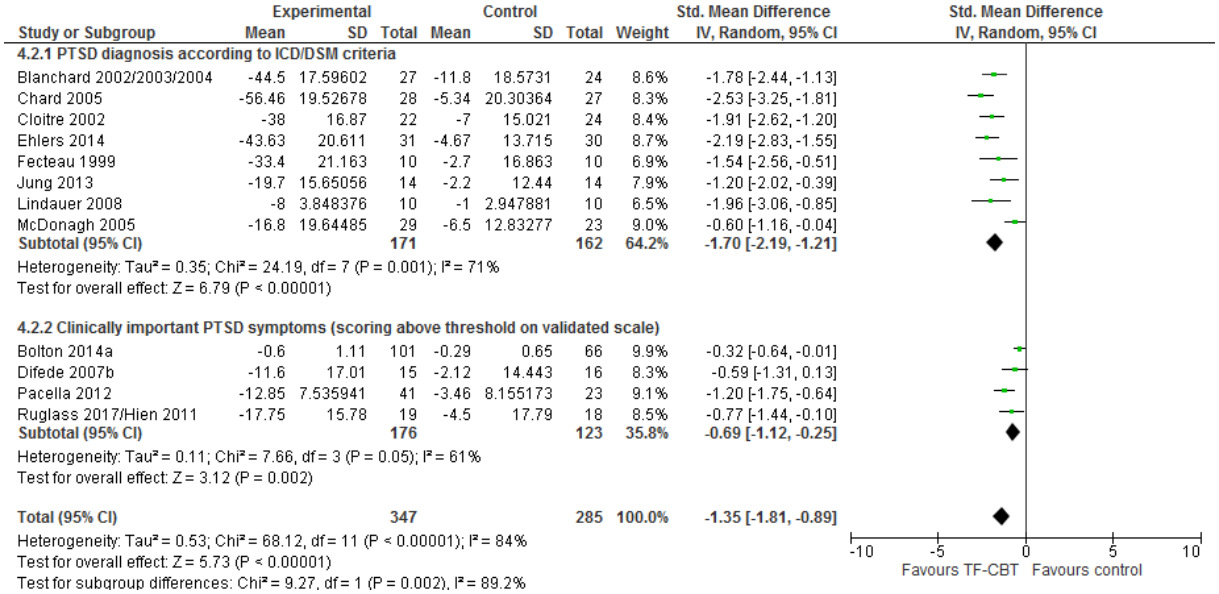
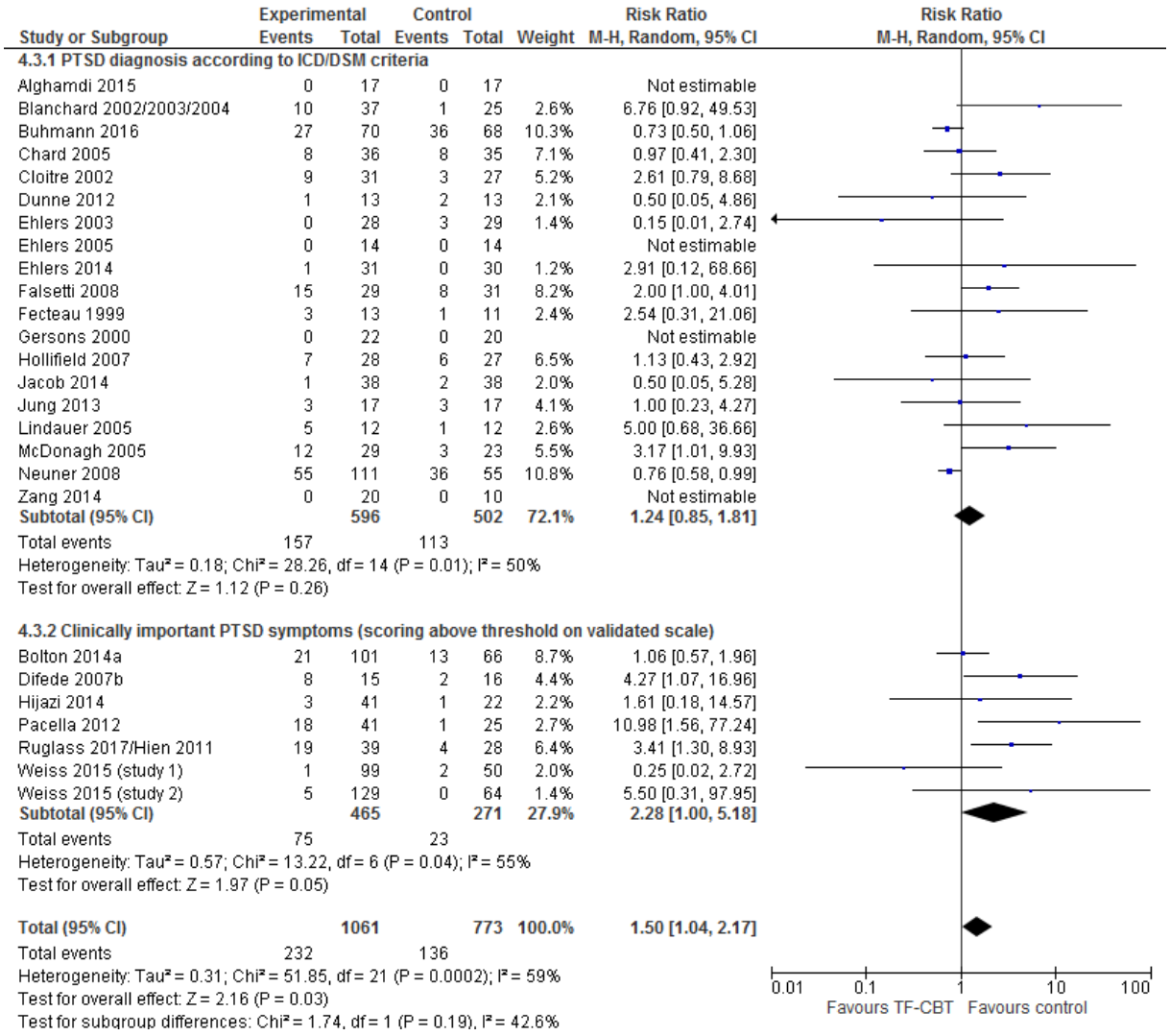


Figure 48: Trauma-focused CBT versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)



Sub-analysis by diagnostic status at baseline: Trauma-focused CBT versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD

Figure 49: Trauma-focused CBT versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated at endpoint (PCL/SPTSS/HTQ/MPSS/PDS/PSS-SR/IES-R change score)

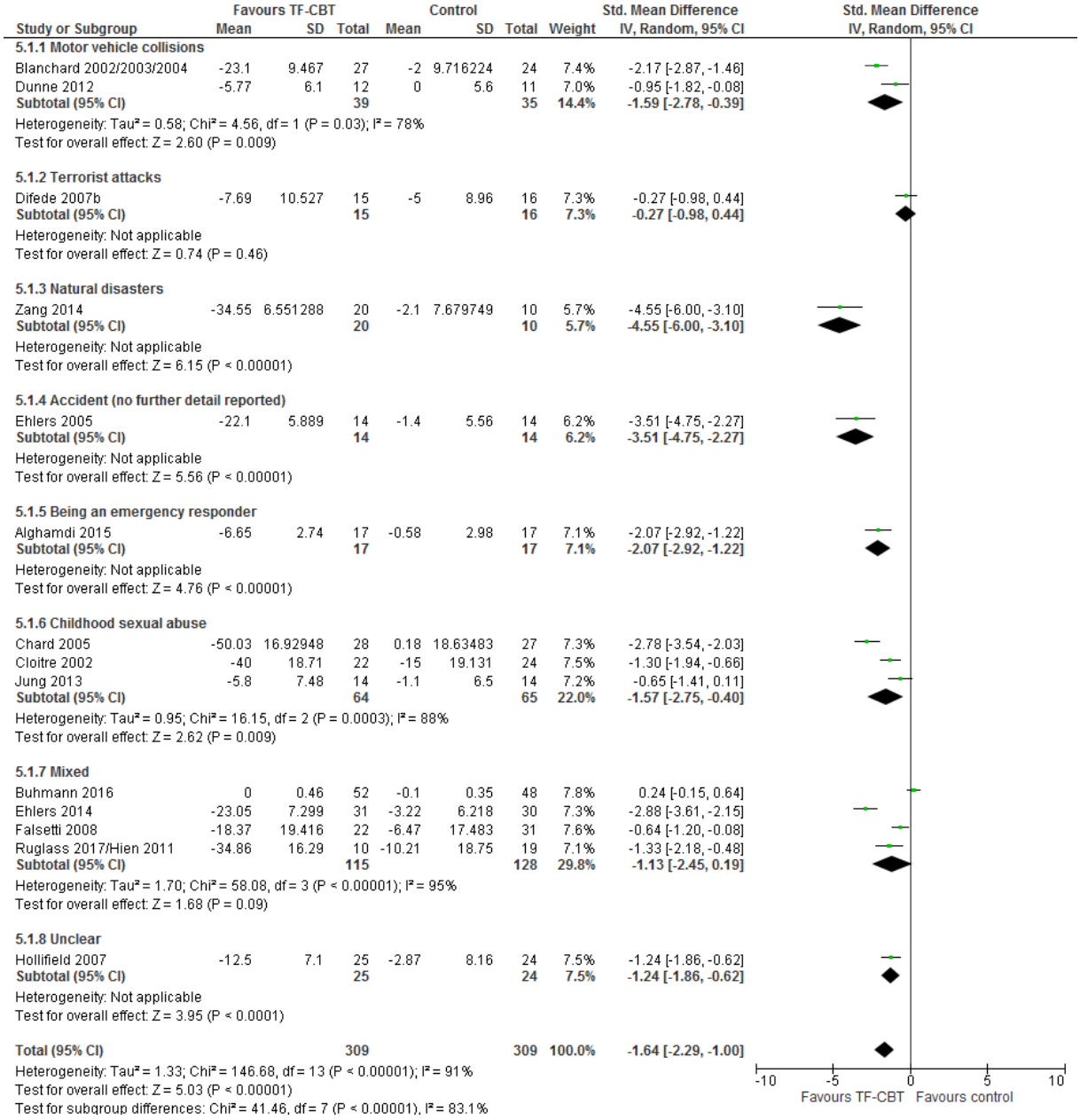


Figure 50: Trauma-focused CBT versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated at endpoint (CAPS/HTQ/SI-PTSD/PSS-I change score)

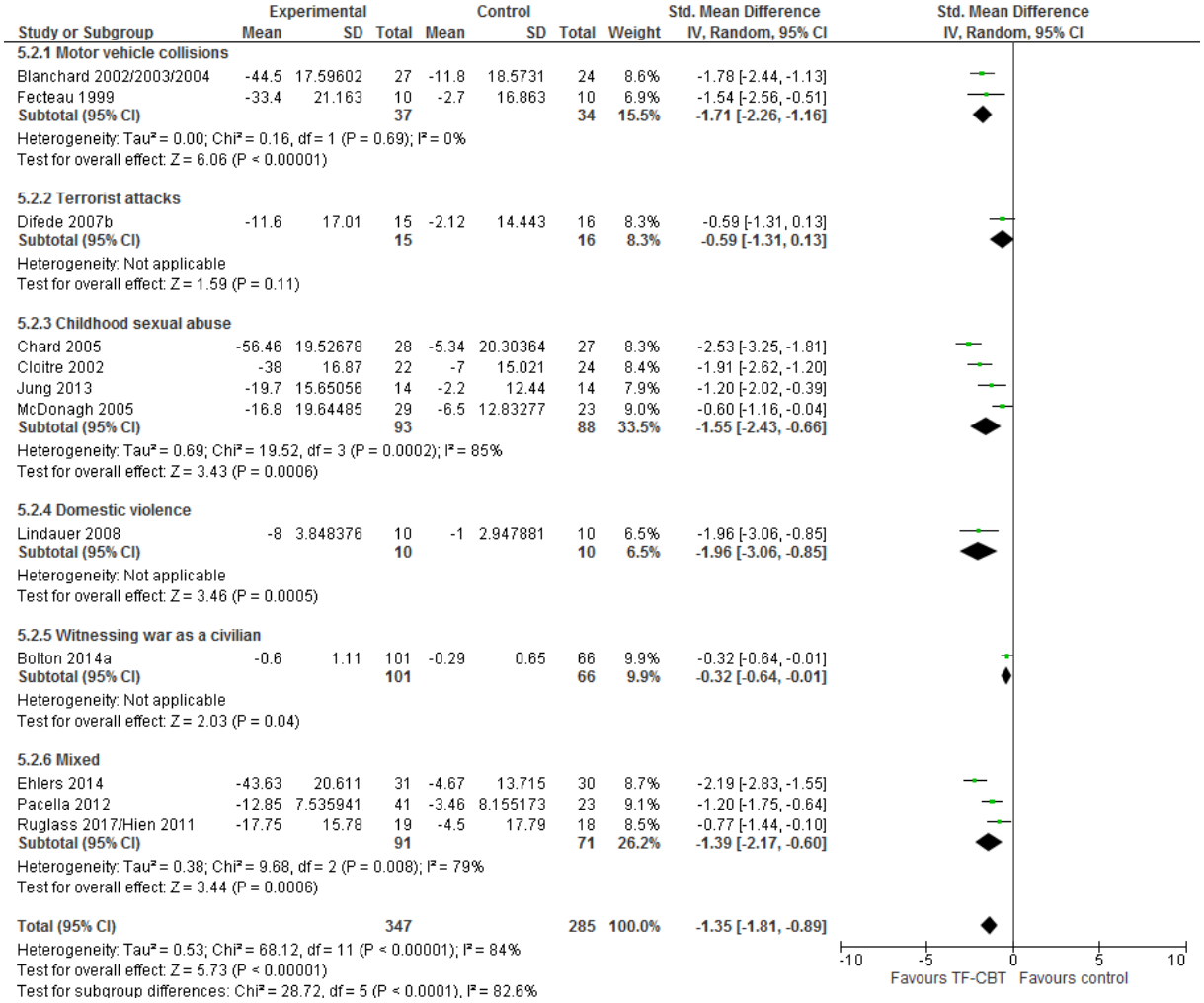


Figure 51: Trauma-focused CBT versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)

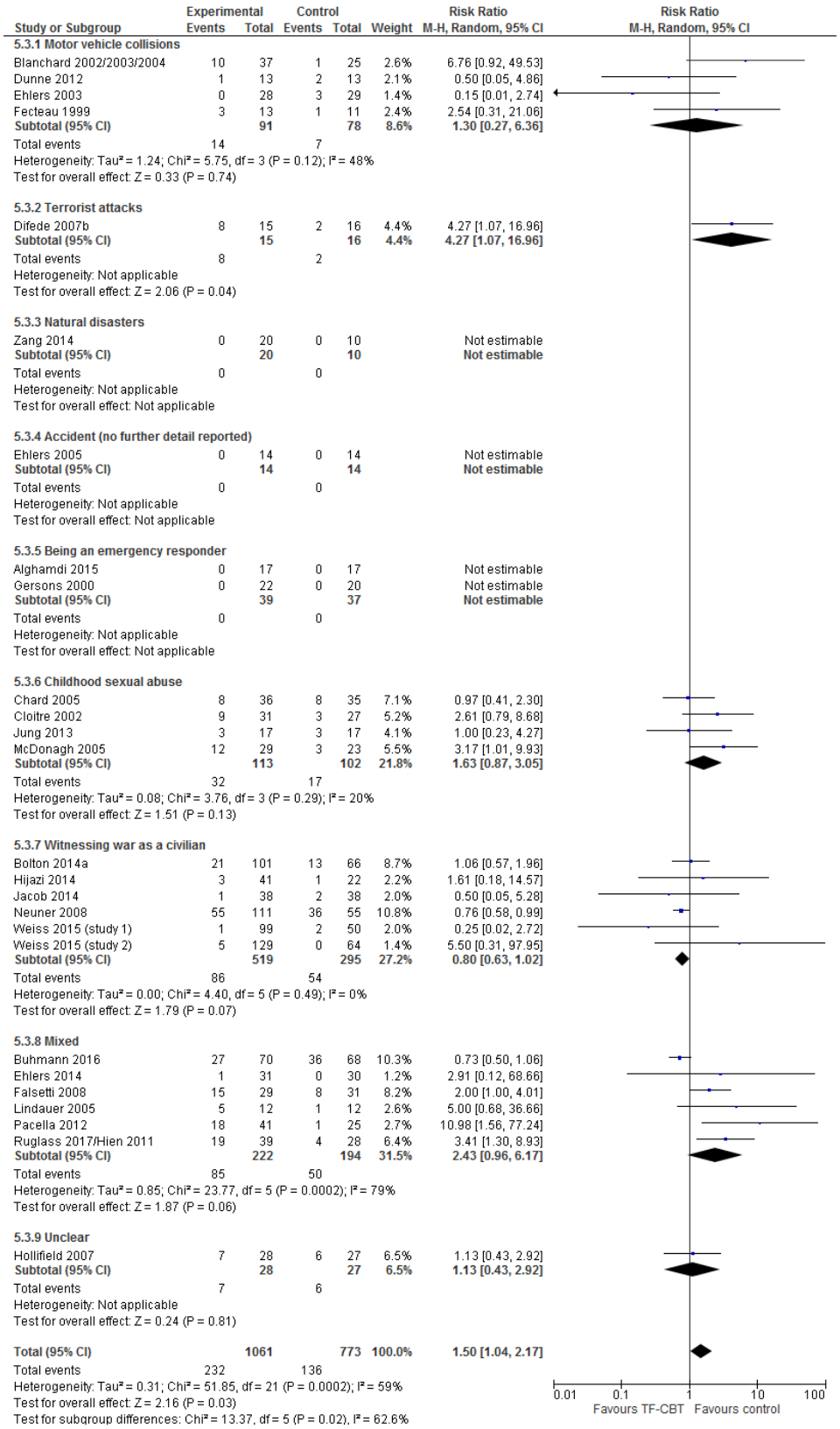

Experimental
Control
Risk Ratio
Risk Ratio
Study or Subgroup Events Total Events Total Weight M-H, Random, 95% CI
M-H, Random, 95% CI
5.3.1 Motor vehicle collisions
Blanchard 2002/2003/2004 10 37 1 25 2.6% 6.76 [0.92, 49.53]
Dunne 2012 1 13 2 13 2.1% 0.50 [0.05, 4.86]
Ehlers 2003 0 28 3 29 1.4% 0.15 [0.01, 2.74]
Fecteau 1999 3 13 1 11 2.4% 2.54 [0.31, 21.06]
Subtotal (95% CI) 91 78 8.6% 1.30 [0.27, 6.36]
Total events 14 7
Heterogeneity: Tau² = 1.24; Chi² = 5.75, df = 3 (P = 0.12); I² = 48%
Test for overall effect: Z = 0.33 (P = 0.74)
5.3.2 Terrorist attacks
Difede 2007b 8 15 2 16 4.4% 4.27 [1.07, 16.96]
Subtotal (95% CI) 15 16 4.4% 4.27 [1.07, 16.96]
Total events 8 2
Heterogeneity: Not applicable
Test for overall effect: Z = 2.06 (P = 0.04)
5.3.3 Natural disasters
Zang 2014 0 20 0 10 Not estimable
Subtotal (95% CI) 20 10 Not estimable
Total events 0 0
Heterogeneity: Not applicable
Test for overall effect: Not applicable
5.3.4 Accident (no further detail reported)
Ehlers 2005 0 14 0 14 Not estimable
Subtotal (95% CI) 14 14 Not estimable
Total events 0 0
Heterogeneity: Not applicable
Test for overall effect: Not applicable
5.3.5 Being an emergency responder
Alghamdi 2015 0 17 0 17 Not estimable
Gersons 2000 0 22 0 20 Not estimable
Subtotal (95% CI) 39 37 Not estimable
Total events 0 0
Heterogeneity: Not applicable
Test for overall effect: Not applicable
5.3.6 Childhood sexual abuse
Chard 2005 8 36 8 35 7.1% 0.97 [0.41, 2.30]
Cloitre 2002 9 31 3 27 5.2% 2.61 [0.79, 8.68]
Jung 2013 3 17 3 17 4.1% 1.00 [0.23, 4.27]
McDonagh 2005 12 29 3 23 5.5% 3.17 [1.01, 9.93]
Subtotal (95% CI) 113 102 21.8% 1.63 [0.87, 3.05]
Total events 32 17
Heterogeneity: Tau² = 0.08; Chi² = 3.76, df = 3 (P = 0.29); I² = 20%
Test for overall effect: Z = 1.51 (P = 0.13)
5.3.7 Witnessing war as a civilian
Bolton 2014a 21 101 13 66 8.7% 1.06 [0.57, 1.96]
Hijazi 2014 3 41 1 22 2.2% 1.61 [0.18, 14.57]
Jacob 2014 1 38 2 38 2.0% 0.50 [0.05, 5.28]
Neuner 2008 55 111 36 55 10.8% 0.76 [0.58, 0.99]
Weiss 2015 (study 1) 1 99 2 50 2.0% 0.25 [0.02, 2.72]
Weiss 2015 (study 2) 5 129 0 64 1.4% 5.50 [0.31, 97.95]
Subtotal (95% CI) 519 295 27.2% 0.80 [0.63, 1.02]
Total events 86 54
Heterogeneity: Tau² = 0.00; Chi² = 4.40, df = 5 (P = 0.49); I² = 0%
Test for overall effect: Z = 1.79 (P = 0.07)
5.3.8 Mixed
Buhmann 2016 27 70 36 68 10.3% 0.73 [0.50, 1.06]
Ehlers 2014 1 31 0 30 1.2% 2.91 [0.12, 68.66]
Falsetti 2008 15 29 8 31 8.2% 2.00 [1.00, 4.01]
Lindauer 2005 5 12 1 12 2.6% 5.00 [0.68, 36.66]
Pacella 2012 18 41 1 25 2.7% 10.98 [1.56, 77.24]
Ruglass 2017/Hien 2011 19 39 4 28 6.4% 3.41 [1.30, 8.93]
Subtotal (95% CI) 222 194 31.5% 2.43 [0.96, 6.17]
Total events 85 50
Heterogeneity: Tau² = 0.85; Chi² = 23.77, df = 5 (P = 0.0002); I² = 79%
Test for overall effect: Z = 1.87 (P = 0.06)
5.3.9 Unclear
Hollifield 2007 7 28 6 27 6.5% 1.13 [0.43, 2.92]
Subtotal (95% CI) 28 27 6.5% 1.13 [0.43, 2.92]
Total events 7 6
Heterogeneity: Not applicable
Test for overall effect: Z = 0.24 (P = 0.81)
Total (95% CI) 1061 773 100.0% 1.50 [1.04, 2.17]
Total events 232 136
Heterogeneity: Tau² = 0.31; Chi² = 51.85, df = 21 (P = 0.0002); I² = 59%
Test for overall effect: Z = 2.16 (P = 0.03)
Test for subgroup differences: Chi² = 13.37, df = 5 (P = 0.02), I² = 62.6%
0.01 0.1 1 10 100
Favours TF-CBT Favours control

Figure 52: Trauma-focused CBT + medication/TAU versus medication/TAU only (or+ attention-placebo) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated at endpoint (IES/IES-R/PDS/PSS-SR/HTQ/DTS/PCL/MPSS change score)

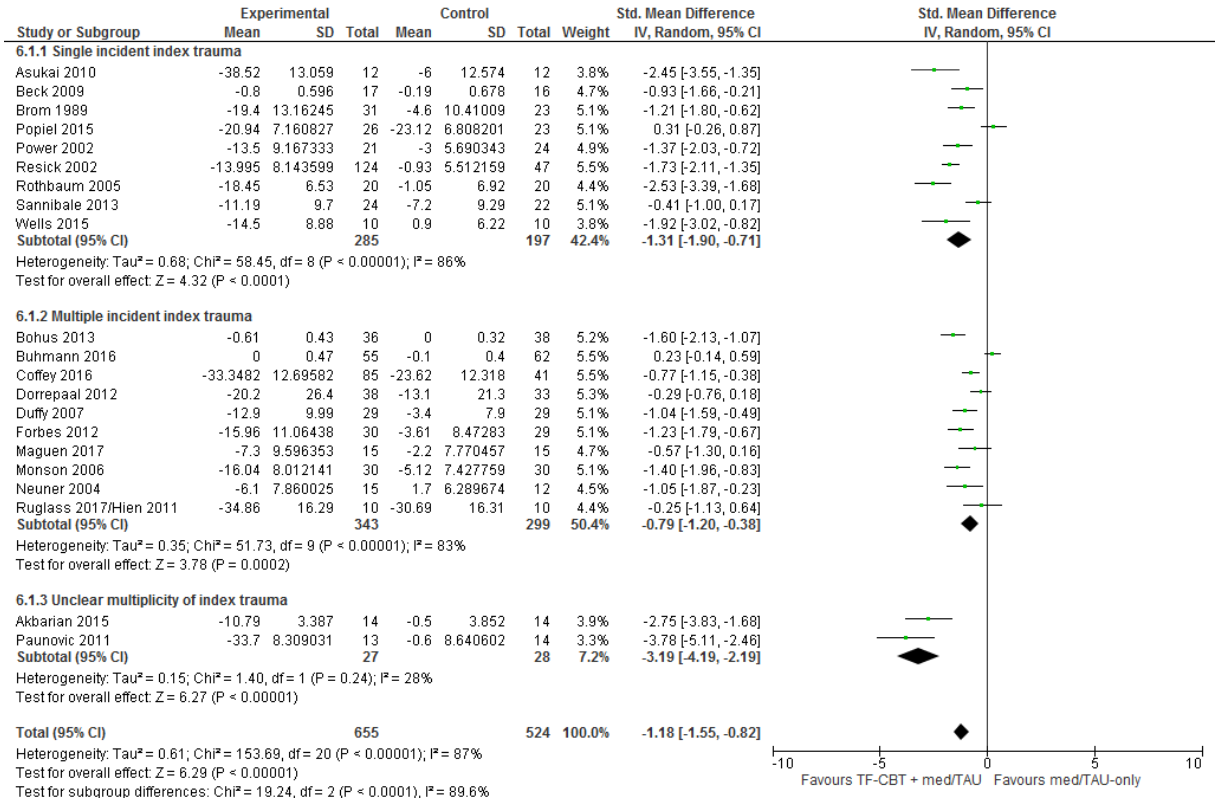


Figure 53: Trauma-focused CBT + medication/TAU versus medication/TAU only (or+ attention-placebo) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated at 1-month follow-up (PCL/PDS change score)

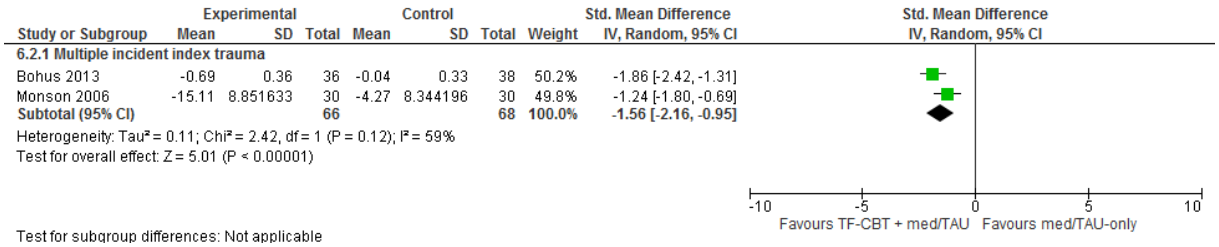


Figure 54: Trauma-focused CBT + medication/TAU versus medication/TAU only (or+ attention-placebo) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated at 3-4 month follow-up (PCL/PDS/IES-R change score)

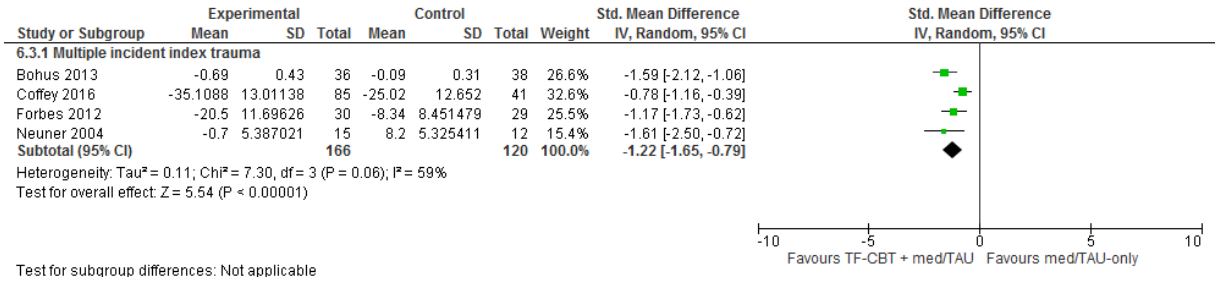


Figure 55: Trauma-focused CBT + medication/TAU versus medication/TAU only (or+ attention-placebo) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated at 5-6 month follow-up (IES-R/PDS change score)

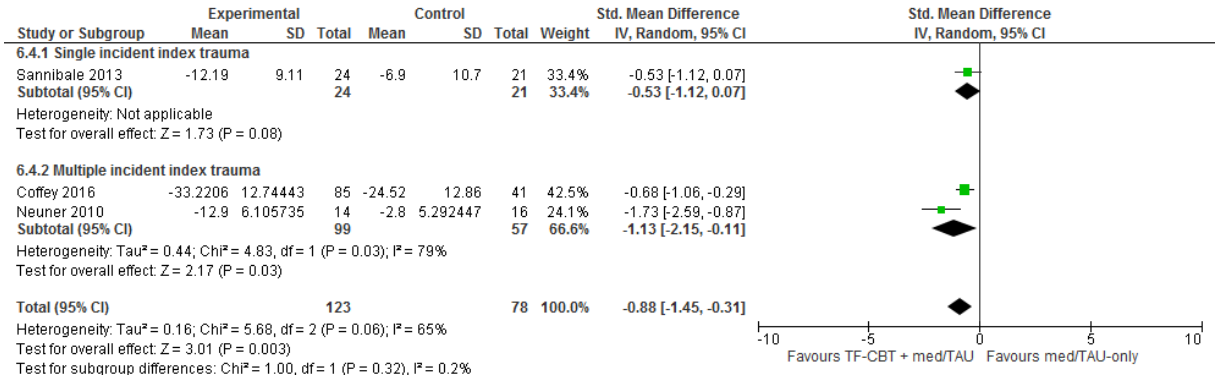


Figure 56: Trauma-focused CBT + medication/TAU versus medication/TAU only (or+ attention-placebo) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated at 9-12 month follow-up (PDS change score)

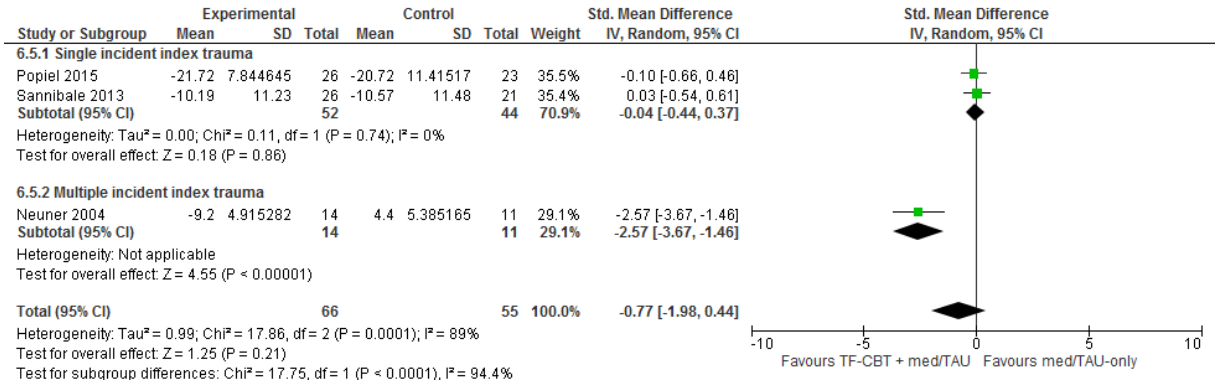


Figure 57: Trauma-focused CBT + medication/TAU versus medication/TAU only (or+ attention-placebo) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated at endpoint (CAPS/HTQ/PSS-I/SI-PTSD change score)

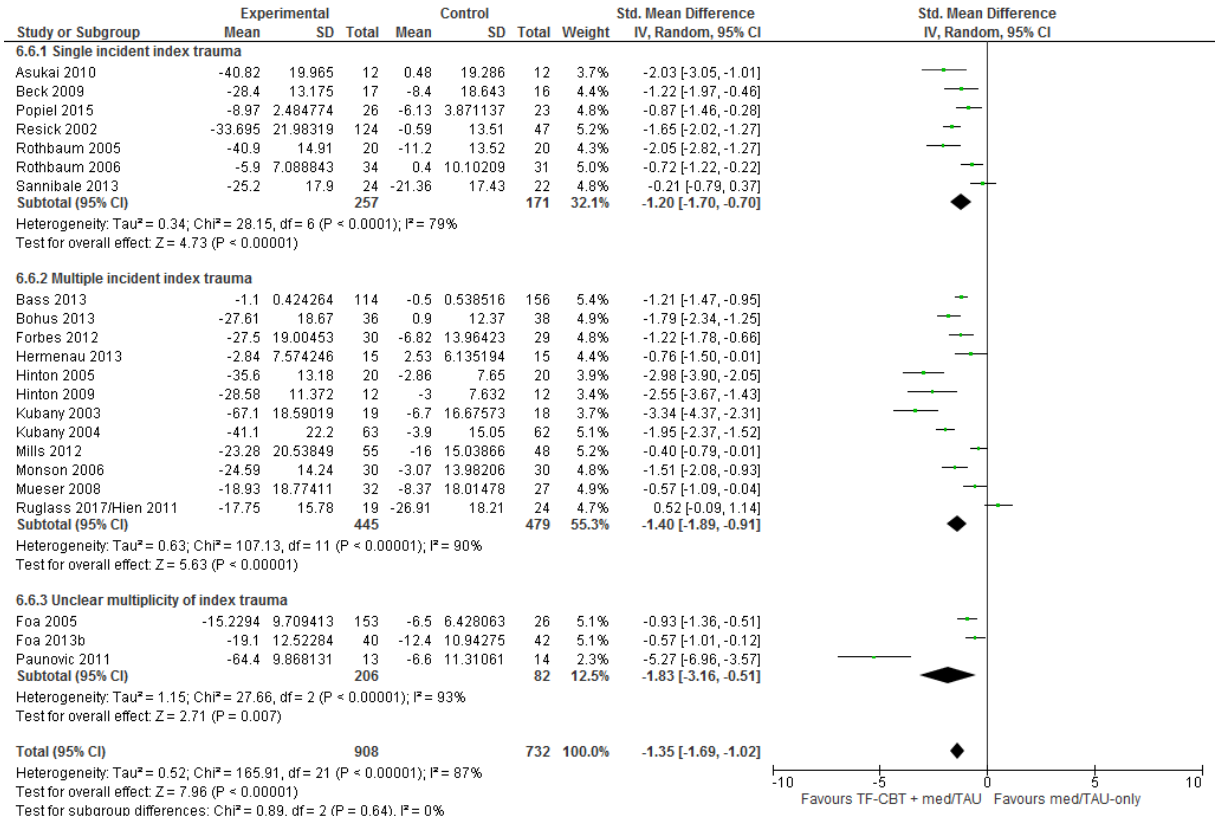


Figure 58: Trauma-focused CBT + medication/TAU versus medication/TAU only (or+ attention-placebo) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated at 1-month follow-up (CAPS change score)

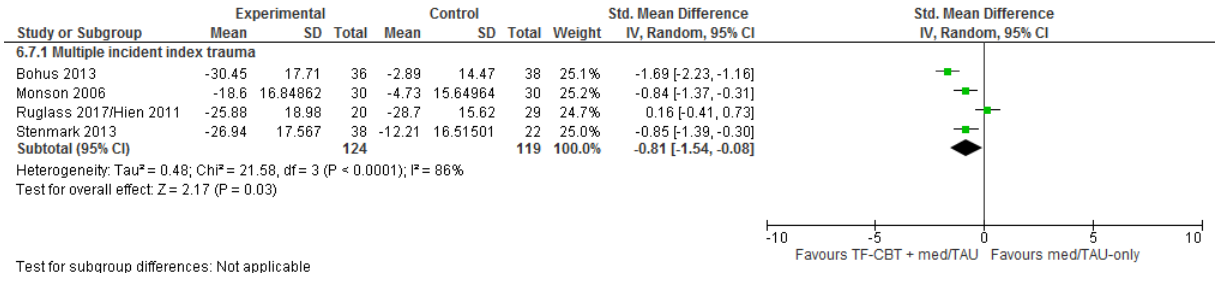


Figure 59: Trauma-focused CBT + medication/TAU versus medication/TAU only (or+ attention-placebo) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated at 3-4 month follow-up (CAPS change score)

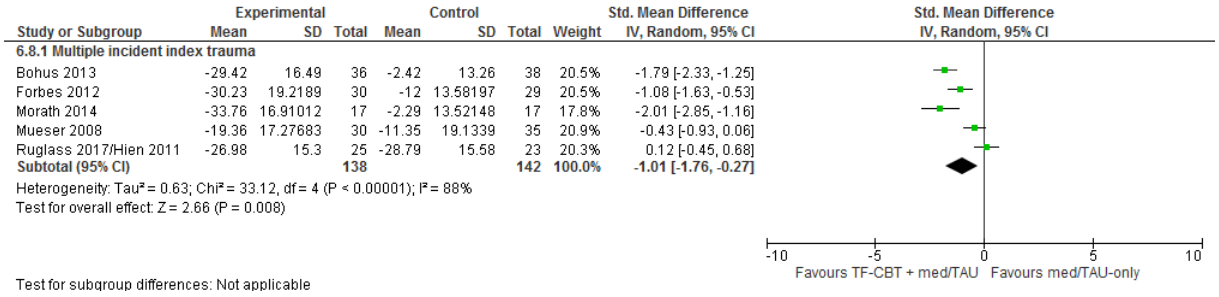


Figure 60: Trauma-focused CBT + medication/TAU versus medication/TAU only (or+ attention-placebo) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated at 5-6 month follow-up (CAPS/HTQ/PSS-I/PDS change score)

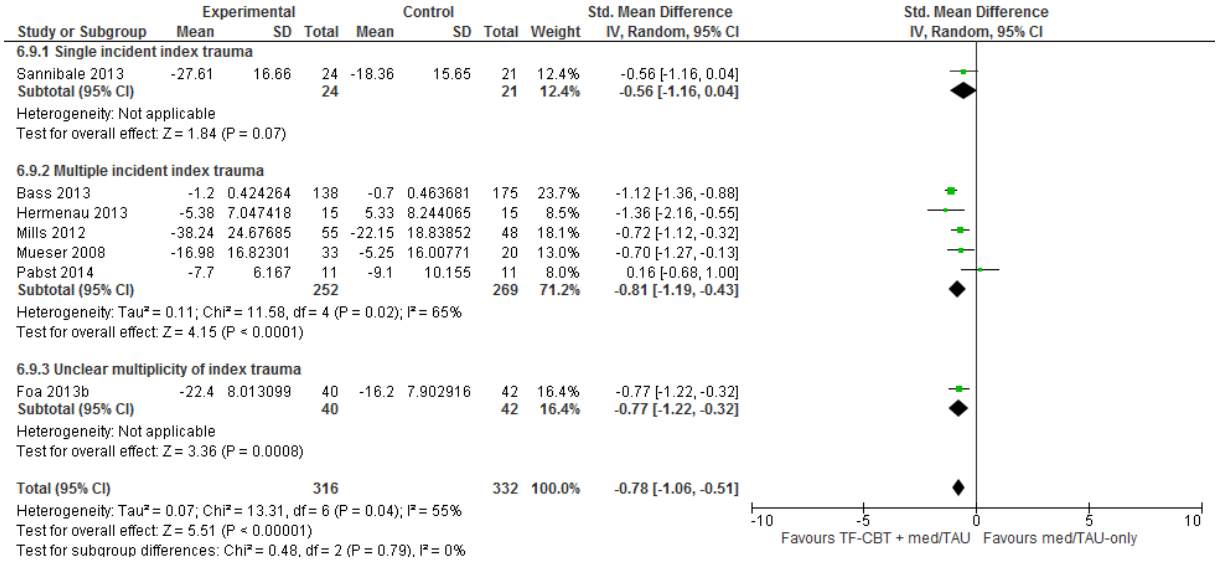


Figure 61: Trauma-focused CBT + medication/TAU versus medication/TAU only (or+ attention-placebo) for delayed treatment (>3 months) of clinically important

symptoms/PTSD: PTSD symptomatology clinician-rated at 5-6 month follow-up (CAPS/PDS-I/CIDI-PT SD change score)

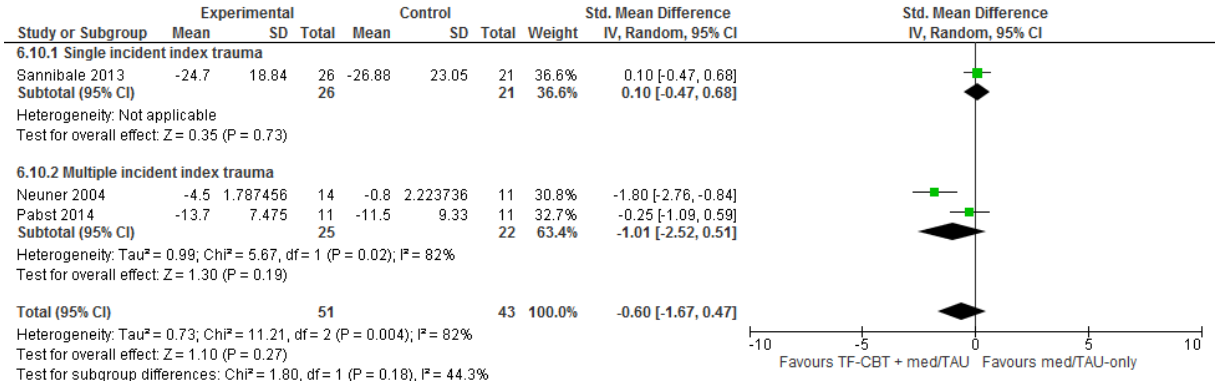


Figure 62: Trauma-focused CBT + medication/TAU versus medication/TAU only (or+ attention-placebo) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Remission at endpoint (number of people no longer meeting diagnostic criteria/above threshold on a scale for PTSD)

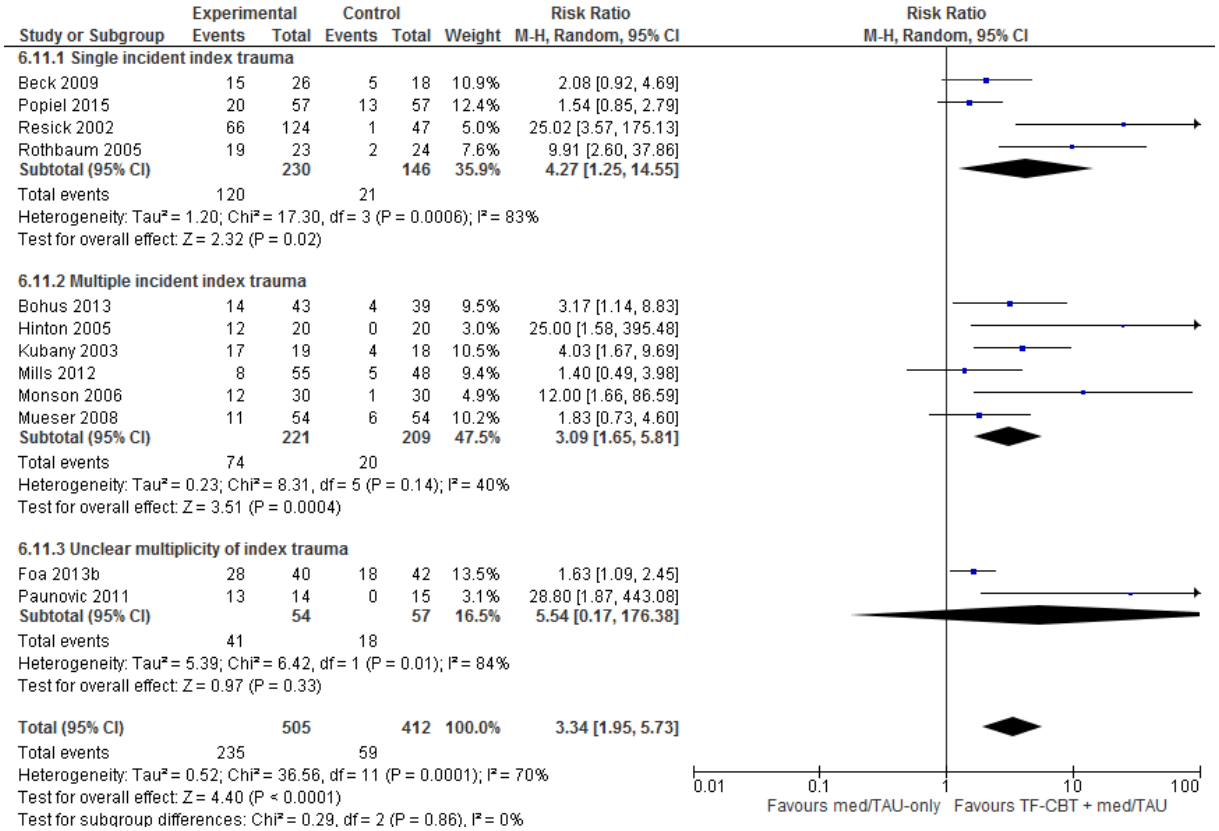


Figure 63: Trauma-focused CBT + medication/TAU versus medication/TAU only (or+ attention-placebo) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Remission at 1-3 month follow-up (number of people no longer meeting diagnostic criteria for PTSD)

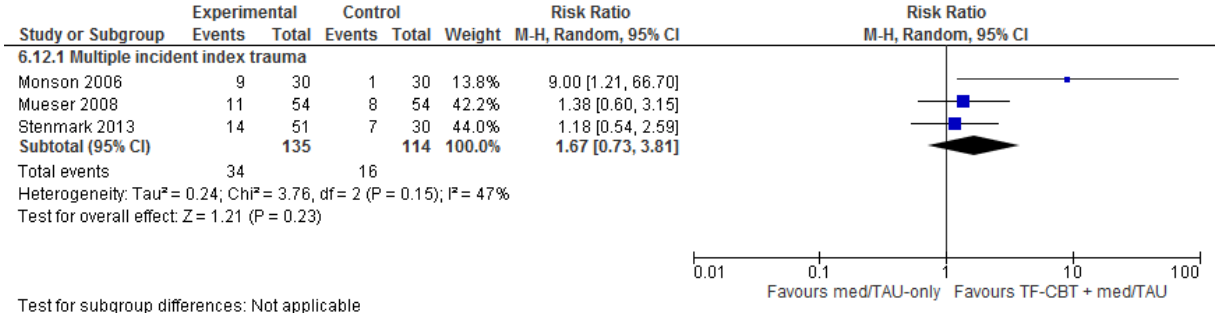


Figure 64: Trauma-focused CBT + medication/TAU versus medication/TAU only (or+ attention-placebo) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Remission at 6-month follow-up (number of people no longer meeting diagnostic criteria for PTSD)

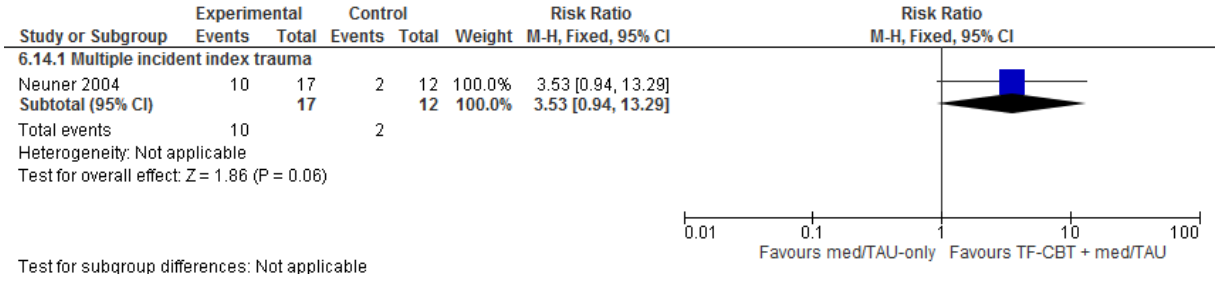


Figure 65: Trauma-focused CBT + medication/TAU versus medication/TAU only (or+ attention-placebo) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Remission at 1-year follow-up (number of people no longer meeting diagnostic criteria for PTSD)

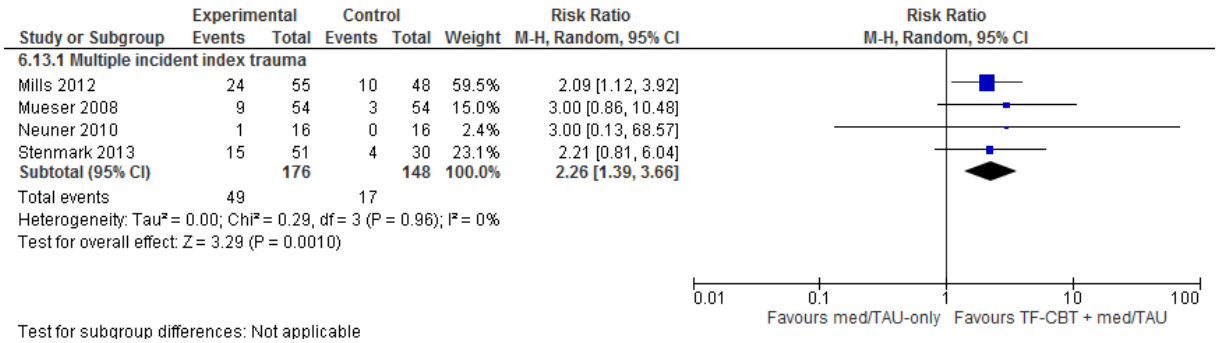


Figure 66: Trauma-focused CBT + medication/TAU versus medication/TAU only (or+ attention-placebo) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Response self-rated at endpoint (number of people

showing clinically significant improvement based on reliable change indices [RCI] on IES/IES-R/DTS)

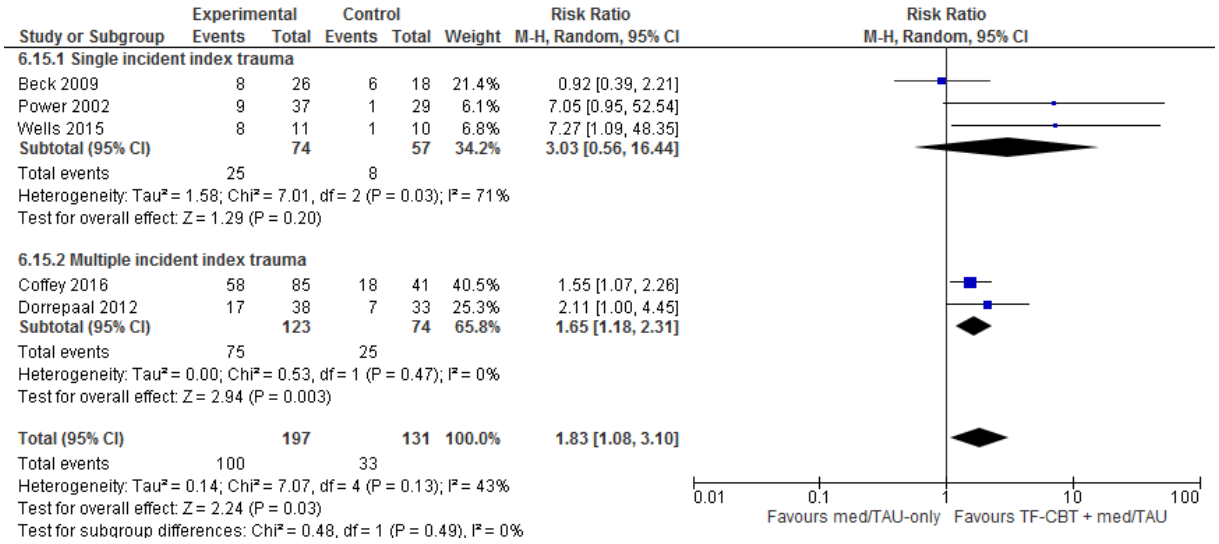


Figure 67: Trauma-focused CBT + medication/TAU versus medication/TAU only (or+ attention-placebo) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Response self-rated at 6-month follow-up (number of people showing clinically significant improvement (based on reliable change indices [RCI] on PDS)

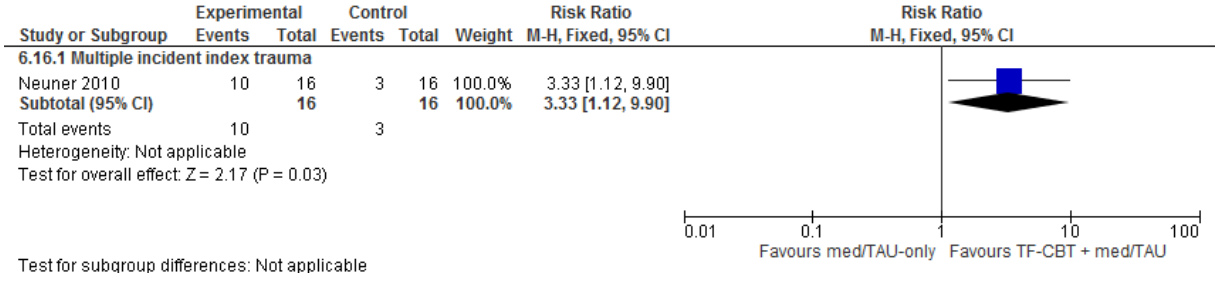


Figure 68: Trauma-focused CBT + medication/TAU versus medication/TAU only (or+ attention-placebo) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Response clinician-rated at endpoint (number of people

showing clinically significant improvement based on reliable change indices [RCI]/improvement at least 12/30 points on CAPS)

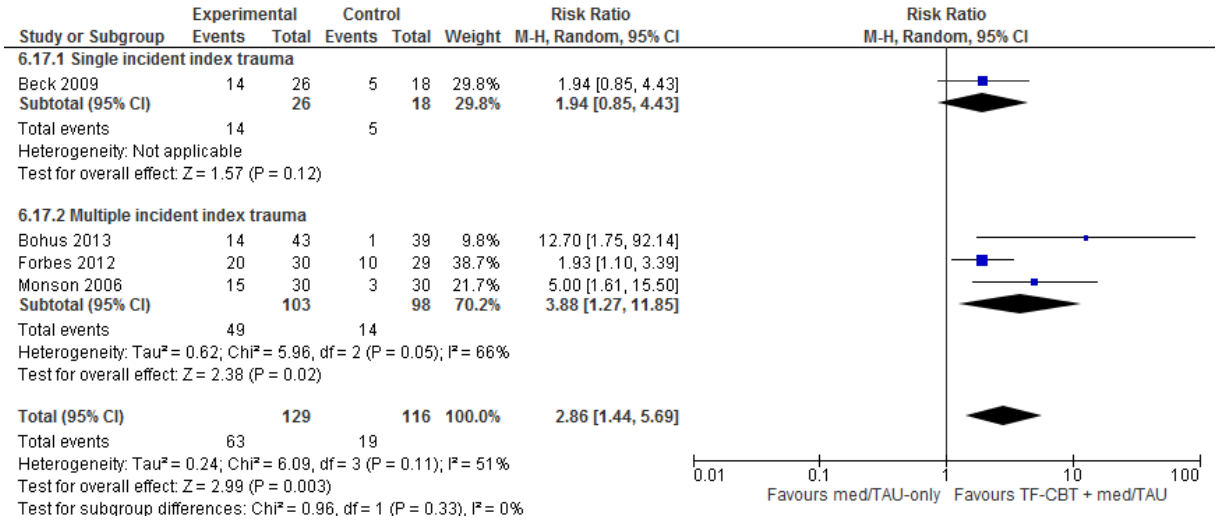


Figure 69: Trauma-focused CBT + medication/TAU versus medication/TAU only (or+ attention-placebo) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Response clinician-rated at 1-month follow-up (number of people showing clinically significant improvement based on reliable change indices [RCI]/improvement of at least 12 points on CAPS)

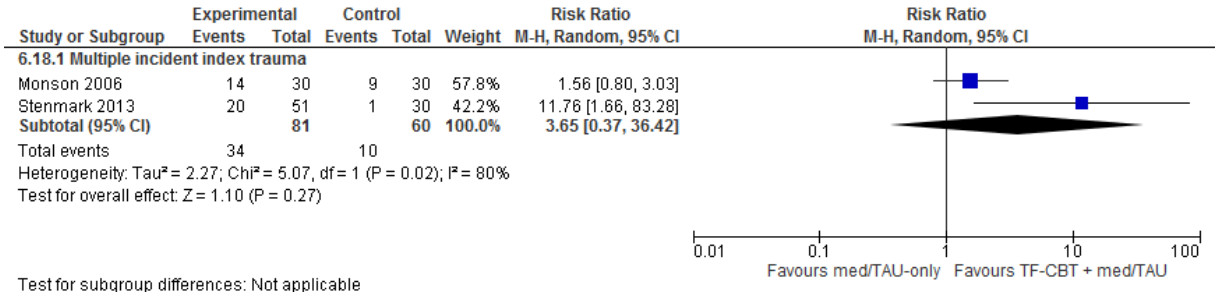


Figure 70: Trauma-focused CBT + medication/TAU versus medication/TAU only (or+ attention-placebo) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Dissociative symptoms at endpoint (DES change score)

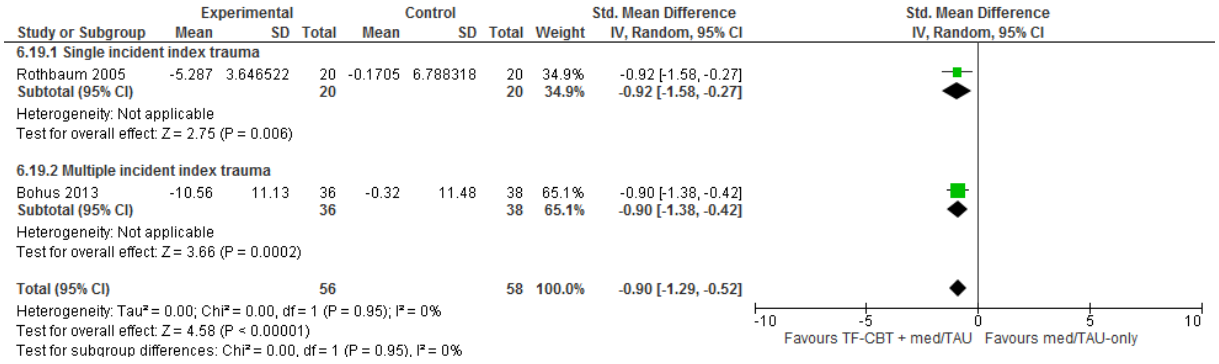


Figure 71: Trauma-focused CBT + medication/TAU versus medication/TAU only (or+ attention-placebo) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Dissociative symptoms at follow-up (DES change score); Multiple incident index trauma

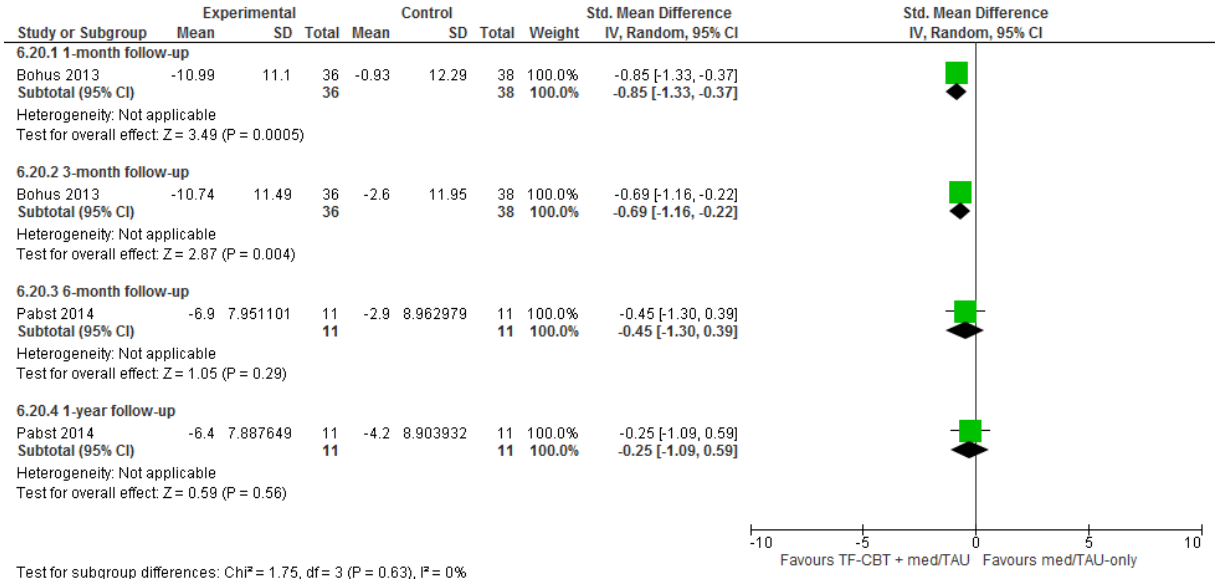


Figure 72: Trauma-focused CBT + medication/TAU versus medication/TAU only (or+ attention-placebo) for delayed treatment (>3 months) of clinically important

symptoms/PTSD: Anxiety symptoms at endpoint (BAI/HAM-A/STAI State change score)

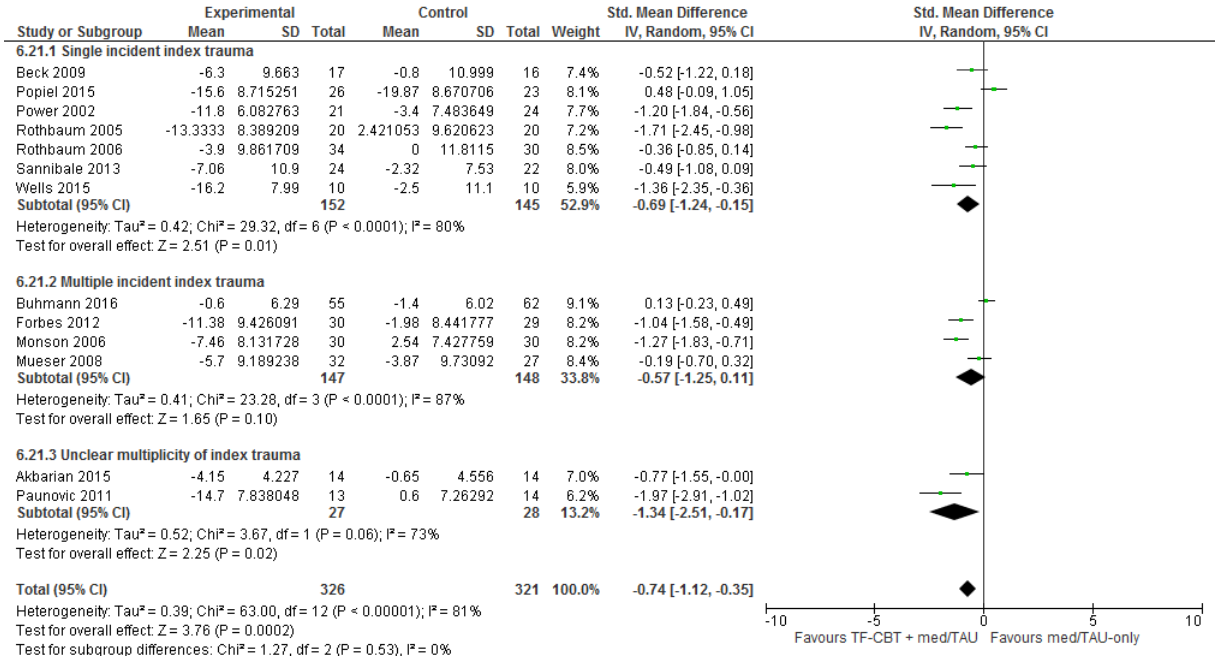


Figure 73: Trauma-focused CBT + medication/TAU versus medication/TAU only (or+ attention-placebo) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Anxiety symptoms at 1-month follow-up (STAI State change score)

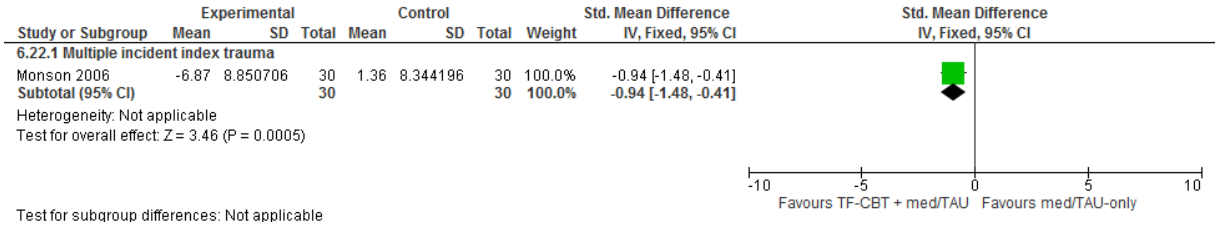


Figure 74: Trauma-focused CBT + medication/TAU versus medication/TAU only (or+ attention-placebo) for delayed treatment (>3 months) of clinically important

symptoms/PTSD: Anxiety symptoms at 3-month follow-up (BAI/STAI State change score)

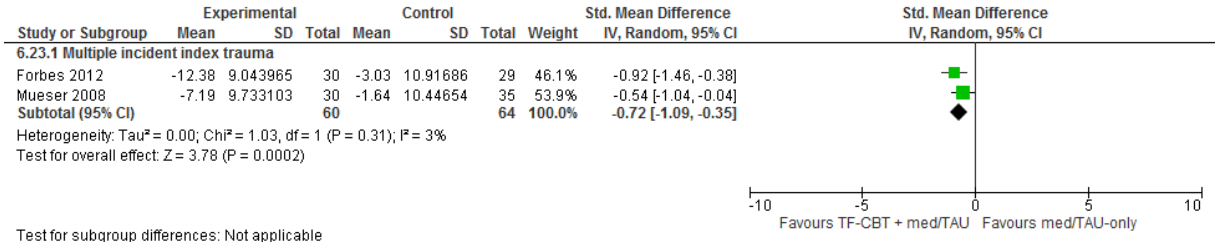


Figure 75: Trauma-focused CBT + medication/TAU versus medication/TAU only (or+ attention-placebo) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Anxiety symptoms at 5-6 month follow-up (BAI/STAI State change score)

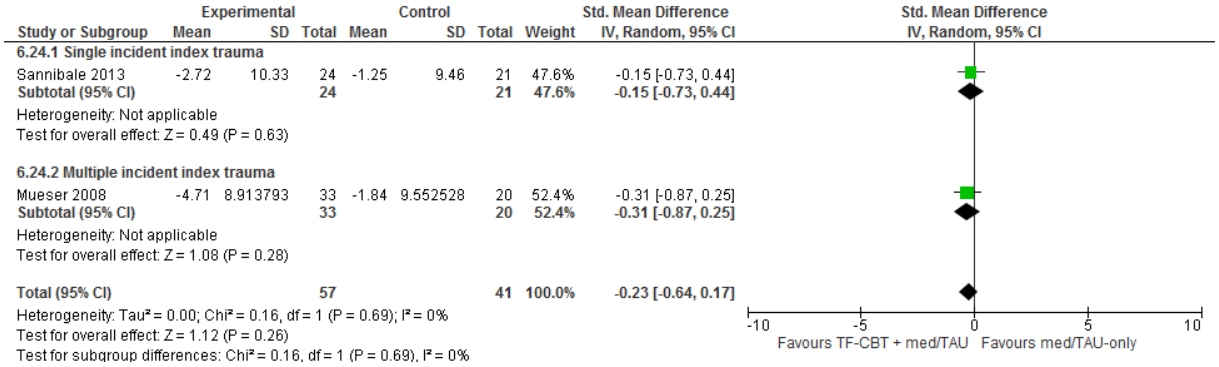


Figure 76: Trauma-focused CBT + medication/TAU versus medication/TAU only (or+ attention-placebo) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Anxiety symptoms at 9-12 month follow-up (STAI State change score)

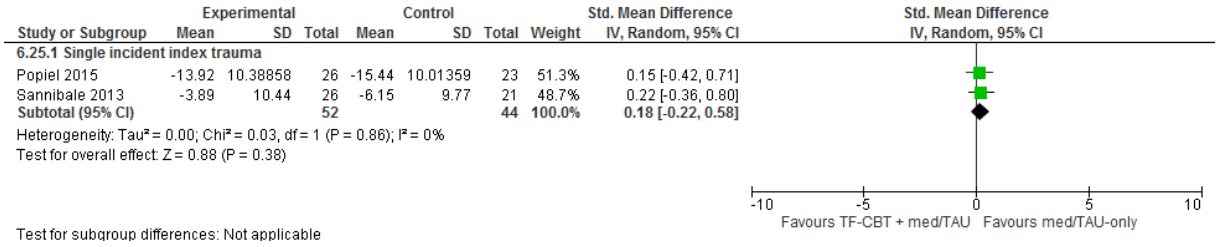


Figure 77: Trauma-focused CBT + medication/TAU versus medication/TAU only (or+ attention-placebo) for delayed treatment (>3 months) of clinically important

symptoms/PTSD: Depression symptoms at endpoint (BDI/BDI-II/CES-D/HAMD/MADRS change score)

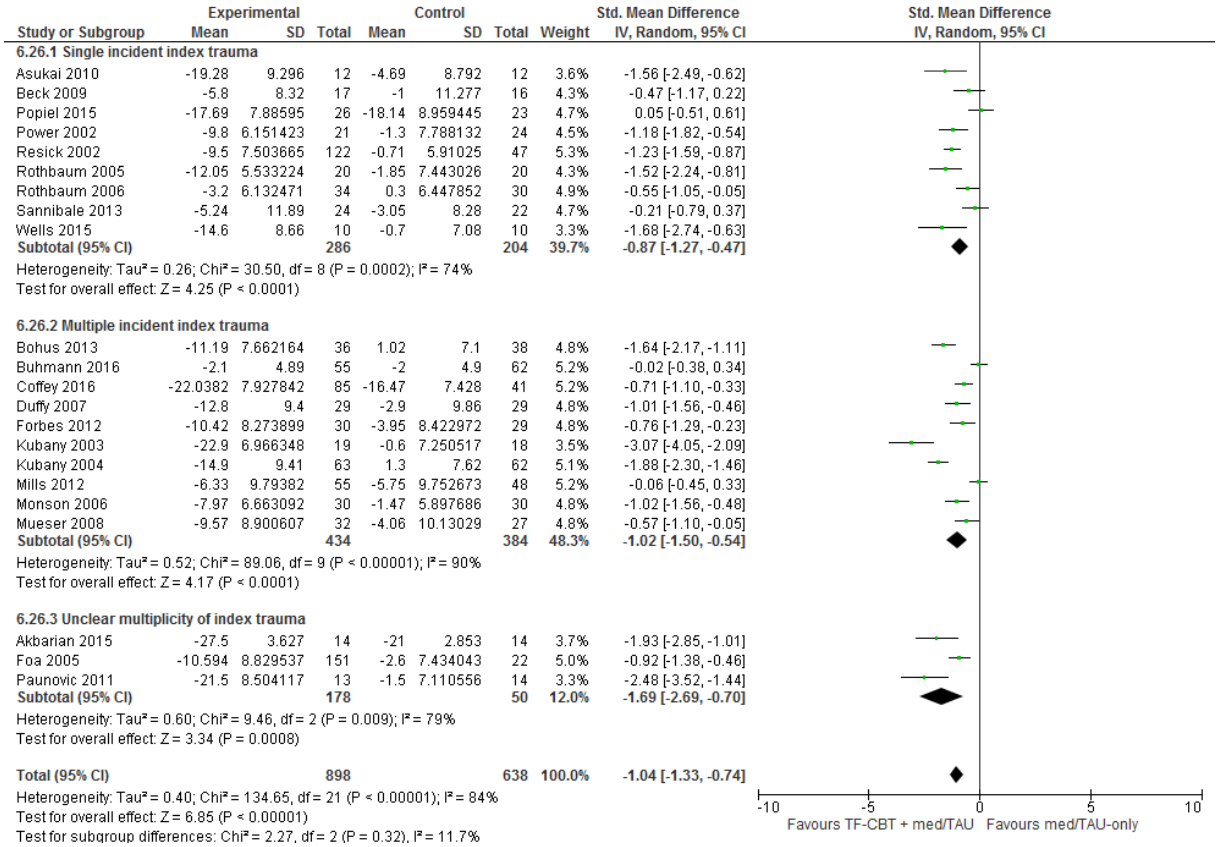


Figure 78: Trauma-focused CBT + medication/TAU versus medication/TAU only (or+ attention-placebo) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms at 1-month follow-up (BDI/BDI-II/HAMD change score)

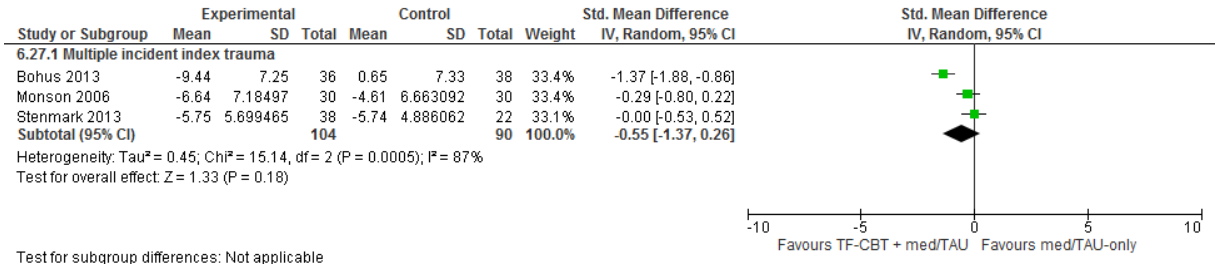


Figure 79: Trauma-focused CBT + medication/TAU versus medication/TAU only (or+ attention-placebo) for delayed treatment (>3 months) of clinically important

symptoms/PTSD: Depression symptoms at 3-4 month follow-up (BDI-II/HAMD change score)

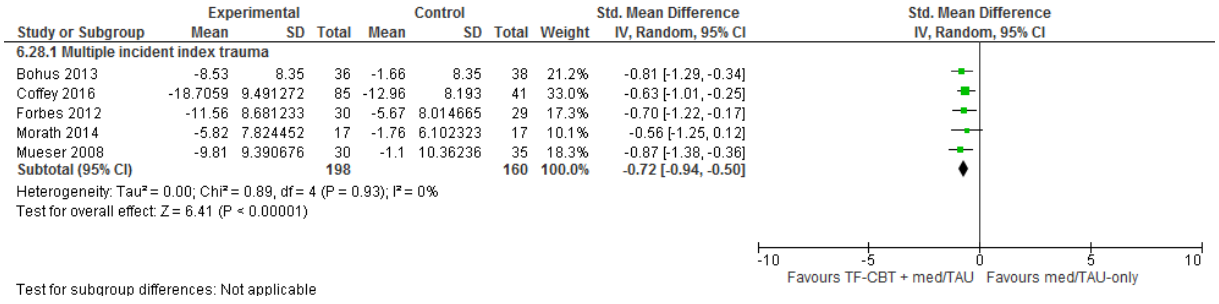


Figure 80: Trauma-focused CBT + medication/TAU versus medication/TAU only (or+ attention-placebo) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms at 5-6 month follow-up (BDI-II/HSCL-25 Depression/HAMD change score)

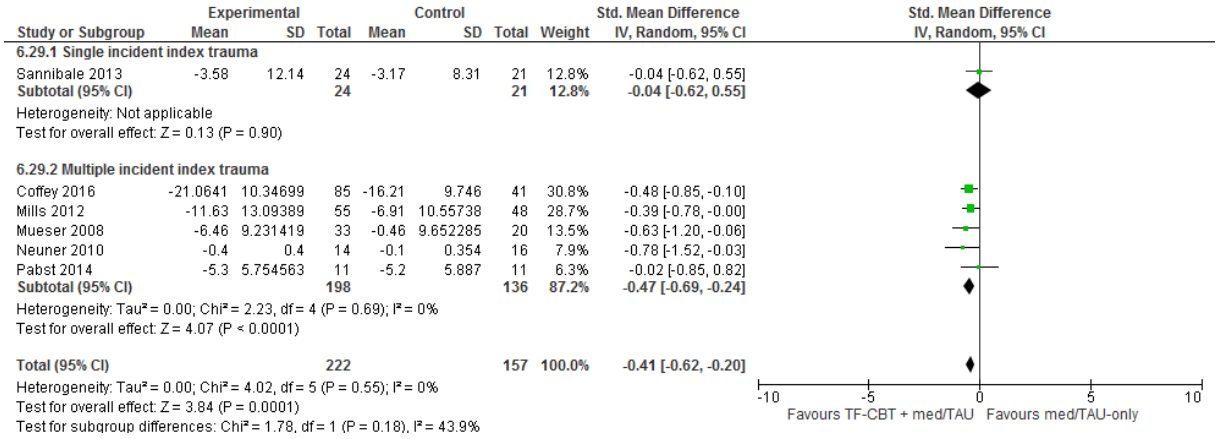


Figure 81: Trauma-focused CBT + medication/TAU versus medication/TAU only (or+ attention-placebo) for delayed treatment (>3 months) of clinically important

symptoms/PTSD: Depression symptoms at 9-12 month follow-up (HAMD/BDI-II change score)

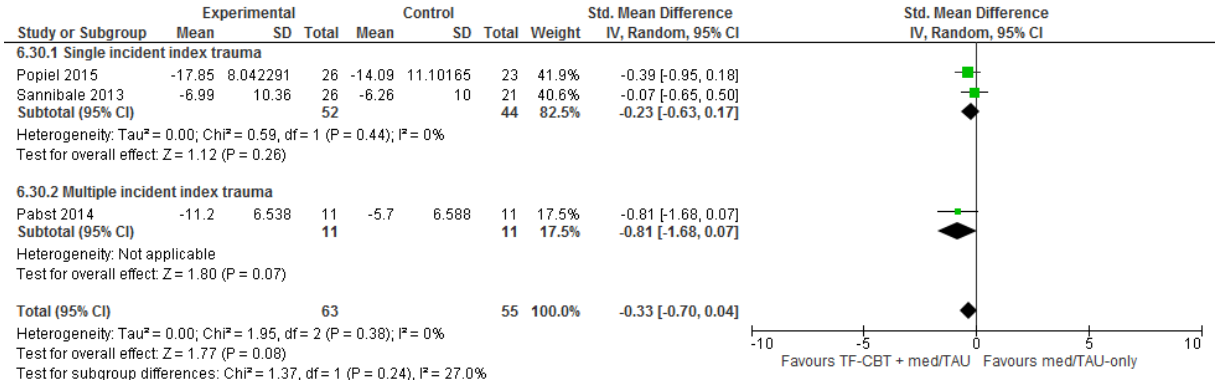


Figure 82: Trauma-focused CBT + medication/TAU versus medication/TAU only (or+ attention-placebo) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Personality disorder symptoms (BSL change score); Multiple incident index trauma

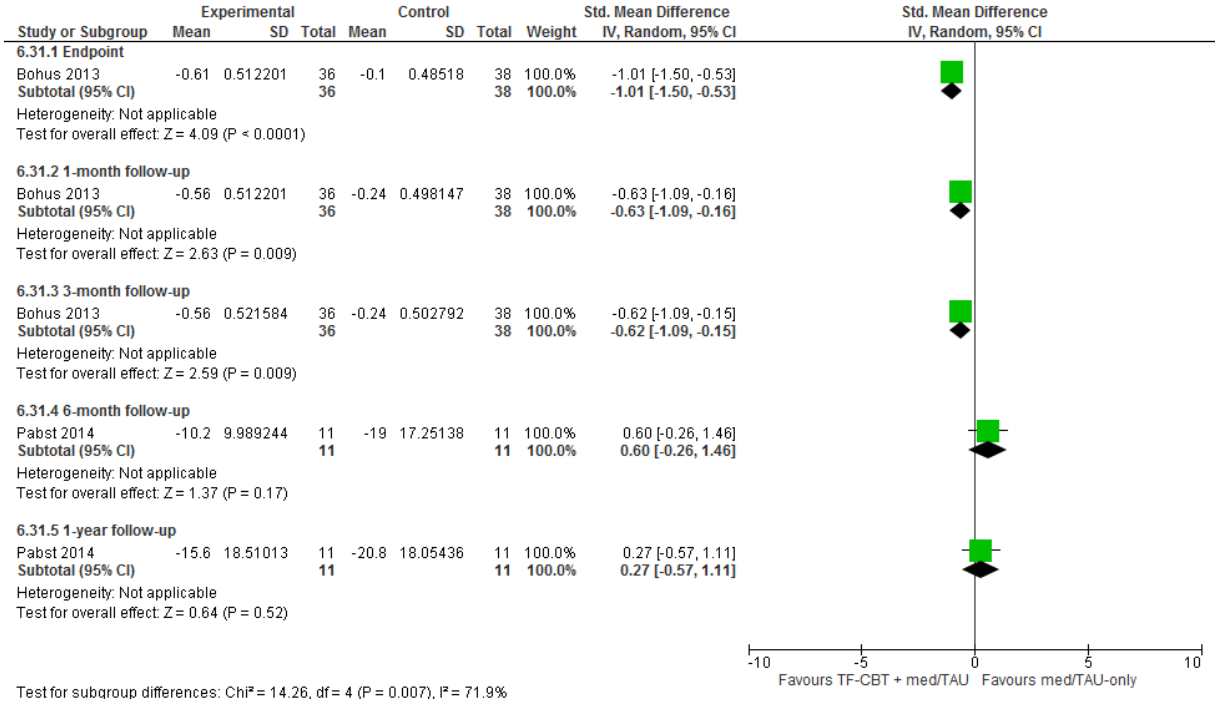


Figure 83: Trauma-focused CBT + medication/TAU versus medication/TAU only (or+ attention-placebo) for delayed treatment (>3 months) of clinically important

symptoms/PTSD: Alcohol use disorder symptoms at endpoint (AUDIT/SADQ change score)

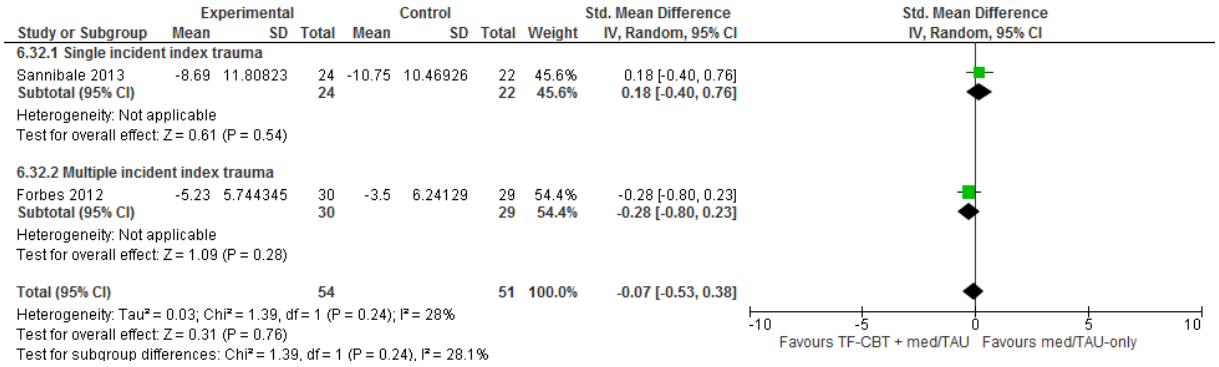


Figure 84: Trauma-focused CBT + medication/TAU versus medication/TAU only (or+ attention-placebo) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Alcohol use disorder symptoms at 3-5 month follow-up (AUDIT/SADQ change score)

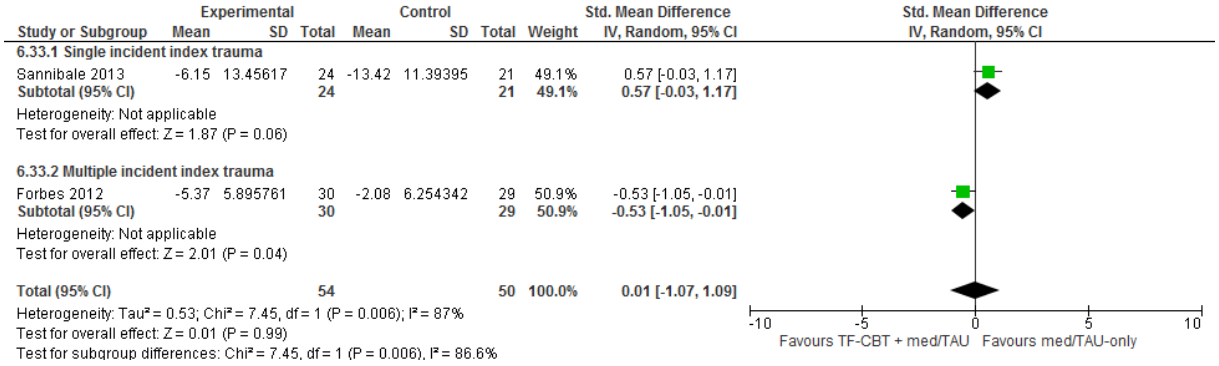


Figure 85: Trauma-focused CBT + medication/TAU versus medication/TAU only (or+ attention-placebo) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Alcohol use disorder symptoms at 9 month follow-up (SADQ change score)

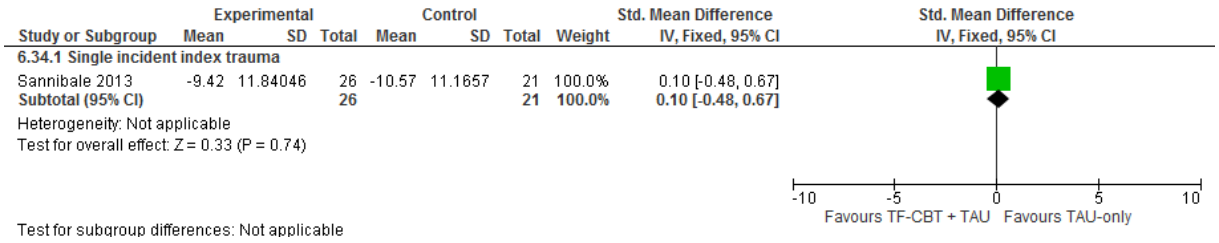


Figure 86: Trauma-focused CBT + medication/TAU versus medication/TAU only (or+ attention-placebo) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Alcohol use (TLFB: Percent days abstinent from alcohol, change score); Multiple incident index trauma

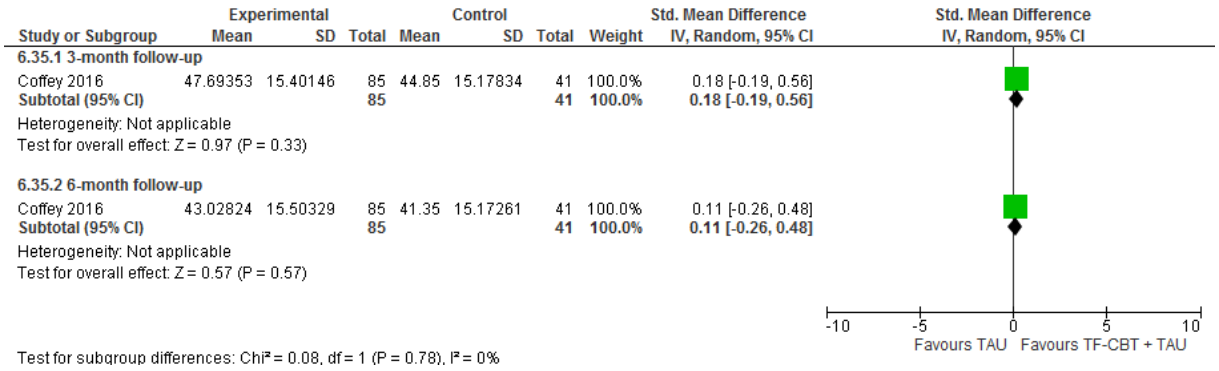


Figure 87: Trauma-focused CBT + medication/TAU versus medication/TAU only (or+ attention-placebo) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Alcohol use (TLFB: Percent drinking days, change score); Unclear multiplicity of index trauma

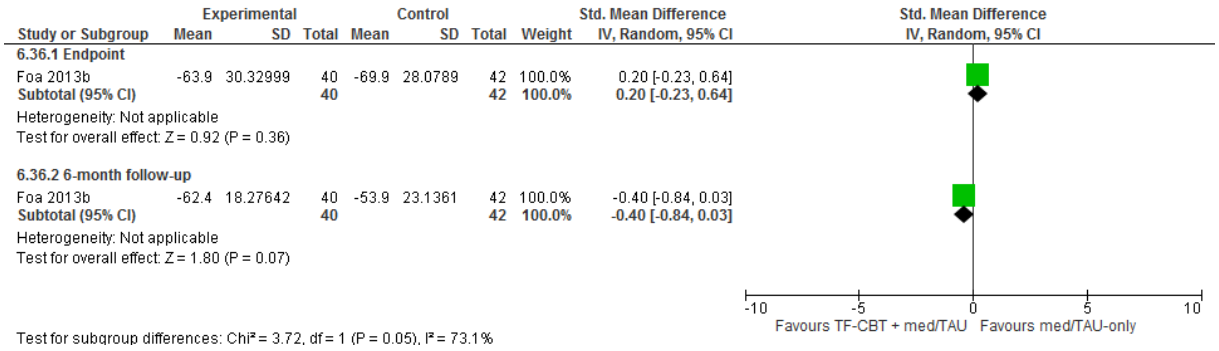


Figure 88: Trauma-focused CBT + medication/TAU versus medication/TAU only (or+ attention-placebo) for delayed treatment (>3 months) of clinically important

symptoms/PTSD: Alcohol use (TLFB: Drinks per drinking day, change score); Single incident index trauma

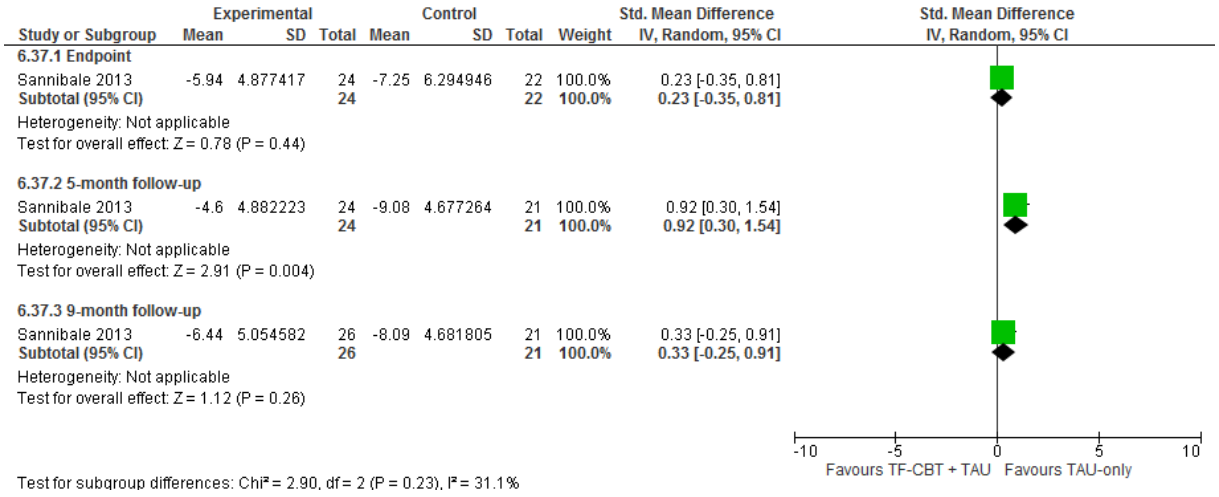


Figure 89: Trauma-focused CBT + medication/TAU versus medication/TAU only (or+ attention-placebo) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Drug use (TLFB: Percent days abstinent from drugs, change score); Multiple incident index trauma

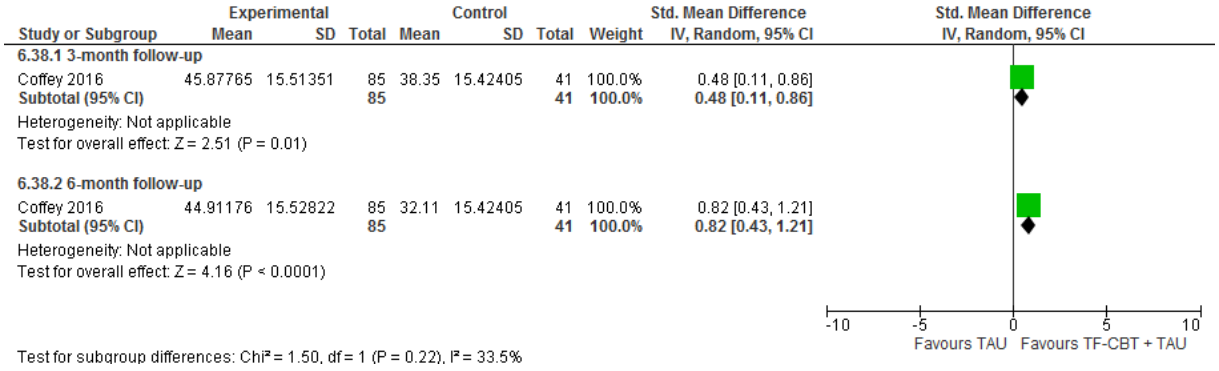


Figure 90: Trauma-focused CBT + medication/TAU versus medication/TAU only (or+ attention-placebo) for delayed treatment (>3 months) of clinically important

symptoms/PTSD: Substance use (number of days primary substance use in past 30 days; ASI-Lite change score)

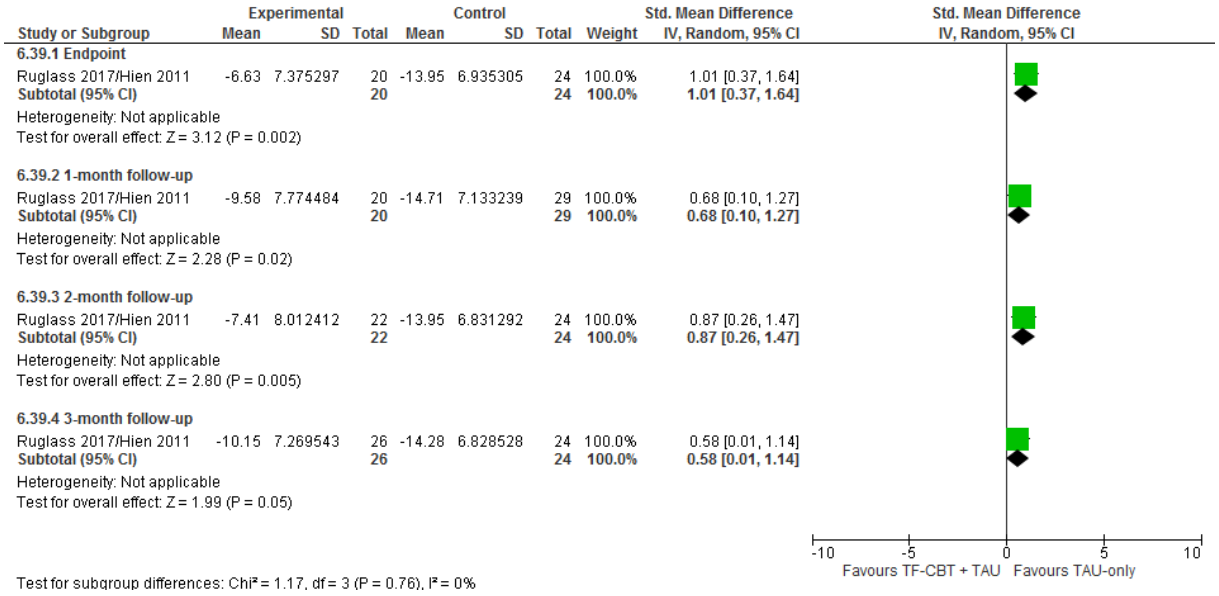


Figure 91: Trauma-focused CBT + medication/TAU versus medication/TAU only (or+ attention-placebo) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Substance dependence remission at endpoint (number of people no longer meeting diagnostic criteria for substance dependence)

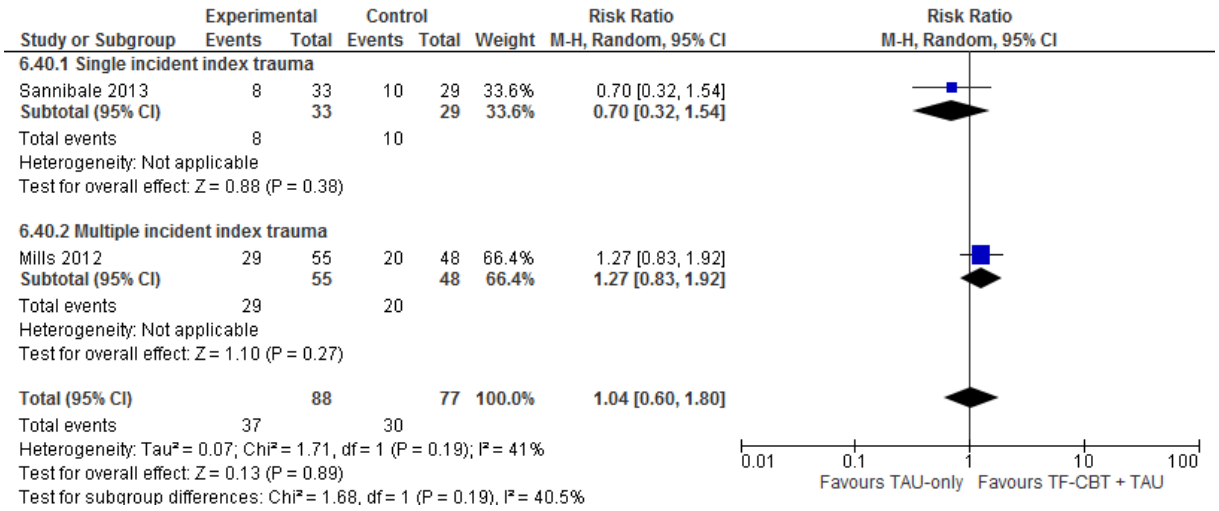


Figure 92: Trauma-focused CBT + medication/TAU versus medication/TAU only (or+ attention-placebo) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Substance dependence remission at 5-6 month follow-up

(number of people no longer meeting diagnostic criteria for substance dependence)

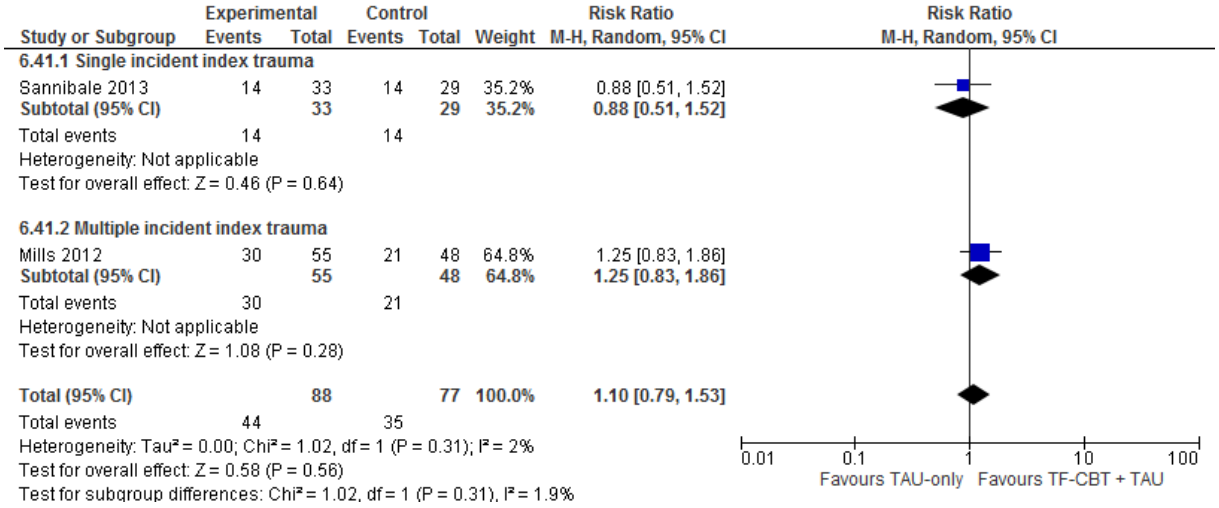


Figure 93: Trauma-focused CBT + medication/TAU versus medication/TAU only (or+ attention-placebo) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Substance dependence remission at 9-month follow-up (number of people no longer meeting diagnostic criteria for substance dependence)

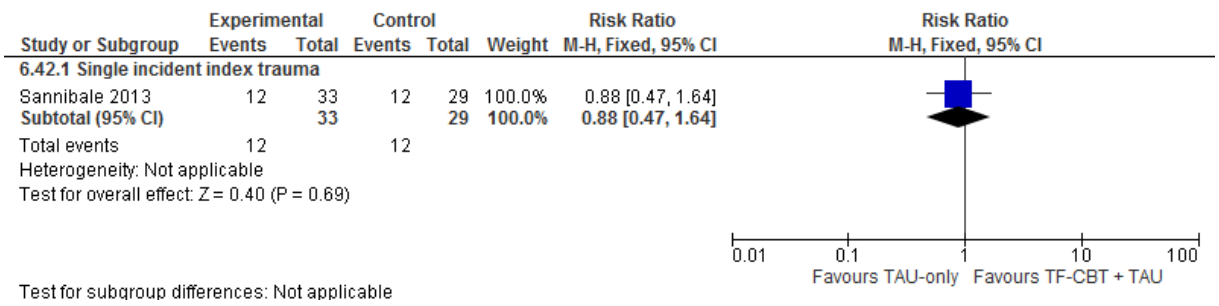


Figure 94: Trauma-focused CBT + medication/TAU versus medication/TAU only (or+ attention-placebo) for delayed treatment (>3 months) of clinically important

symptoms/PTSD: Global functioning (GAF change score); Multiple incident index trauma

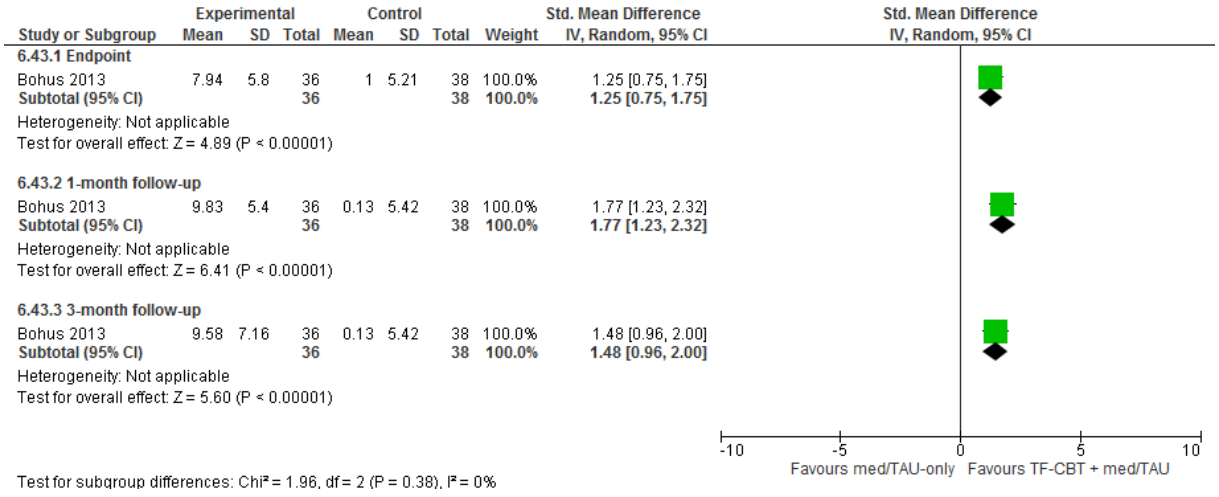


Figure 95: Trauma-focused CBT + medication/TAU versus medication/TAU only (or+ attention-placebo) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Functional impairment (SDS/M2C change score/SAS endpoint)

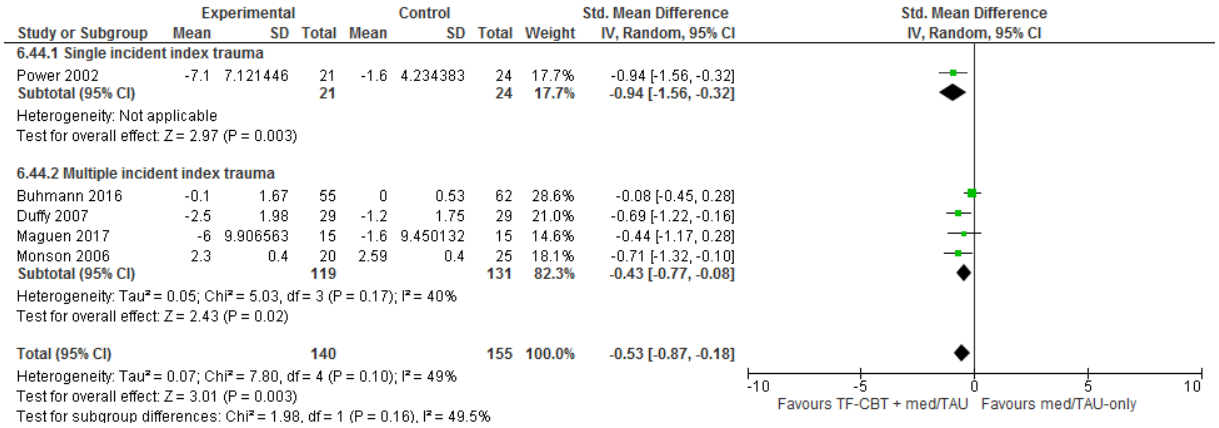


Figure 96: Trauma-focused CBT + medication/TAU versus medication/TAU only (or+ attention-placebo) for delayed treatment (>3 months) of clinically important

symptoms/PTSD: Emotional and behavioural problems: Aggression/Anger (AAS/DARS-7 change score); Multiple incident index trauma

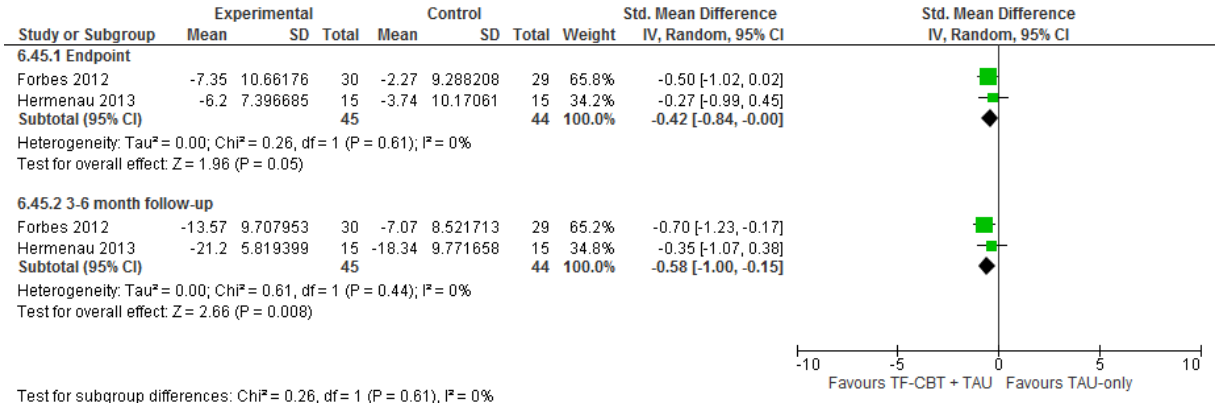


Figure 97: Trauma-focused CBT + medication/TAU versus medication/TAU only (or+ attention-placebo) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Quality of life (WHO-5/SF-12 change score); Multiple incident index trauma

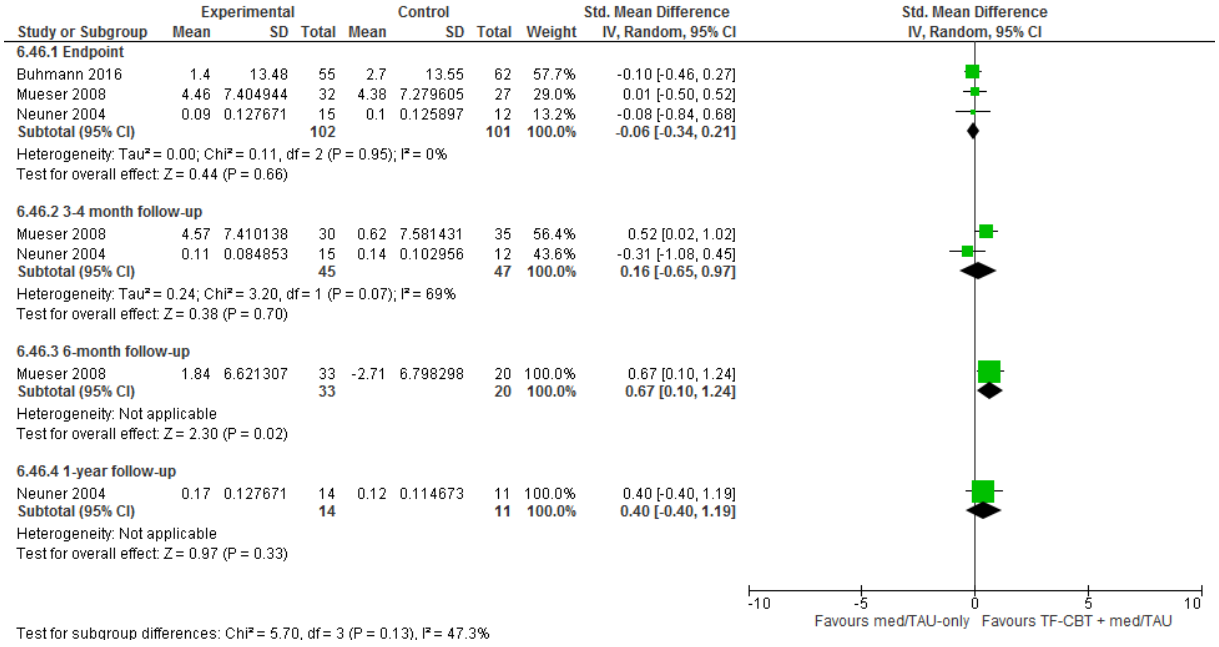


Figure 98: Trauma-focused CBT + medication/TAU versus medication/TAU only (or+ attention-placebo) for delayed treatment (>3 months) of clinically important

symptoms/PTSD: Relationship difficulties (ADAS change score); Multiple incident index trauma

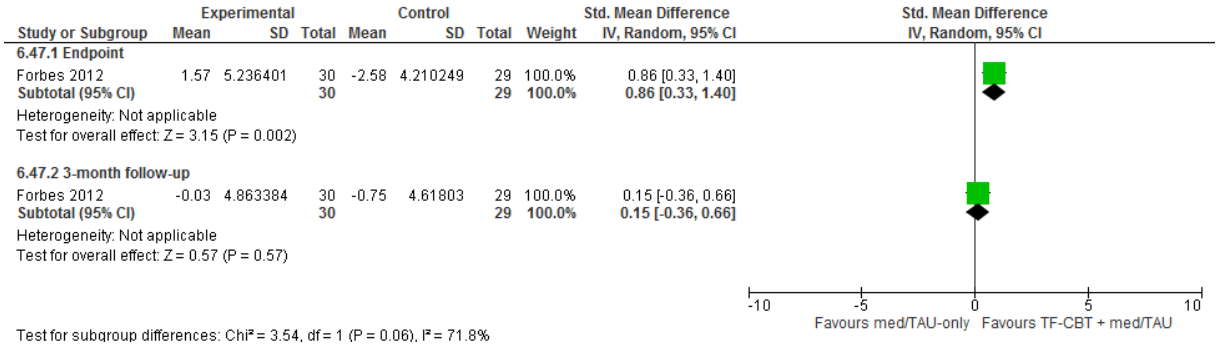
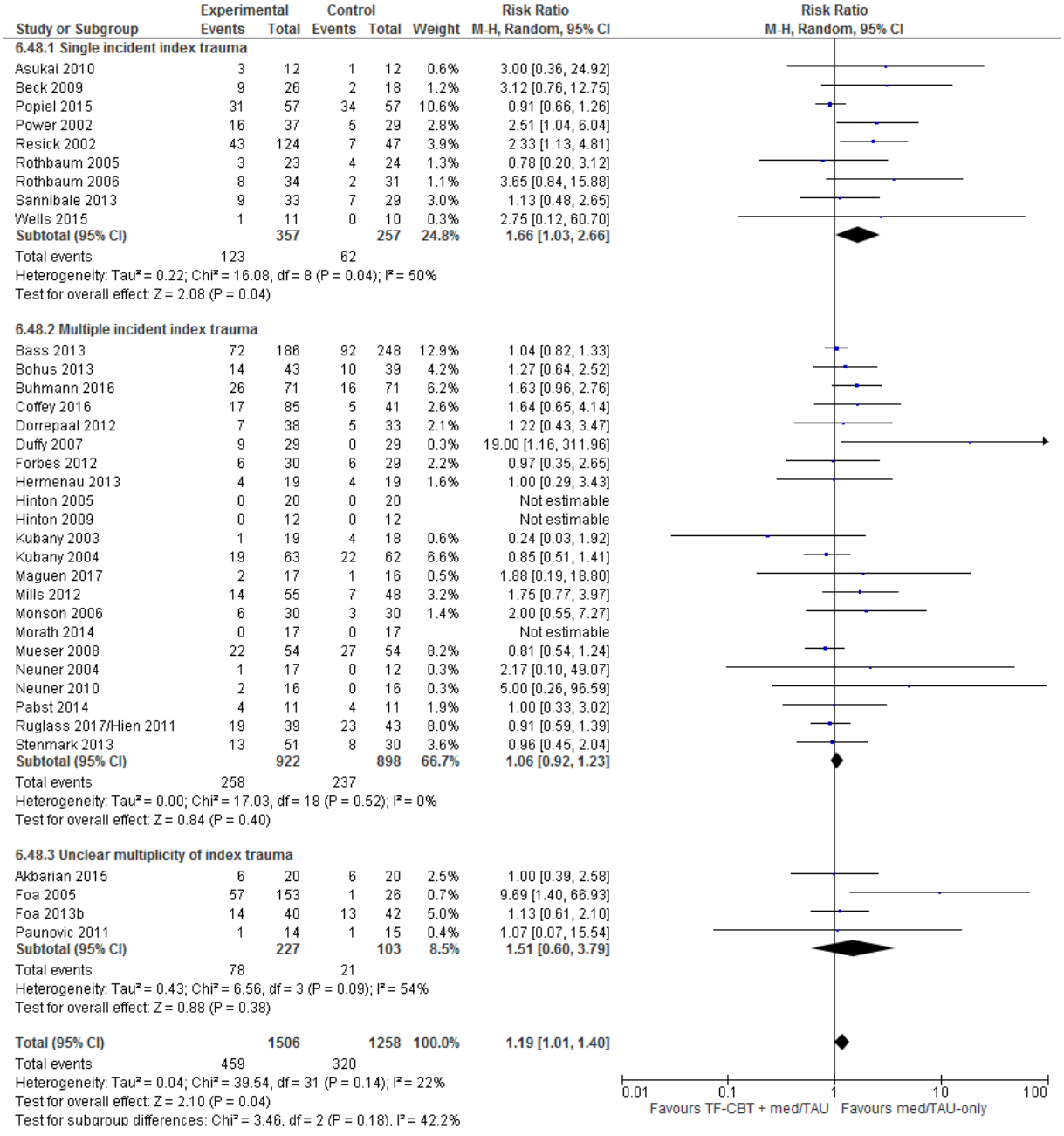


Figure 99: Trauma-focused CBT + medication/TAU versus medication/TAU only (or+ attention-placebo) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)



Sub-analysis by specific intervention: Trauma-focused CBT+ medication/TAU versus medication/TAU-only (or + attention –placebo) for delayed treatment (>3 months) of clinically important symptoms /PTSD

Figure 100: Trauma-focused CBT+ medication/TAU versus medication/TAU-only (or + attention –placebo) for delayed treatment (>3 months) of clinically important symptoms /PTSD: PTSD symptomatology for self-rated at endpoint (IES/IES-R/PDS/PSS-SR/HTQ/DTS/PCL/MPSS change score)

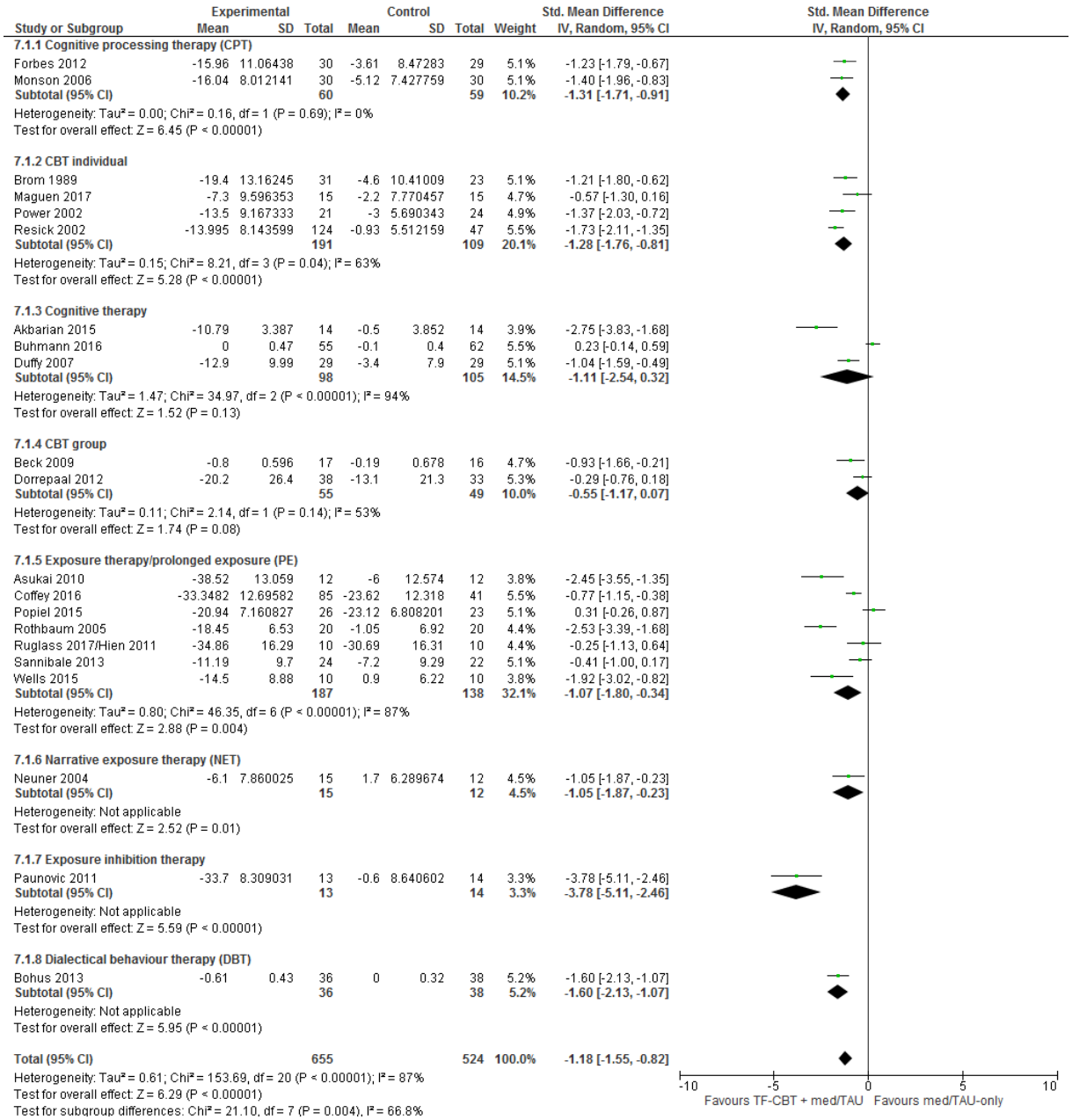


Figure 101: Trauma-focused CBT+ medication/TAU versus medication/TAU-only (or + attention –placebo) for delayed treatment (>3 months) of clinically important

symptoms /PTSD: PTSD symptomatology clinician-rated at endpoint (CAPS/HTQ/PSS-I/SI-PTSD change score)

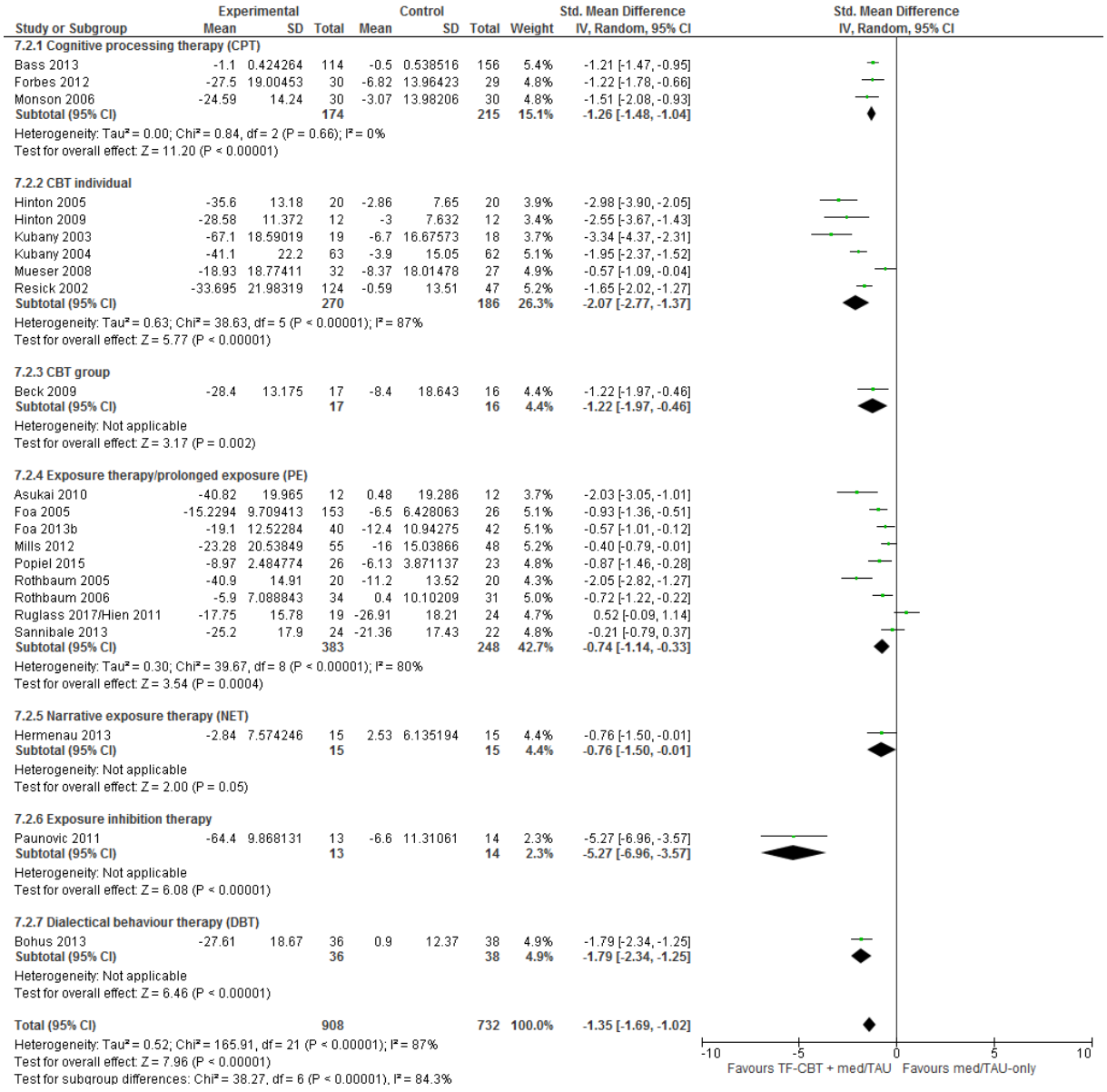
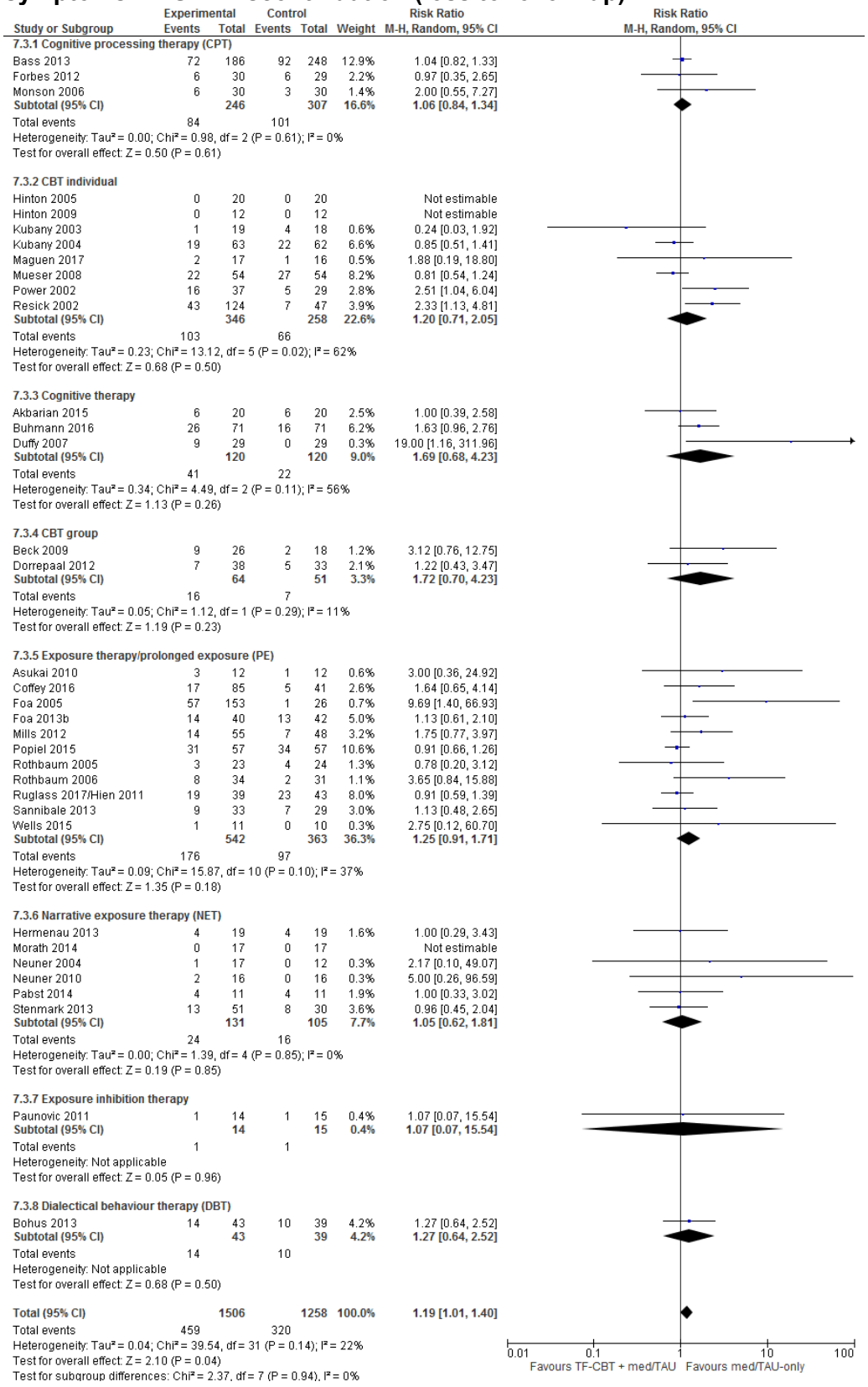


Figure 102: Trauma-focused CBT+ medication/TAU versus medication/TAU-only (or + attention –placebo) for delayed treatment (>3 months) of clinically important

symptoms /PTSD: Discontinuation (loss to follow-up)



Sub-analysis by diagnostic status at baseline: Trauma-focused CBT+medication/TAU versus medication/TAU-only (or + attention-placebo) for delayed treatment (> 3months) of clinically important symptoms/PTSD

Figure 103: Trauma-focused CBT+medication/TAU versus medication/TAU-only (or + attention-placebo) for delayed treatment (> 3months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated at endpoint (IES/IES-R/PDS/PSS-SR/HTQ/DTS/PCL/MPSS change score)

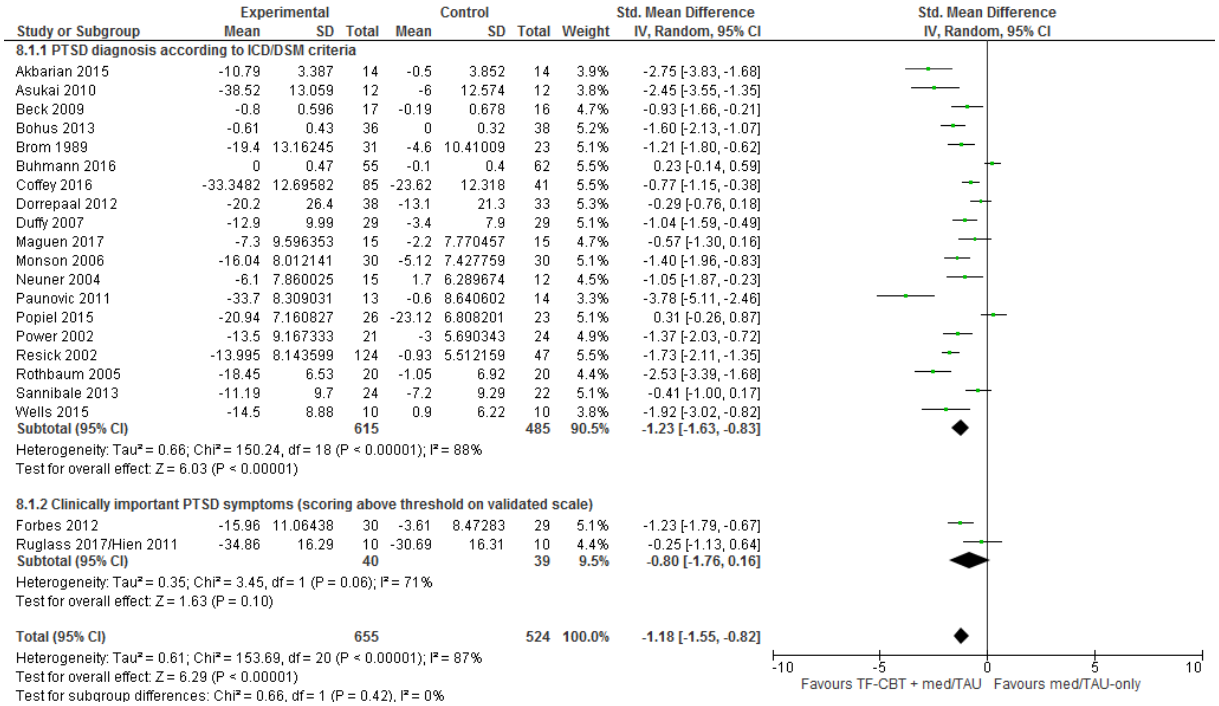


Figure 104: Trauma-focused CBT+medication/TAU versus medication/TAU-only (or + attention-placebo) for delayed treatment (> 3months) of clinically important

symptoms/PTSD: PTSD symptomatology clinician-rated at end-point (CAPS/HTQ/PSS-I/SI-PTSD change score)

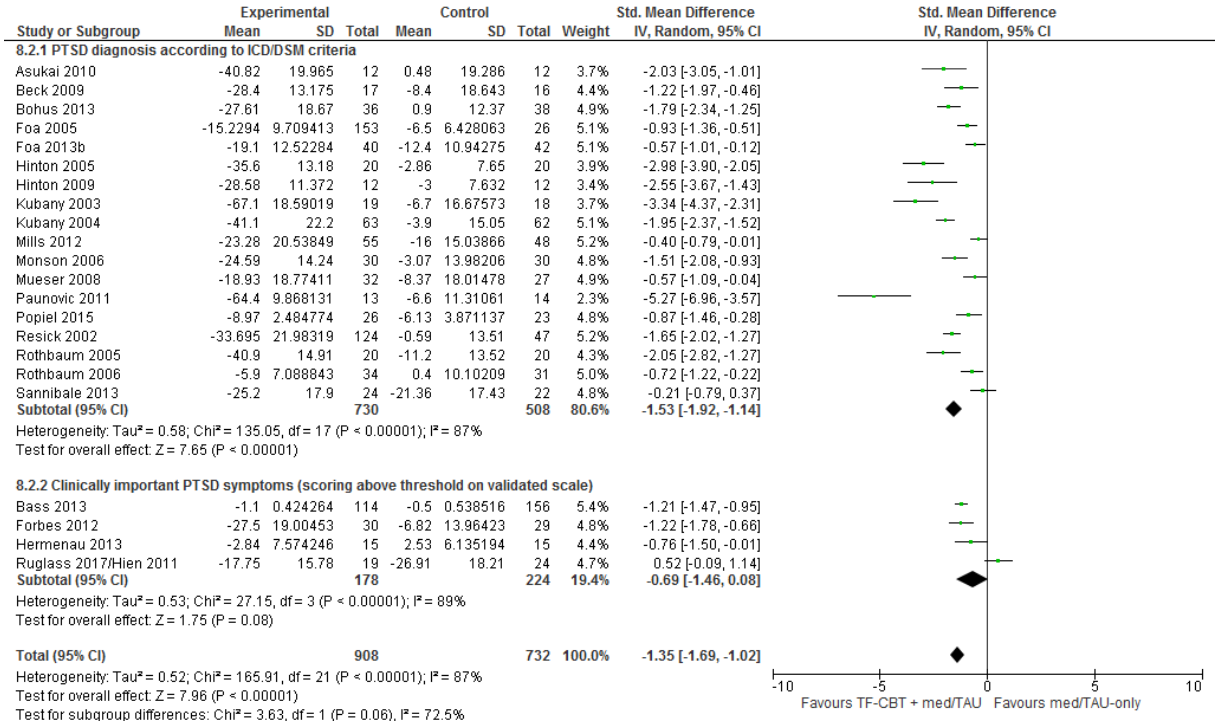
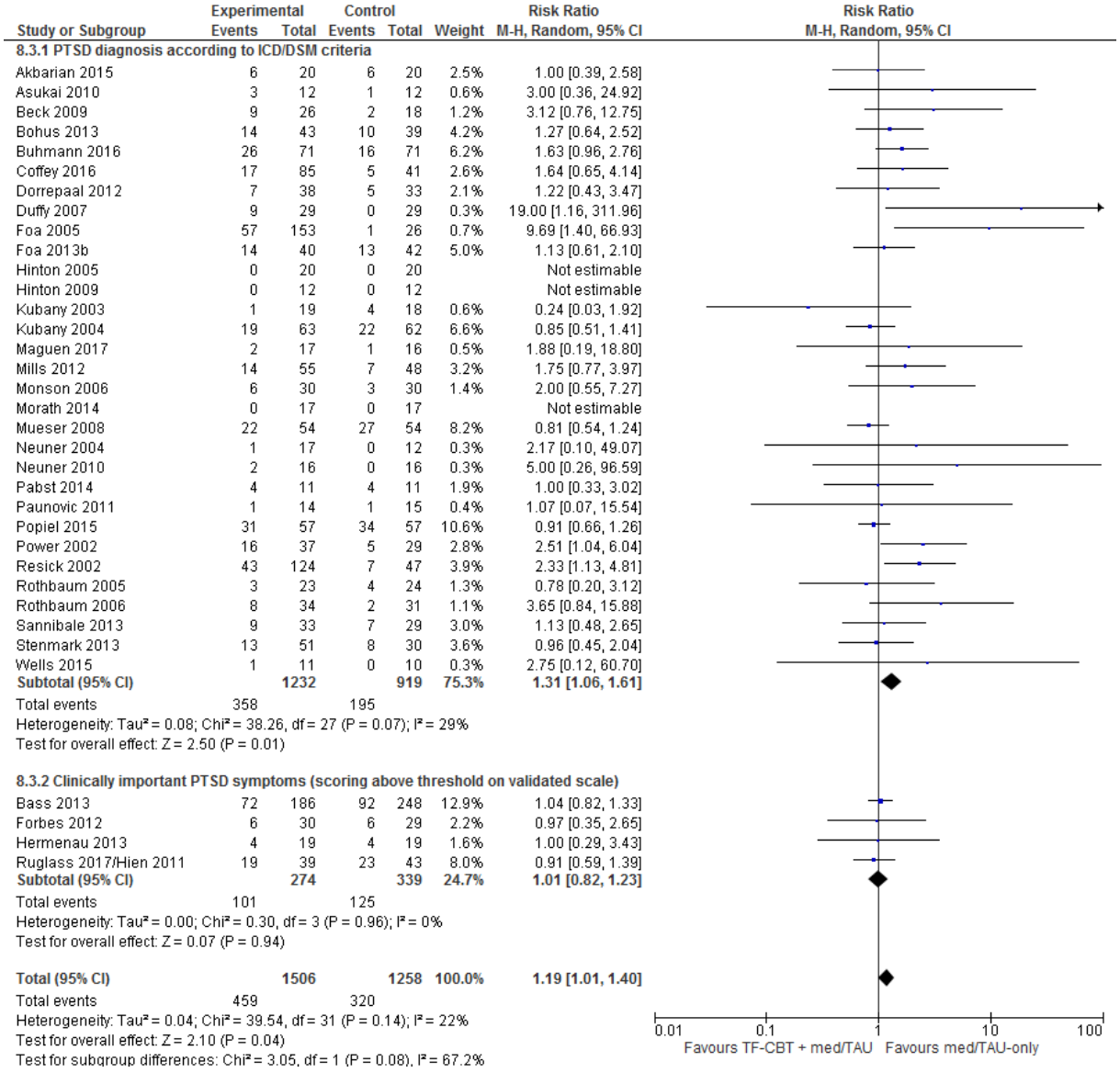


Figure 105: Trauma-focused CBT+medication/TAU versus medication/TAU-only (or + attention-placebo) for delayed treatment (> 3months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)



Sub-analysis by trauma type: Trauma-focused CBT+medication/TAU versus medication/TAU-only (or + attention-placebo) for delayed treatment (>3 months) of clinically important symptoms/PTSD

Figure 106: Trauma-focused CBT+medication/TAU versus medication/TAU-only (or + attention-placebo) for delayed treatment (>3 months) of clinically important

symptoms/PTSD: PTSD symptomatology self-rated at endpoint (IES/IES-R/PDS/PSS-SR/HTQ/DTS/PCL/MPSS change score)

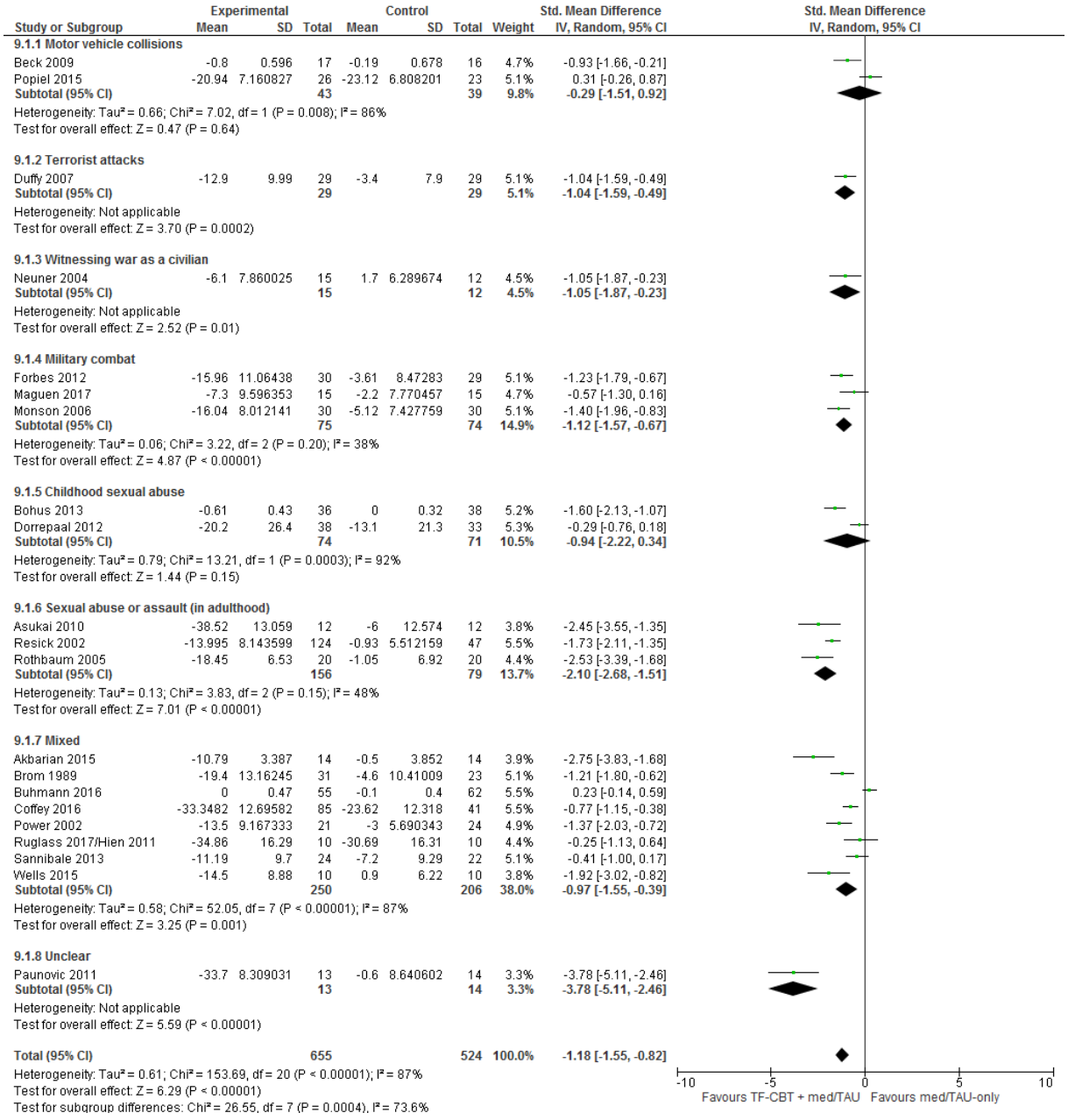


Figure 107: Trauma-focused CBT+medication/TAU versus medication/TAU-only (or + attention-placebo) for delayed treatment (>3 months) of clinically important

symptoms/PTSD: PTSD symptomatology clinician-rated at endpoint (CAPS/HTQ/PSS-I/SI-PTSD change score)

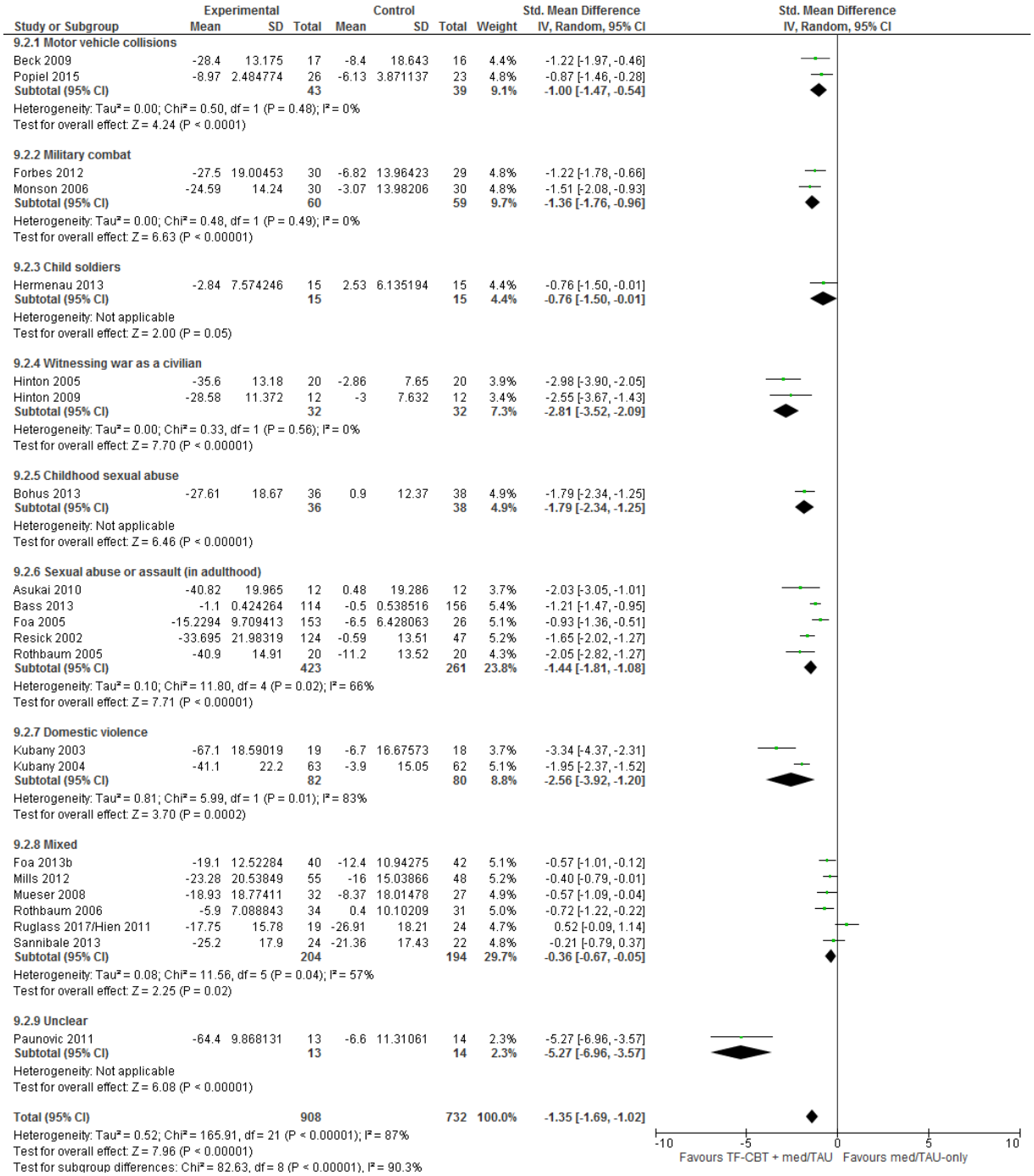
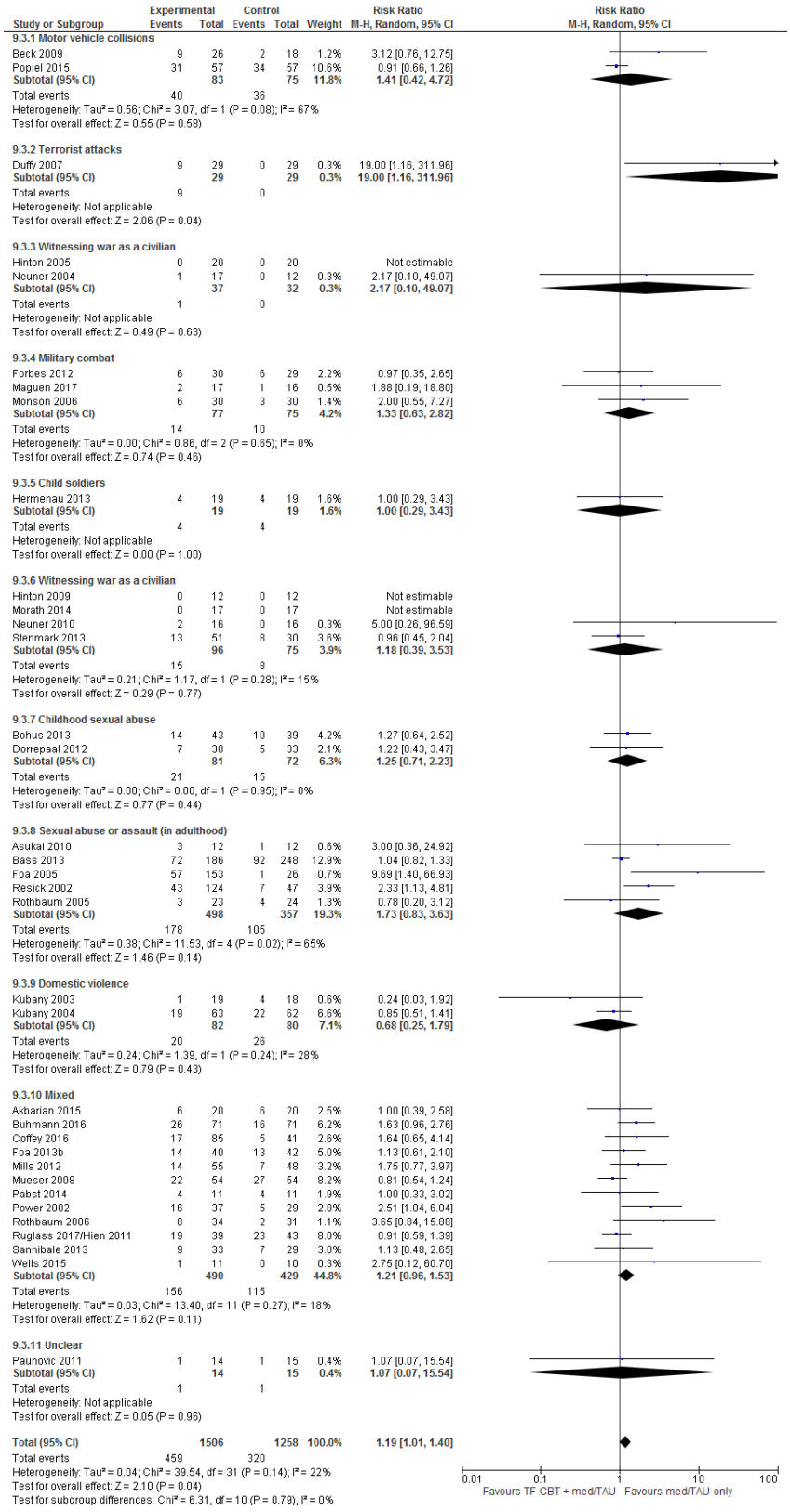


Figure 108: Trauma-focused CBT+medication/TAU versus medication/TAU-only (or + attention-placebo) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)


Experimental
Control
Risk Ratio
Risk Ratio
Study or Subgroup Events Total Events Total Weight M-H, Random, 95% CI
M-H, Random, 95% CI
9.3.1 Motor vehicle collisions
Beck 2009 9 26 2 18 1.2% 3.12 [0.76, 12.75]
Popiel 2015 31 57 34 57 10.6% 0.91 [0.66, 1.26]
Subtotal (95% CI) 83 75 11.8% 1.41 [0.42, 4.72]
Total events 40 36
Heterogeneity: Tau² = 0.56; Chi² = 3.07, df = 1 (P = 0.08); I² = 67%
Test for overall effect: Z = 0.55 (P = 0.58)
9.3.2 Terrorist attacks
Duffy 2007 9 29 0 29 0.3% 19.00 [1.16, 311.96]
Subtotal (95% CI) 29 29 0.3% 19.00 [1.16, 311.96]
Total events 9 0
Heterogeneity: Not applicable
Test for overall effect: Z = 2.06 (P = 0.04)
9.3.3 Witnessing war as a civilian
Hinton 2005 0 20 0 20 Not estimable
Neuner 2004 1 17 0 12 0.3% 2.17 [0.10, 49.07]
Subtotal (95% CI) 37 32 0.3% 2.17 [0.10, 49.07]
Total events 1 0
Heterogeneity: Not applicable
Test for overall effect: Z = 0.49 (P = 0.63)
9.3.4 Military combat
Forbes 2012 6 30 6 29 2.2% 0.97 [0.35, 2.65]
Maguen 2017 2 17 1 16 0.5% 1.88 [0.19, 18.80]
Monson 2006 6 30 3 30 1.4% 2.00 [0.55, 7.27]
Subtotal (95% CI) 77 75 4.2% 1.33 [0.63, 2.82]
Total events 14 10
Heterogeneity: Tau² = 0.00; Chi² = 0.86, df = 2 (P = 0.65); I² = 0%
Test for overall effect: Z = 0.74 (P = 0.46)
9.3.5 Child soldiers
Hermenau 2013 4 19 4 19 1.6% 1.00 [0.29, 3.43]
Subtotal (95% CI) 19 19 1.6% 1.00 [0.29, 3.43]
Total events 4 4
Heterogeneity: Not applicable
Test for overall effect: Z = 0.00 (P = 1.00)
9.3.6 Witnessing war as a civilian
Hinton 2009 0 12 0 12 Not estimable
Morath 2014 0 17 0 17 Not estimable
Neuner 2010 2 16 0 16 0.3% 5.00 [0.26, 96.59]
Stenmark 2013 13 51 8 30 3.6% 0.96 [0.45, 2.04]
Subtotal (95% CI) 96 75 3.9% 1.18 [0.39, 3.53]
Total events 15 8
Heterogeneity: Tau² = 0.21; Chi² = 1.17, df = 1 (P = 0.28); I² = 15%
Test for overall effect: Z = 0.29 (P = 0.77)
9.3.7 Childhood sexual abuse
Bohus 2013 14 43 10 39 4.2% 1.27 [0.64, 2.52]
Dorrepaal 2012 7 38 5 33 2.1% 1.22 [0.43, 3.47]
Subtotal (95% CI) 81 72 6.3% 1.25 [0.71, 2.23]
Total events 21 15
Heterogeneity: Tau² = 0.00; Chi² = 0.00, df = 1 (P = 0.95); I² = 0%
Test for overall effect: Z = 0.77 (P = 0.44)
9.3.8 Sexual abuse or assault (in adulthood)
Asukai 2010 3 12 1 12 0.6% 3.00 [0.36, 24.92]
Bass 2013 72 186 92 248 12.9% 1.04 [0.82, 1.33]
Foa 2005 57 153 1 26 0.7% 9.69 [1.40, 66.93]
Resick 2002 43 124 7 47 3.9% 2.33 [1.13, 4.81]
Rothbaum 2005 3 23 4 24 1.3% 0.78 [0.20, 3.12]
Subtotal (95% CI) 498 357 19.3% 1.73 [0.83, 3.63]
Total events 178 105
Heterogeneity: Tau² = 0.38; Chi² = 11.53, df = 4 (P = 0.02); I² = 65%
Test for overall effect: Z = 1.46 (P = 0.14)
9.3.9 Domestic violence
Kubany 2003 1 19 4 18 0.6% 0.24 [0.03, 1.92]
Kubany 2004 19 63 22 62 6.6% 0.85 [0.51, 1.41]
Subtotal (95% CI) 82 80 7.1% 0.68 [0.25, 1.79]
Total events 20 26
Heterogeneity: Tau² = 0.24; Chi² = 1.39, df = 1 (P = 0.24); I² = 28%
Test for overall effect: Z = 0.79 (P = 0.43)
9.3.10 Mixed
Akbarian 2015 6 20 6 20 2.5% 1.00 [0.39, 2.58]
Buhmann 2016 26 71 16 71 6.2% 1.63 [0.96, 2.76]
Coffey 2016 17 85 5 41 2.6% 1.64 [0.65, 4.14]
Foa 2013b 14 40 13 42 5.0% 1.13 [0.61, 2.10]
Mills 2012 14 55 7 48 3.2% 1.75 [0.77, 3.97]
Mueser 2008 22 54 27 54 8.2% 0.81 [0.54, 1.24]
Pabst 2014 4 11 4 11 1.9% 1.00 [0.33, 3.02]
Power 2002 16 37 5 29 2.8% 2.51 [1.04, 6.04]
Rothbaum 2006 8 34 2 31 1.1% 3.65 [0.84, 15.88]
Ruglass 2017/Hien 2011 19 39 23 43 8.0% 0.91 [0.59, 1.39]
Sannibale 2013 9 33 7 29 3.0% 1.13 [0.48, 2.65]
Wells 2015 1 11 0 10 0.3% 2.75 [0.12, 60.70]
Subtotal (95% CI) 490 429 44.8% 1.21 [0.96, 1.53]
Total events 156 115
Heterogeneity: Tau² = 0.03; Chi² = 13.40, df = 11 (P = 0.27); I² = 18%
Test for overall effect: Z = 1.62 (P = 0.11)
9.3.11 Unclear
Paunovic 2011 1 14 1 15 0.4% 1.07 [0.07, 15.54]
Subtotal (95% CI) 14 15 0.4% 1.07 [0.07, 15.54]
Total events 1 1
Heterogeneity: Not applicable
Test for overall effect: Z = 0.05 (P = 0.96)
Total (95% CI) 1506 1258 100.0% 1.19 [1.01, 1.40]
Total events 459 320
Heterogeneity: Tau² = 0.04; Chi² = 39.54, df = 31 (P = 0.14); I² = 22%
Test for overall effect: Z = 2.10 (P = 0.04)
Test for subgroup differences: Chi² = 6.31, df = 10 (P = 0.79), I² = 0%
0.01 0.1 1 10 100
Favours TF-CBT + med/TAU Favours med/TAU-only

Sub-analysis by personality disorder: Trauma-focused CBT+TAU versus TAU-only for delayed treatment (>3 months) of clinically important symptoms/PTSD

Figure 109: Trauma-focused CBT+TAU versus TAU-only for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated at endpoint (CAPS change score)

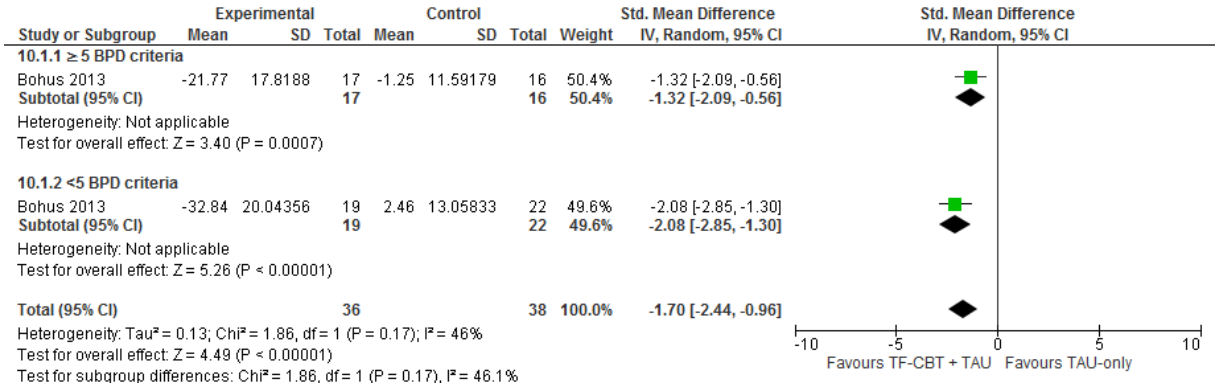


Figure 110: Trauma-focused CBT+TAU versus TAU-only for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated at endpoint (PDS change score)

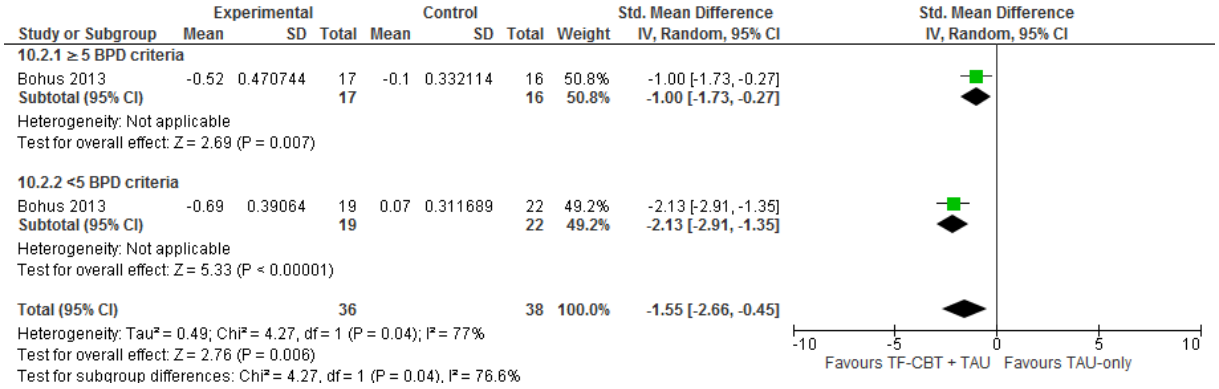


Figure 111: Trauma-focused CBT+TAU versus TAU-only for delayed treatment (>3 months) of clinically important symptoms/PTSD: Global functioning at endpoint (GAF change score)

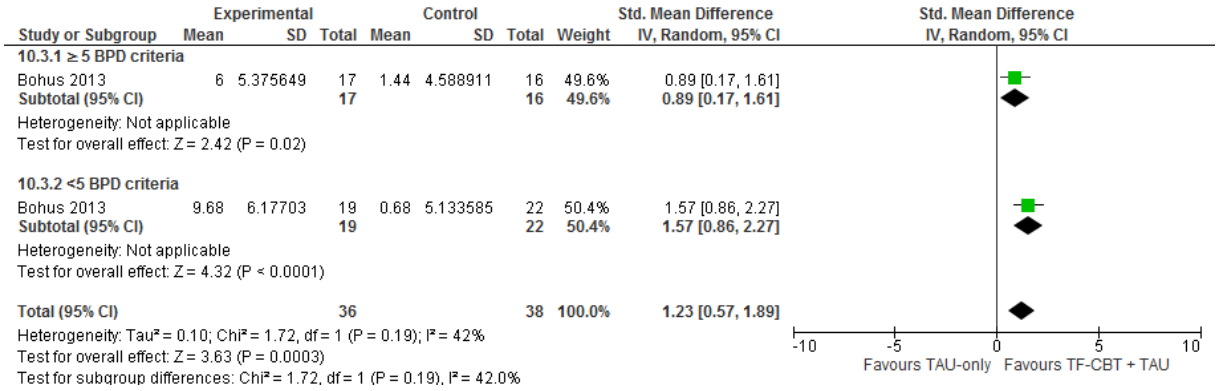


Figure 112: Trauma-focused CBT+TAU versus TAU-only for delayed treatment (>3 months) of clinically important symptoms/PTSD: Dissociative symptoms at endpoint (DES change score)

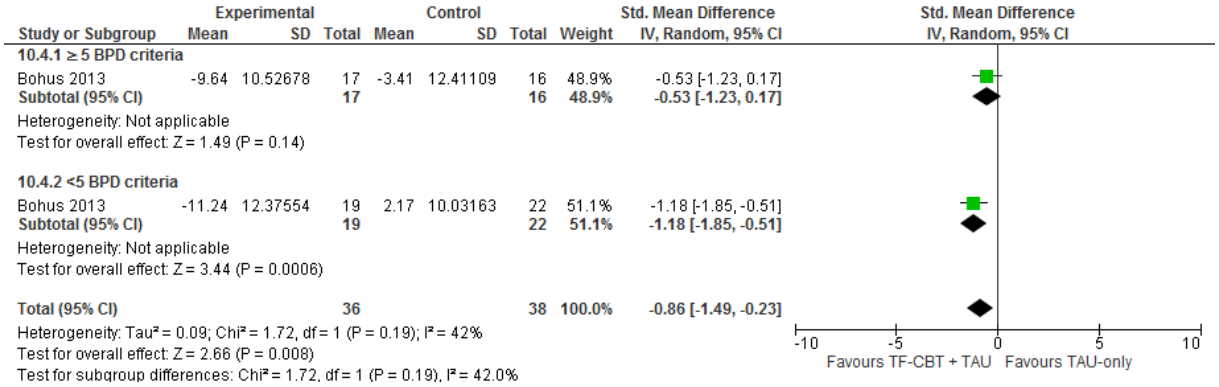


Figure 113: Trauma-focused CBT+TAU versus TAU-only for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms at endpoint (BDI-II change score)

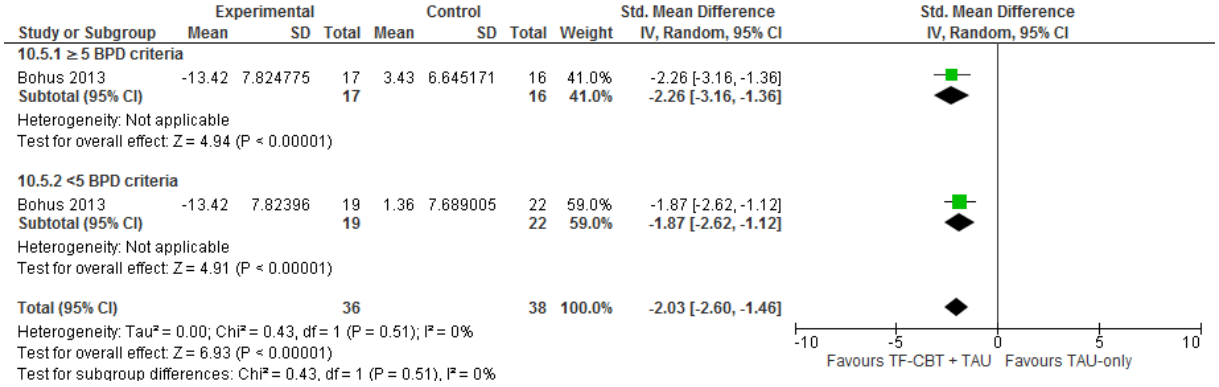


Figure 114: Trauma-focused CBT (±TAU) versus eye movement desensitisation and reprocessing (EMDR; ±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated at endpoint (IES/IES-R/PSS-SR change score)

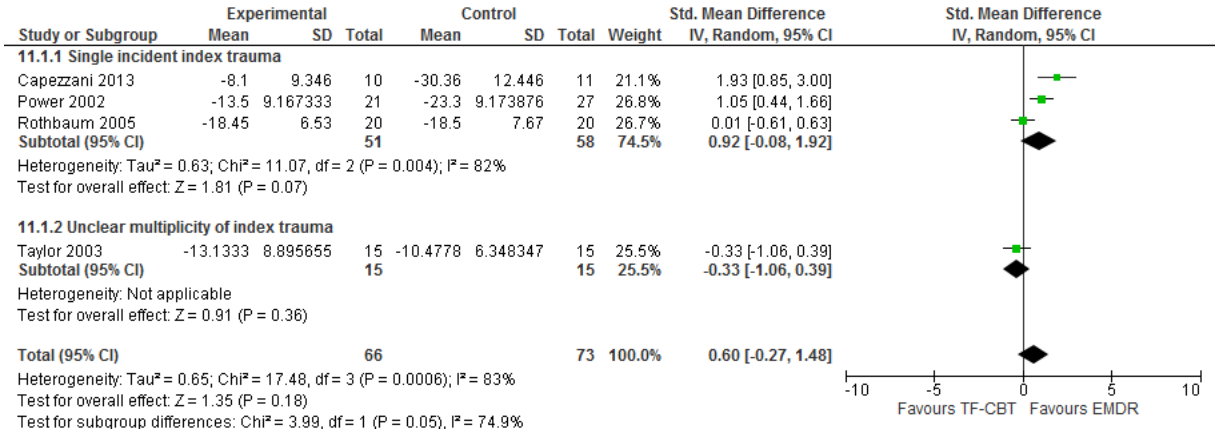


Figure 115: Trauma-focused CBT (±TAU) versus eye movement desensitisation and reprocessing (EMDR; ±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated at 3-month follow-up (PSS-SR change score)

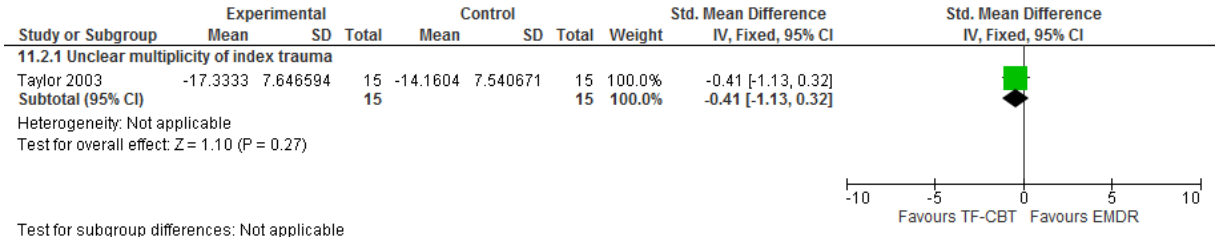


Figure 116: Trauma-focused CBT (±TAU) versus eye movement desensitisation and reprocessing (EMDR; ±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated at 6-month follow-up (PSS-SR change score)

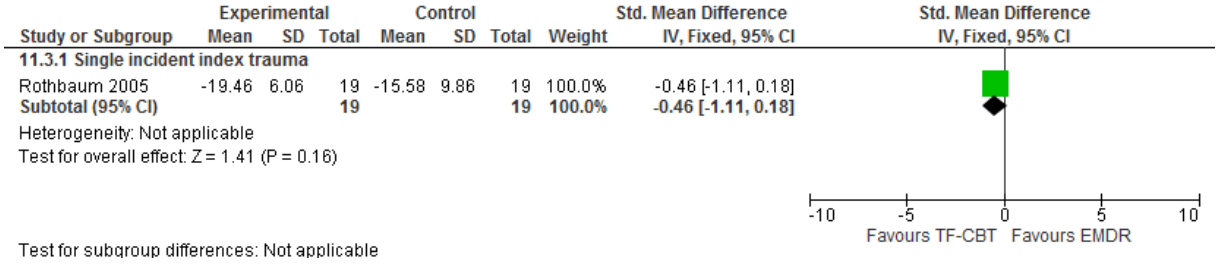


Figure 117: Trauma-focused CBT (±TAU) versus eye movement desensitisation and reprocessing (EMDR; ±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated at endpoint (CAPS/SI-PTSD change score)

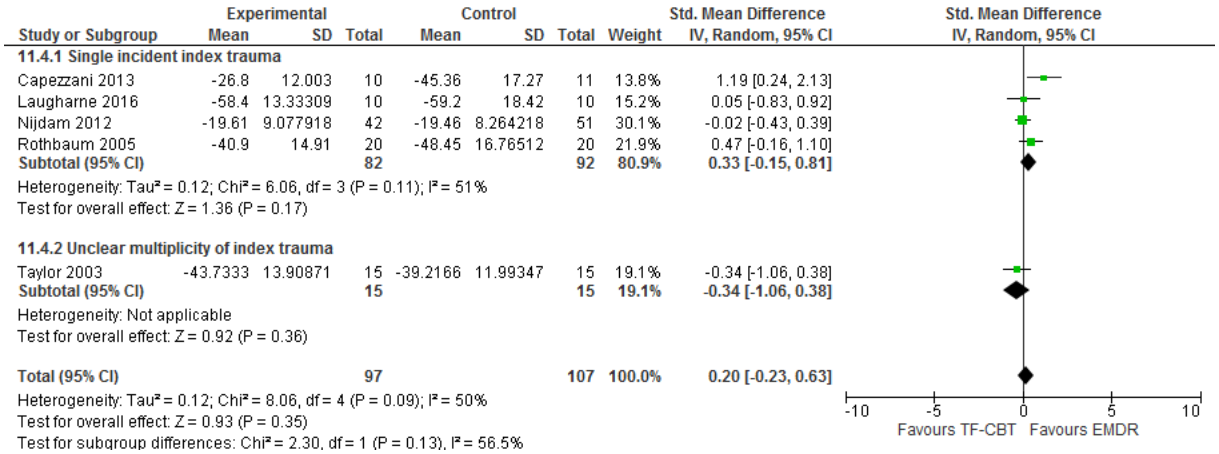


Figure 118: Trauma-focused CBT (±TAU) versus eye movement desensitisation and reprocessing (EMDR; ±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated at 3-month follow-up (CAPS change score)

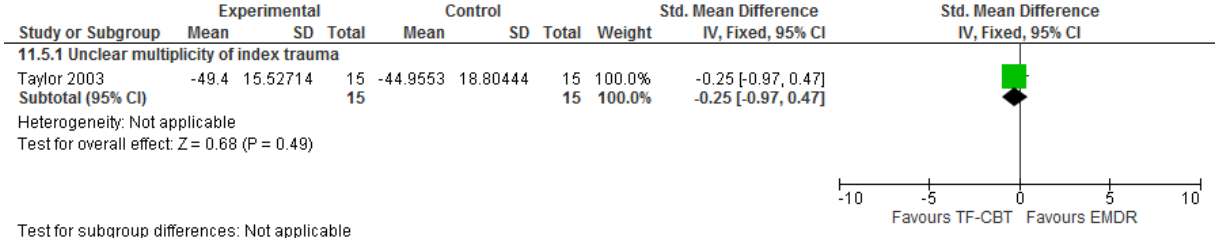


Figure 119: Trauma-focused CBT (±TAU) versus eye movement desensitisation and reprocessing (EMDR; ±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated at 6-month follow-up (CAPS change score)

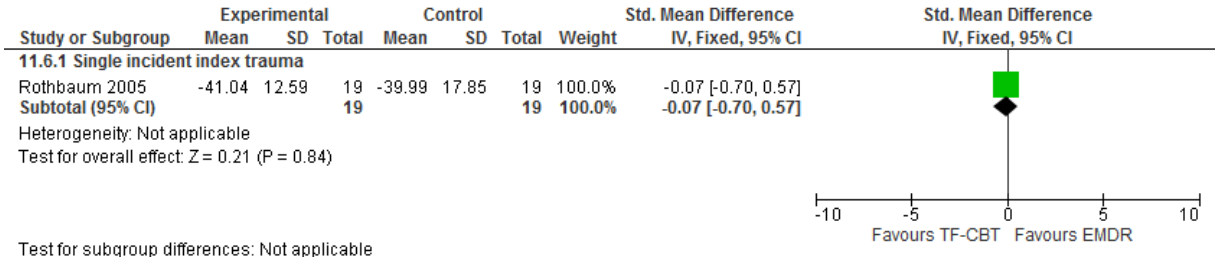


Figure 120: Trauma-focused CBT (±TAU) versus eye movement desensitisation and reprocessing (EMDR; ±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Remission at endpoint (number of people no longer meeting diagnostic criteria or no longer above clinical threshold on scale for PTSD)

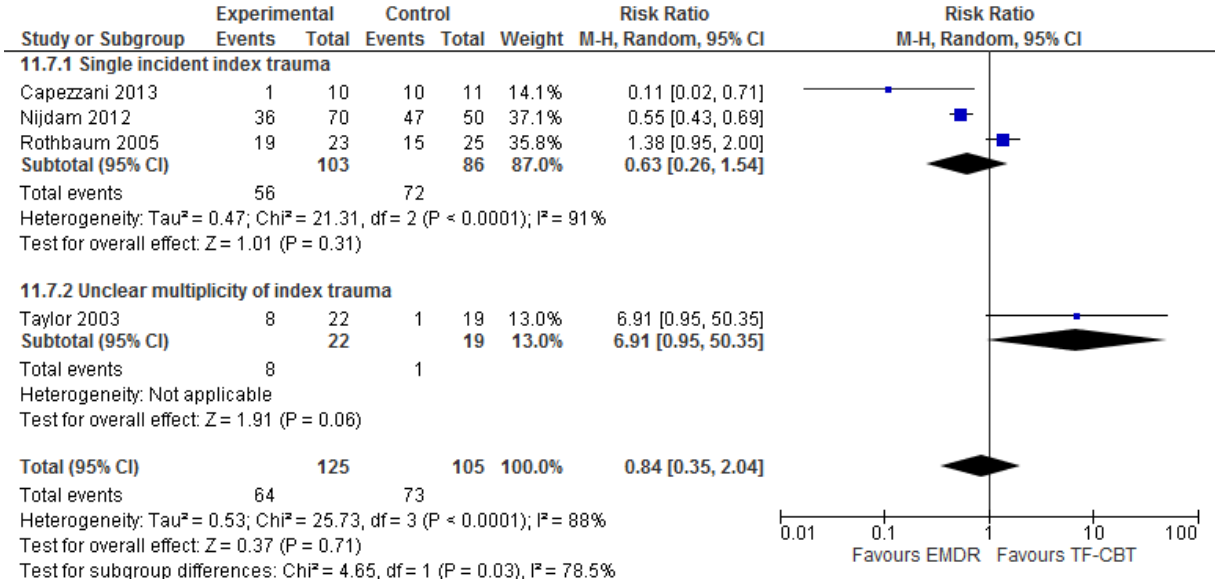


Figure 121: Trauma-focused CBT (±TAU) versus eye movement desensitisation and reprocessing (EMDR; ±TAU) for delayed treatment (>3 months) of clinically

important symptoms/PTSD: Remission at 3-month follow-up (number of people no longer above clinical threshold on scale for PTSD)

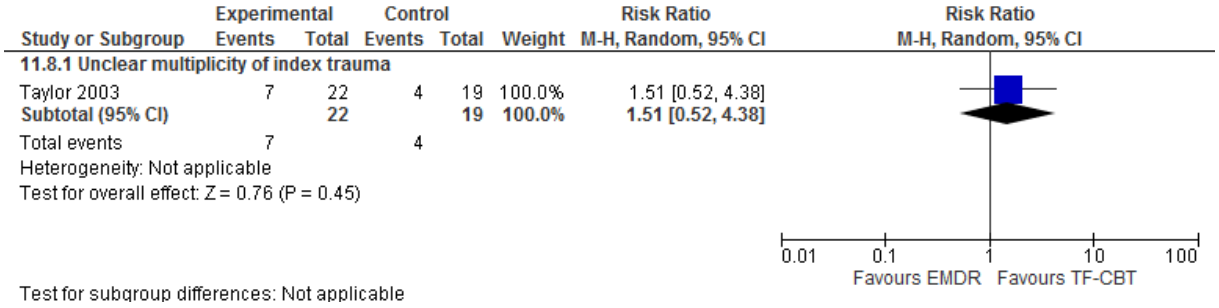


Figure 122: Trauma-focused CBT (±TAU) versus eye movement desensitisation and reprocessing (EMDR; ±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Remission at 6-month follow-up (number of people no longer meeting diagnostic criteria for PTSD)

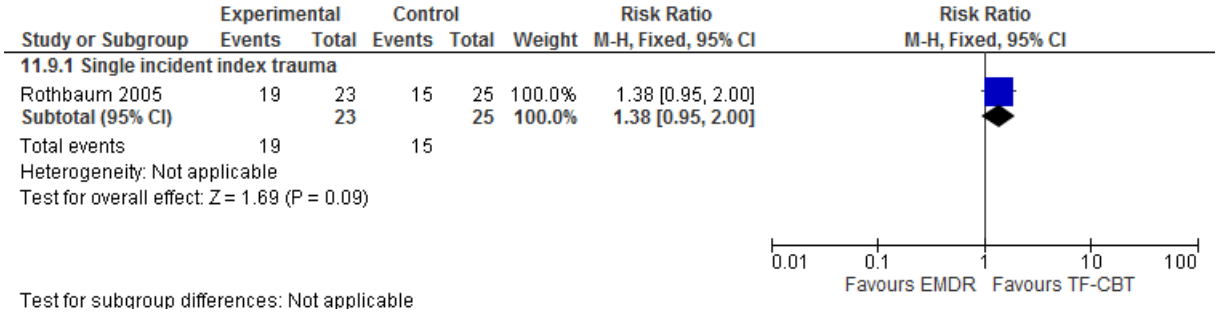


Figure 123: Trauma-focused CBT (±TAU) versus eye movement desensitisation and reprocessing (EMDR; ±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Response self-rated at endpoint (number of people showing clinically significant improvement based on reliable change indices [RCI] on IES)

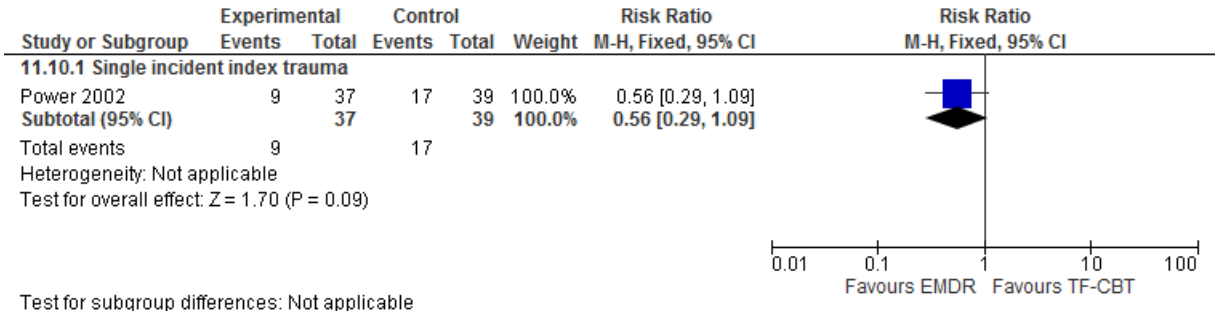


Figure 124: Trauma-focused CBT (±TAU) versus eye movement desensitisation and reprocessing (EMDR; ±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Response self-rated at 15-month follow-up

(number of people showing clinically significant improvement based on reliable change indices [RCI] on IES)

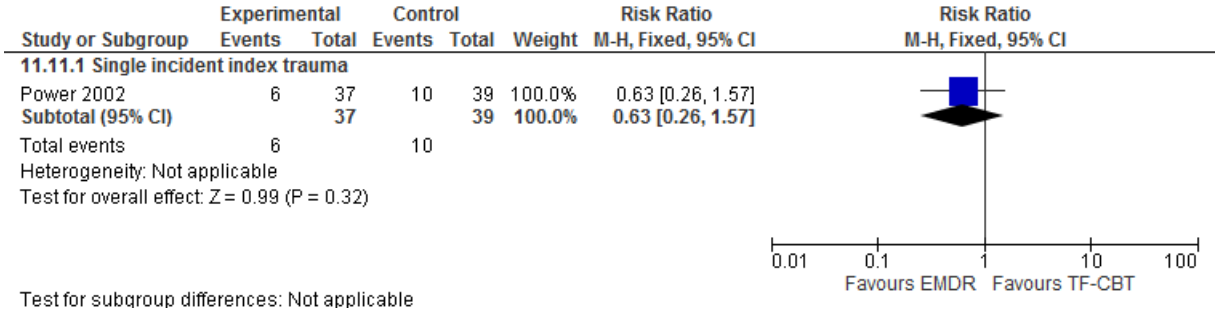


Figure 125: Trauma-focused CBT (±TAU) versus eye movement desensitisation and reprocessing (EMDR; ±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Dissociative symptoms at endpoint (DES/CAPS dissociation cluster change score)

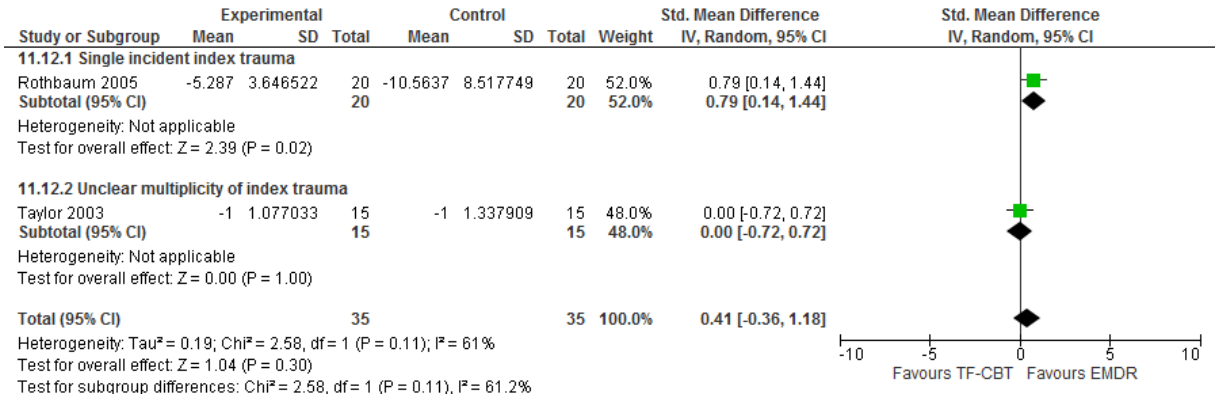


Figure 126: Trauma-focused CBT (±TAU) versus eye movement desensitisation and reprocessing (EMDR; ±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Dissociative symptoms at 3-month follow-up (CAPS dissociation cluster change score)

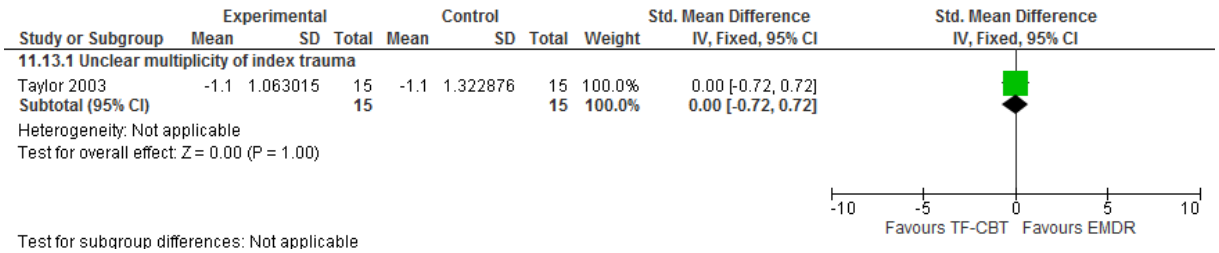


Figure 127: Trauma-focused CBT (±TAU) versus eye movement desensitisation and reprocessing (EMDR; ±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Dissociative symptoms at 6-month follow-up (DES change score)

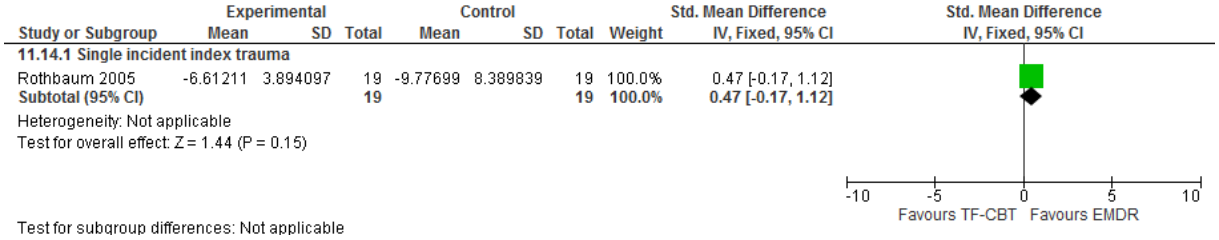


Figure 128: Trauma-focused CBT (±TAU) versus eye movement desensitisation and reprocessing (EMDR; ±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Anxiety symptoms at endpoint (STAI State/HADS-A/HAM-A change score)

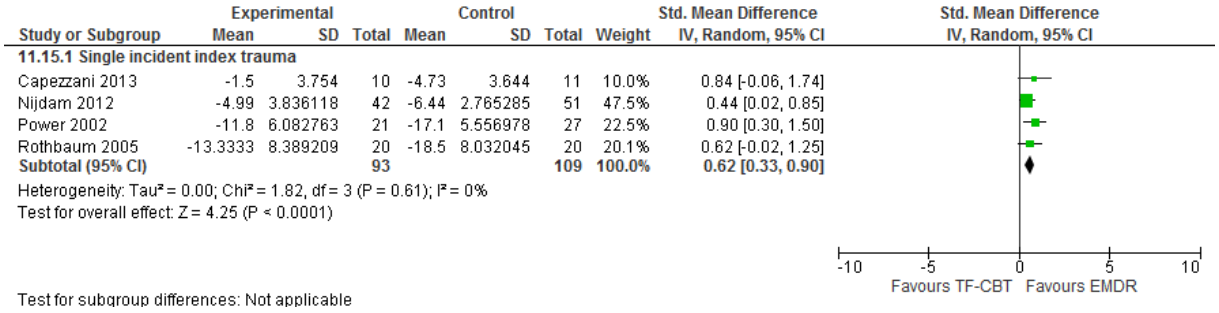


Figure 129: Trauma-focused CBT (±TAU) versus eye movement desensitisation and reprocessing (EMDR; ±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Anxiety symptoms at 6-month follow-up (STAI State change score)

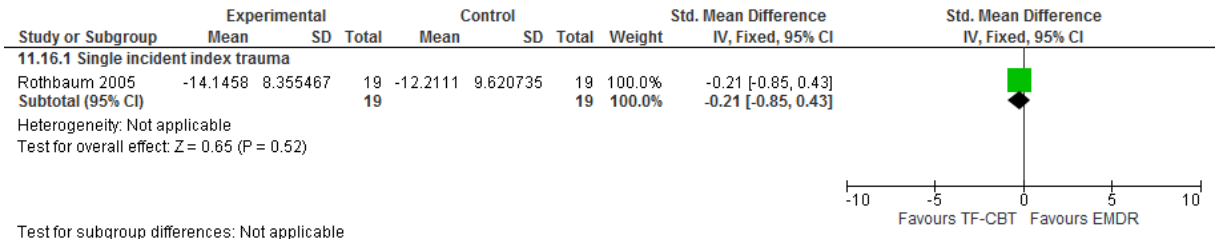


Figure 130: Trauma-focused CBT (±TAU) versus eye movement desensitisation and reprocessing (EMDR; ±TAU) for delayed treatment (>3 months) of clinically

important symptoms/PTSD: Depression symptoms at endpoint (BDI/BDI-II/HADS-D/MADRS change score)

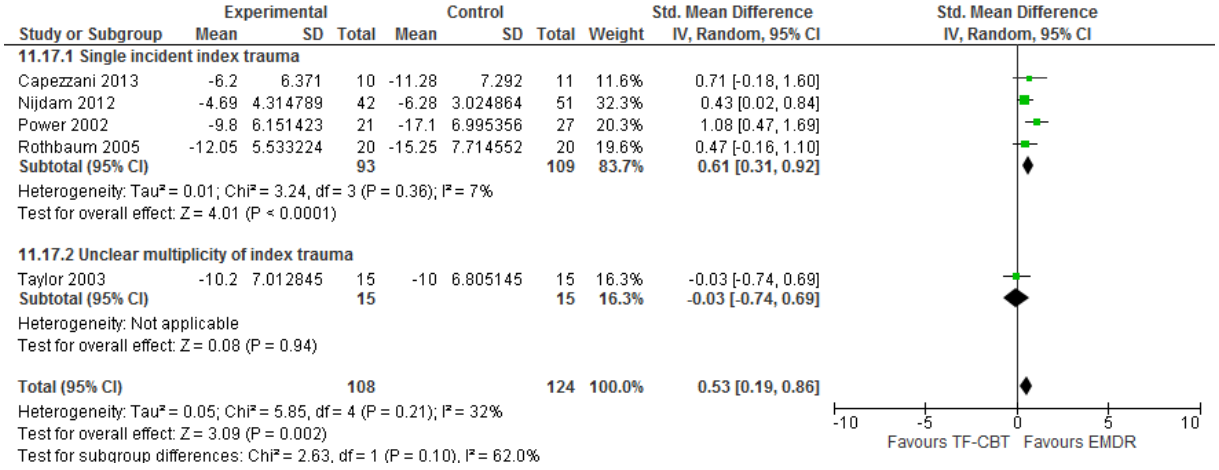


Figure 131: Trauma-focused CBT (±TAU) versus eye movement desensitisation and reprocessing (EMDR; ±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms at 3-month follow-up (BDI change score)

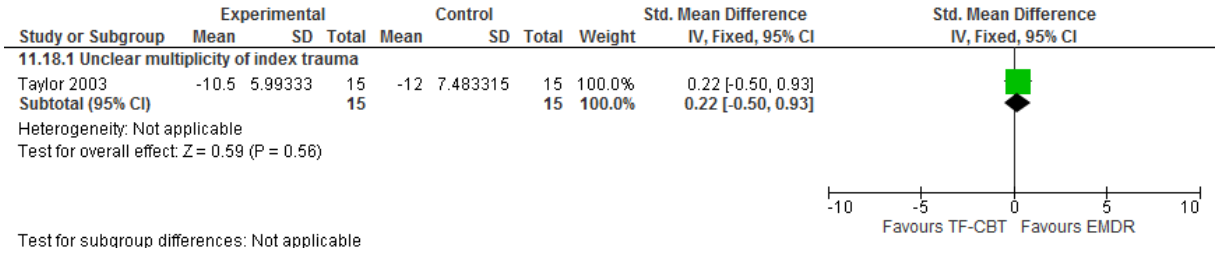


Figure 132: Trauma-focused CBT (±TAU) versus eye movement desensitisation and reprocessing (EMDR; ±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms at 6-month follow-up (BDI change score)

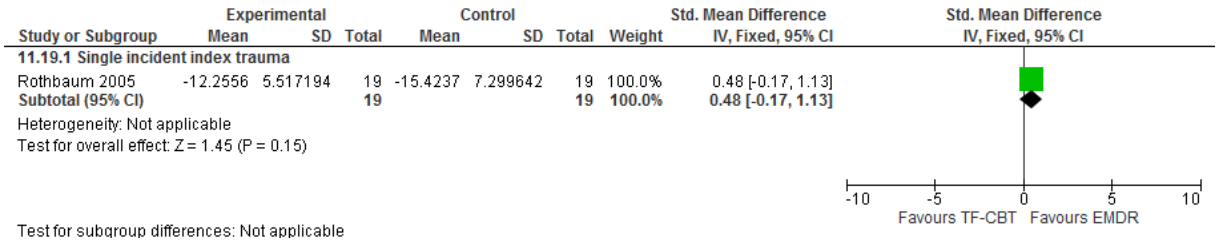


Figure 133: Trauma-focused CBT (±TAU) versus eye movement desensitisation and reprocessing (EMDR; ±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Functional impairment (SDS change score)

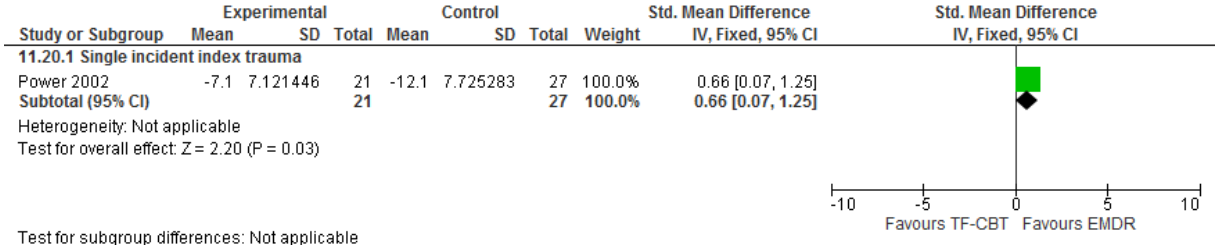
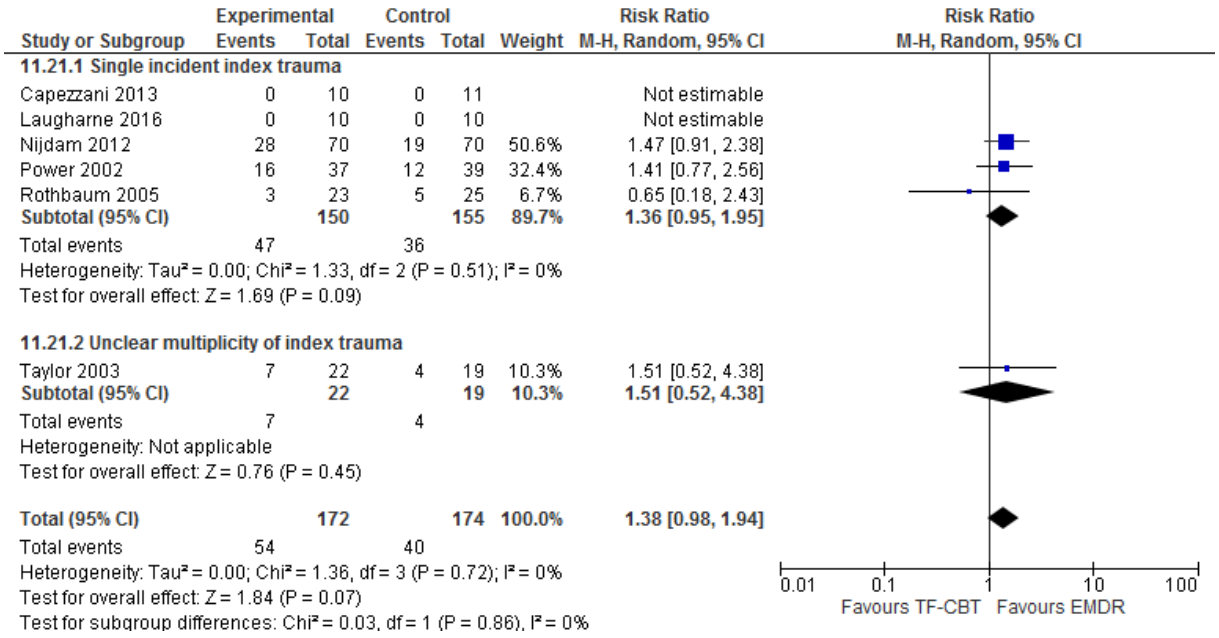


Figure 134: Trauma-focused CBT (±TAU) versus eye movement desensitisation and reprocessing (EMDR; ±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)



Sub-analysis by specific intervention: Trauma-focused CBT (±TAU) versus eye movement desensitisation and reprocessing (EMDR; ±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD

Figure 135: Trauma-focused CBT (±TAU) versus eye movement desensitisation and reprocessing (EMDR; ±TAU) for delayed treatment (>3 months) of clinically

important symptoms/PTSD: PTSD symptomatology self-rated at endpoint (IES/IES-R/PSS-SR change score)

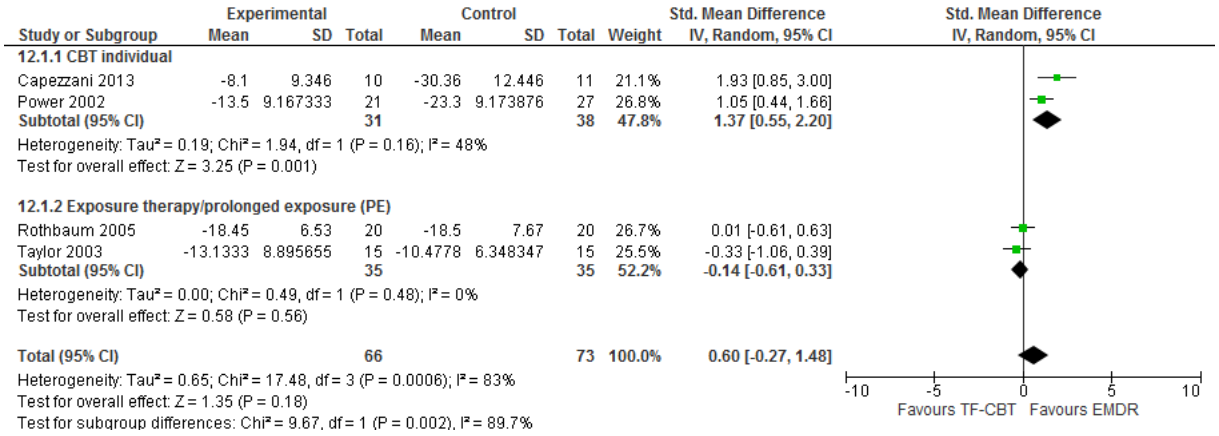


Figure 136: Trauma-focused CBT (±TAU) versus eye movement desensitisation and reprocessing (EMDR; ±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated at endpoint (CAPS/SI-PTSD change score)

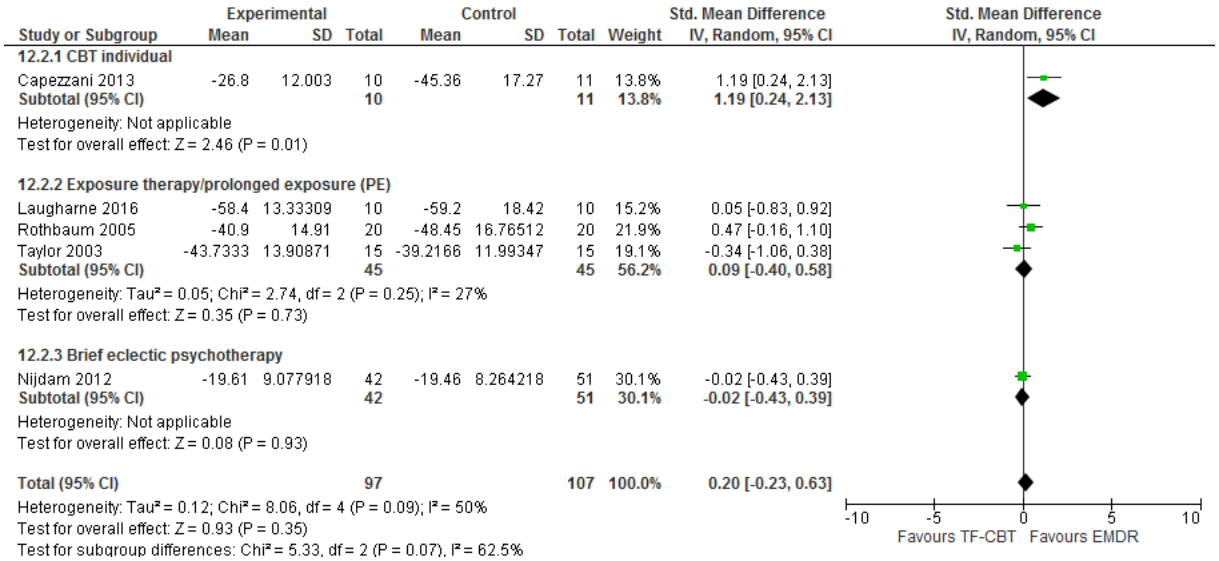
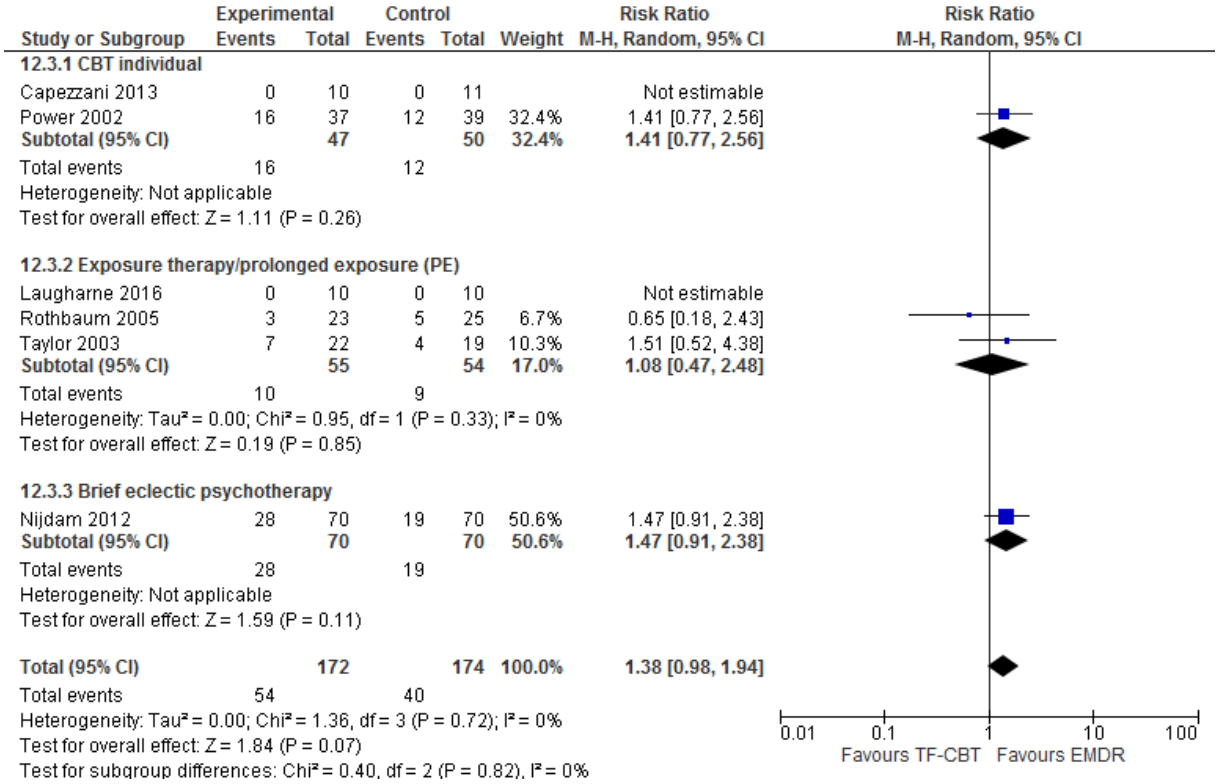


Figure 137: Trauma-focused CBT (±TAU) versus eye movement desensitisation and reprocessing (EMDR; ±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)



Sub-analysis by diagnostic status at baseline: Trauma-focused CBT (±TAU) versus eye movement desensitisation and reprocessing (EMDR; ±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD

Figure 138: Trauma-focused CBT (±TAU) versus eye movement desensitisation and reprocessing (EMDR; ±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated at endpoint (IES/IES-R/PSS-SR change score)

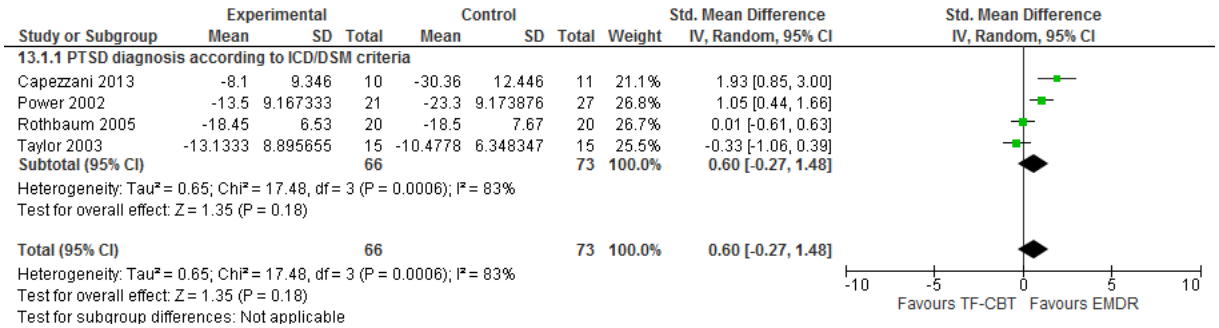


Figure 139: Trauma-focused CBT (±TAU) versus eye movement desensitisation and reprocessing (EMDR; ±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated at endpoint (CAPS/SI-PTSD change score)

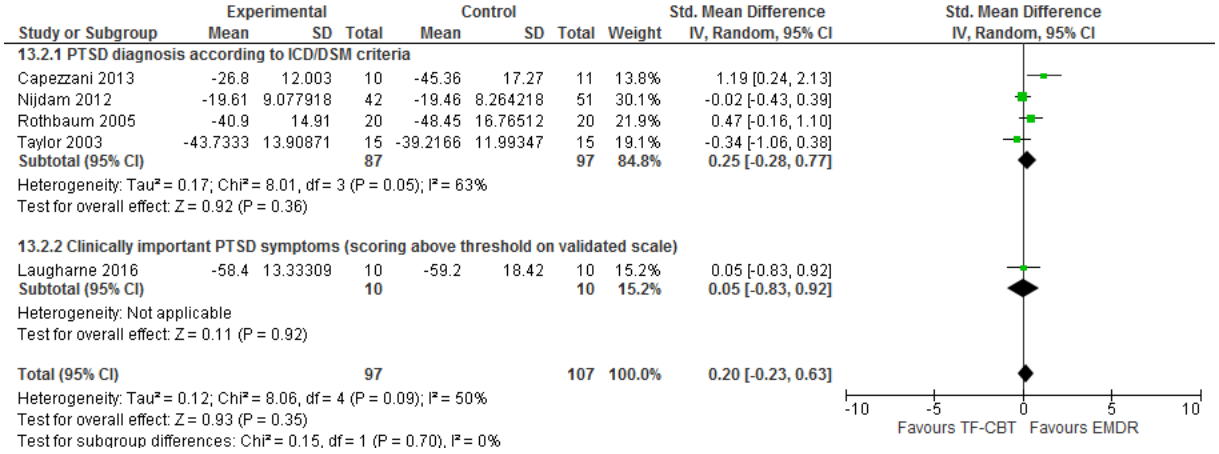
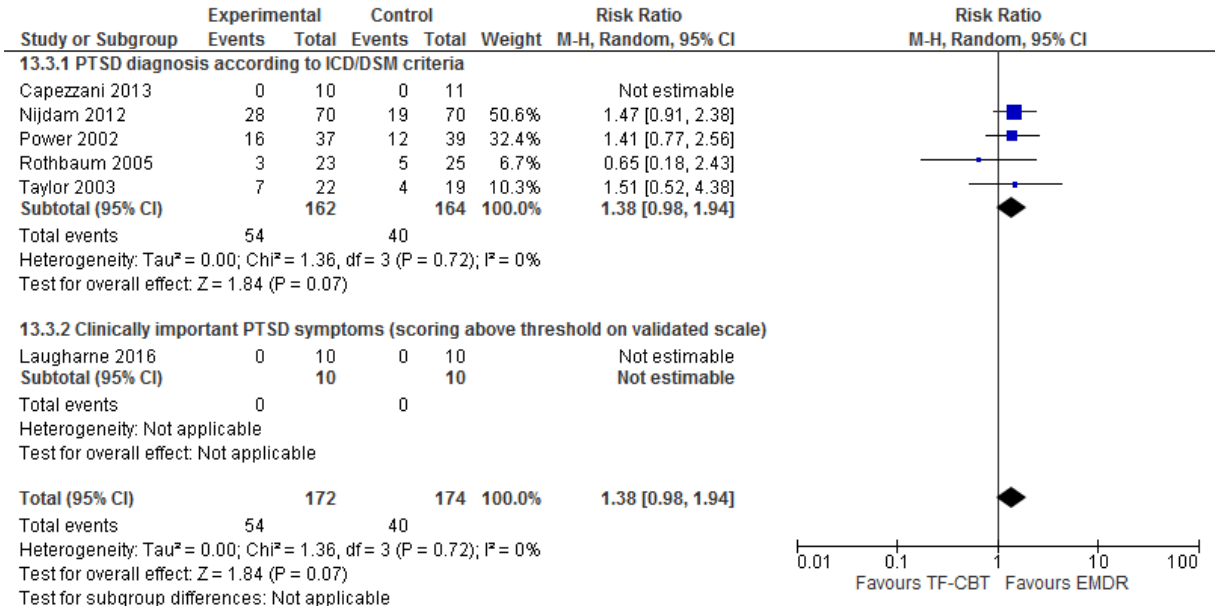


Figure 140: Trauma-focused CBT (±TAU) versus eye movement desensitisation and reprocessing (EMDR; ±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)



Sub-analysis by trauma type: Trauma-focused CBT (±TAU) versus eye movement desensitisation and reprocessing (EMDR; ±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD

Figure 141: Trauma-focused CBT (±TAU) versus eye movement desensitisation and reprocessing (EMDR; ±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated at endpoint (IES/IES-R/PSS-SR change score)

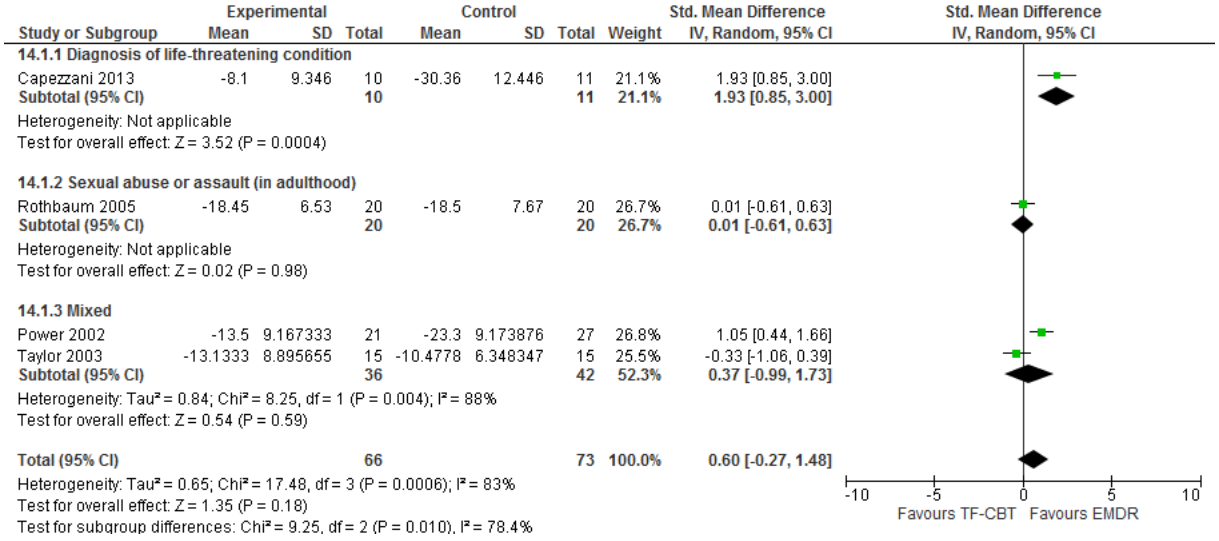


Figure 142: Trauma-focused CBT (±TAU) versus eye movement desensitisation and reprocessing (EMDR; ±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated at endpoint (CAPS/SI-PTSD change score)

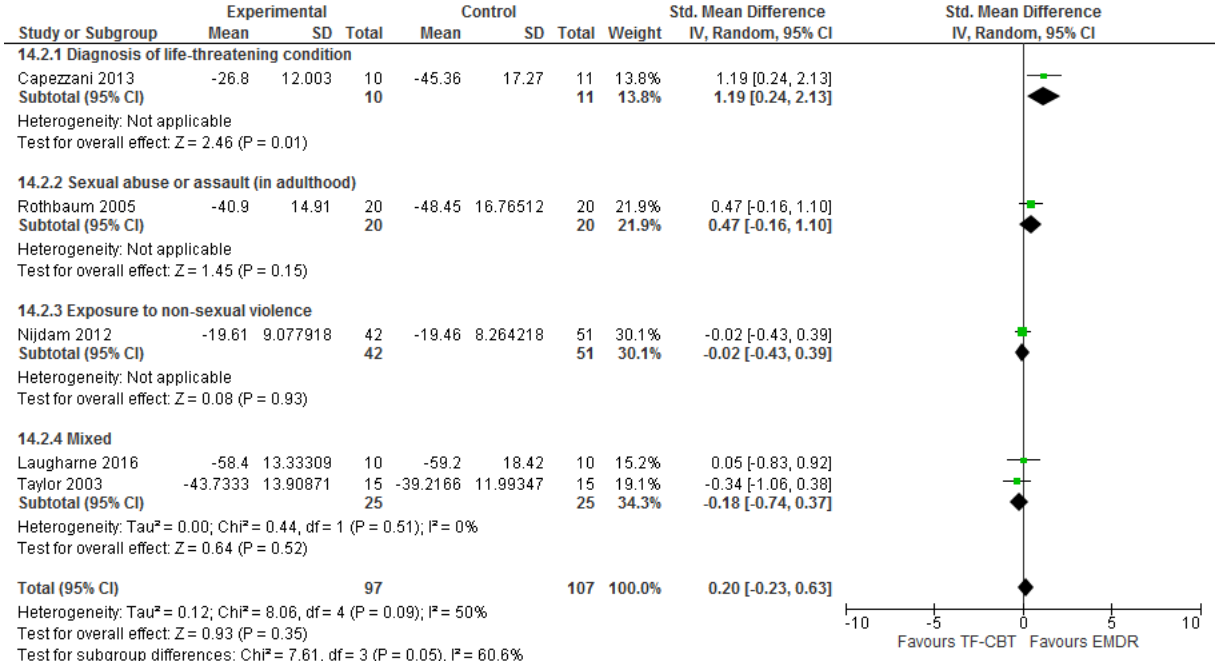
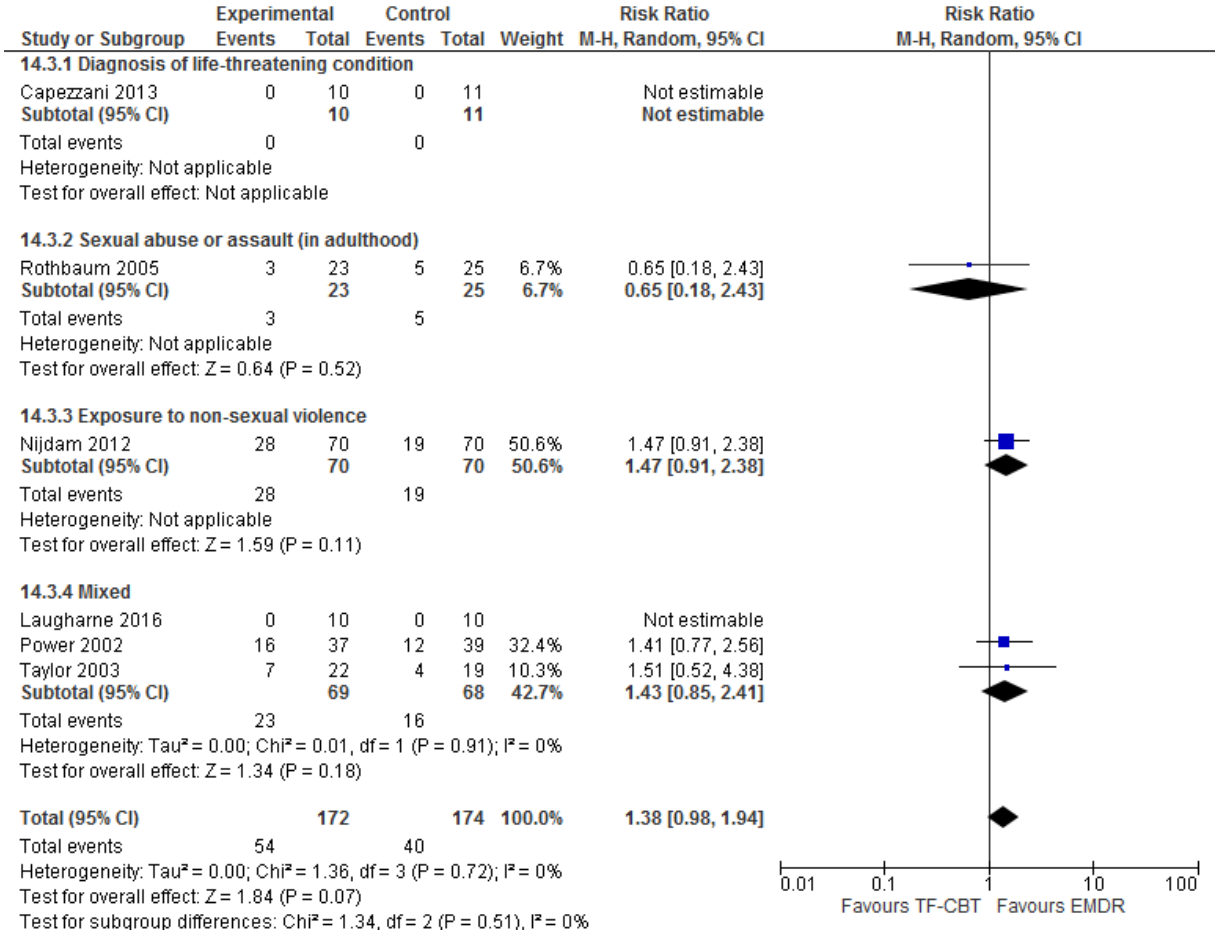


Figure 143: Trauma-focused CBT (±TAU) versus eye movement desensitisation and reprocessing (EMDR; ±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)



Sub-analysis by diagnostic status at baseline: Trauma-focused CBT (±TAU) versus eye movement desensitisation and reprocessing (EMDR; ±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD

Figure 144: Trauma-focused CBT (±TAU) versus eye movement desensitisation and reprocessing (EMDR; ±TAU) for delayed treatment (>3 months) of clinically

important symptoms/PTSD: PTSD symptomatology self-rated at endpoint (PCL/PDS/PSS-SR change score)

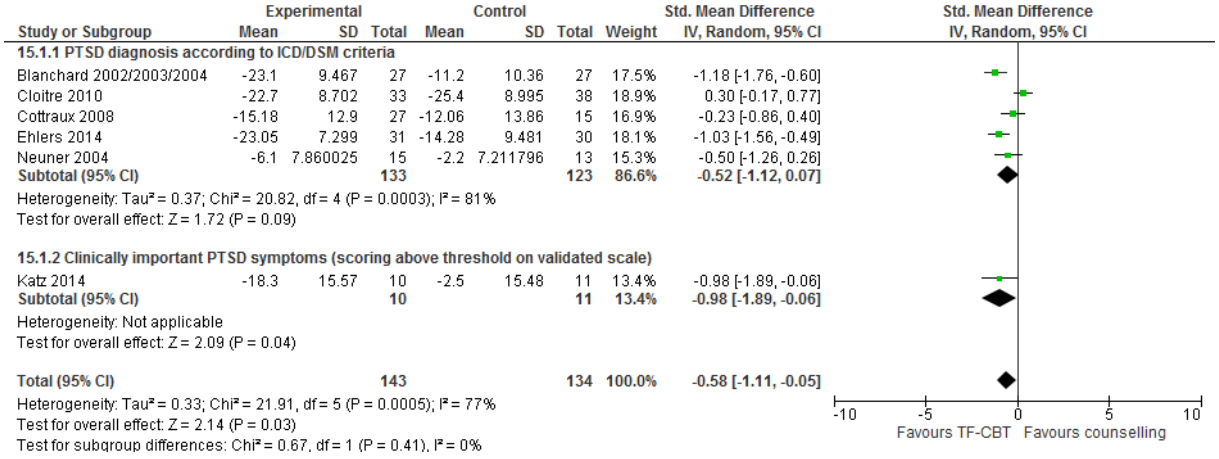


Figure 145: Trauma-focused CBT (±TAU) versus eye movement desensitisation and reprocessing (EMDR; ±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated at endpoint (CAPS/PSS-I change score)

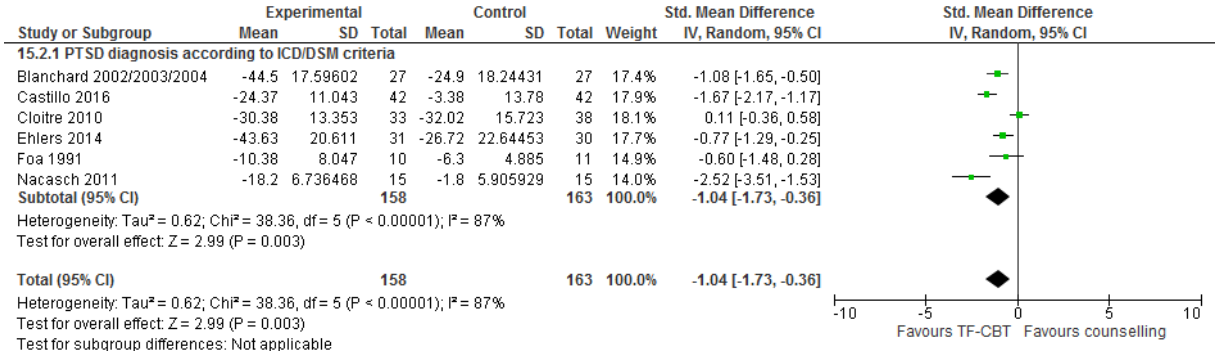


Figure 146: Trauma-focused CBT (±TAU) versus eye movement desensitisation and reprocessing (EMDR; ±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)

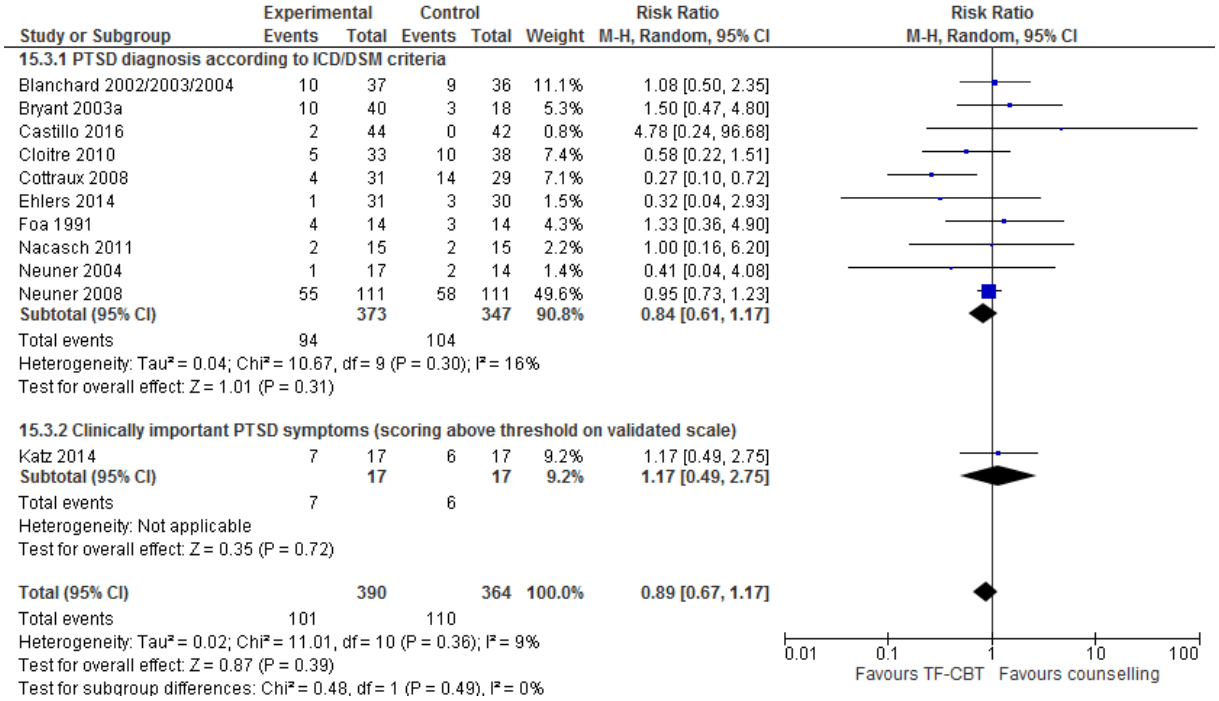


Figure 147: Trauma-focused CBT (±TAU) versus non-trauma-focused CBT (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated at follow-up (PCL change score); Multiple incident index trauma

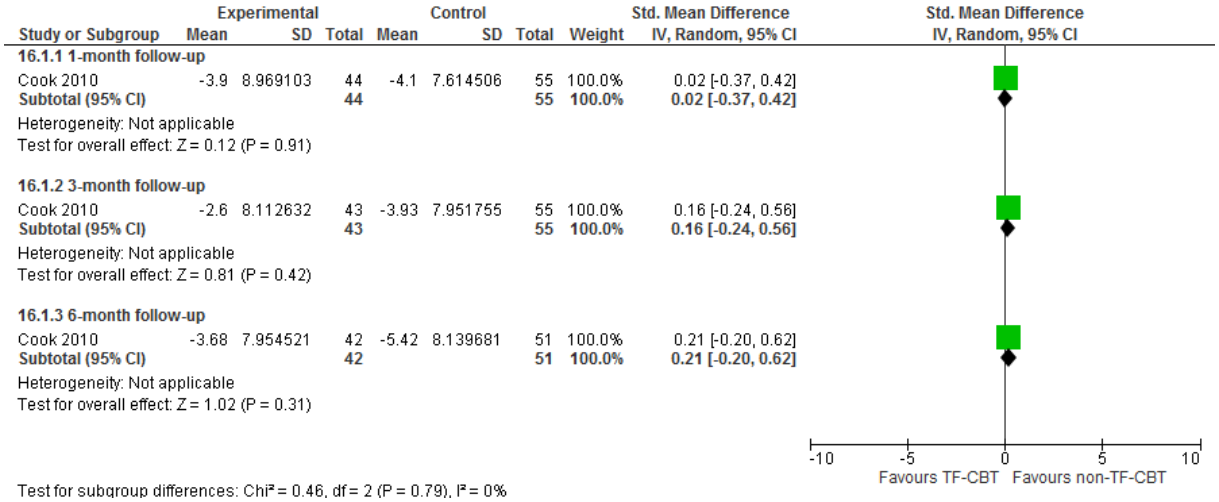


Figure 148: Trauma-focused CBT (±TAU) versus non-trauma-focused CBT (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated at endpoint (PSS-I/CAPS change score)

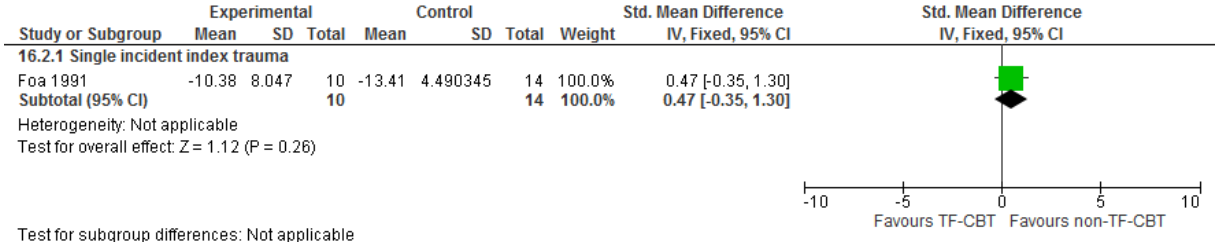


Figure 149: Trauma-focused CBT (±TAU) versus non-trauma-focused CBT (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated at follow-up (CAPS change score); Multiple incident index trauma

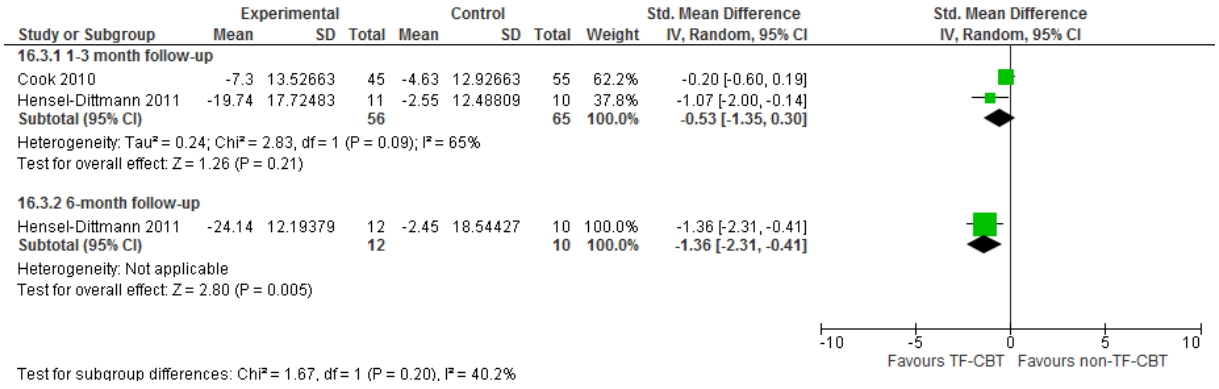


Figure 150: Trauma-focused CBT (±TAU) versus non-trauma-focused CBT (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Remission at endpoint (number of people no longer meeting diagnostic criteria for PTSD)

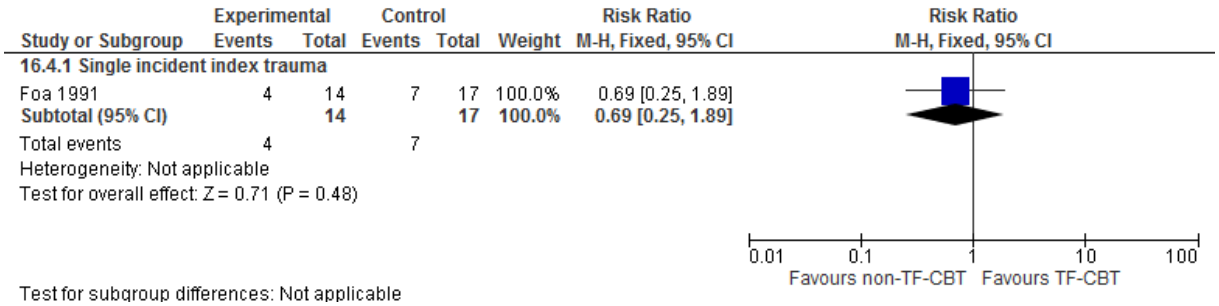


Figure 151: Trauma-focused CBT (±TAU) versus non-trauma-focused CBT (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Remission at follow-up (number of people no longer meeting diagnostic criteria for PTSD); Multiple incident index trauma

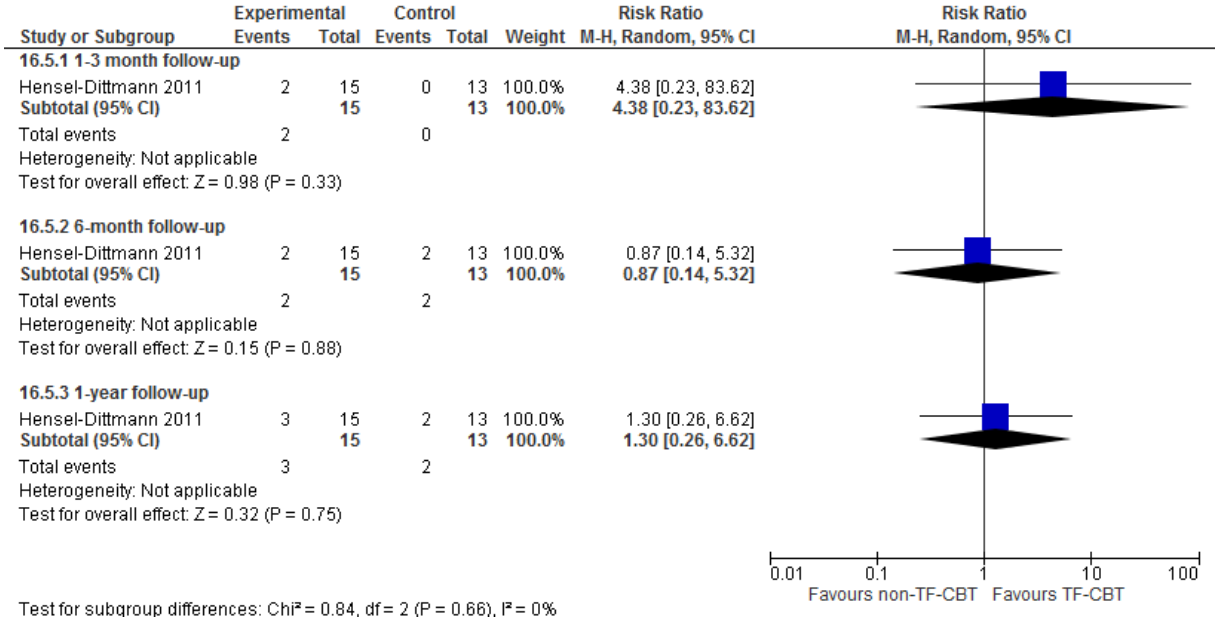


Figure 152: Trauma-focused CBT (±TAU) versus non-trauma-focused CBT (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Response clinician-rated at endpoint (number of people showing clinically signficant improvement based on reliable change indices [RCI] on PSS-I)

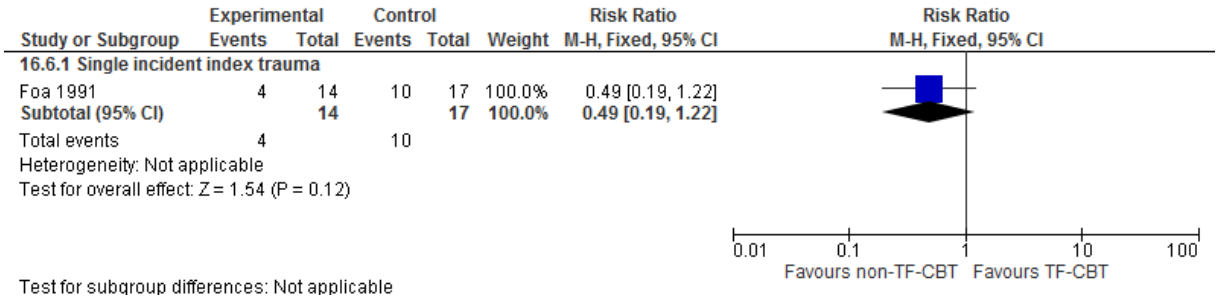


Figure 153: Trauma-focused CBT (±TAU) versus non-trauma-focused CBT (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Anxiety symptoms (STAI Stage change score)

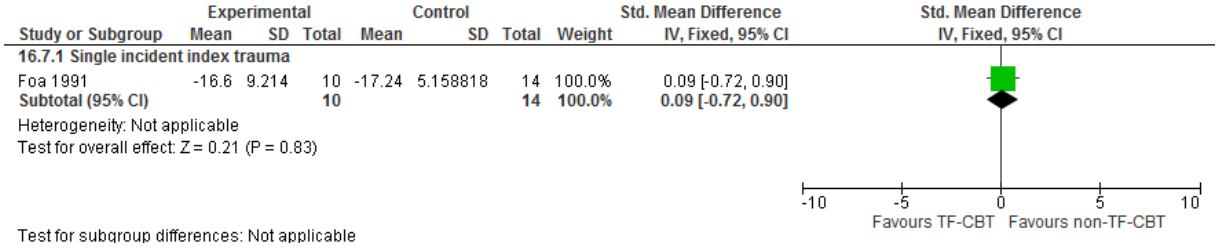


Figure 154: Trauma-focused CBT (±TAU) versus non-trauma-focused CBT (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms at endpoint (BDI change score)

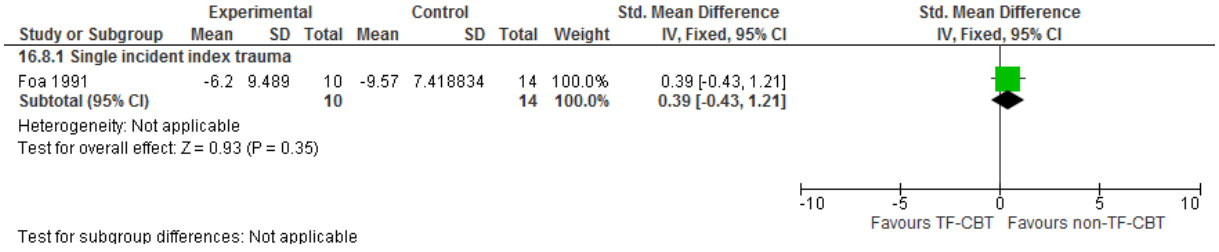


Figure 155: Trauma-focused CBT (±TAU) versus non-trauma-focused CBT (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms at follow-up (BDI/HAMD change score); Multiple incident index trauma

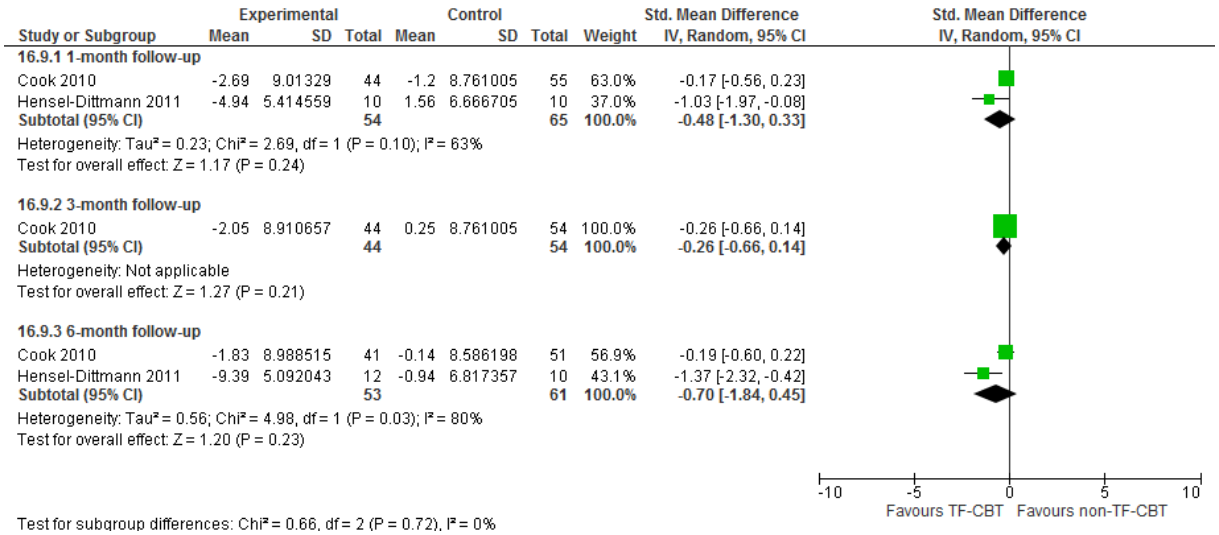


Figure 156: Trauma-focused CBT (±TAU) versus non-trauma-focused CBT (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Sleeping difficulties (PSQI change score); Multiple incident index trauma

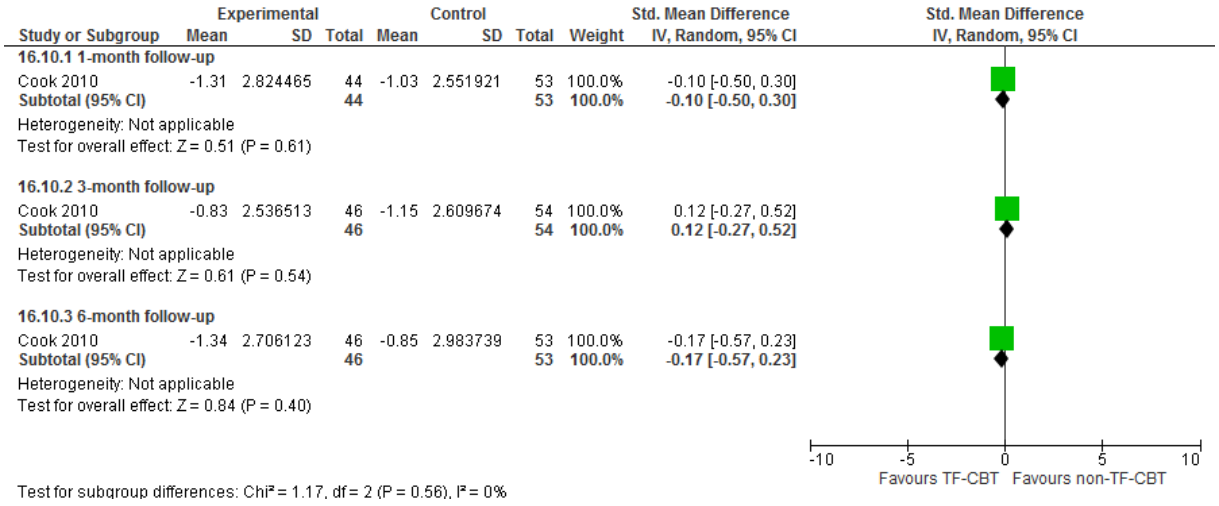


Figure 157: Trauma-focused CBT (±TAU) versus non-trauma-focused CBT (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Quality of life (QOLI/SF-36 MH change score); Multiple incident index trauma

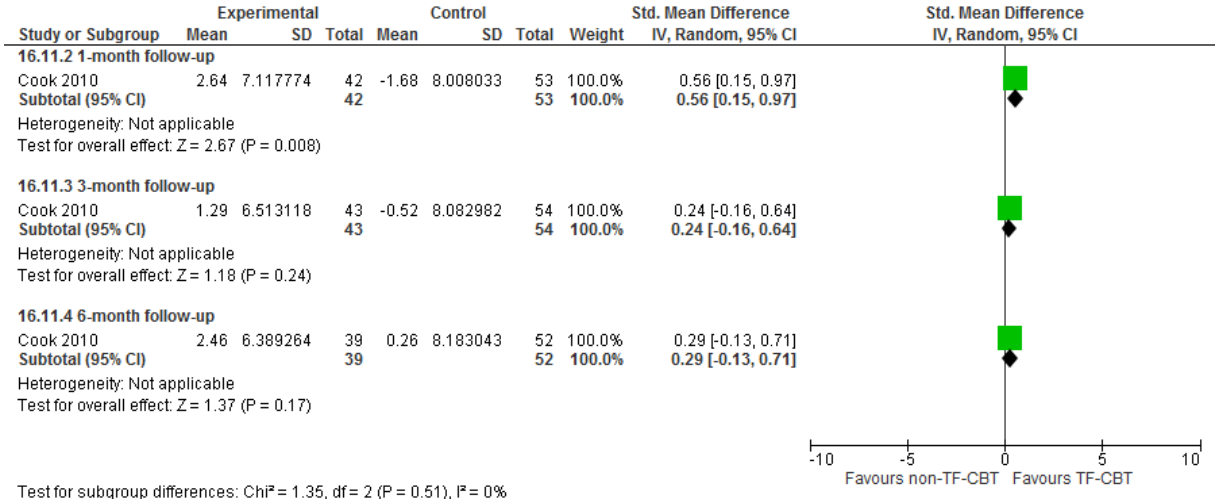


Figure 158: Trauma-focused CBT (±TAU) versus non-trauma-focused CBT (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)

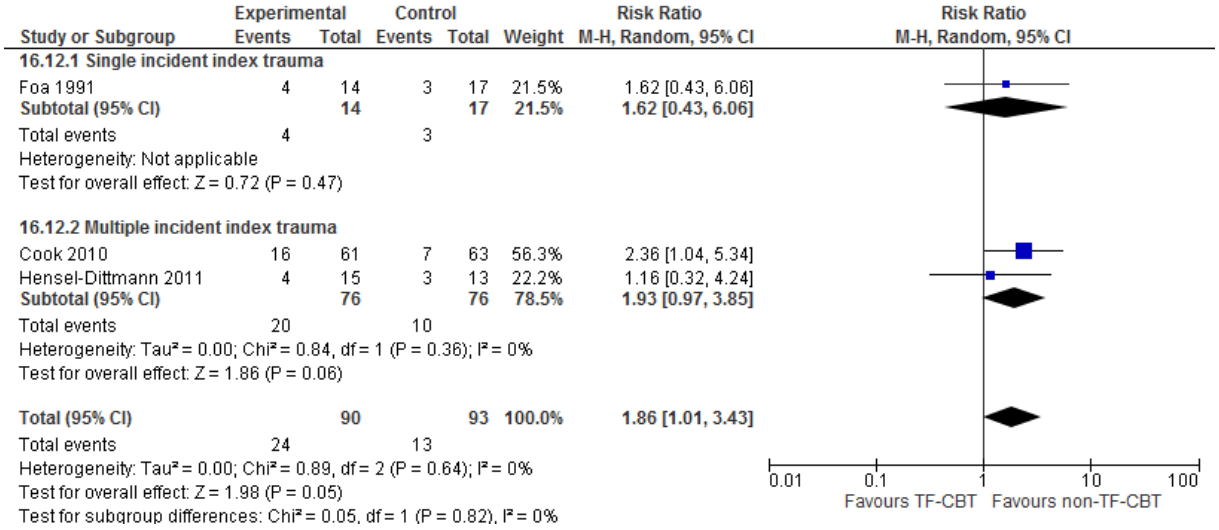


Figure 159: Trauma-focused CBT (±TAU) versus counselling (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated at endpoint (PCL/PDS/PSS-SR change score)

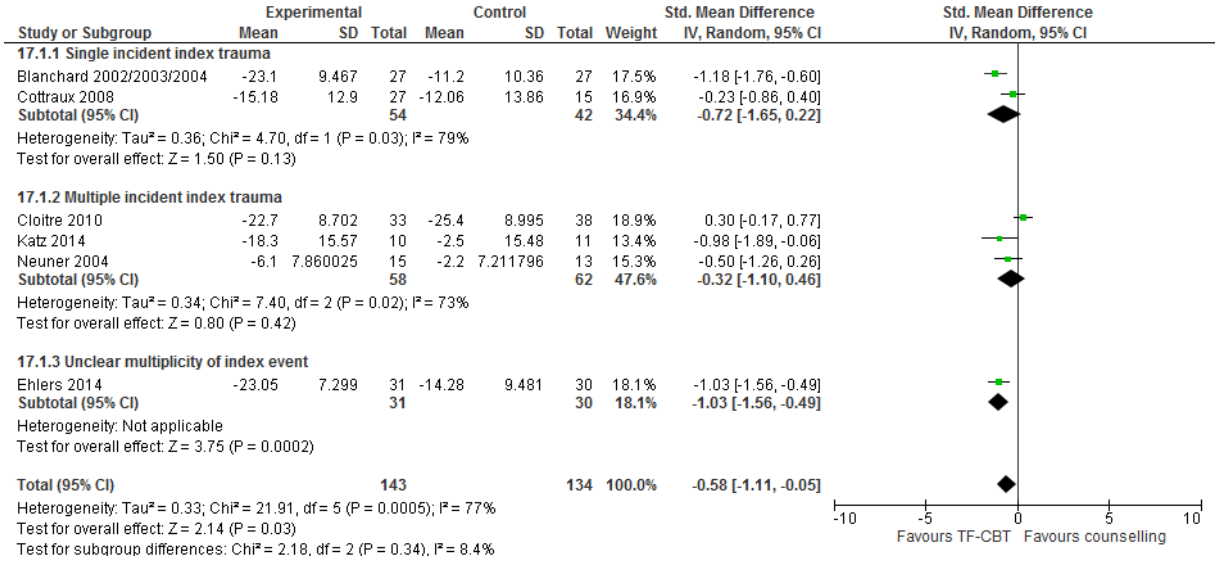


Figure 160: Trauma-focused CBT (±TAU) versus counselling (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD

symptomatology self-rated at 2-4 month follow-up (PCL/PDS/PSS-SR change score)

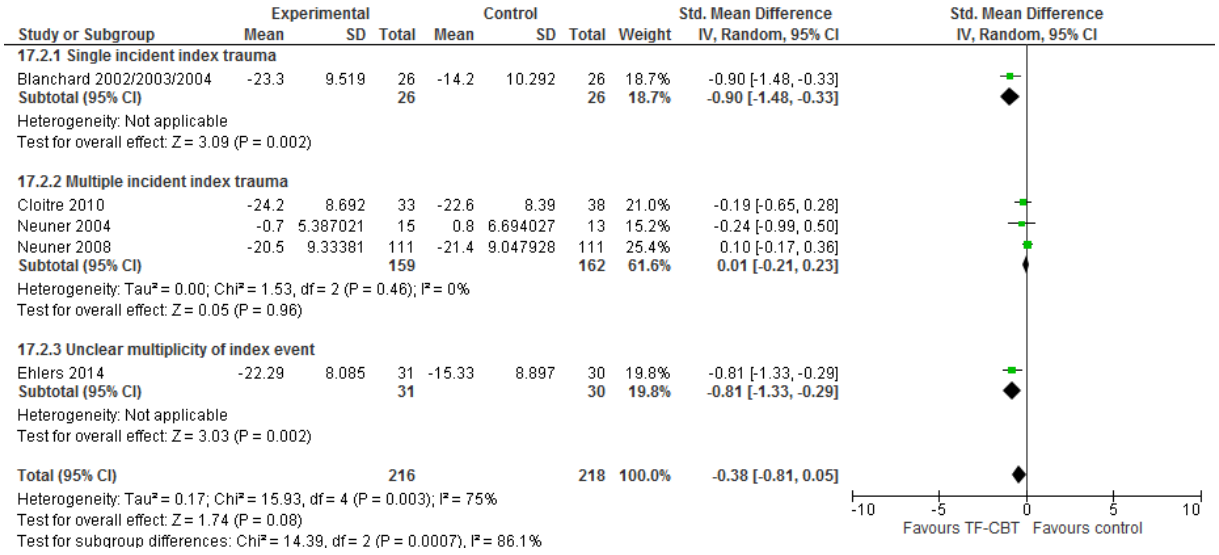


Figure 161: Trauma-focused CBT (±TAU) versus counselling (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated at 6-8 month follow-up (PCL/PDS/PSS-SR change score)

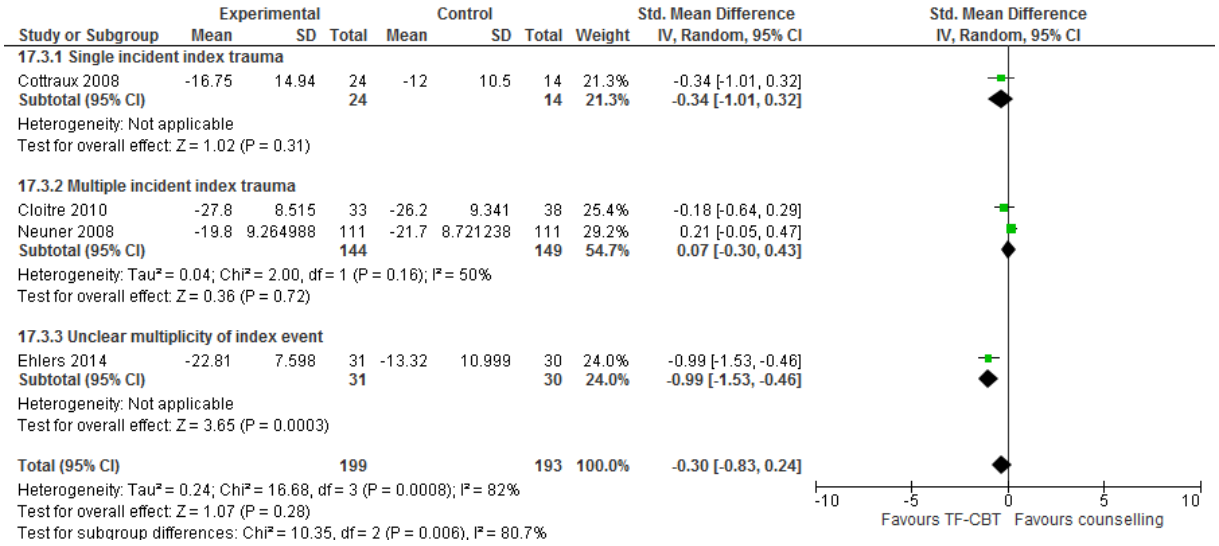


Figure 162: Trauma-focused CBT (±TAU) versus counselling (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD

symptomatology self-rated at 1-year follow-up (PCL/PDS/PSS-SR change score)

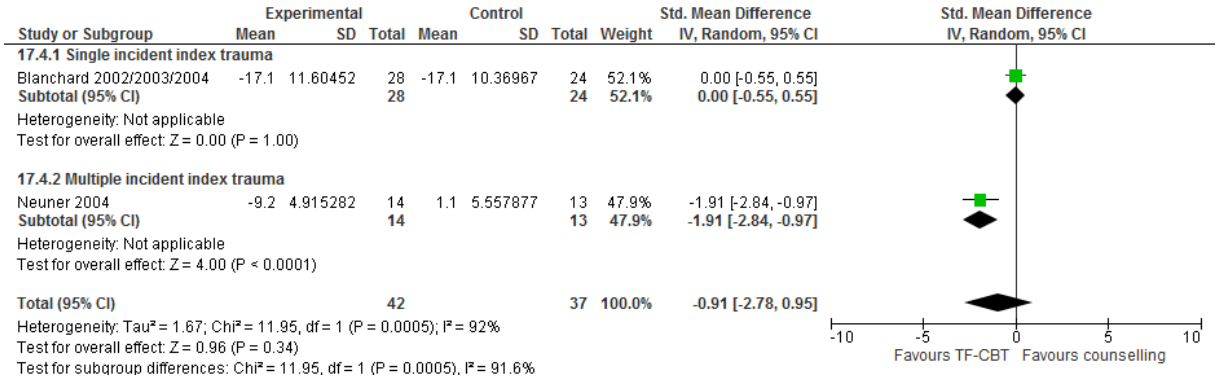


Figure 163: Trauma-focused CBT (±TAU) versus counselling (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated at 2-year follow-up (PCL change score)

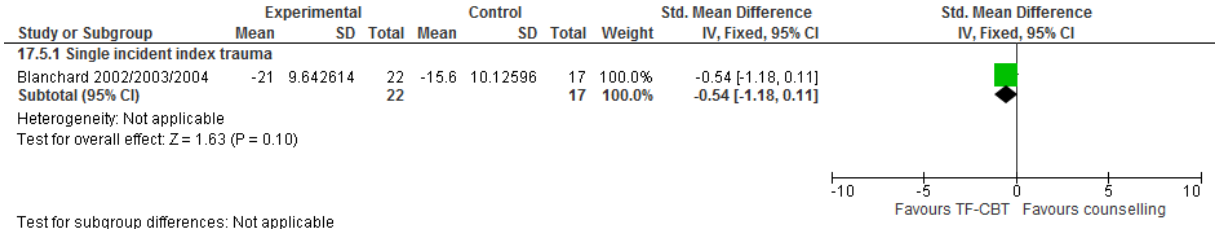


Figure 164: Trauma-focused CBT (±TAU) versus counselling (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated at endpoint (PCL change score)

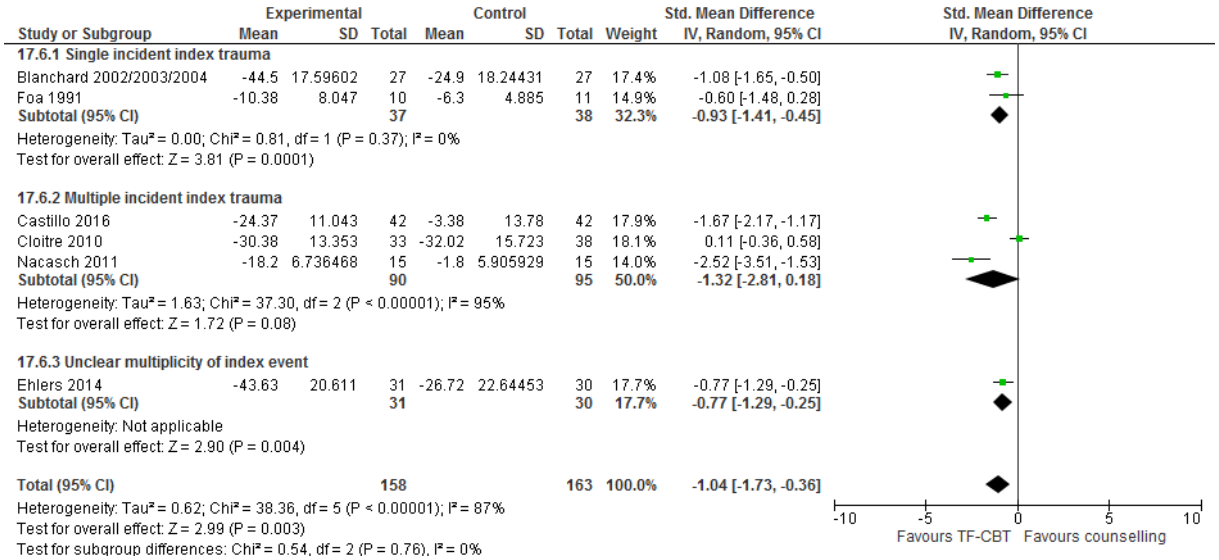


Figure 165: Trauma-focused CBT (±TAU) versus counselling (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated at 3-month follow-up (CAPS change score)

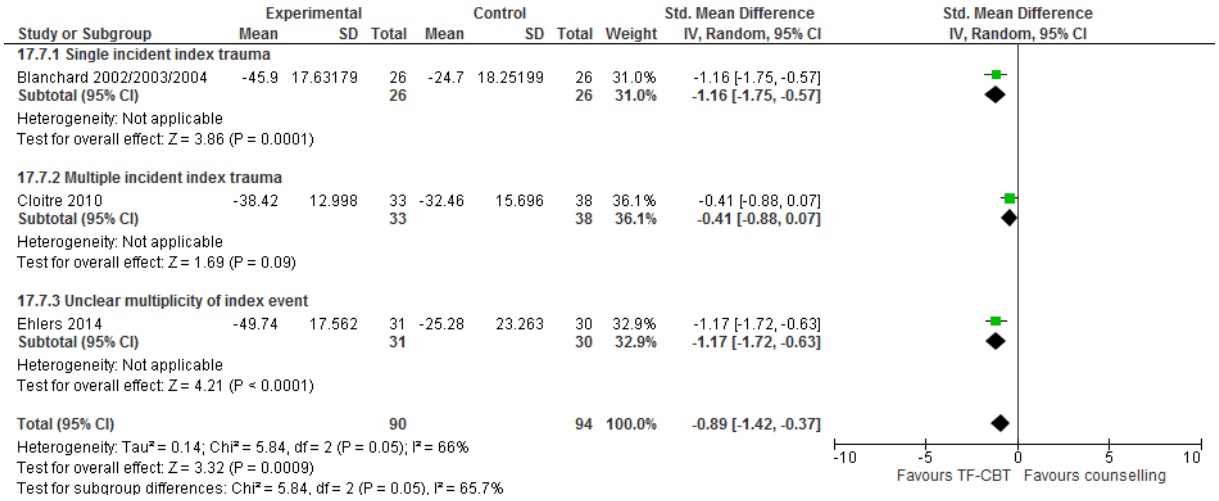


Figure 166: Trauma-focused CBT (±TAU) versus counselling (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated at 6-month follow-up (CAPS change score)

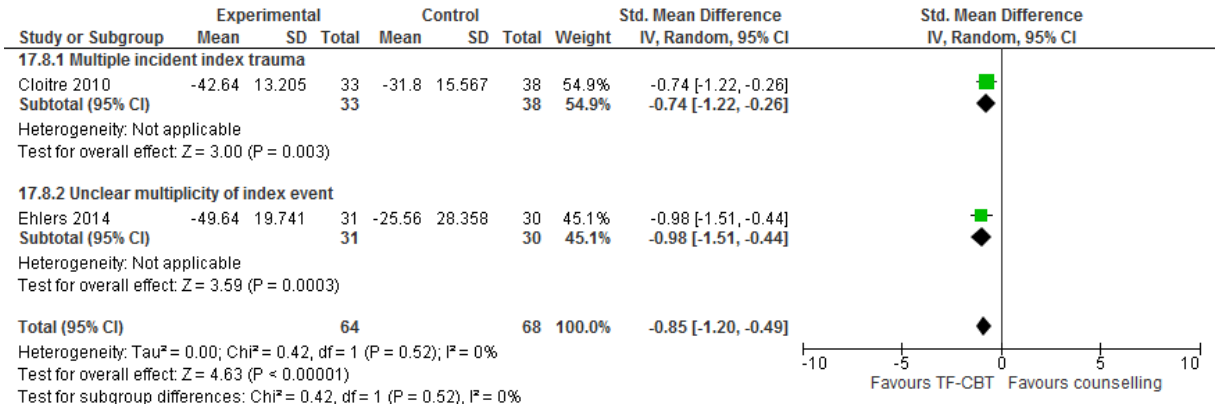


Figure 167: Trauma-focused CBT (±TAU) versus counselling (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD

symptomatology clinician-rated at 1-year follow-up (CAPS/PSS-I/CIDI-PTSD change score)

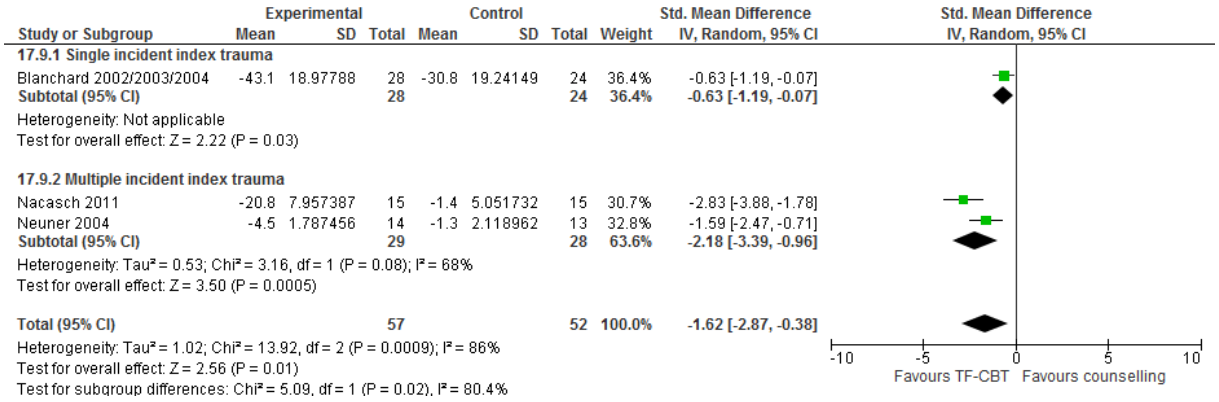


Figure 168: Trauma-focused CBT (±TAU) versus counselling (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated at 2-year follow-up (CAPS change score)

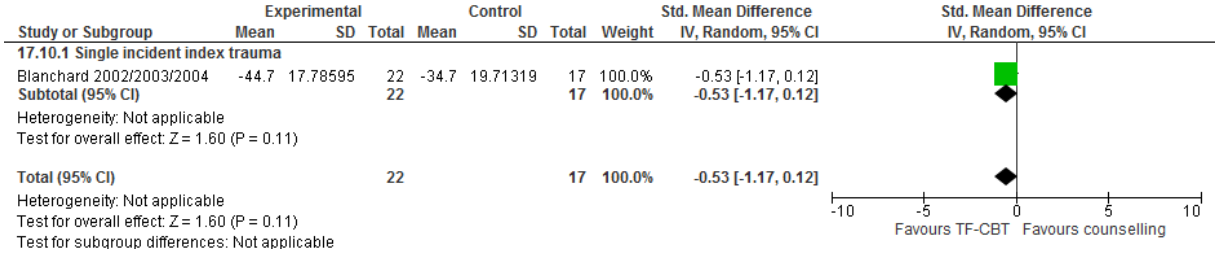


Figure 169: Trauma-focused CBT (±TAU) versus counselling (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Remission at

endpoint (number of people no longer meeting diagnostic criteria or no longer above threshold on a scale for PTSD)

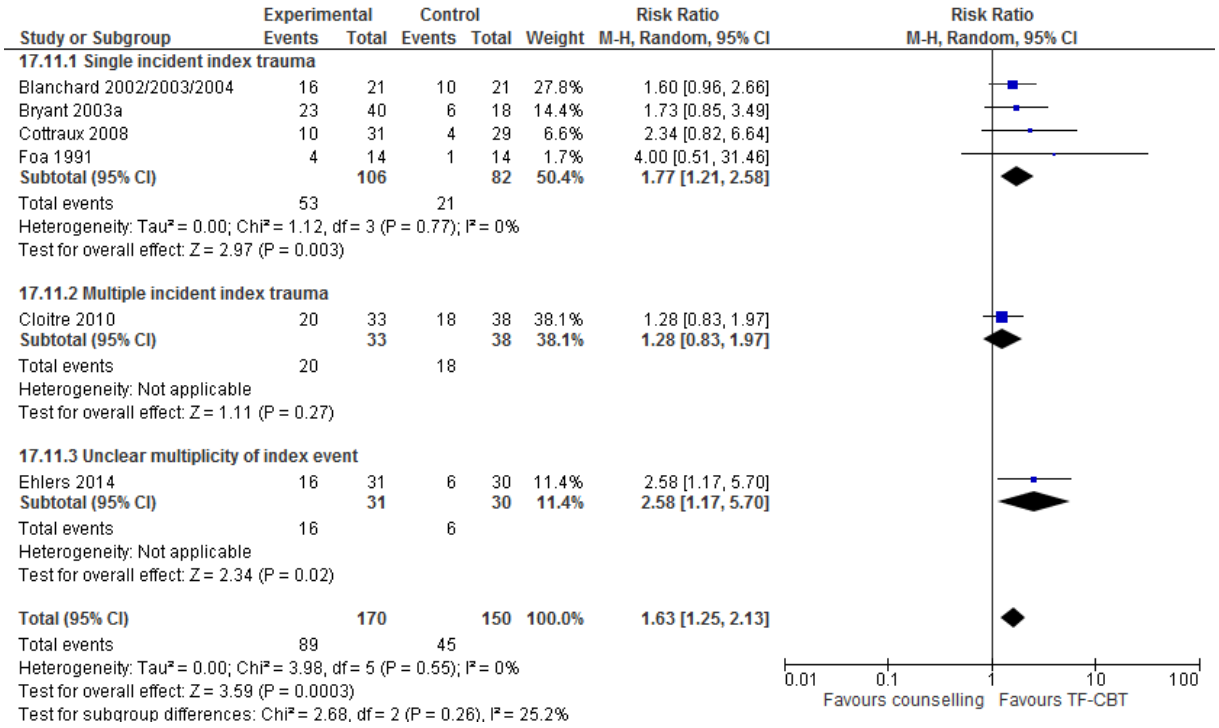


Figure 170: Trauma-focused CBT (±TAU) versus counselling (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Remission at 3-month follow-up (number of people no longer meeting diagnostic criteria or no longer above threshold on a scale for PTSD)

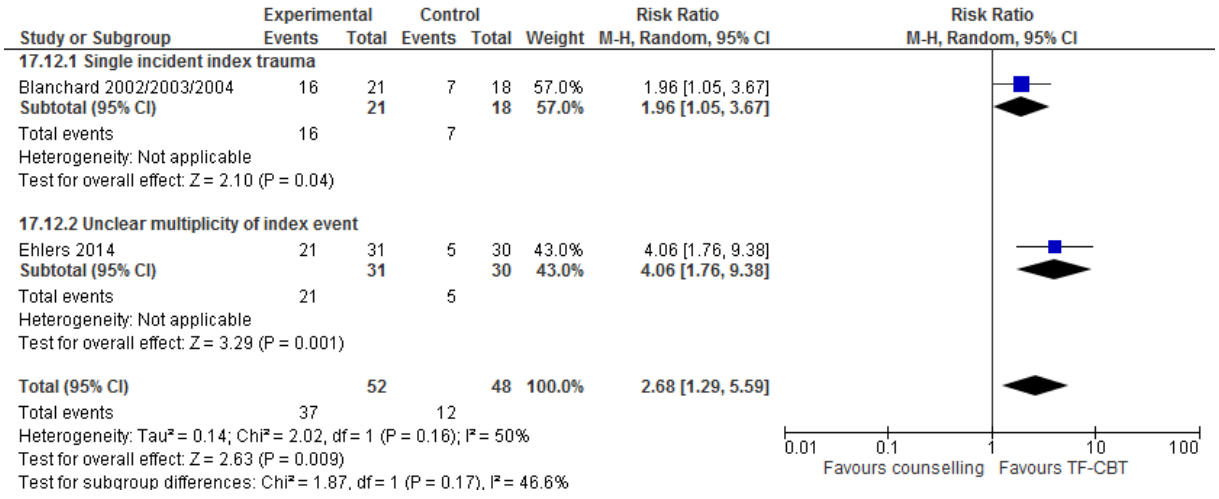


Figure 171: Trauma-focused CBT (±TAU) versus counselling (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Remission at 6-8 month follow-up (number of people no longer meeting diagnostic criteria or no longer above threshold on a scale for PTSD)

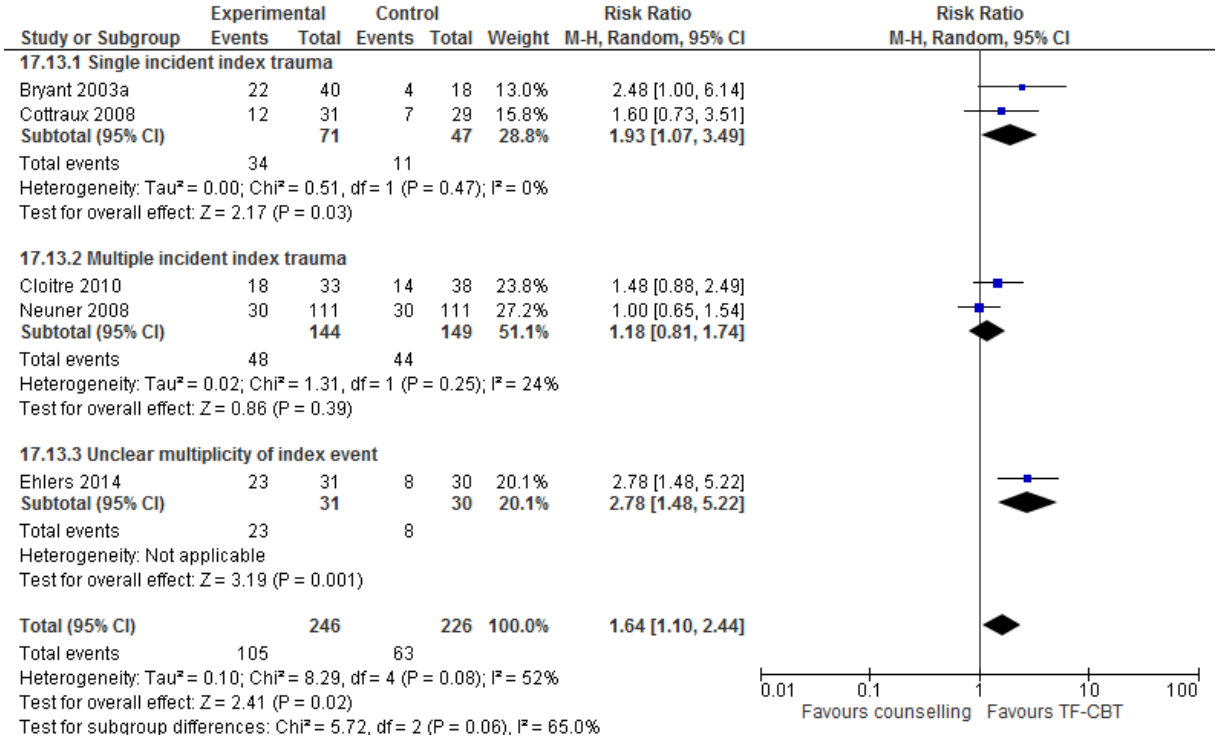


Figure 172: Trauma-focused CBT (±TAU) versus counselling (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Remission at 1-year follow-up (number of people no longer meeting diagnostic criteria or no longer above threshold on a scale for PTSD)

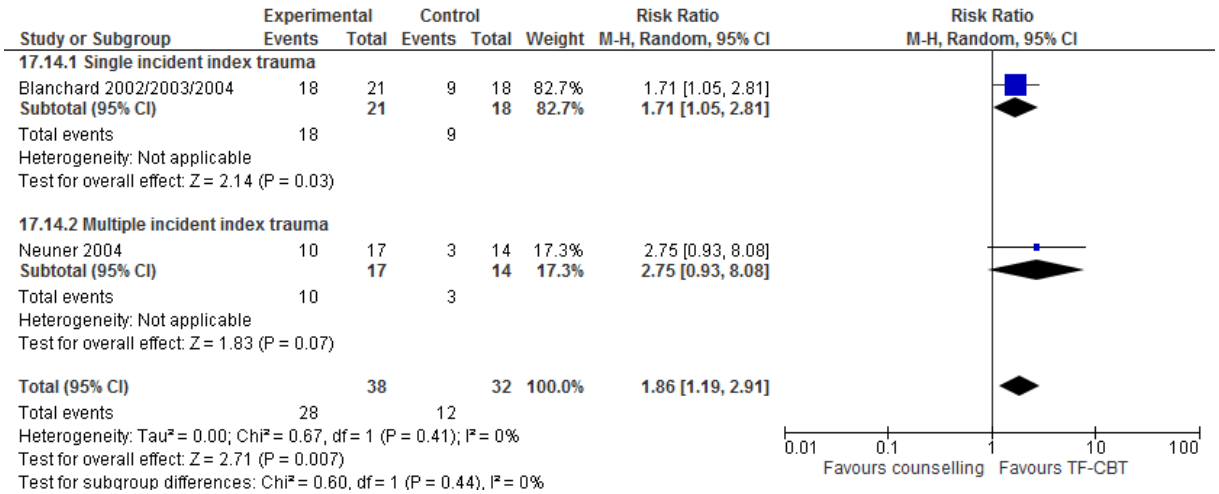


Figure 173: Trauma-focused CBT (±TAU) versus counselling (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Response clinician-rated (number of people showing clinically significant improvement on PSS-I based on reliable change indices [RCI])

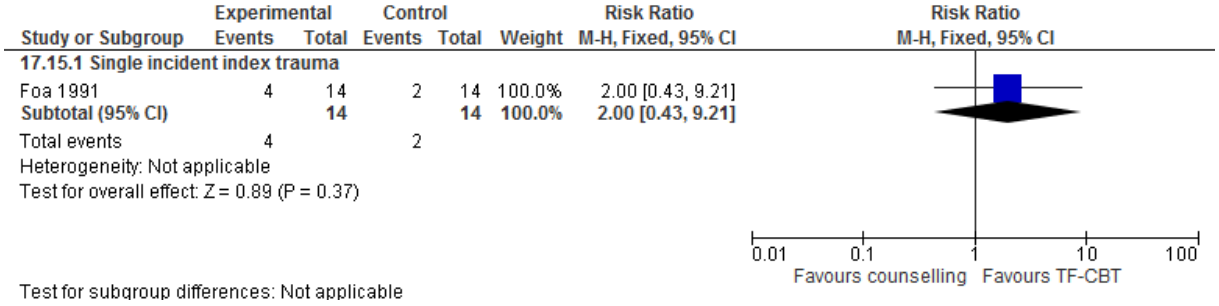


Figure 174: Trauma-focused CBT (±TAU) versus counselling (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Anxiety symptoms at endpoint (BAI/STAI State/BSI anxiety/HAM-A change score)

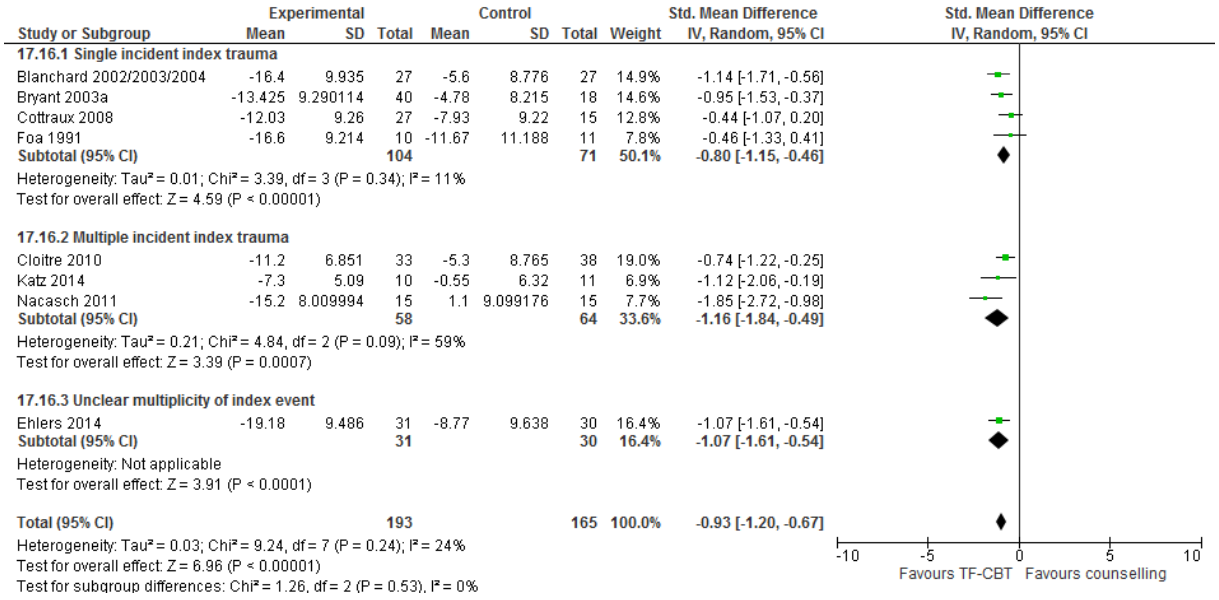


Figure 175: Trauma-focused CBT (±TAU) versus counselling (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Anxiety symptoms at 3-month follow-up (BAI/STAI State change score)

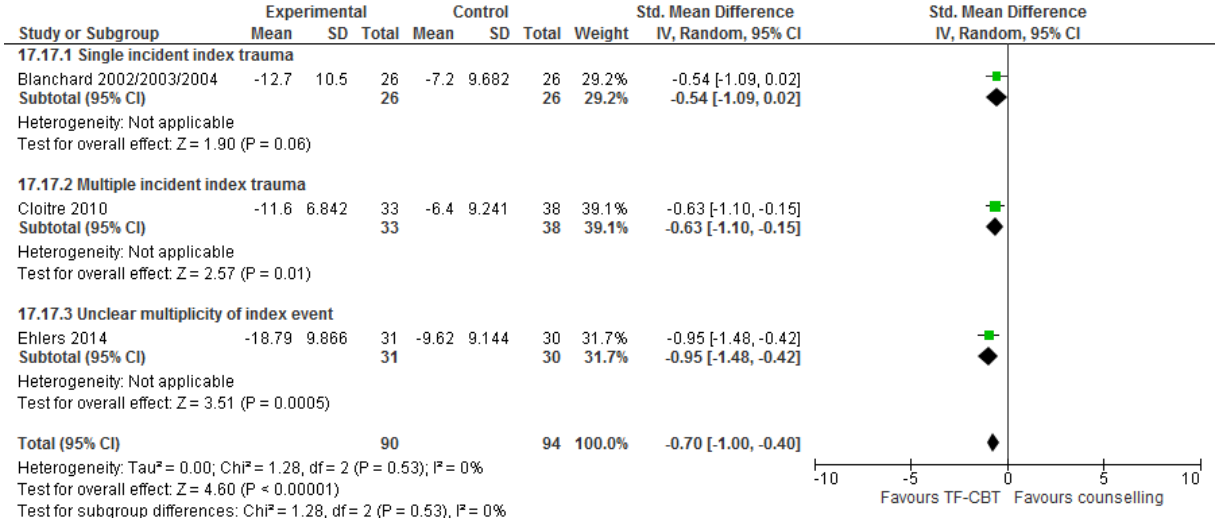


Figure 176: Trauma-focused CBT (±TAU) versus counselling (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Anxiety symptoms at 6-8 month follow-up (BAI/STAI State/HAM-A change score)

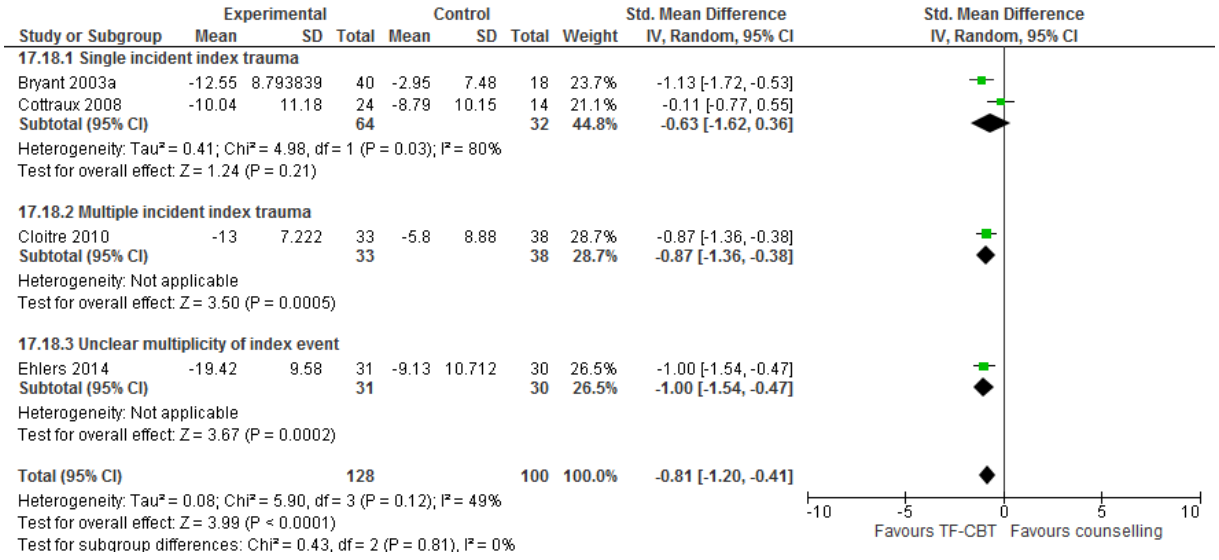


Figure 177: Trauma-focused CBT (±TAU) versus counselling (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Anxiety symptoms at 1-year follow-up (STAI State change score)

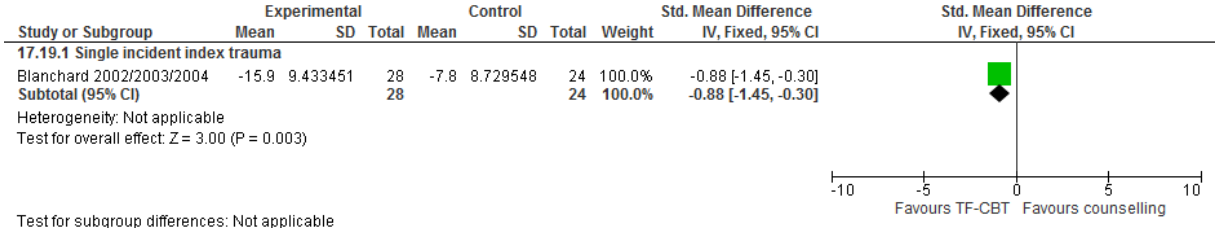


Figure 178: Trauma-focused CBT (±TAU) versus counselling (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Anxiety symptoms at 2-year follow-up (STAI State change score)

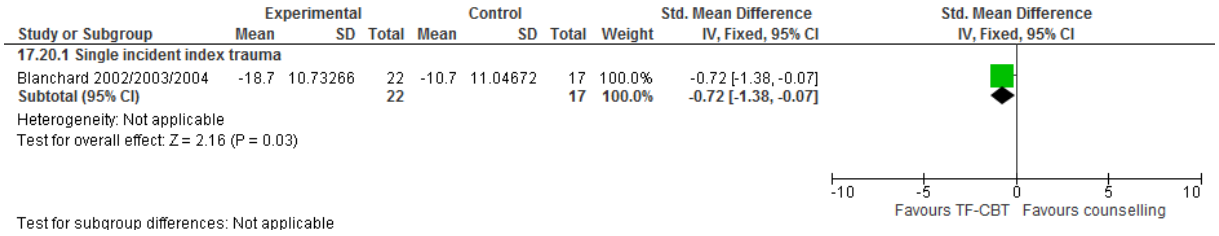


Figure 179: Trauma-focused CBT (±TAU) versus counselling (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms at endpoint (BDI/BDI-II/BDI-13/BSI Depression change score)

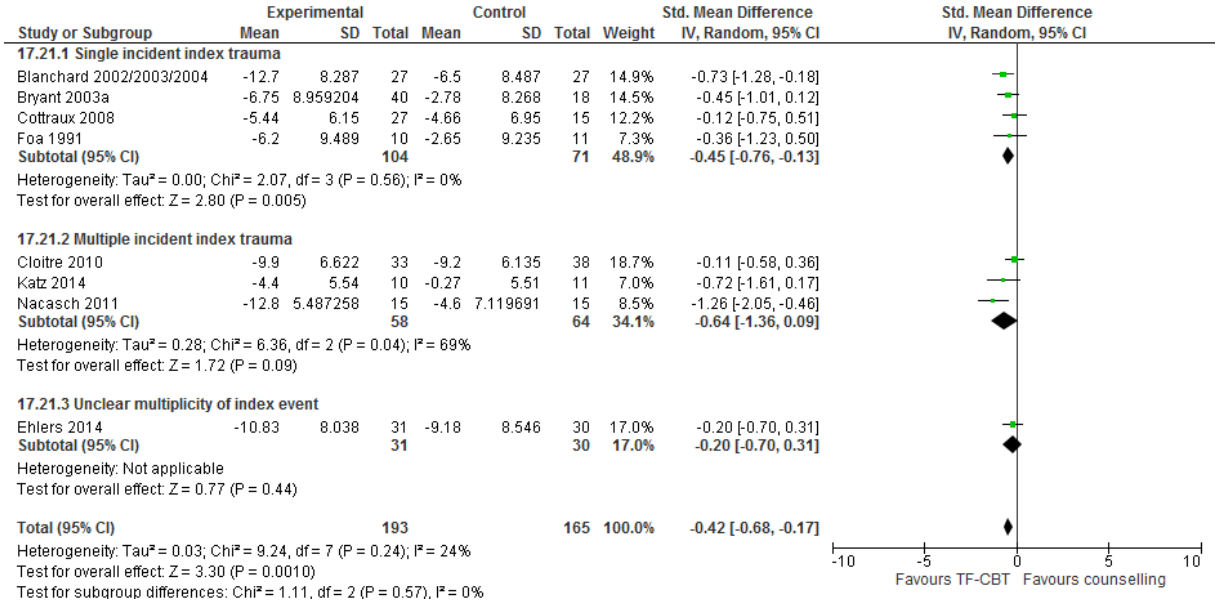


Figure 180: Trauma-focused CBT (±TAU) versus counselling (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms at 3-month follow-up (BDI/BDI-II change score)

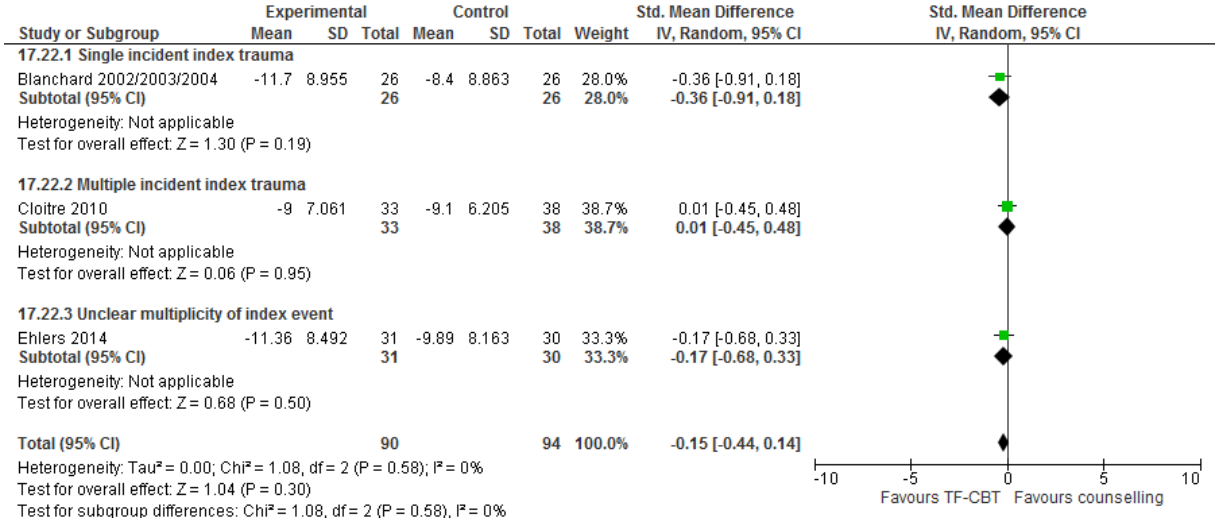


Figure 181: Trauma-focused CBT (±TAU) versus counselling (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms at 6-8 month follow-up (BDI-II/BDI-13 change score)

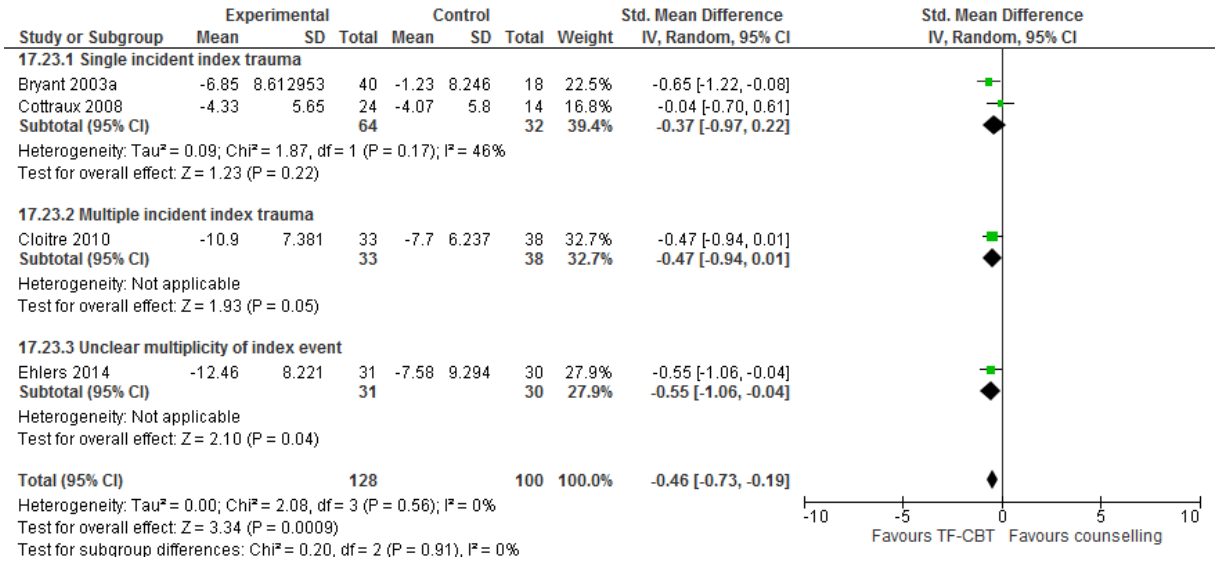


Figure 182: Trauma-focused CBT (±TAU) versus counselling (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms at 1-year follow-up (BDI change score)

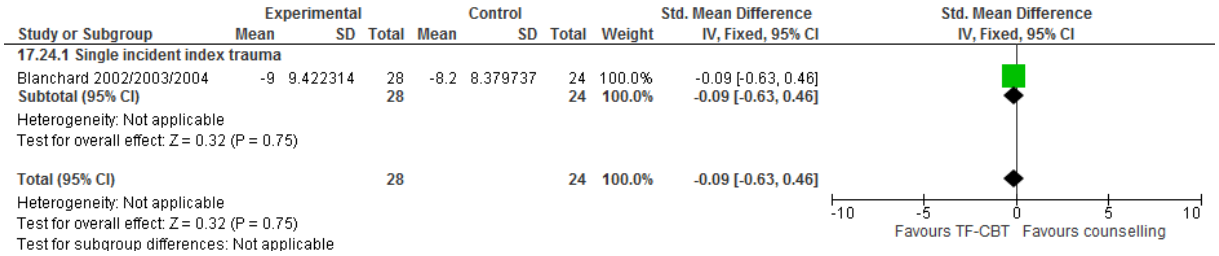


Figure 183: Trauma-focused CBT (±TAU) versus counselling (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms at 2-year follow-up (BDI change score)

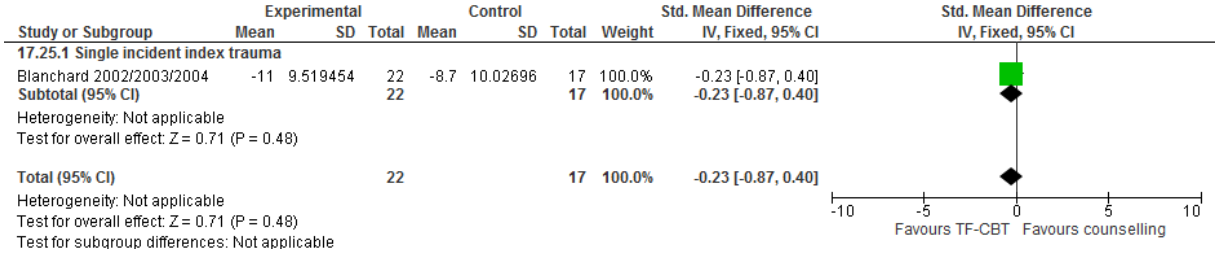


Figure 184: Trauma-focused CBT (±TAU) versus counselling (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Functional impairment (SDS change score); Unclear multiplicity of index event

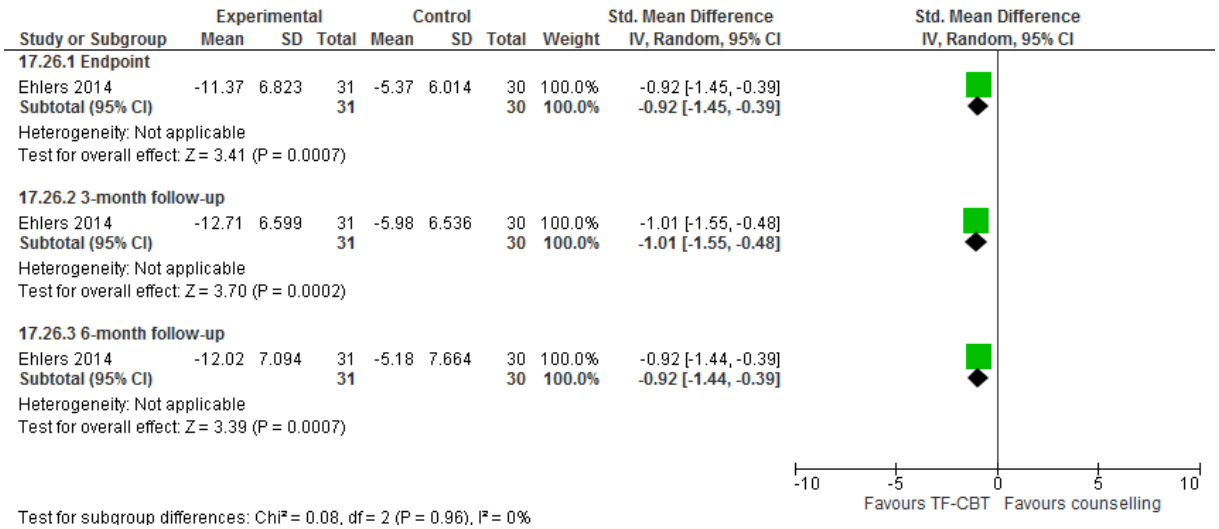


Figure 185: Trauma-focused CBT (±TAU) versus counselling (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Global functioning (GAF change score); Single incident index trauma

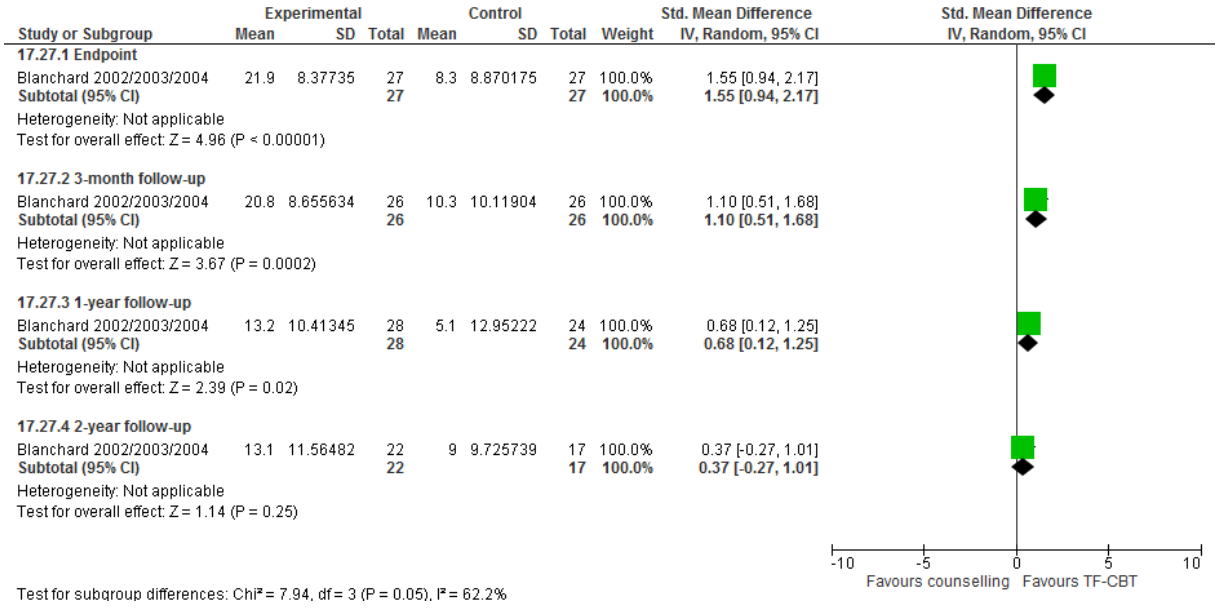


Figure 186: Trauma-focused CBT (±TAU) versus counselling (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Relationship difficulties (IIP change score); Multiple incident index trauma

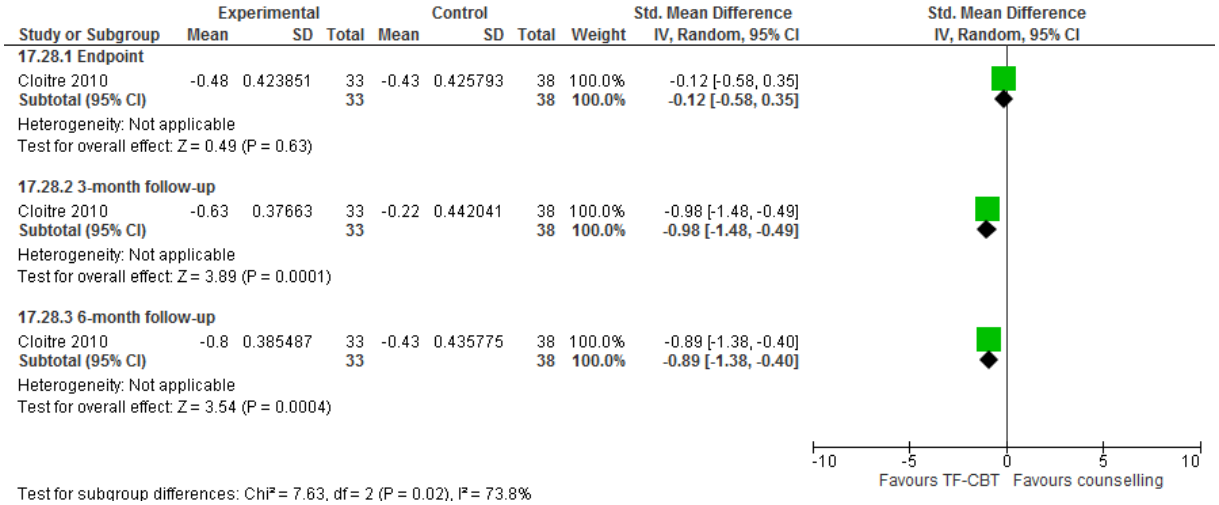


Figure 187: Trauma-focused CBT (±TAU) versus counselling (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Quality of life at endpoint (QOLI/Q-LES-Q-SF/SF-12 change score)

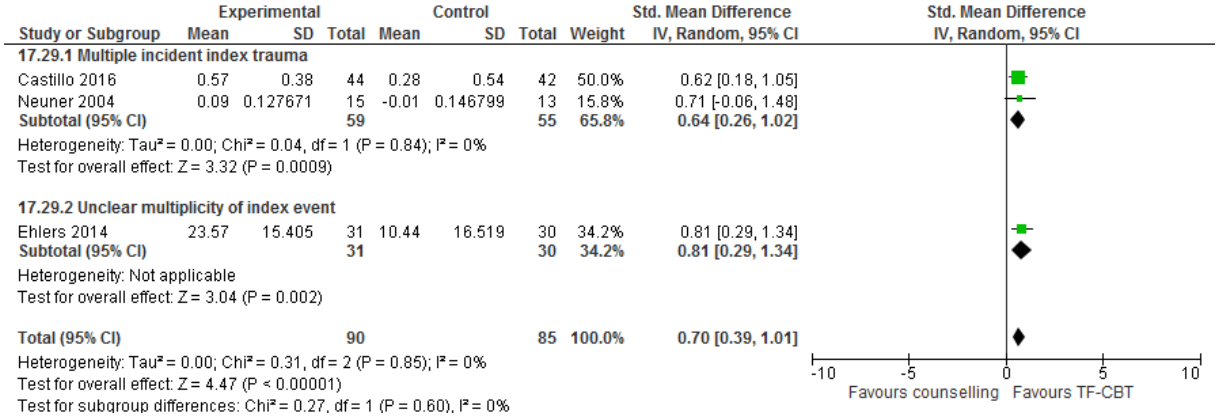


Figure 188: Trauma-focused CBT (±TAU) versus counselling (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Quality of life at 3-4 month follow-up (Q-LES-Q-SF/SF-12 change score)

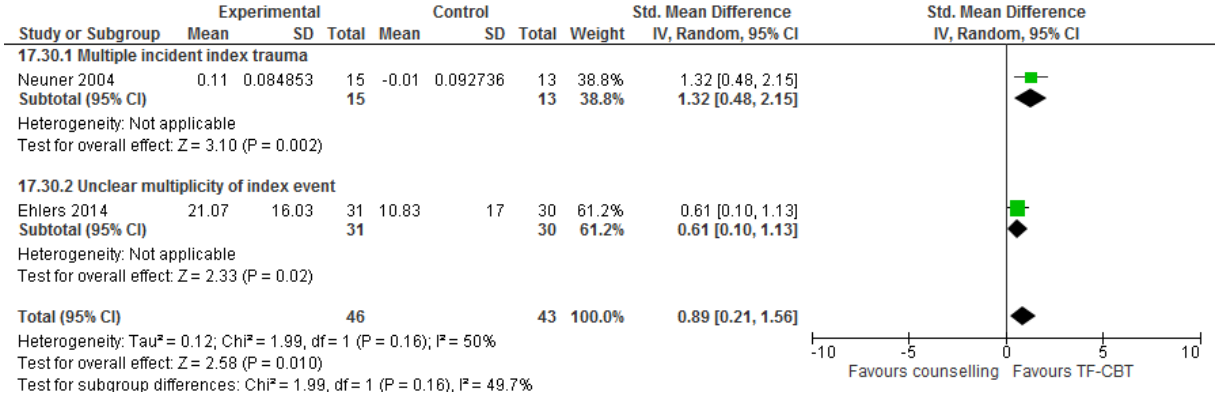


Figure 189: Trauma-focused CBT (±TAU) versus counselling (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Quality of life at 6-month follow-up (Q-LES-Q-SF/SF-12 change score)

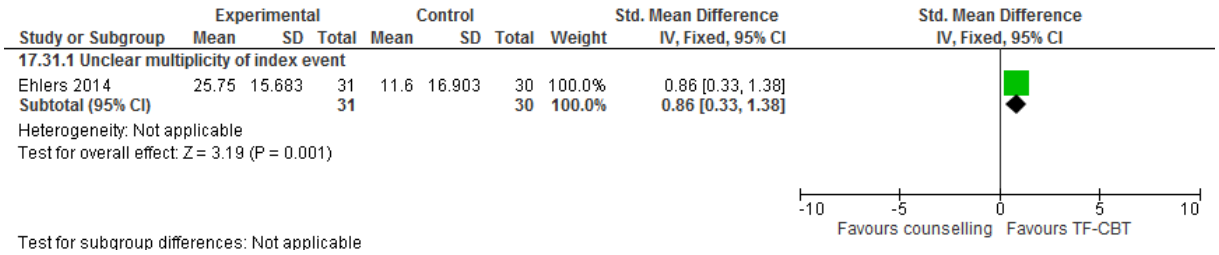


Figure 190: Trauma-focused CBT (±TAU) versus counselling (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Quality of life at 1-year follow-up (SF-12 change score)

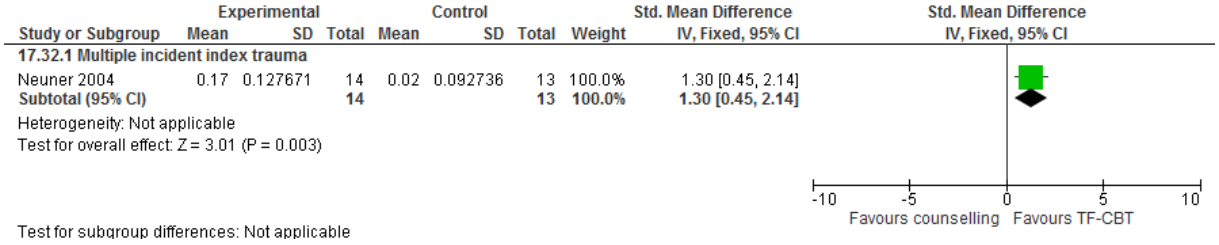
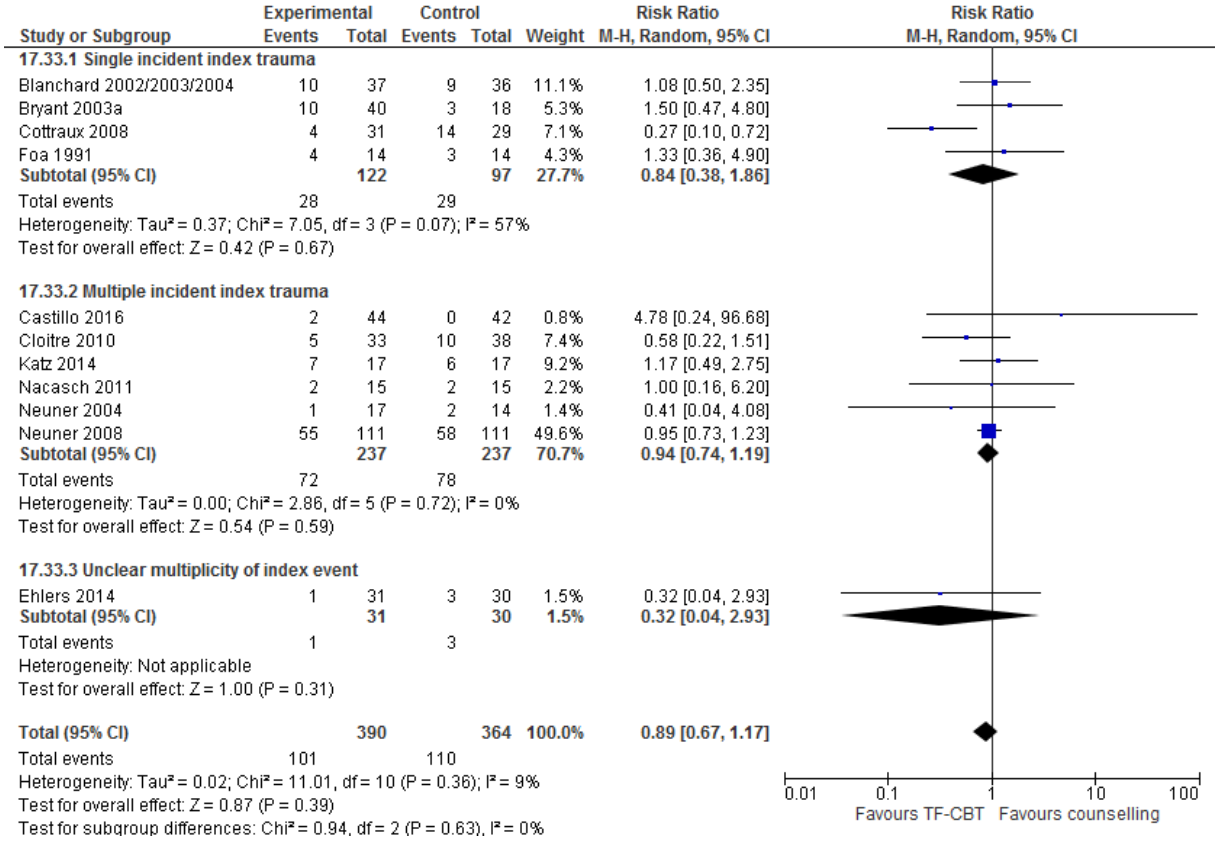


Figure 191: Trauma-focused CBT (±TAU) versus counselling (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)



Sub-analysis by trauma type: Trauma-focused CBT (±TAU) versus counselling (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD

Figure 192: Trauma-focused CBT (±TAU) versus counselling (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated at endpoint (PCL/PDS/PSS-SR change score)

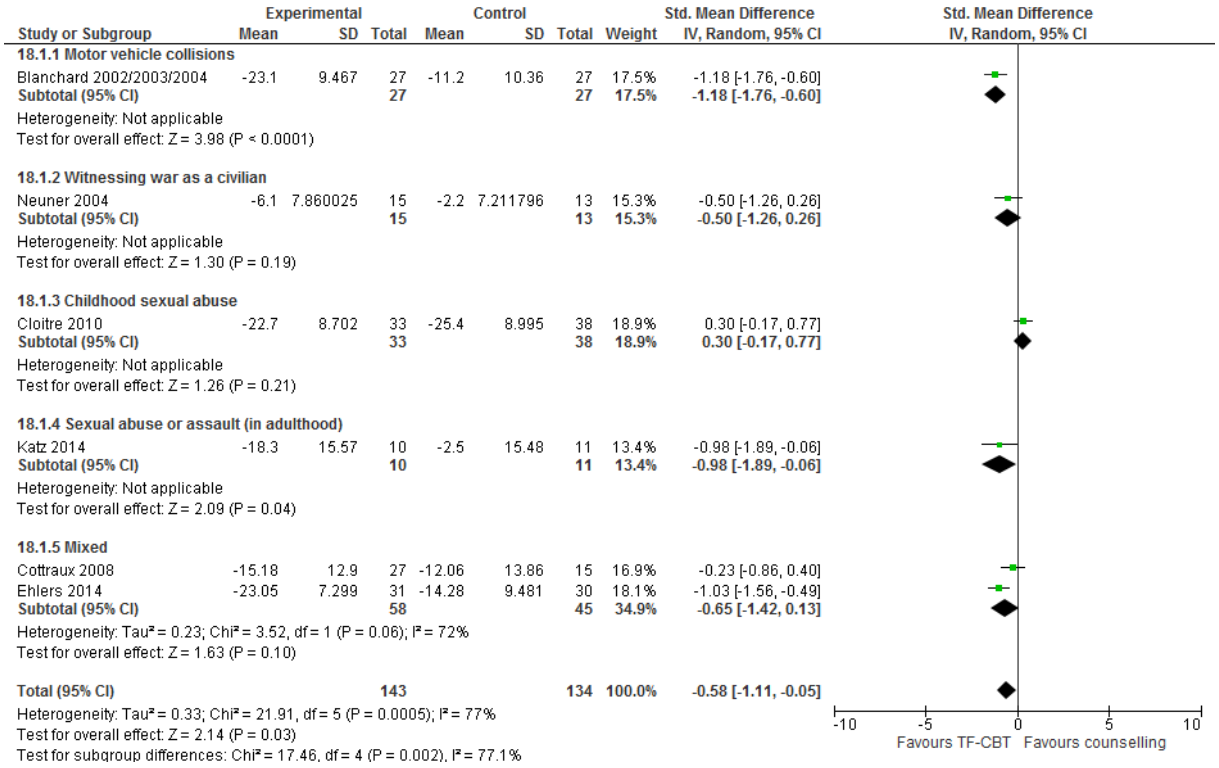


Figure 193: **Trauma-focused CBT (±TAU) versus counselling (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated at endpoint (CAPS/PSS-I change score)**

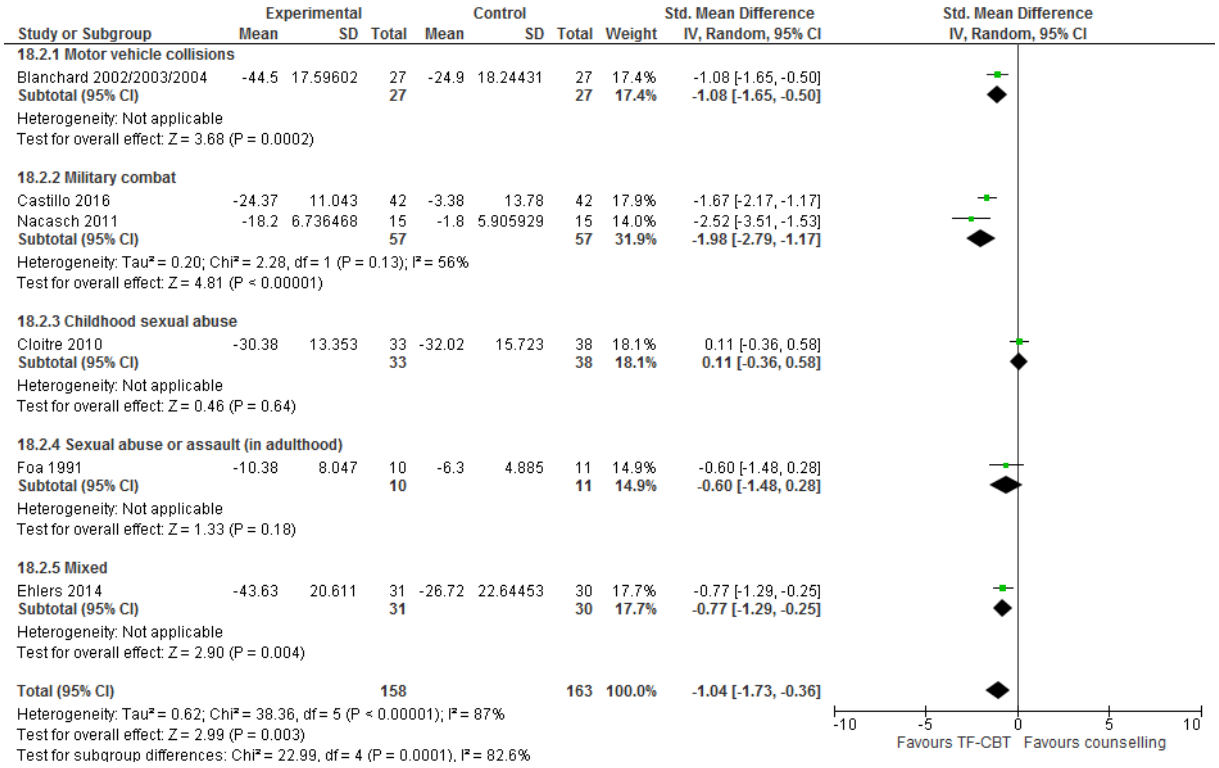
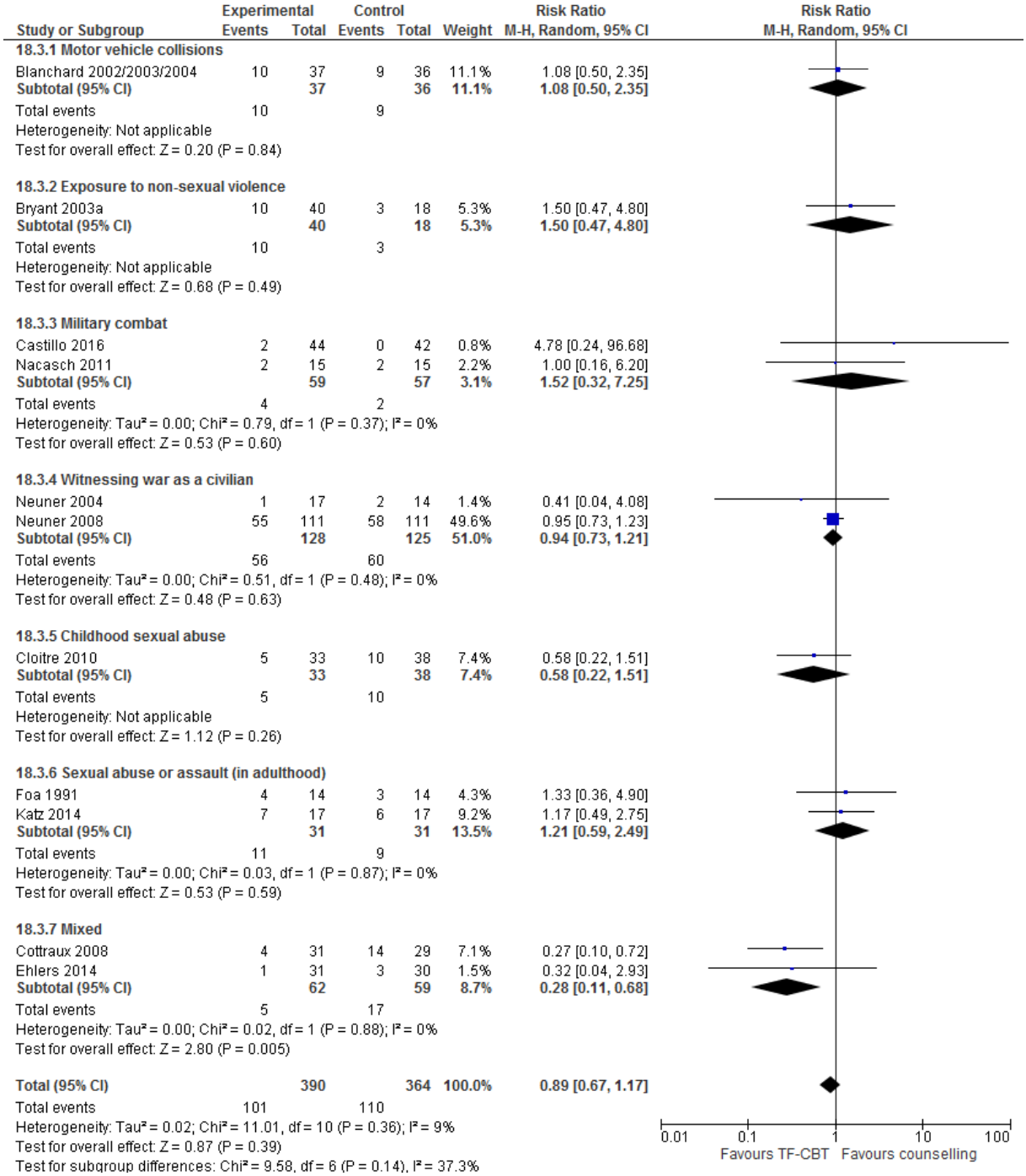


Figure 194: **Trauma-focused CBT (±TAU) versus counselling (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)**



Sub-analysis by specific intervention: Trauma-focused CBT (±TAU) versus counselling (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD

Figure 195: Trauma-focused CBT (±TAU) versus counselling (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated at endpoint (PCL/PDS/PSS-SR change score)

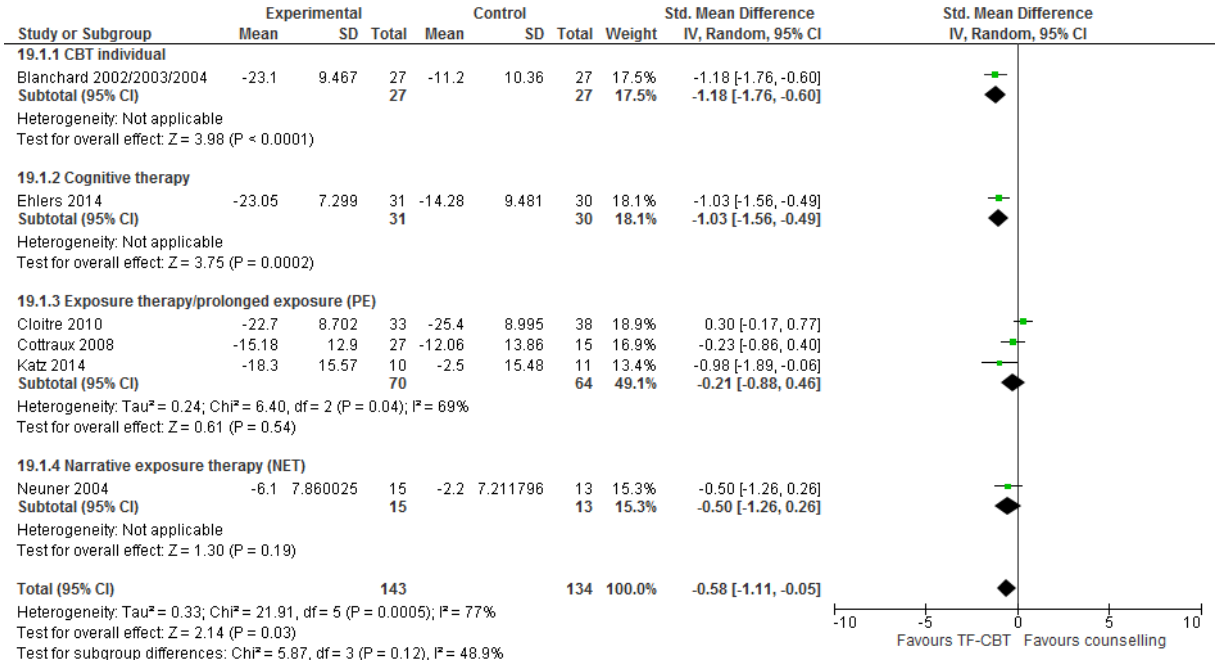


Figure 196: Trauma-focused CBT (±TAU) versus counselling (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated at endpoint (CAPS/PSS-I change score)

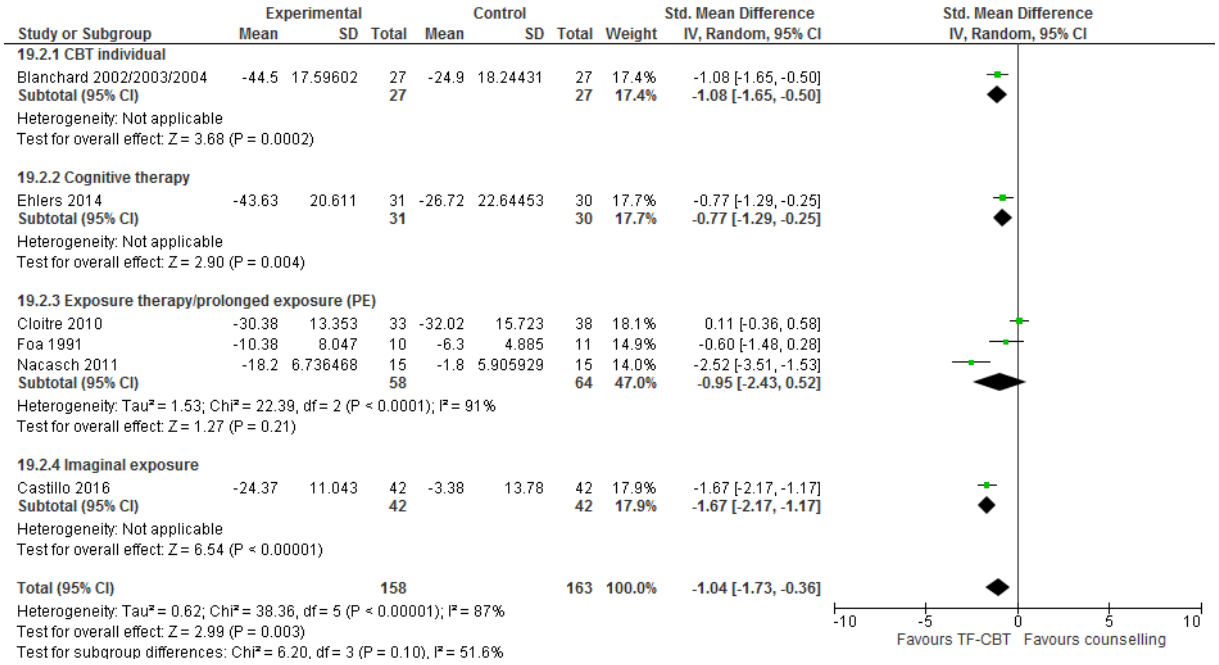


Figure 197: Trauma-focused CBT (±TAU) versus counselling (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)

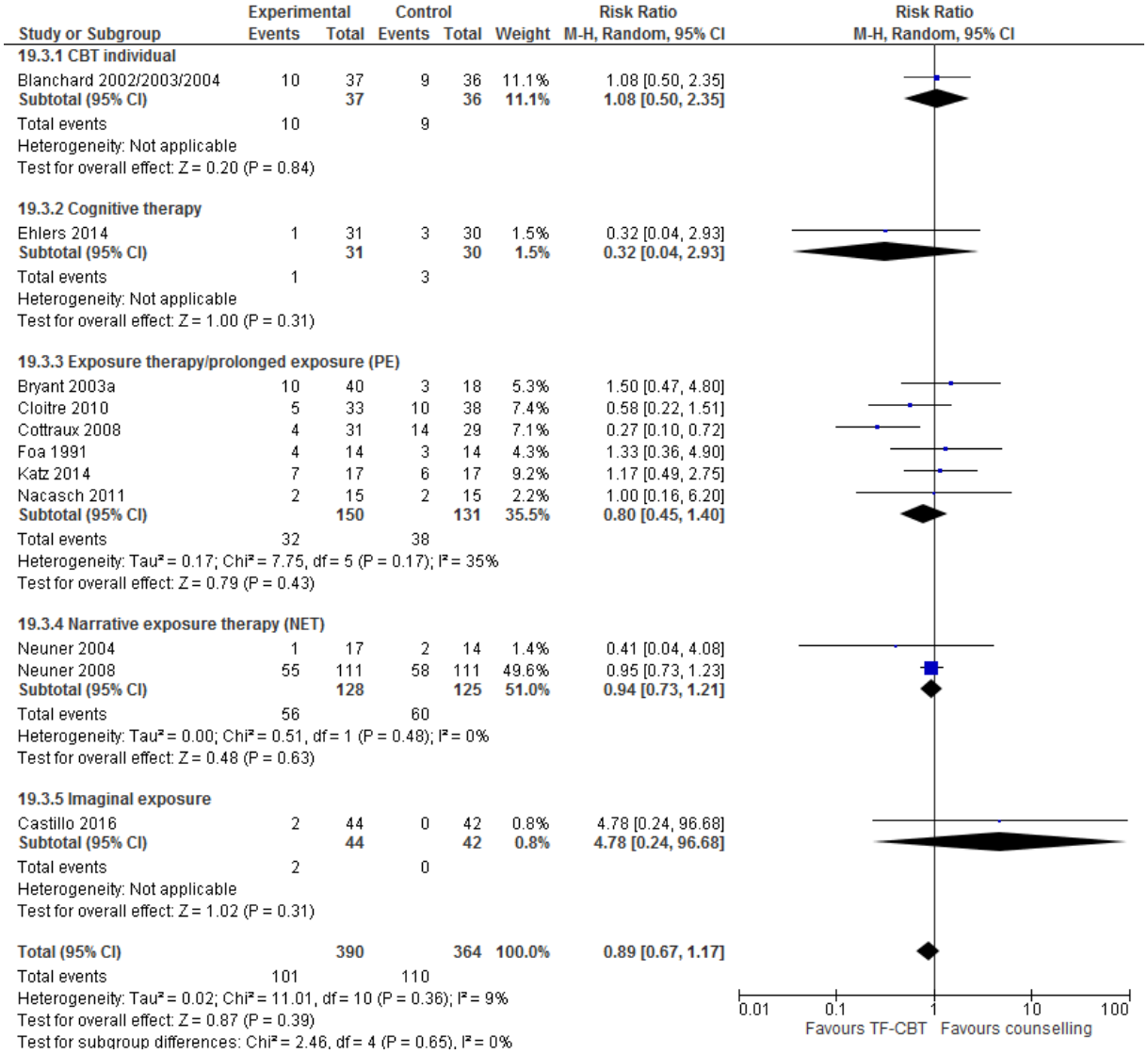


Figure 198: Trauma-focused CBT (±TAU) versus present-centered therapy (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated at endpoint (PCL change score)

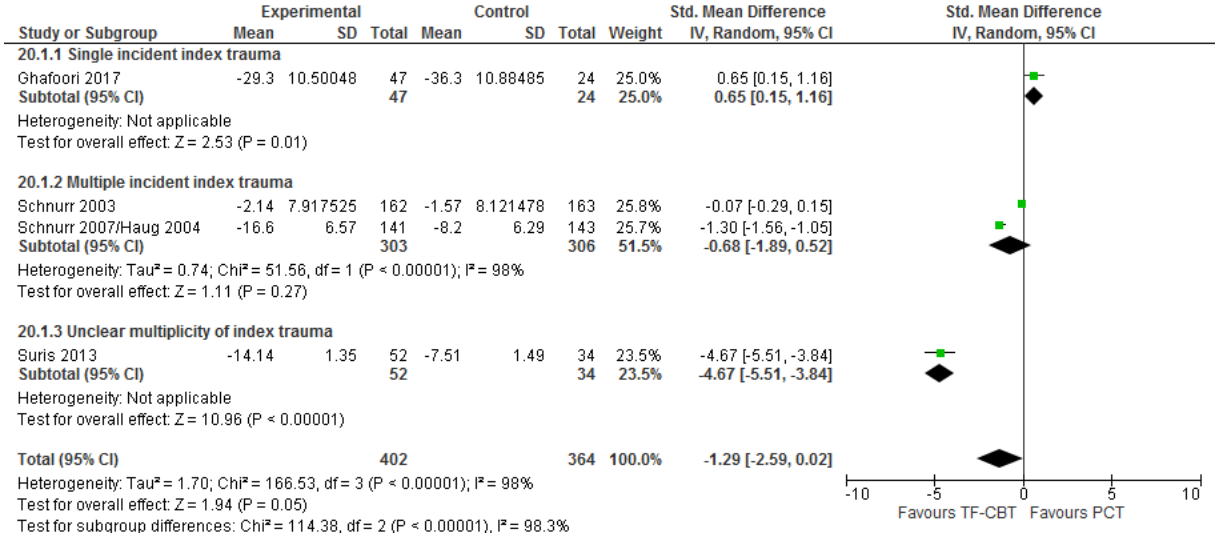


Figure 199: Trauma-focused CBT (±TAU) versus present-centered therapy (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated at 2-3 month follow-up (PCL change score)

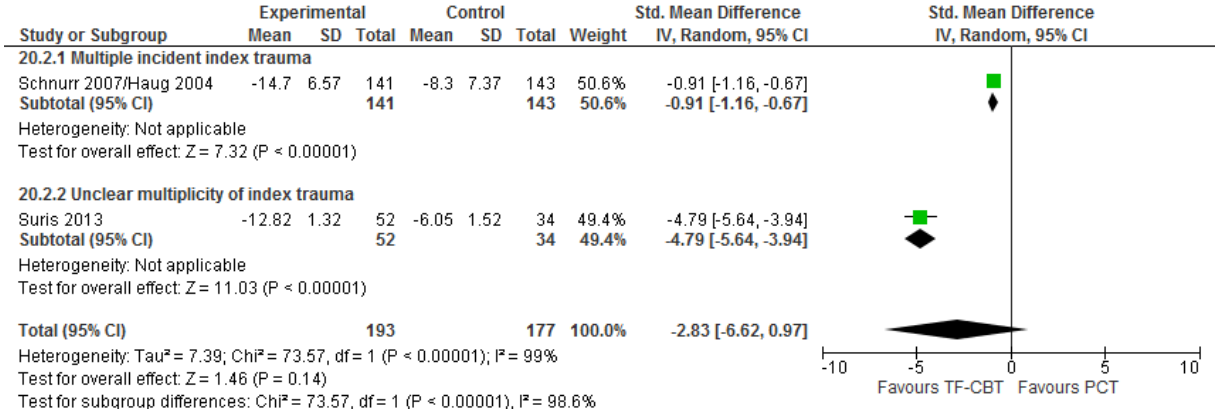


Figure 200: Trauma-focused CBT (±TAU) versus present-centered therapy (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated at 4-month follow-up (PCL change score)

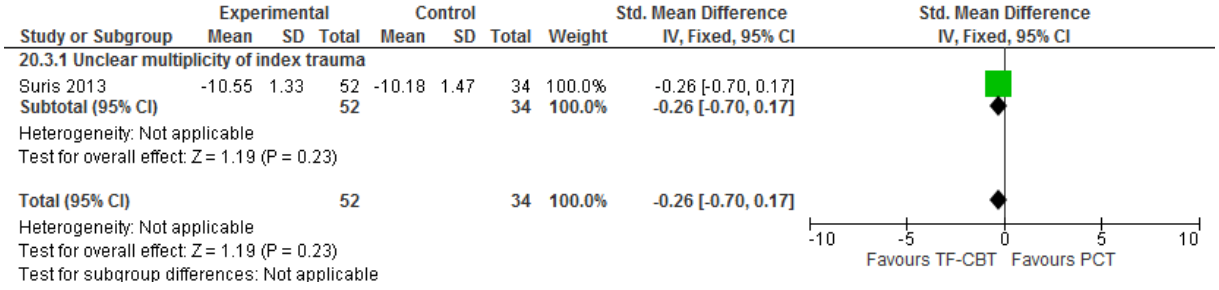


Figure 201: Trauma-focused CBT (±TAU) versus present-centered therapy (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated at 6-month follow-up (PCL change score)

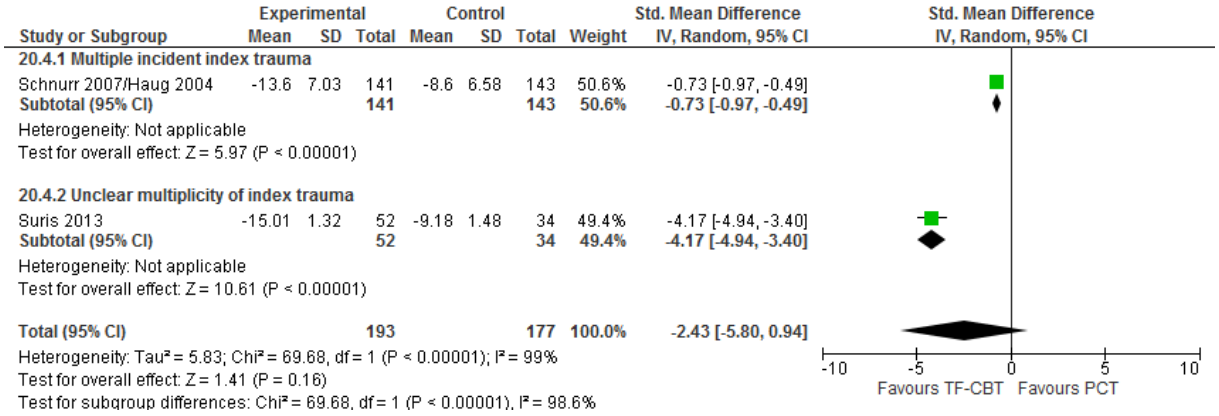


Figure 202: Trauma-focused CBT (±TAU) versus present-centered therapy (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated at endpoint (CAPS change score)

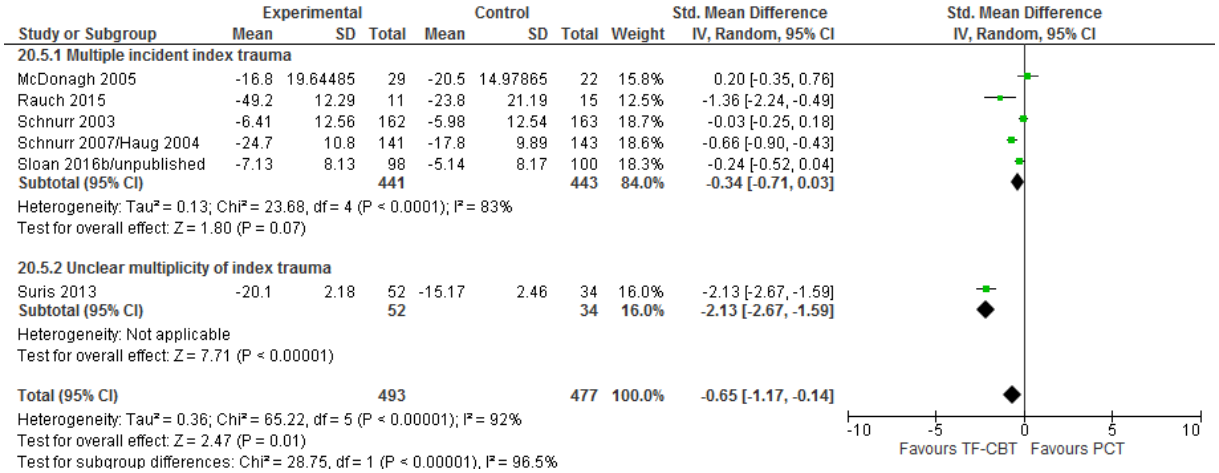


Figure 203: Trauma-focused CBT (±TAU) versus present-centered therapy (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated at 1-3 month follow-up (CAPS change score)

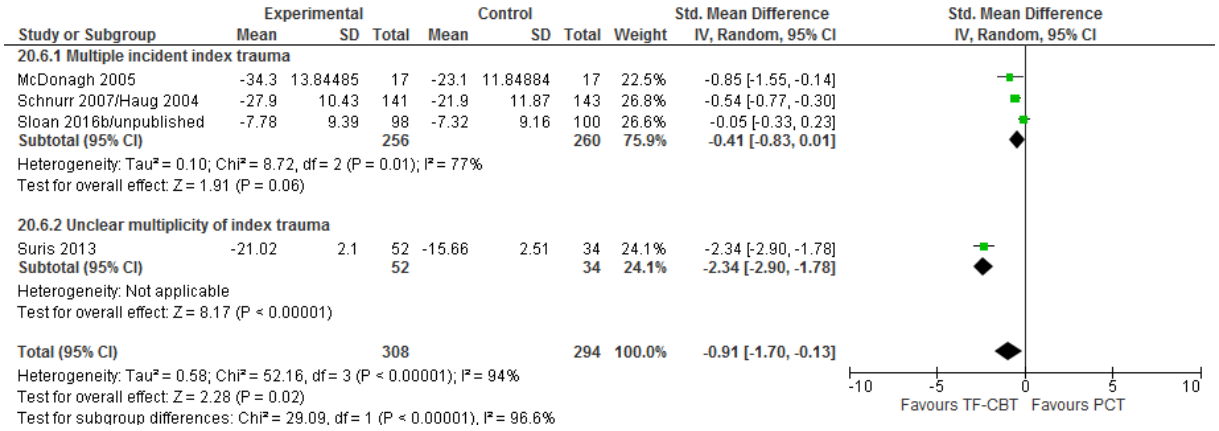


Figure 204: Trauma-focused CBT (±TAU) versus present-centered therapy (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated at 4-month follow-up (CAPS change score)

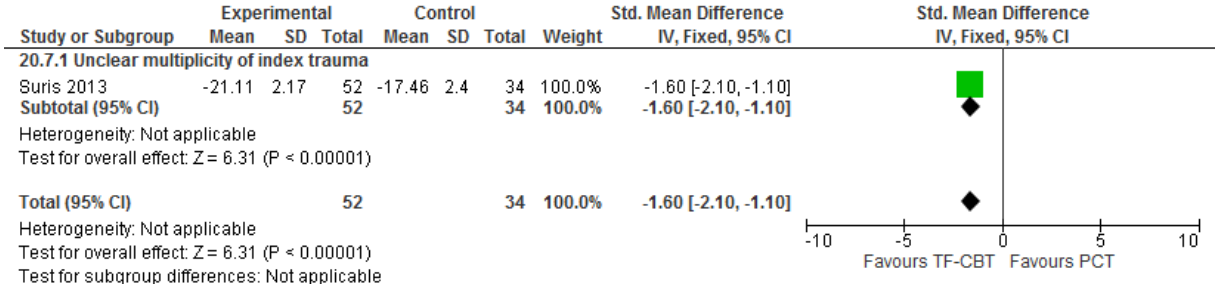


Figure 205: Trauma-focused CBT (±TAU) versus present-centered therapy (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated at 6-month follow-up (CAPS change score)

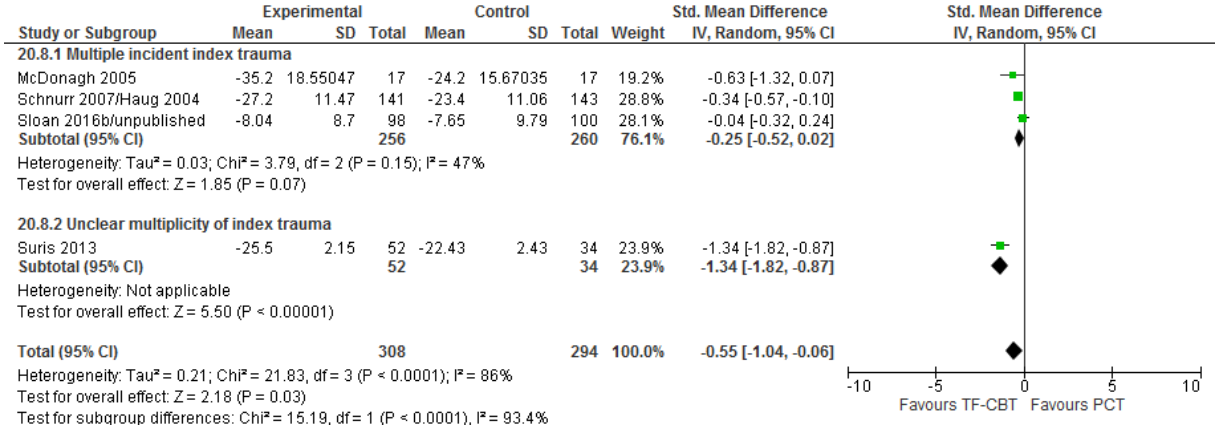


Figure 206: Trauma-focused CBT (±TAU) versus present-centered therapy (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Remission at endpoint (number of people no longer meeting diagnostic criteria for PTSD)

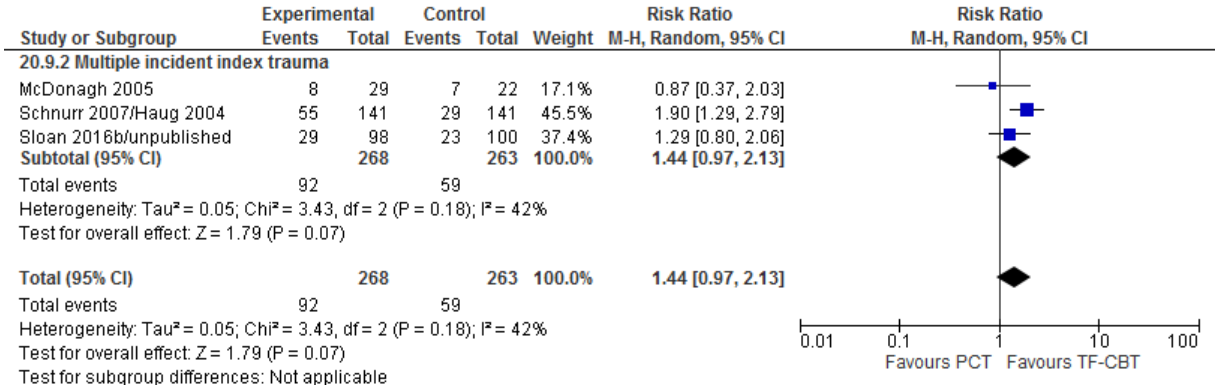


Figure 207: Trauma-focused CBT (±TAU) versus present-centered therapy (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD:

Remission at 1-3 month follow-up (number of people no longer meeting diagnostic criteria for PTSD)

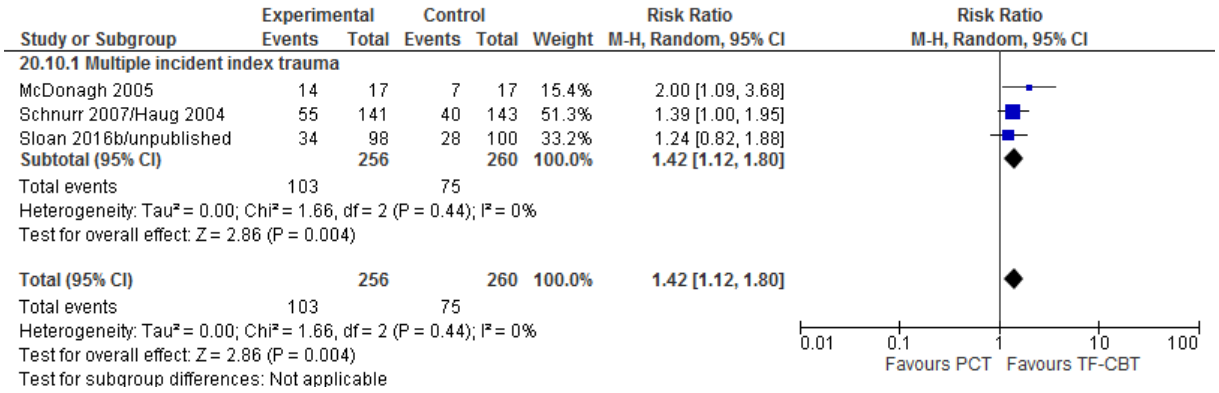


Figure 208: Trauma-focused CBT (±TAU) versus present-centered therapy (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Remission at 6-month follow-up (number of people no longer meeting diagnostic criteria for PTSD)

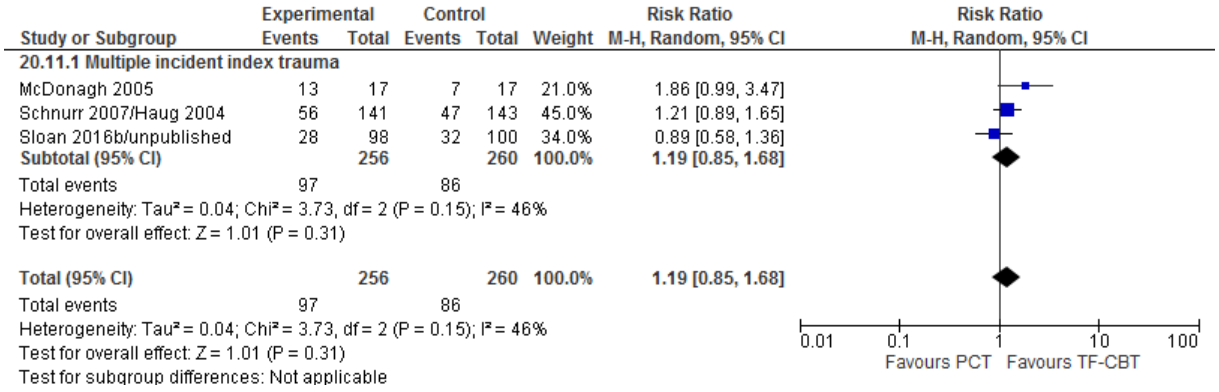


Figure 209: Trauma-focused CBT (±TAU) versus present-centered therapy (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Response clinician-rated at endpoint (number of people showing clinically

significant improvement based on reliable change indices [RCI] on PSS-I/at least 10-point improvement on CAPS)

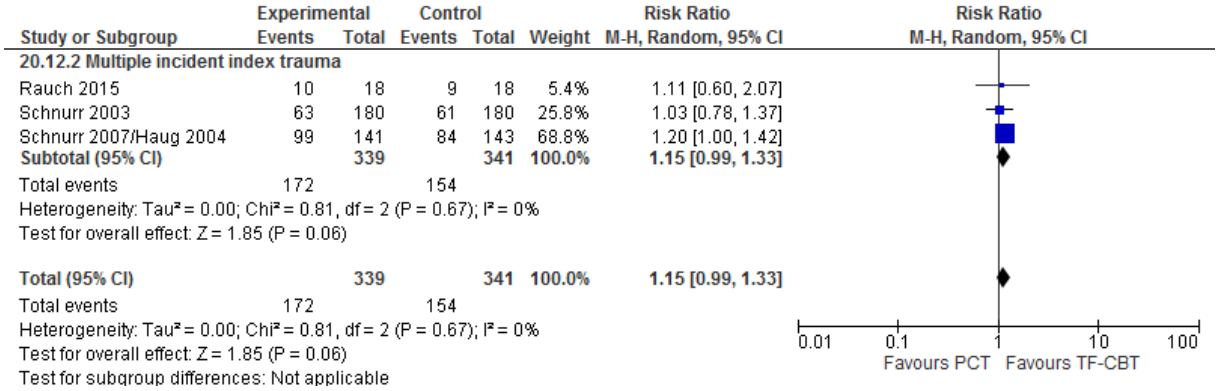


Figure 210: Trauma-focused CBT (±TAU) versus present-centered therapy (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Response clinician-rated at 3-month follow-up (number of people showing at least 10-point improvement on CAPS)

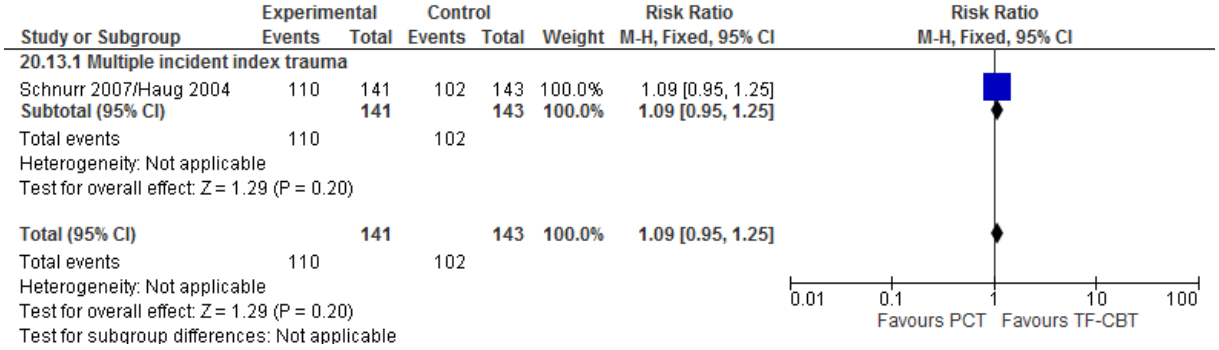


Figure 211: Trauma-focused CBT (±TAU) versus present-centered therapy (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Response clinician-rated at 6-month follow-up (number of people showing at least 10-point improvement on CAPS)

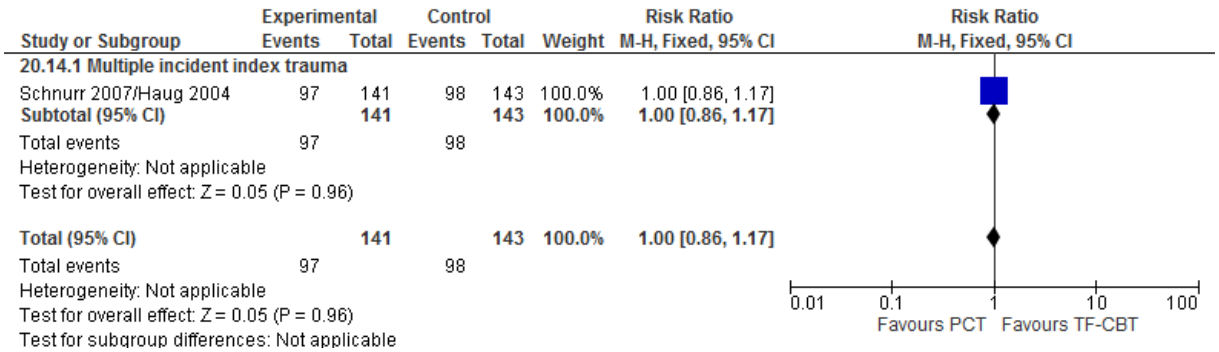


Figure 212: Trauma-focused CBT (±TAU) versus present-centered therapy (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Dissociative symptoms (DES change score); Multiple incident index trauma

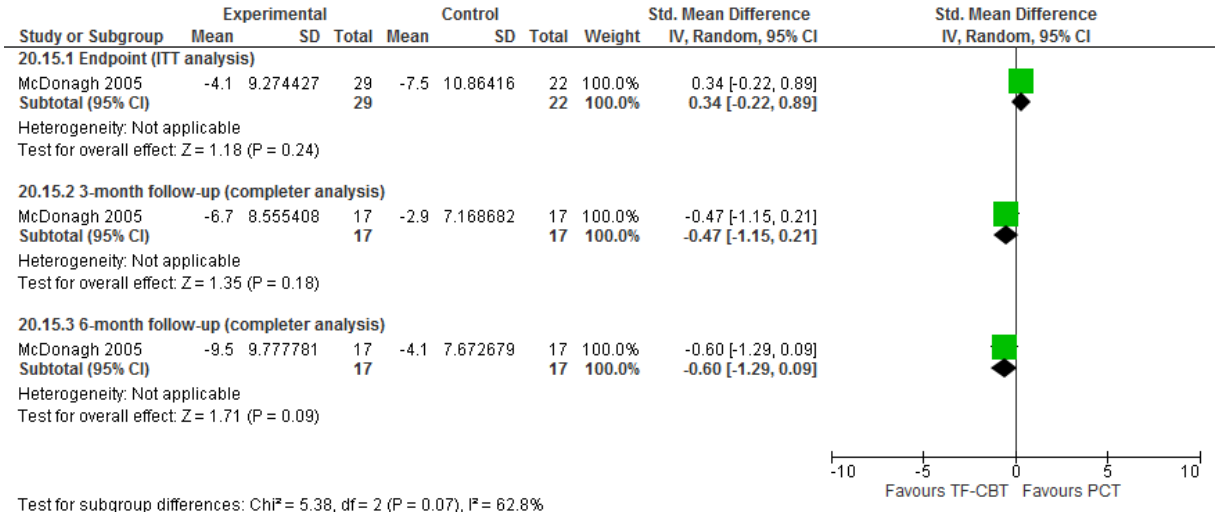


Figure 213: Trauma-focused CBT (±TAU) versus present-centered therapy (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Anxiety symptoms at endpoint (BAI/STAI State/BSI Anxiety change score)

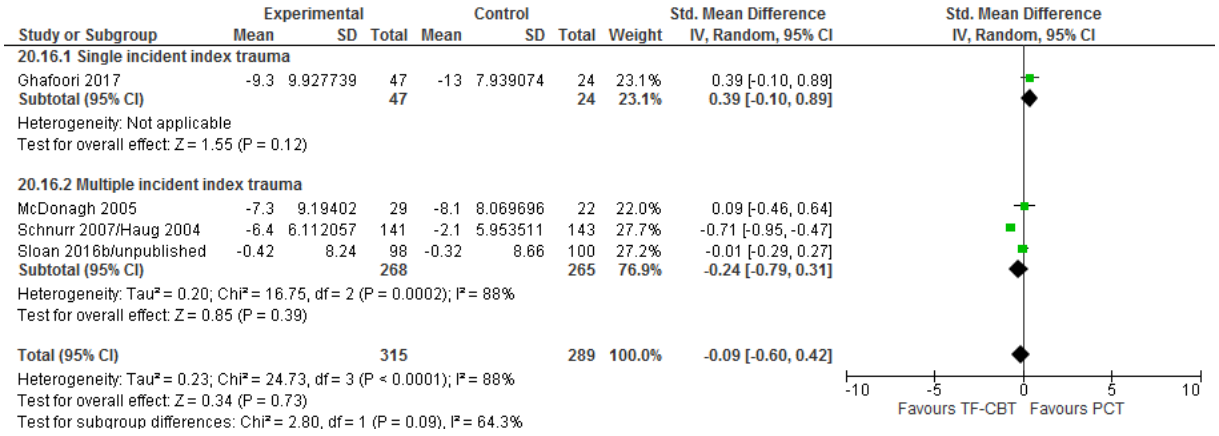


Figure 214: Trauma-focused CBT (±TAU) versus present-centered therapy (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Anxiety symptoms at 3-month follow-up (BAI/STAI State change score)

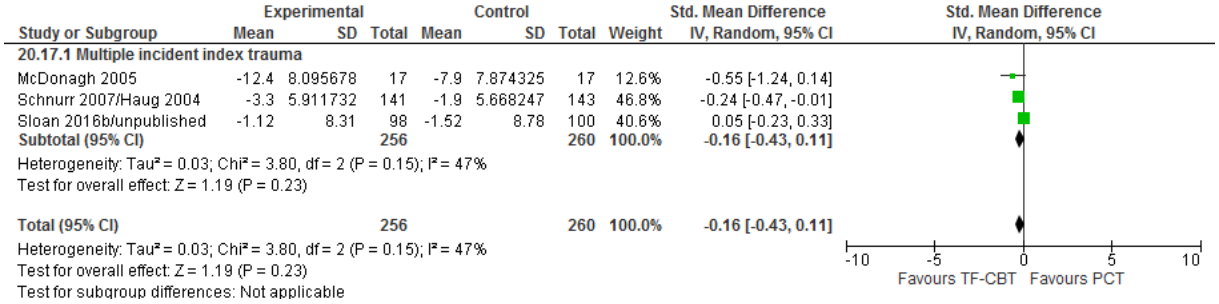


Figure 215: Trauma-focused CBT (±TAU) versus present-centered therapy (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Anxiety symptoms at 6-month follow-up (BAI/STAI State change score)

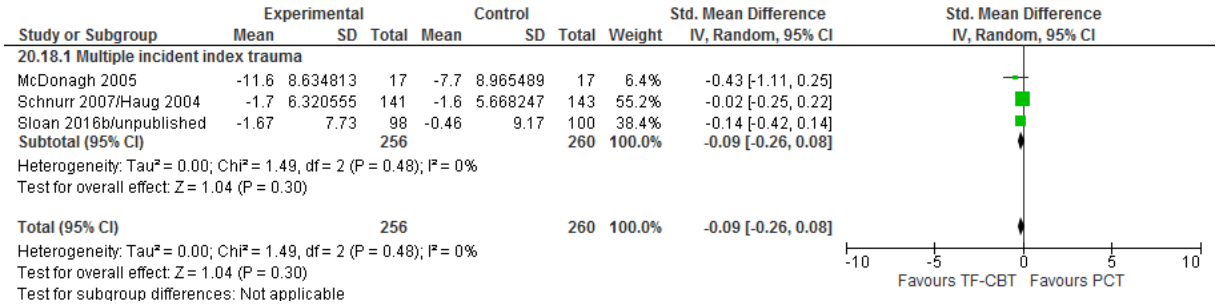


Figure 216: Trauma-focused CBT (±TAU) versus present-centered therapy (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD:

Depression symptoms at endpoint (BDI/BDI-II/QIDS/BSI Depression change score)

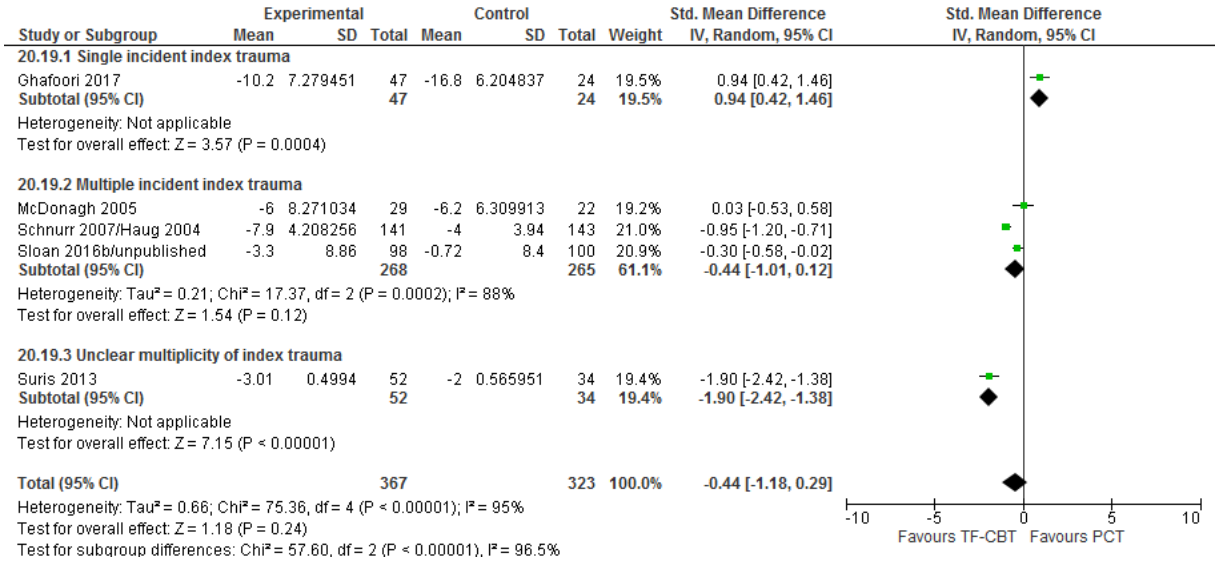


Figure 217: Trauma-focused CBT (±TAU) versus present-centered therapy (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms at 2-3 month follow-up (BDI/BDI-II/QIDS change score)

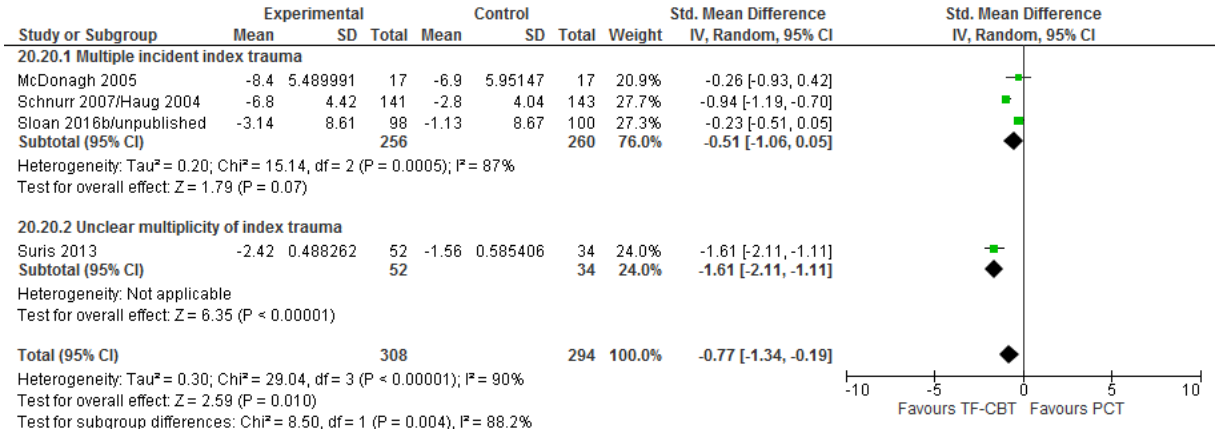


Figure 218: Trauma-focused CBT (±TAU) versus present-centered therapy (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms at 4-month follow-up (QIDS change score)

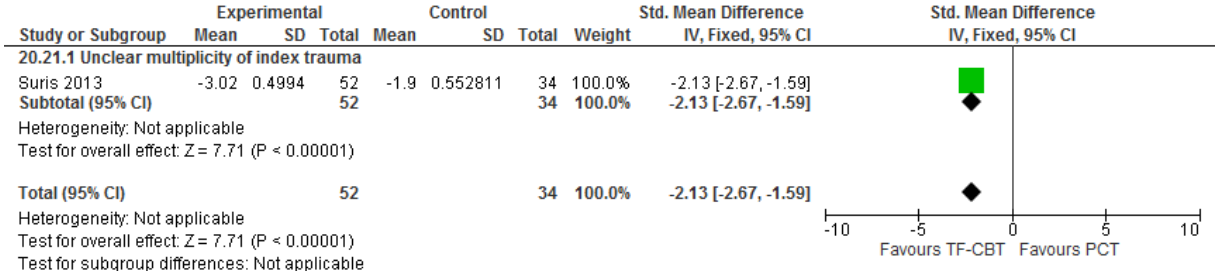


Figure 219: Depression symptoms at 6-month follow-up (BDI/BDI-II/QIDS score)

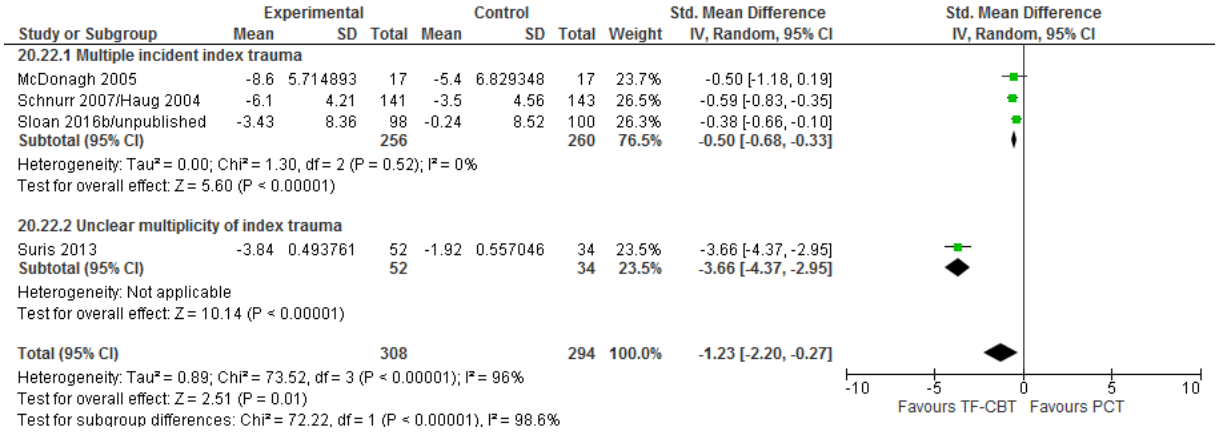


Figure 220: Trauma-focused CBT (±TAU) versus present-centered therapy (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD:

Emotional and behavioural problems: Anger (STAXI change score); Multiple incident index trauma

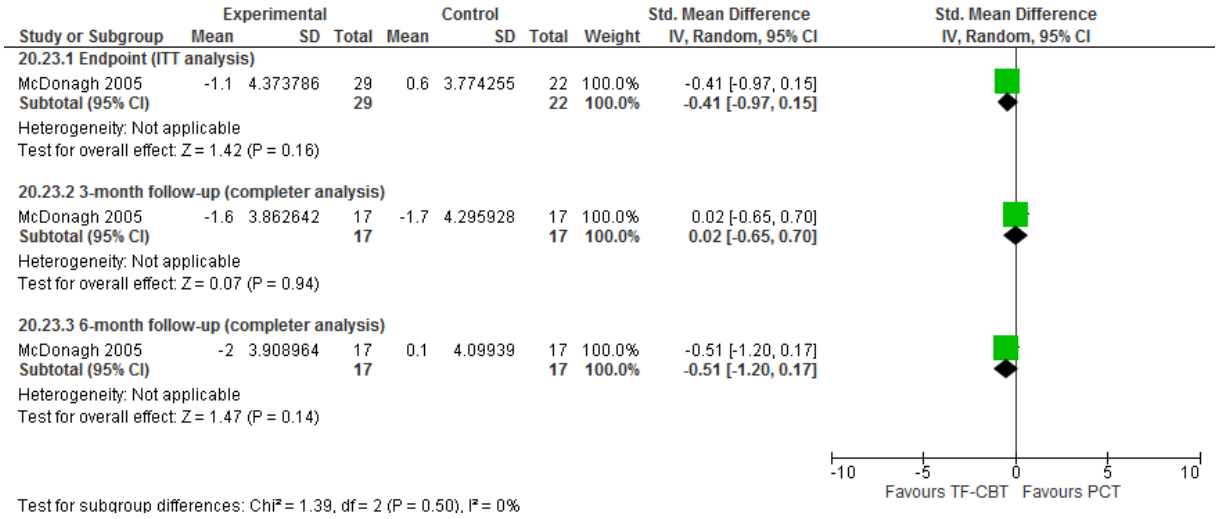


Figure 221: Trauma-focused CBT (±TAU) versus present-centered therapy (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Quality of life (QOLI change score); Multiple incident index trauma

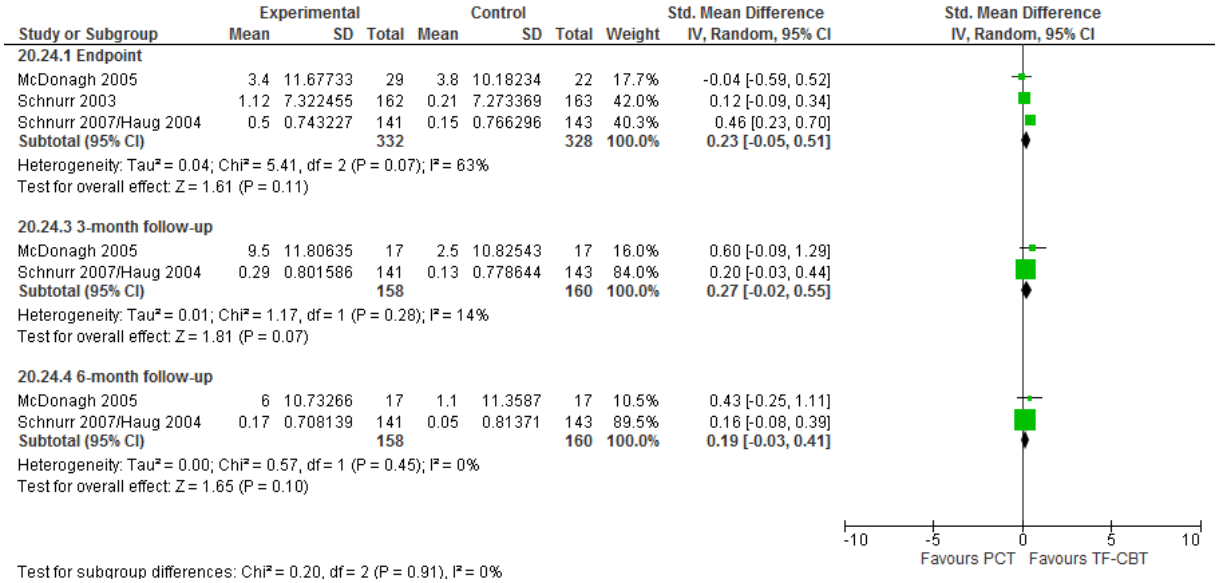
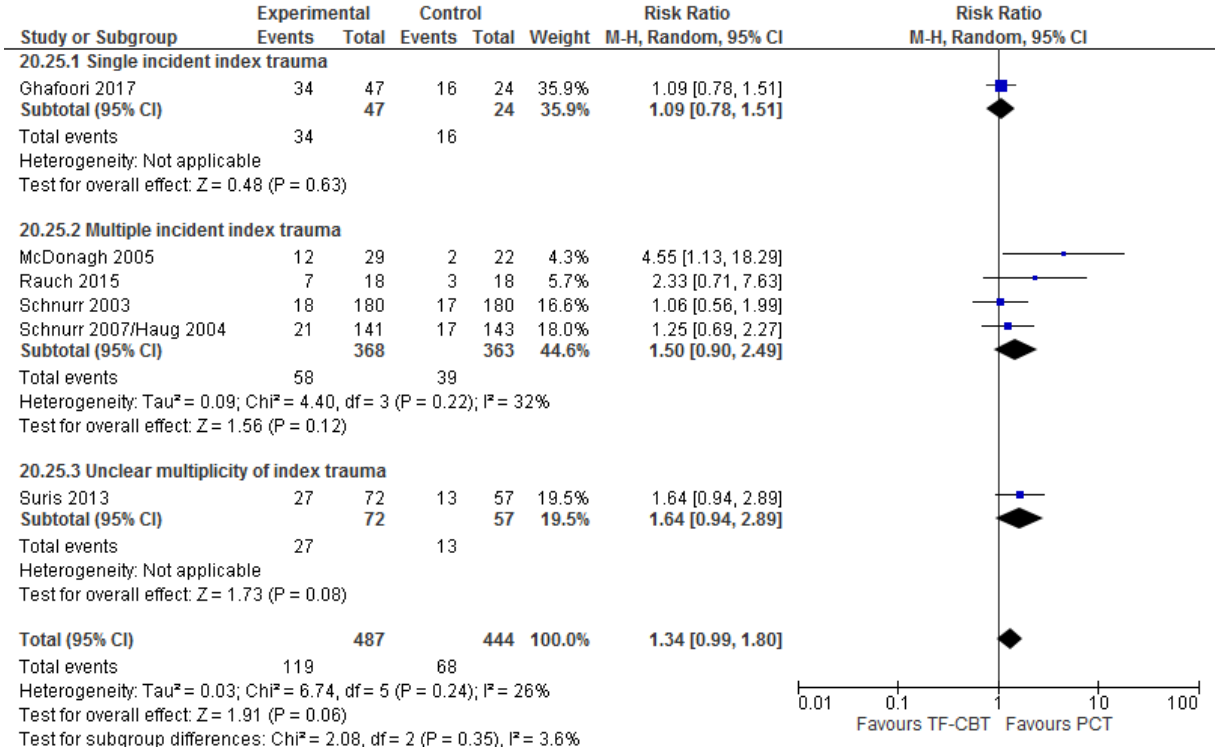


Figure 222: Trauma-focused CBT (±TAU) versus present-centered therapy (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loos to follow-up)



Sub-analysis by specific intervention: Trauma-focused CBT (±TAU) versus present-centered therapy (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD

Figure 223: Trauma-focused CBT (±TAU) versus present-centered therapy (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated at endpoint (PCL change score)

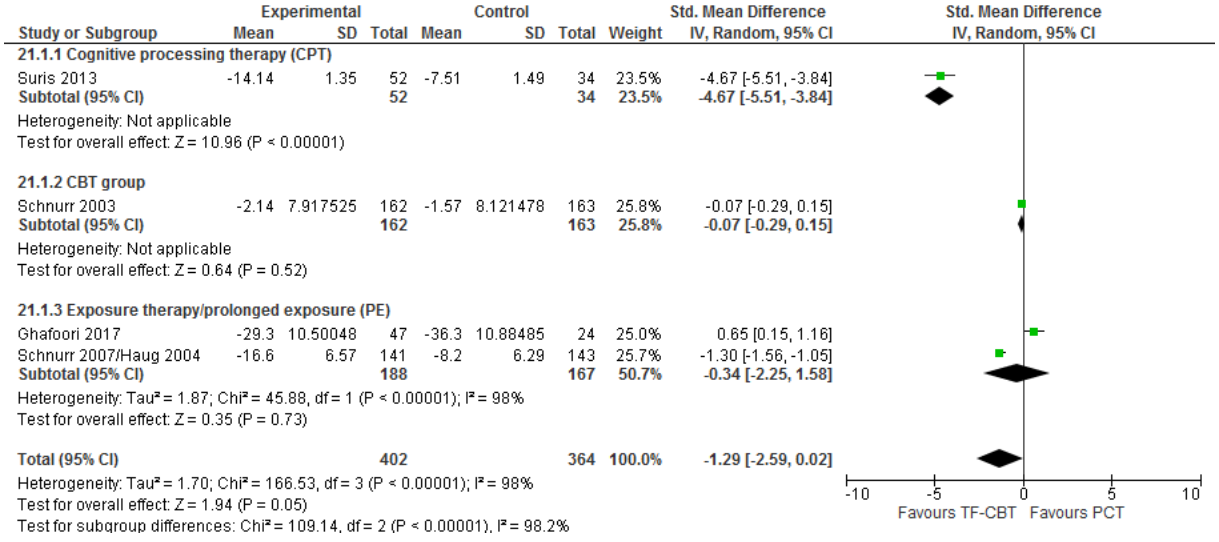


Figure 224: Trauma-focused CBT (±TAU) versus present-centered therapy (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated at endpoint (CAPS change score)

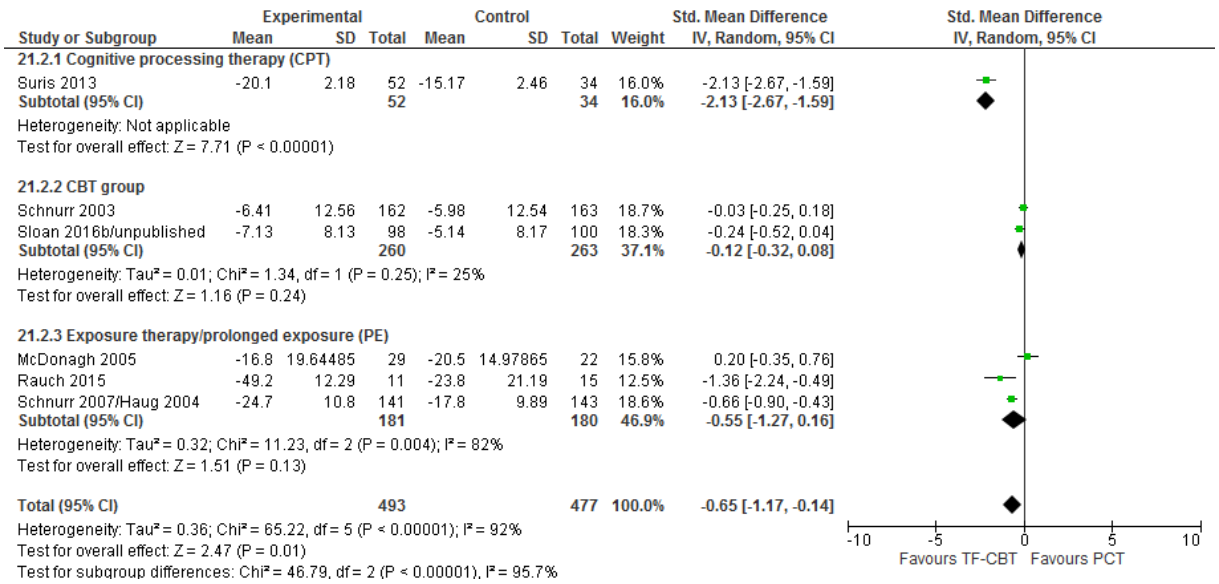
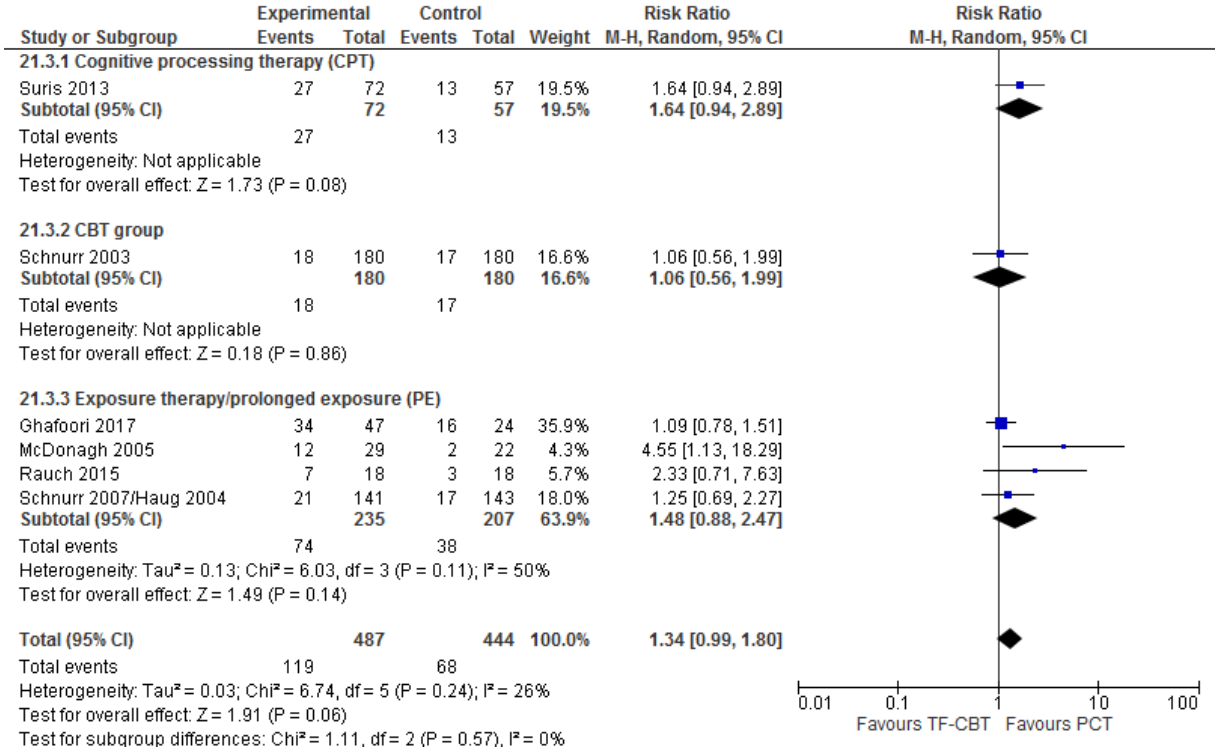


Figure 225: Trauma-focused CBT (±TAU) versus present-centered therapy (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)



Sub-analysis by diagnostic status at baseline: Trauma-focused CBT (±TAU) versus present-centered therapy (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD

Figure 226: Trauma-focused CBT (±TAU) versus present-centered therapy (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated at endpoint (PCL change score)

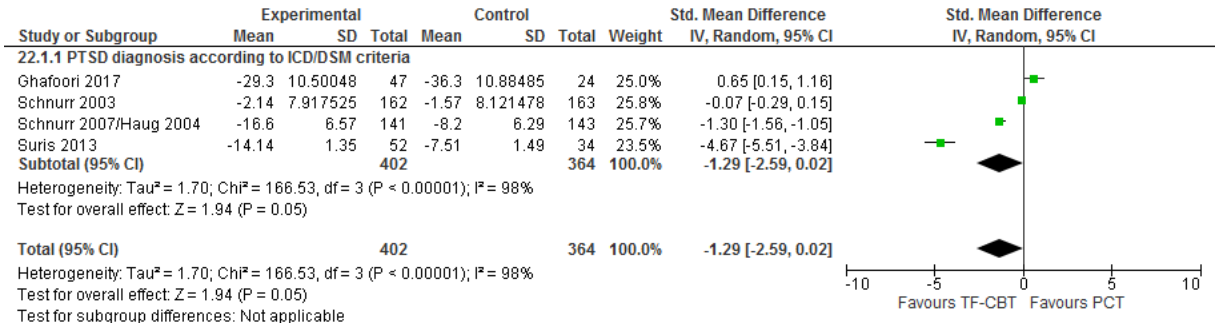


Figure 227: Trauma-focused CBT (±TAU) versus present-centered therapy (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated at endpoint (CAPS change score)

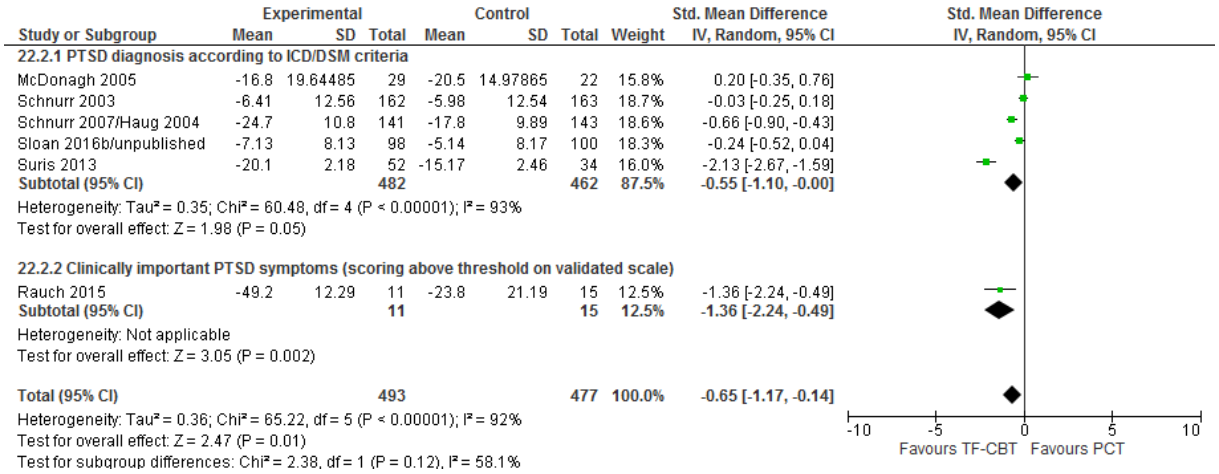
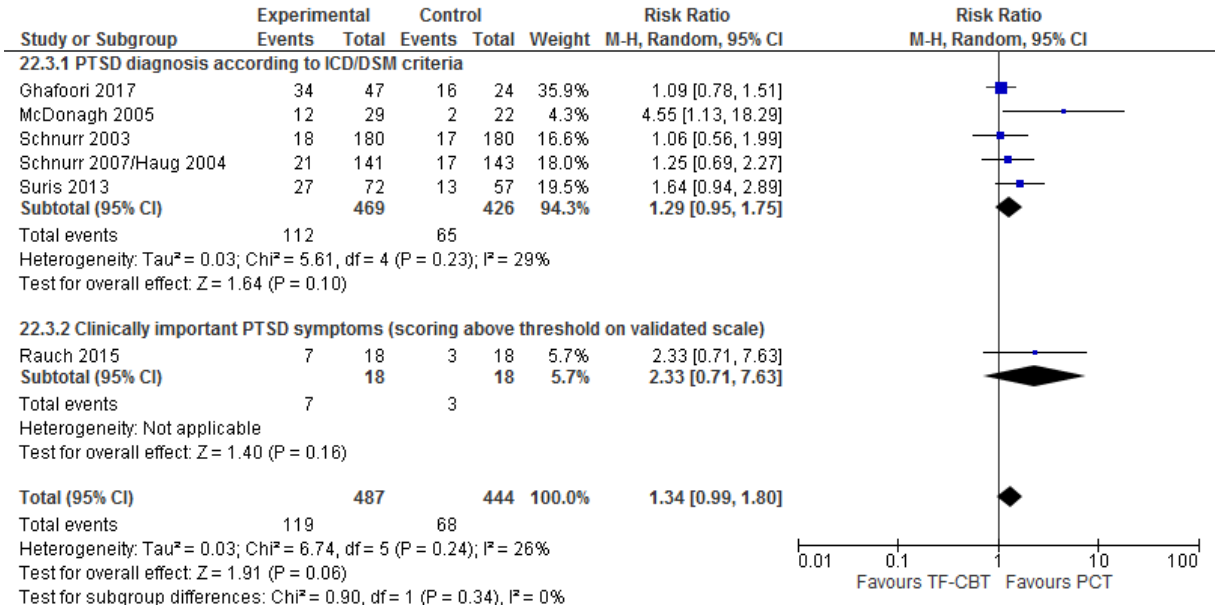


Figure 228: Trauma-focused CBT (±TAU) versus present-centered therapy (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)



Sub-analysis by trauma type: Trauma-focused CBT (±TAU) versus present-centered therapy (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD

Figure 229: Trauma-focused CBT (±TAU) versus present-centered therapy (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated at endpoint (PCL change score)

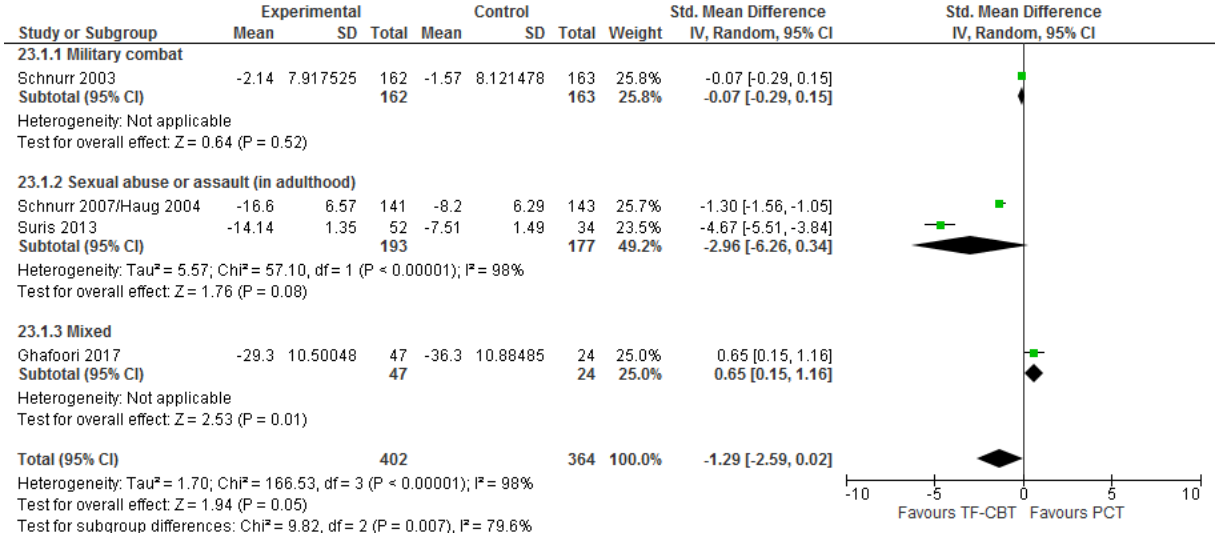


Figure 230: Trauma-focused CBT (±TAU) versus present-centered therapy (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated at endpoint (CAPS change score)

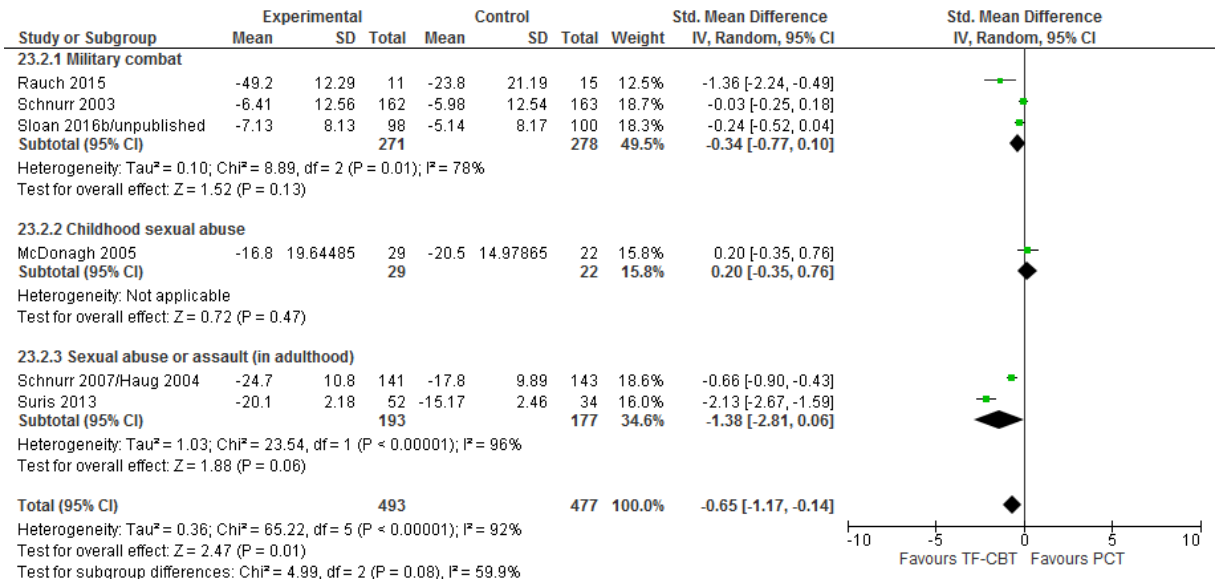


Figure 231: Trauma-focused CBT (±TAU) versus present-centered therapy (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)

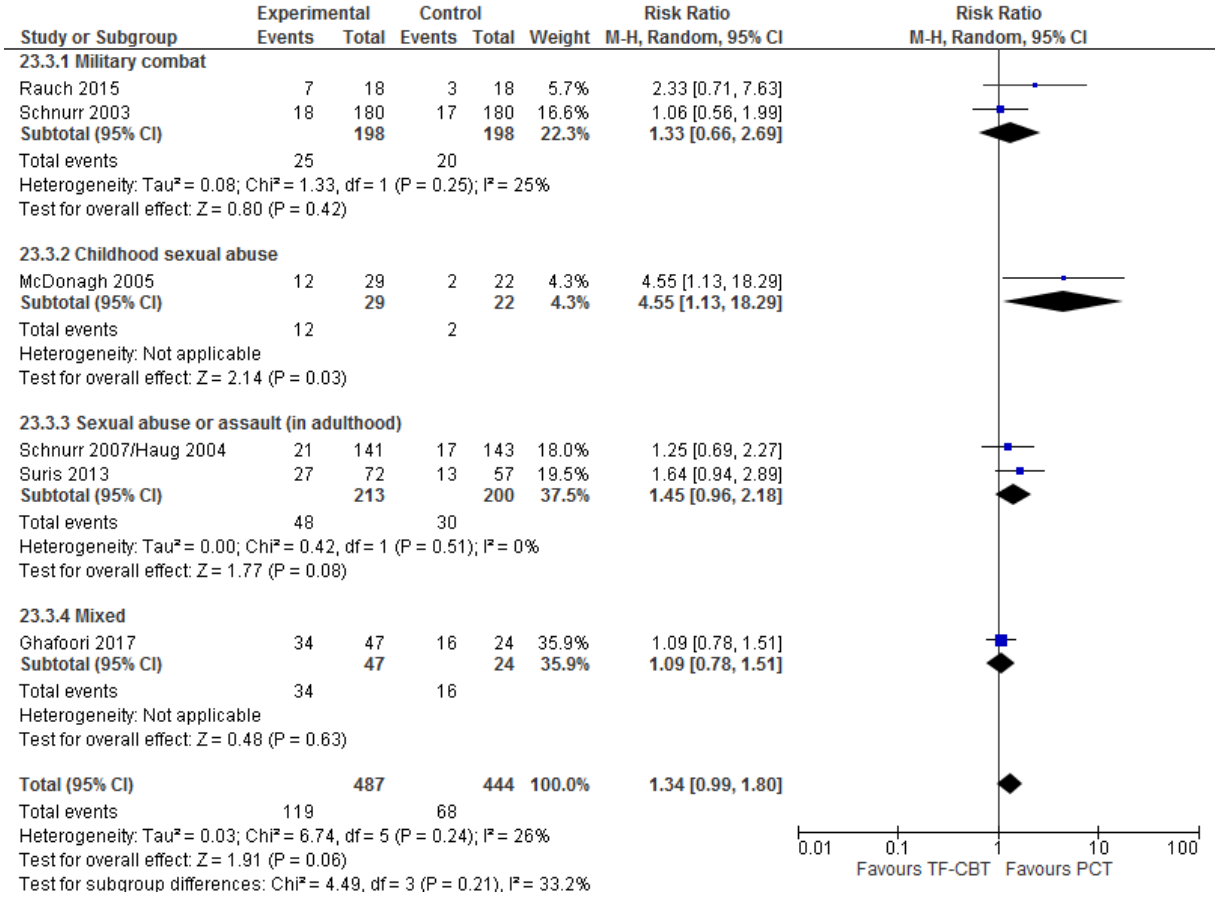


Figure 232: Trauma-focused CBT (+TAU) versus metacognitive (+TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD

symptomatology self-rated (PDS change score); Single incident index trauma

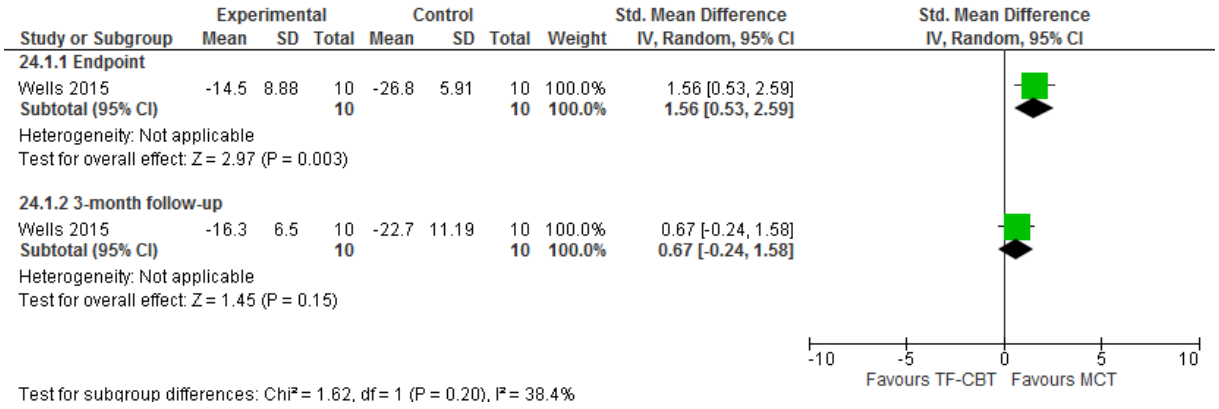


Figure 233: Trauma-focused CBT (+TAU) versus metacognitive (+TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Remission (number of people no longer meeting diagnostic criteria for PTSD)

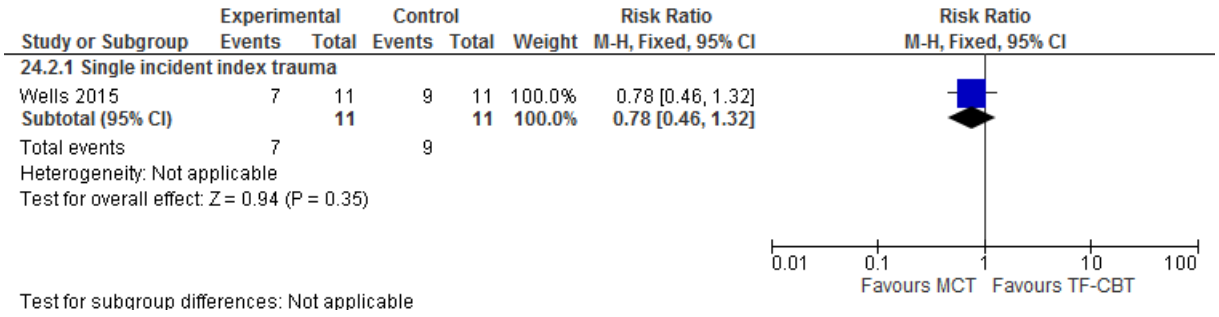


Figure 234: Trauma-focused CBT (+TAU) versus metacognitive (+TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Response self-rated (number of people showing clinically significant improvement based on at least 10-point improvement on IES)

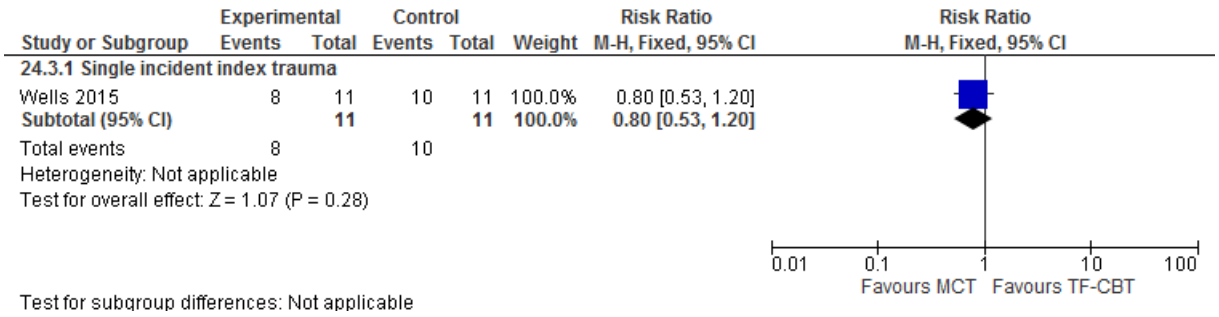


Figure 235: Trauma-focused CBT (+TAU) versus metacognitive (+TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Anxiety symptoms (BAI change score); Single incident index trauma

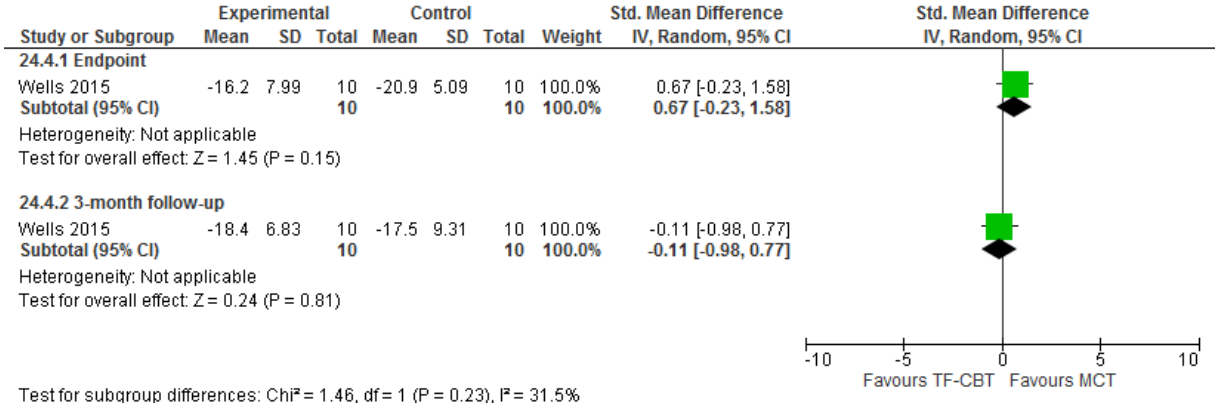


Figure 236: Trauma-focused CBT (+TAU) versus metacognitive (+TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symtpoms (BDI-II change score); Single incident index trauma

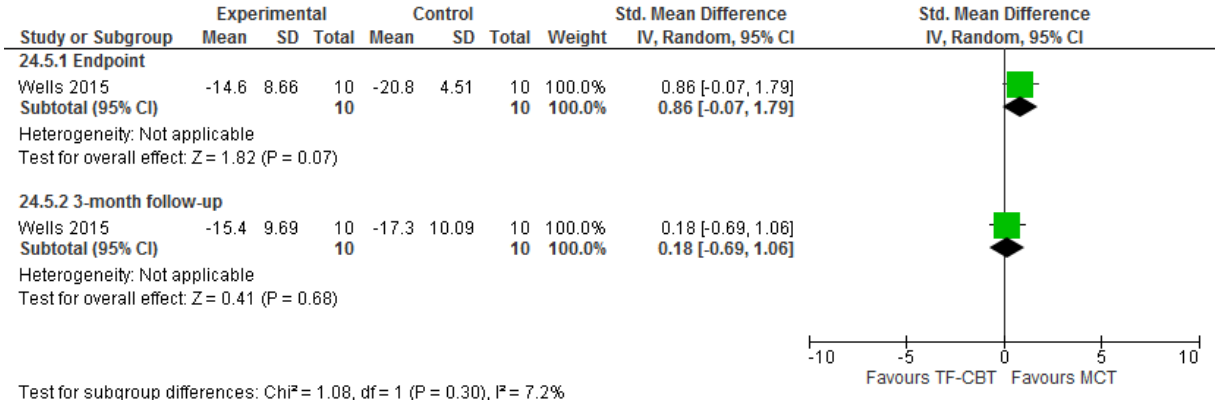


Figure 237: Trauma-focused CBT (+TAU) versus metacognitive (+TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)

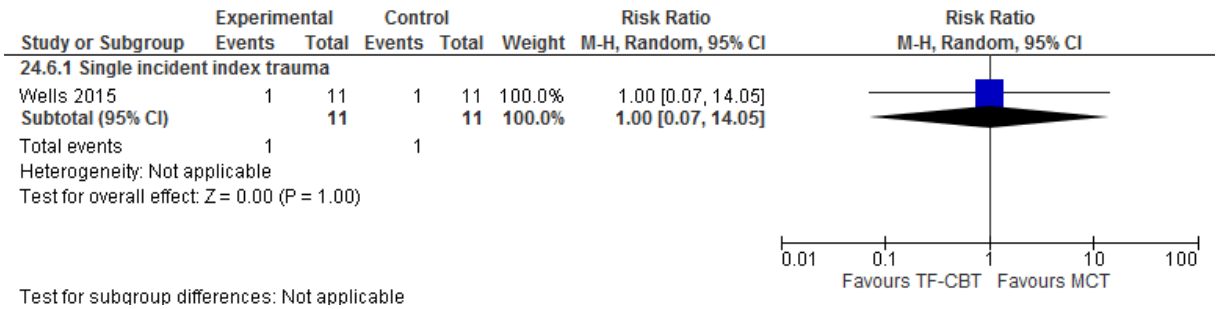


Figure 238: Trauma-focused CBT versus interpersonal psychotherapy (IPT) for delayed treatment (>3months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated (CAPS change score)

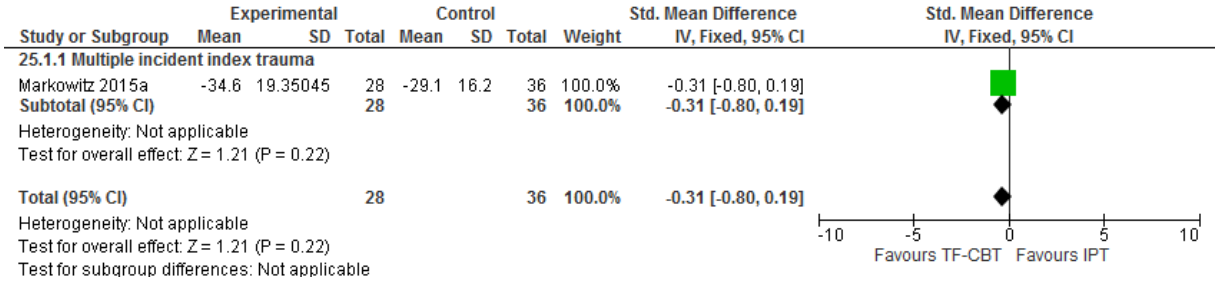


Figure 239: Trauma-focused CBT versus interpersonal psychotherapy (IPT) for delayed treatment (>3months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated (PSS-SR change score)

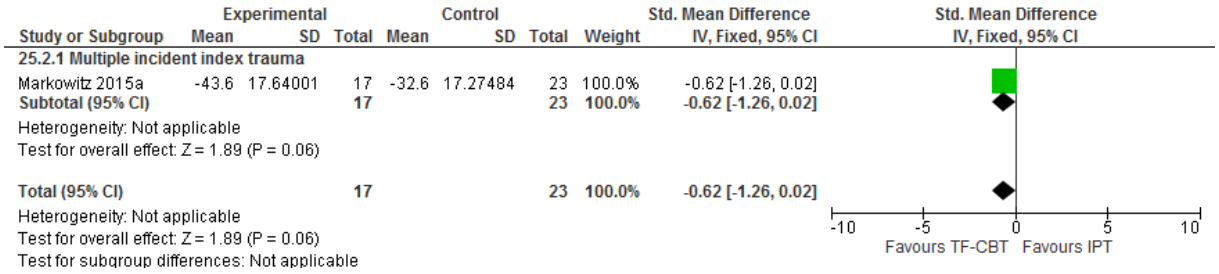


Figure 240: Trauma-focused CBT versus interpersonal psychotherapy (IPT) for delayed treatment (>3months) of clinically important symptoms/PTSD: Remission (number of people scoring <20 on CAPS)

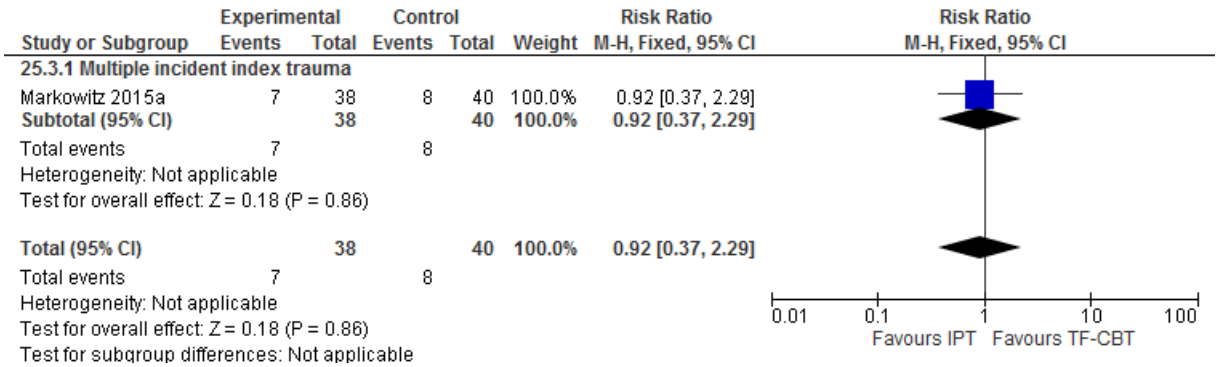


Figure 241: Trauma-focused CBT versus interpersonal psychotherapy (IPT) for delayed treatment (>3months) of clinically important symptoms/PTSD: Response (number of people showing ≥30% improvement on CAPS)

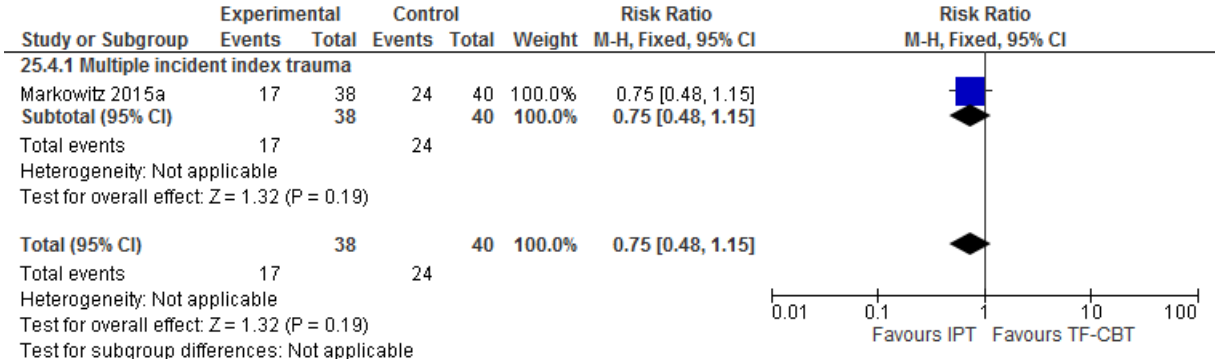


Figure 242: Trauma-focused CBT versus interpersonal psychotherapy (IPT) for delayed treatment (>3months) of clinically important symptoms/PTSD: Depression symptoms (HAMD change score)

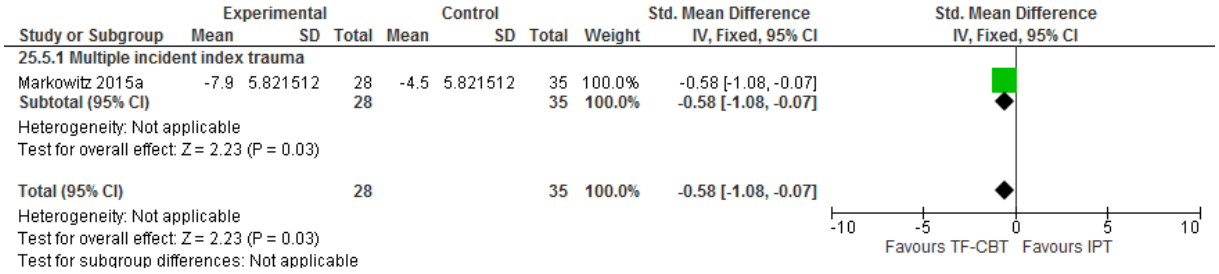


Figure 243: Trauma-focused CBT versus interpersonal psychotherapy (IPT) for delayed treatment (>3months) of clinically important symptoms/PTSD: Functional impairment (SAS change score)

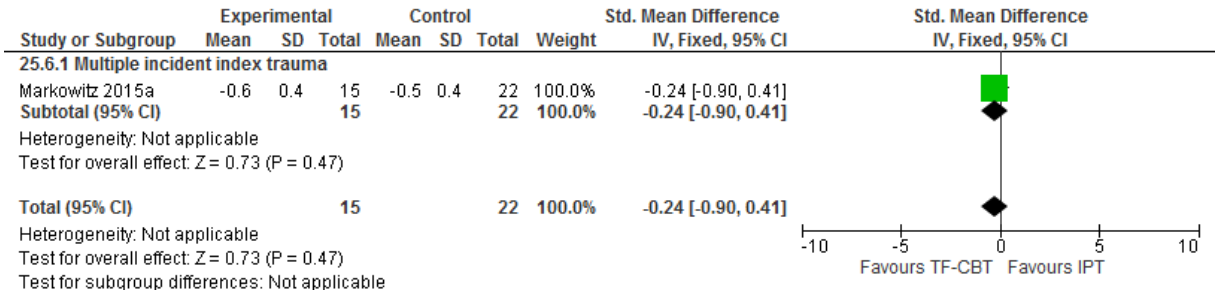


Figure 244: Trauma-focused CBT versus interpersonal psychotherapy (IPT) for delayed treatment (>3months) of clinically important symptoms/PTSD: Quality of life (Q-LES-Q-SF change score)

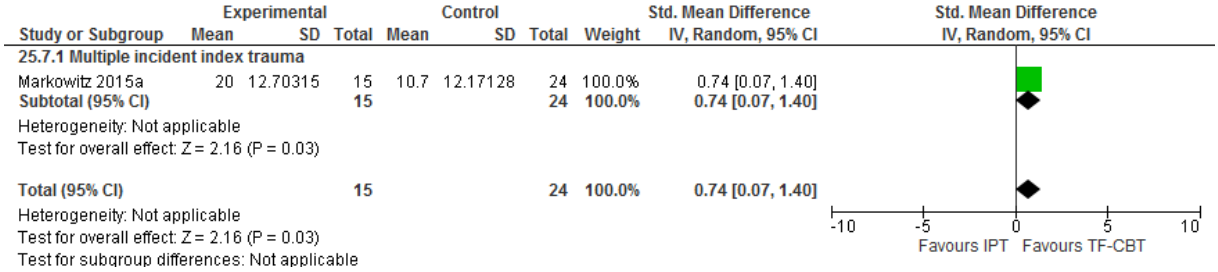


Figure 245: Trauma-focused CBT versus interpersonal psychotherapy (IPT) for delayed treatment (>3months) of clinically important symptoms/PTSD: Relationship difficulties (IIP change score)

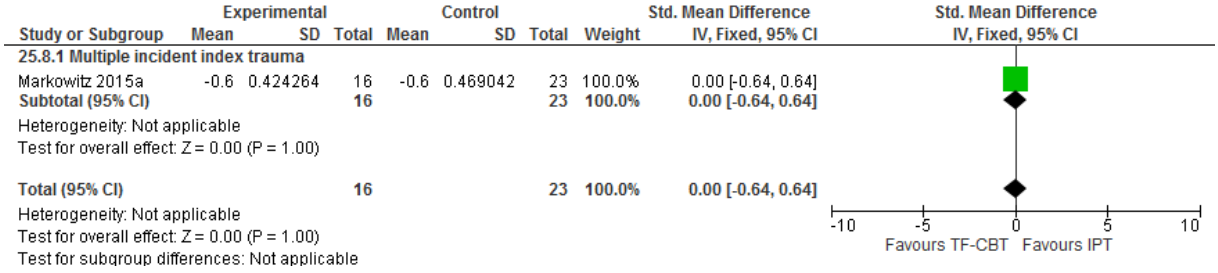


Figure 246: Trauma-focused CBT versus interpersonal psychotherapy (IPT) for delayed treatment (>3months) of clinically important symptoms/PTSD: Discontinuation (loss of follow-up)

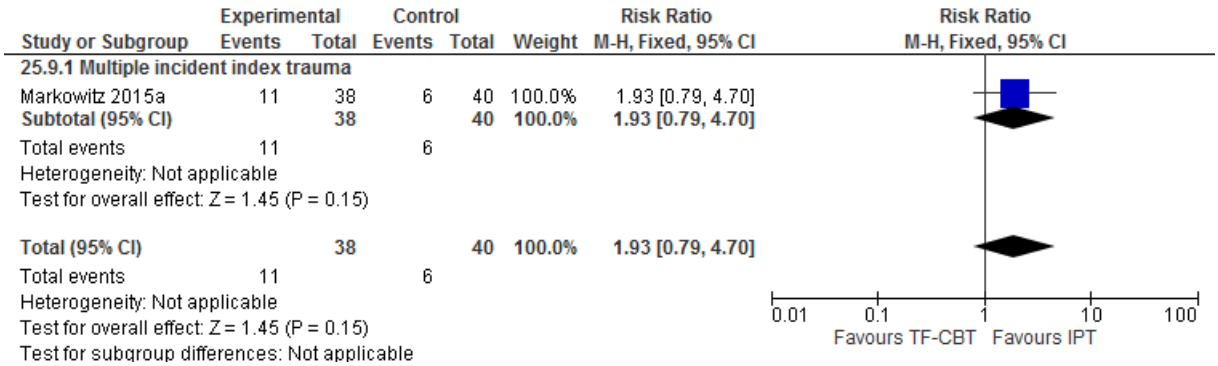


Figure 247: Trauma-focused CBT (+TAU) versus psychodynamic therapy (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated (IES change score); Single incident index trauma

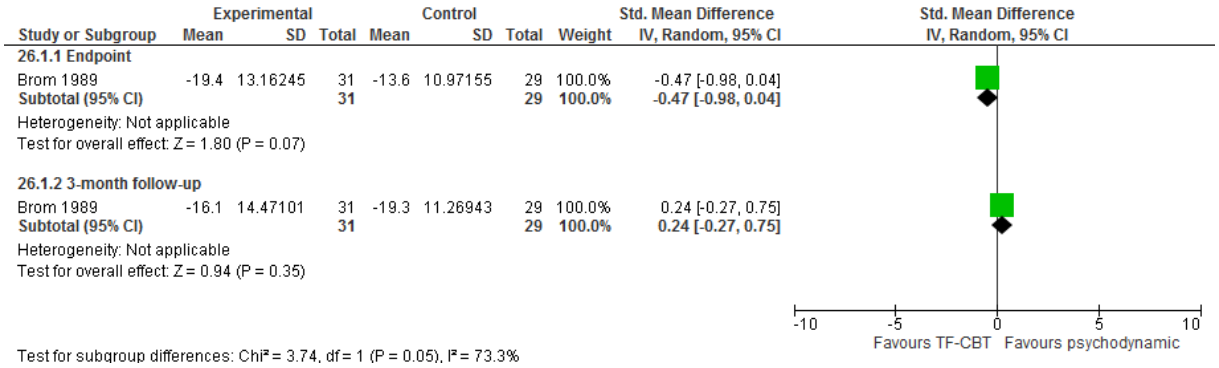


Figure 248: Trauma-focused CBT (±TAU) versus self-help (without support; ± TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated (CAPS change score)

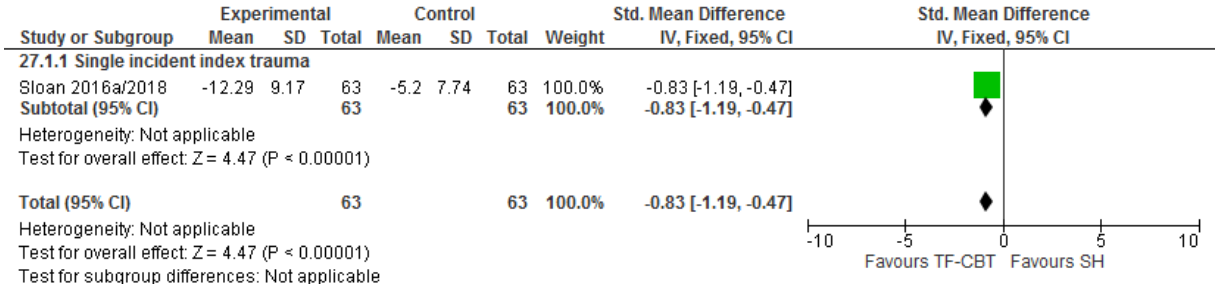


Figure 249: Trauma-focused CBT (±TAU) versus self-help (without support; ± TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD:

Remission at endpoint (number of people no longer meeting diagnostic criteria or scoring below clinical threshold on a scale)

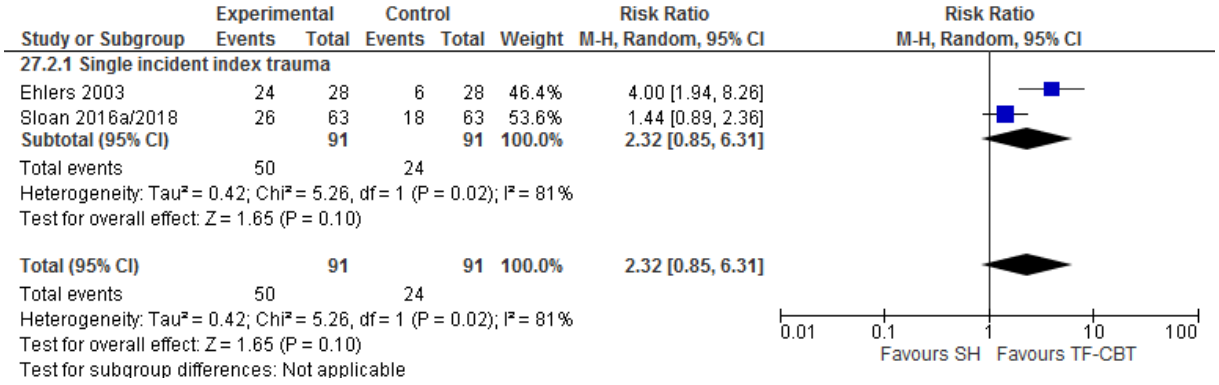


Figure 250: Trauma-focused CBT (±TAU) versus self-help (without support; ± TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Remission at 6-month follow-up (number of people scoring <14 on PDS) S)

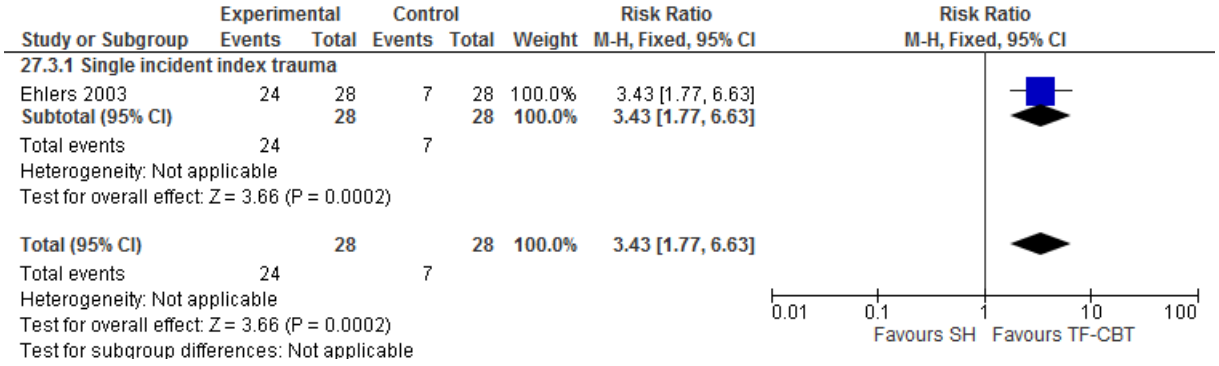


Figure 251: Trauma-focused CBT (±TAU) versus self-help (without support; ± TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Response at endpoint (number of people showing ≥50% improvement on PDS)

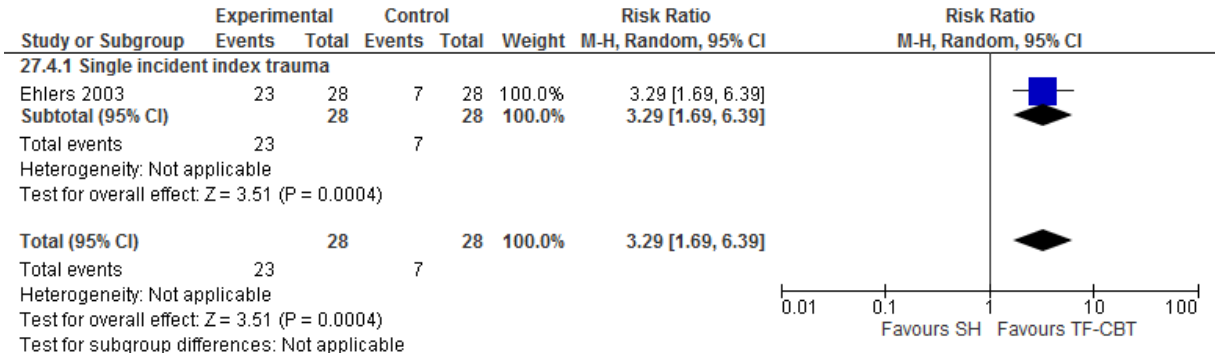


Figure 252: Trauma-focused CBT (±TAU) versus self-help (without support; ± TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Response at 6-month follow-up (number of people showing ≥50% improvement on PDS)

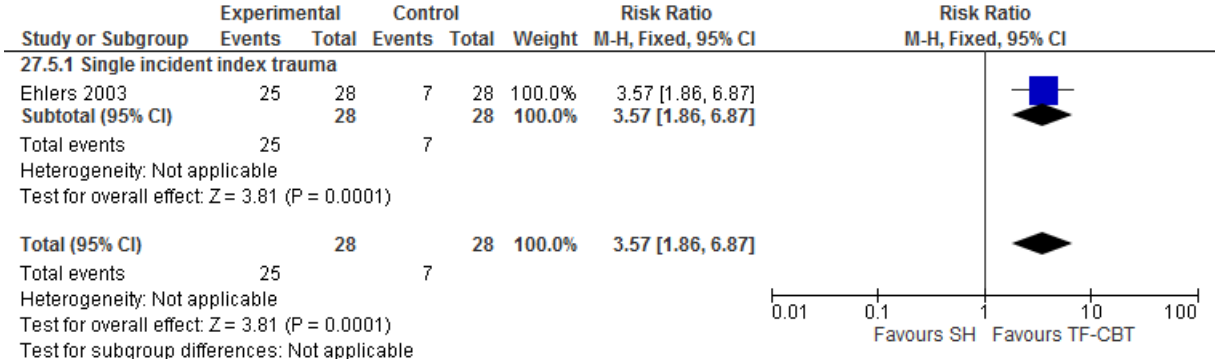


Figure 253: Trauma-focused CBT (±TAU) versus self-help (without support; ± TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms at endpoint (BDI-II change score)

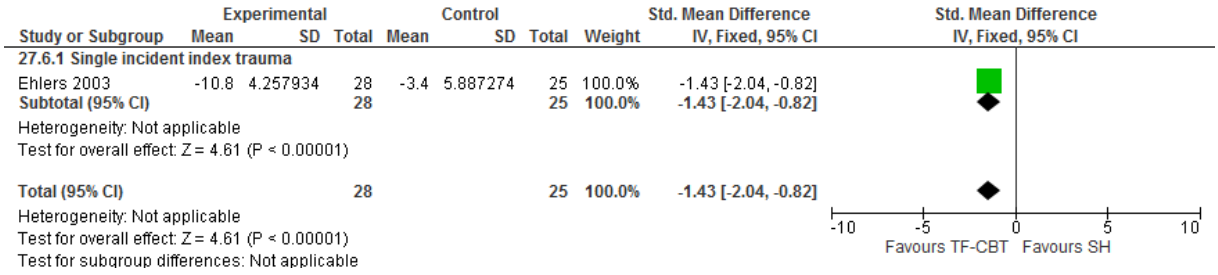


Figure 254: Trauma-focused CBT (±TAU) versus self-help (without support; ± TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms at 6-month follow-up (BDI-II change score)

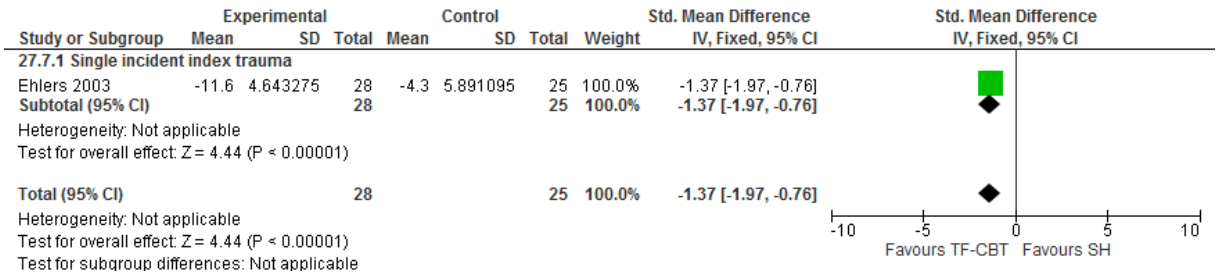


Figure 255: Trauma-focused CBT (±TAU) versus self-help (without support; ± TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Anxiety symptoms at endpoint (BAI change score)

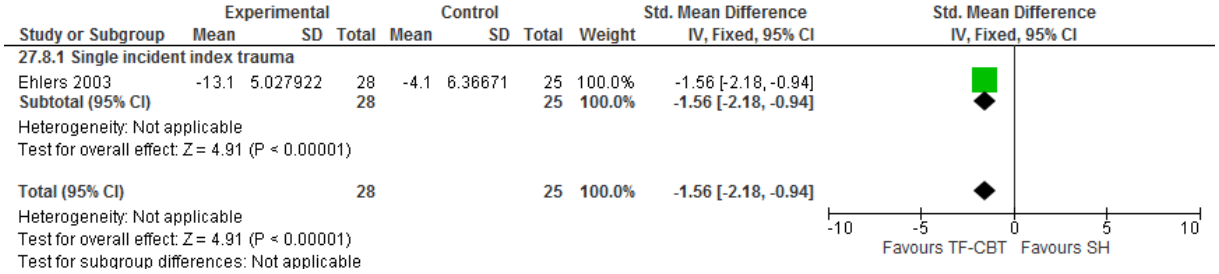


Figure 256: Trauma-focused CBT (±TAU) versus self-help (without support; ± TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Anxiety symptoms at 6-month follow-up (BAI change score)

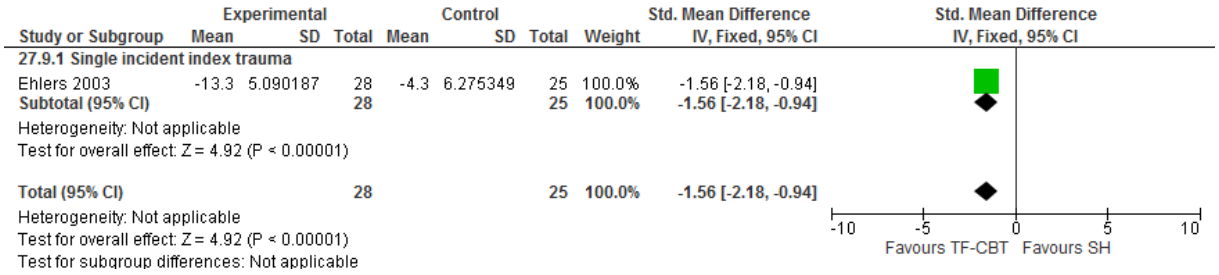


Figure 257: Trauma-focused CBT (±TAU) versus self-help (without support; ± TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Functional impairment at endpoint (SDS change score)

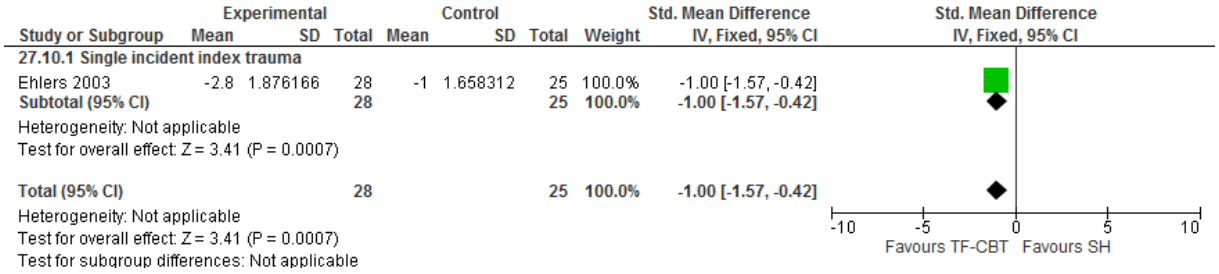


Figure 258: Trauma-focused CBT (±TAU) versus self-help (without support; ± TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Functional impairment at 6-month follow-up (SDS change score)

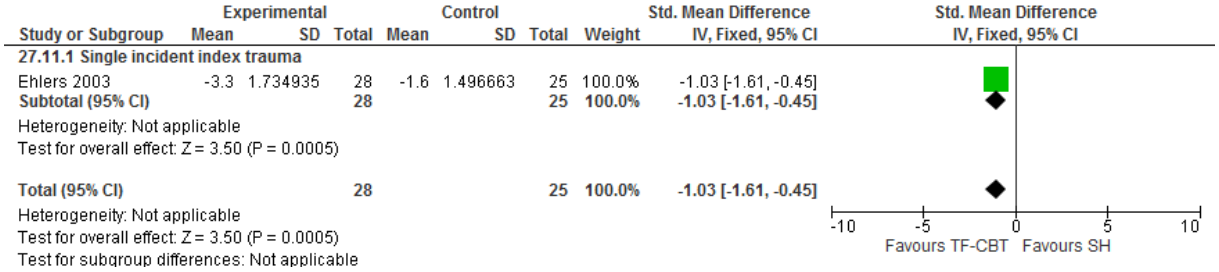


Figure 259: Trauma-focused CBT (±TAU) versus self-help (without support; ± TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)

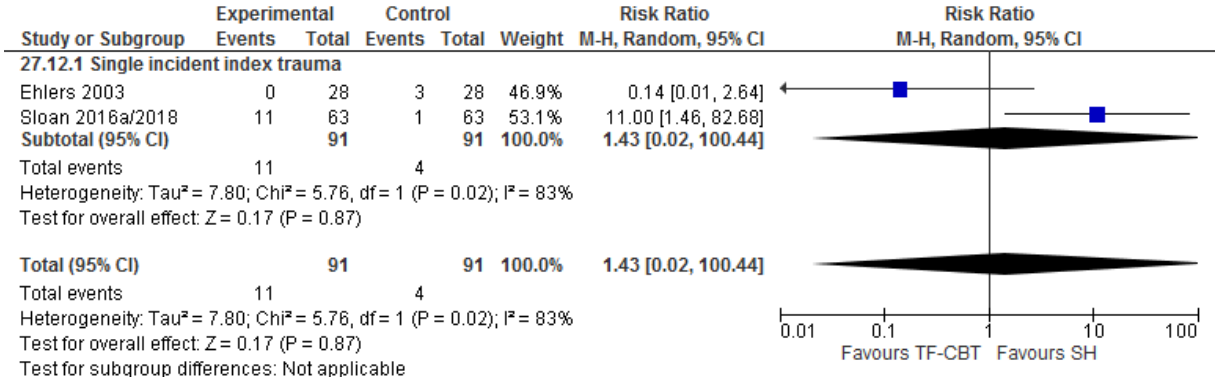


Figure 260: Trauma-focused CBT versus self-help support for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated (IES change score); Single incident index trauma

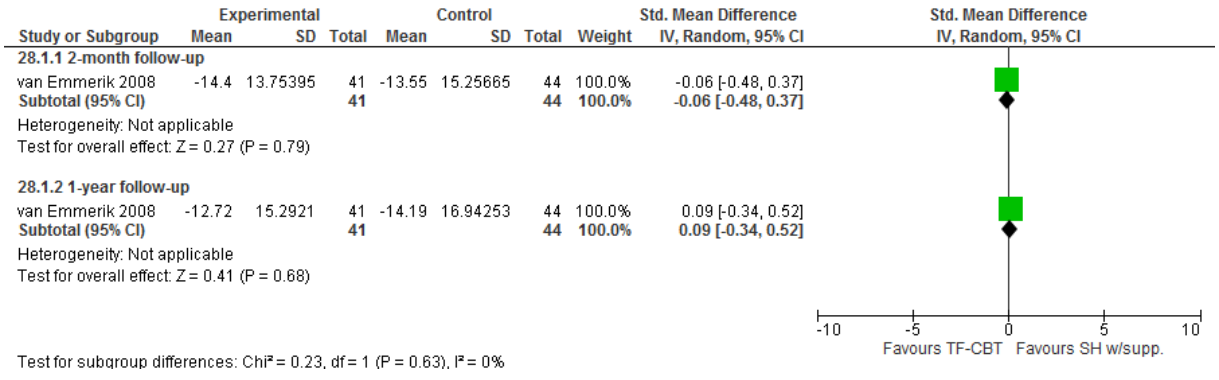


Figure 261: Trauma-focused CBT versus self-help support for delayed treatment (>3 months) of clinically important symptoms/PTSD: Dissociative symptoms (DES change score); Single incident index trauma

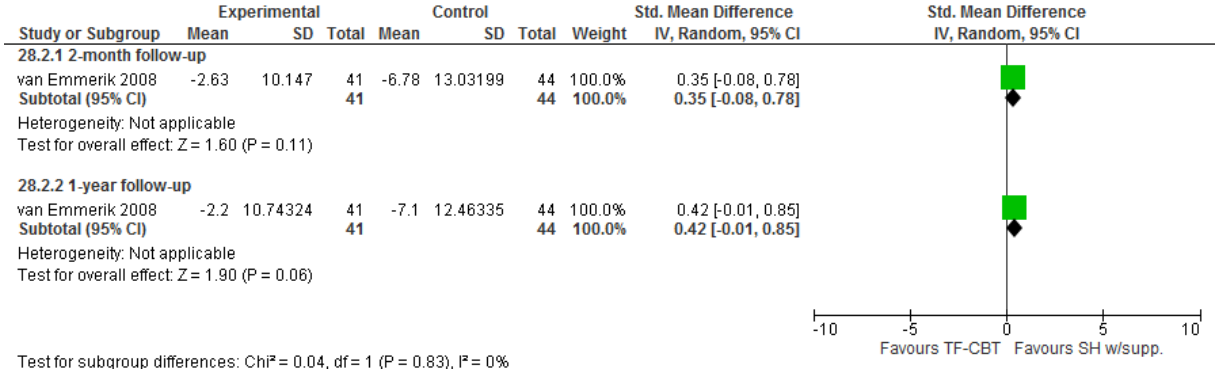


Figure 262: Trauma-focused CBT versus self-help support for delayed treatment (>3 months) of clinically important symptoms/PTSD: Anxiety symptoms (STAI State change score); Single incident index trauma

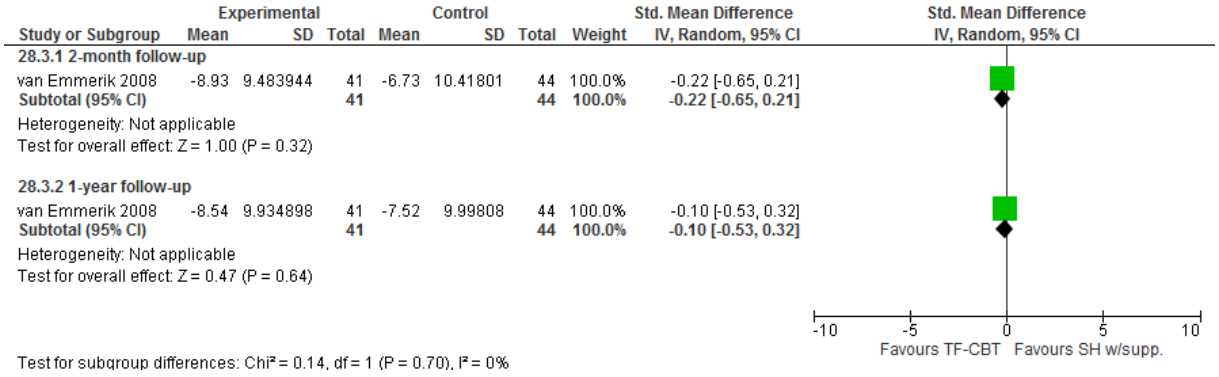


Figure 263: Trauma-focused CBT versus self-help support for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms (BDI change score); Single incident index trauma

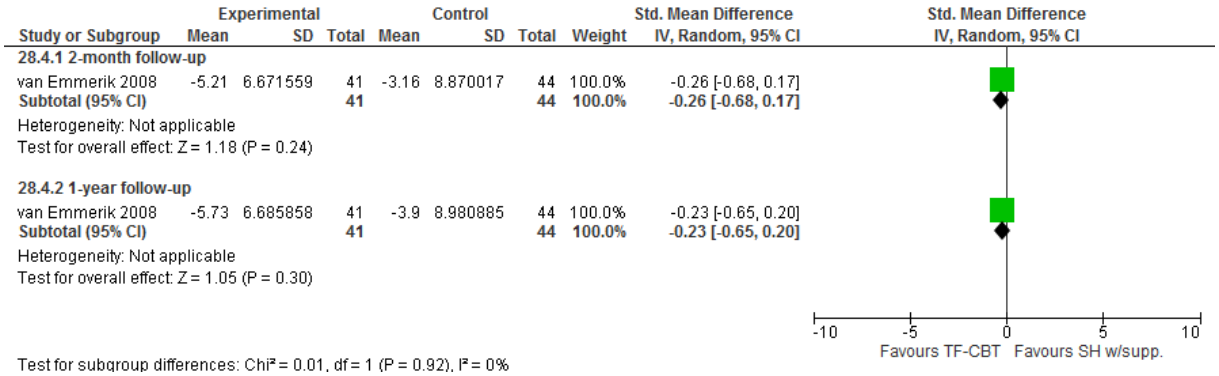


Figure 264: Trauma-focused CBT (+TAU) versus hypnotherapy (+TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated (IES change score); Single incident index trauma

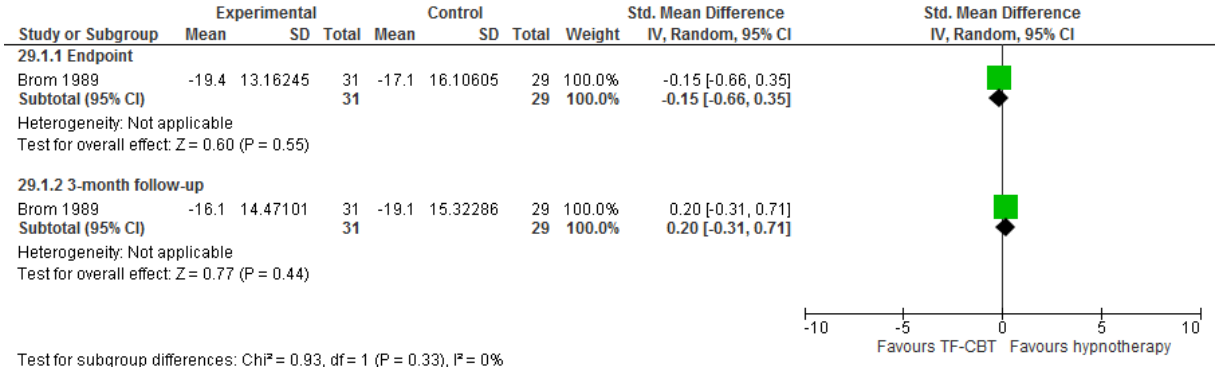


Figure 265: Trauma-focused CBT versus psychoeducational session for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated at endpoint (IES change score)

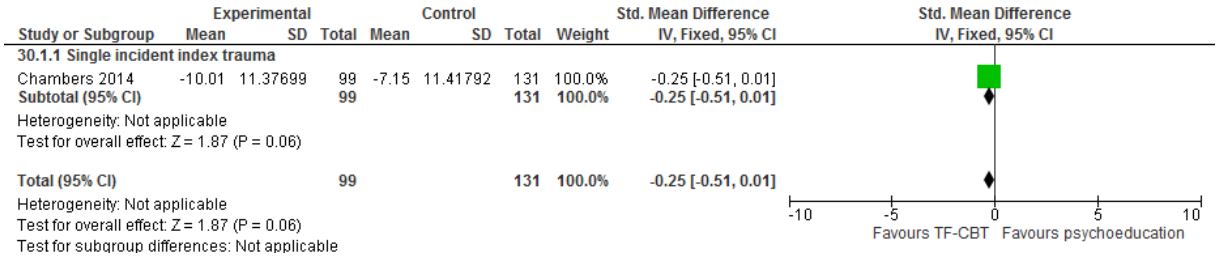


Figure 266: Trauma-focused CBT versus psychoeducational session for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated at 3-month follow-up (IES change score)

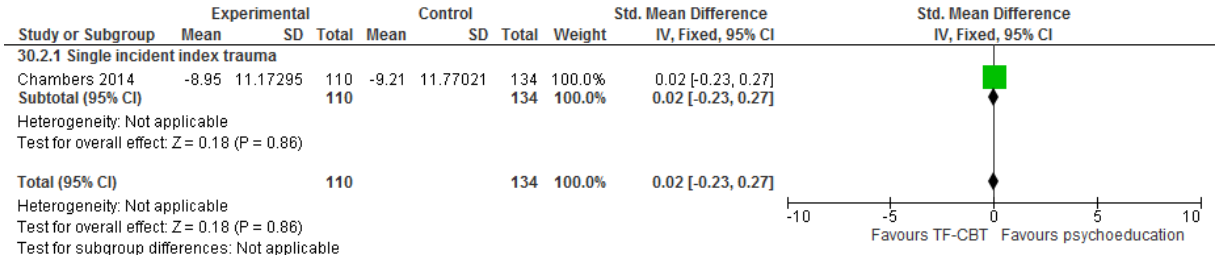


Figure 267: Trauma-focused CBT versus psychoeducational session for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated at 6-month follow-up (IES change score)

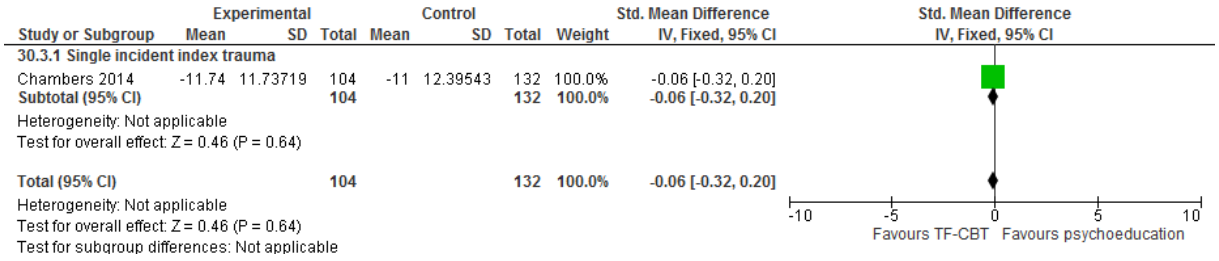


Figure 268: Trauma-focused CBT versus psychoeducational session for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)

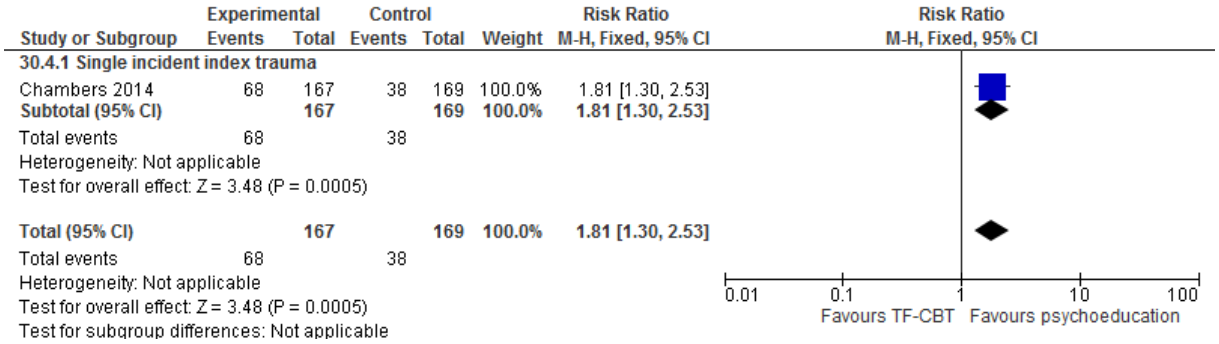


Figure 269: Trauma-focused CBT (±TAU) versus relaxation (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated at endpoint (PCL/PSS-SR change score)

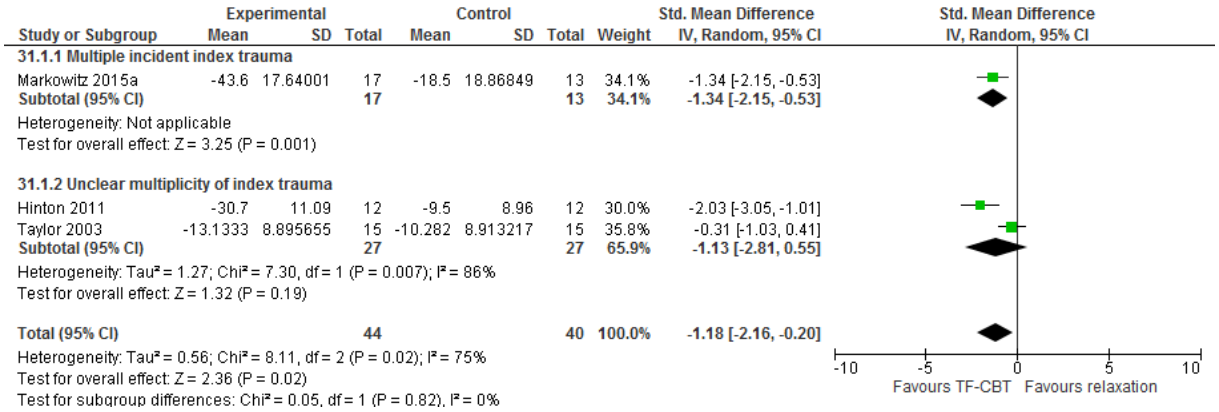


Figure 270: Trauma-focused CBT (±TAU) versus relaxation (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated at 3-month follow-up (PCL/PSS-SR change score)

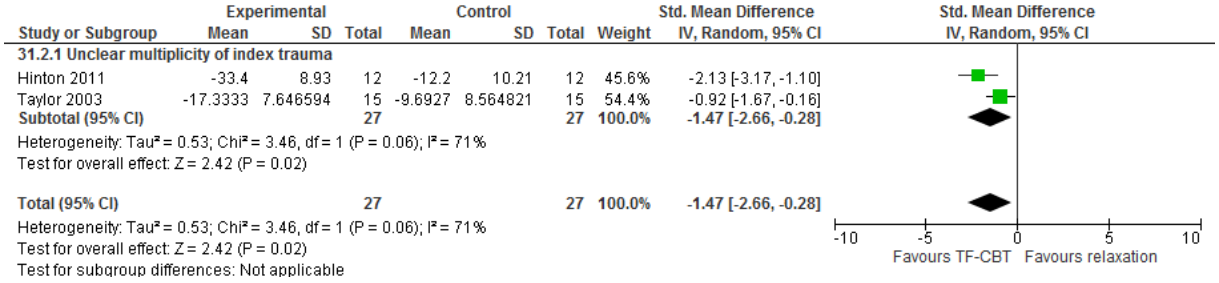


Figure 271: Trauma-focused CBT (±TAU) versus relaxation (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated at endpoint (CAPS change score)

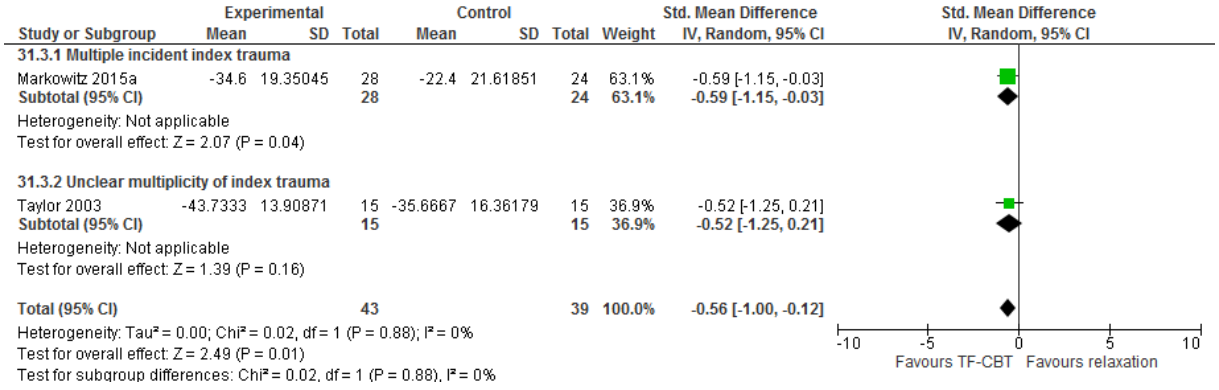


Figure 272: Trauma-focused CBT (±TAU) versus relaxation (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated at 3-month follow-up (CAPS change score)

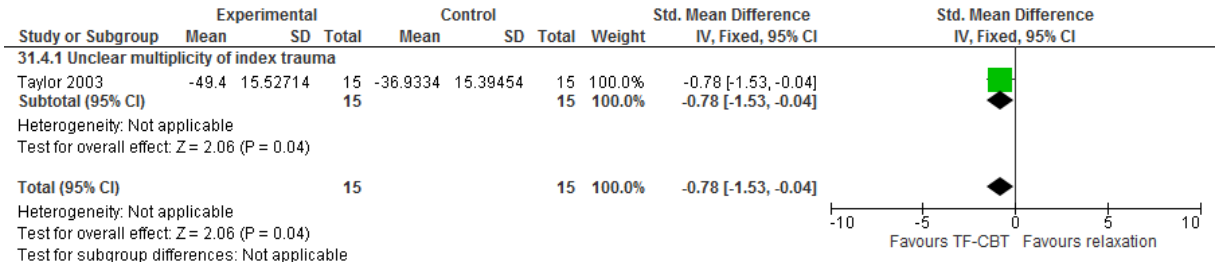


Figure 273: Trauma-focused CBT (±TAU) versus relaxation (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Remission at endpoint (number of people scoring <20 on CAPS)

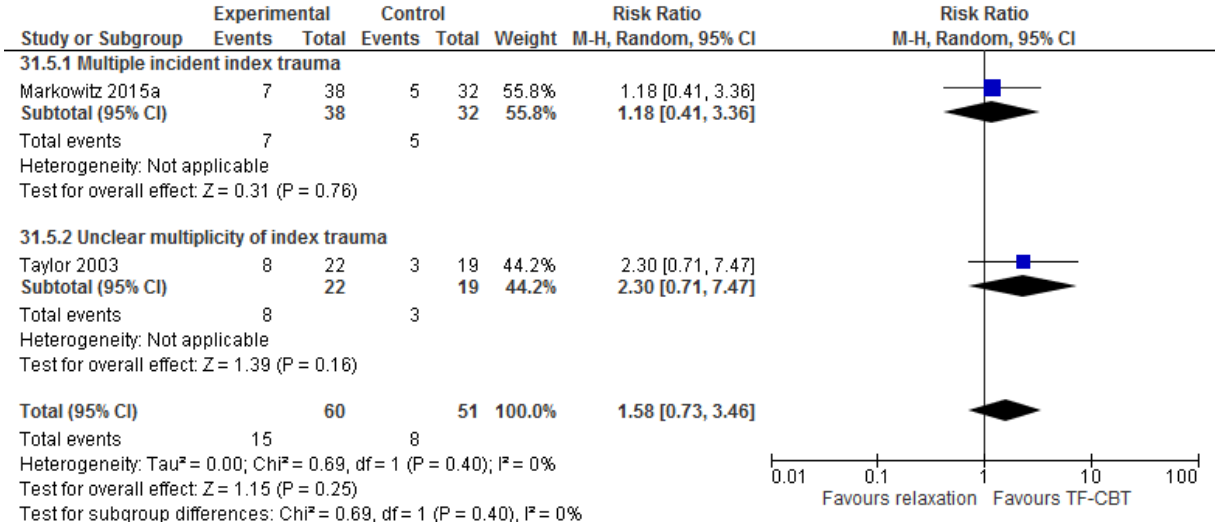


Figure 274: Trauma-focused CBT (±TAU) versus relaxation (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Remission at 3-month follow-up (number of people scoring <20 on CAPS)

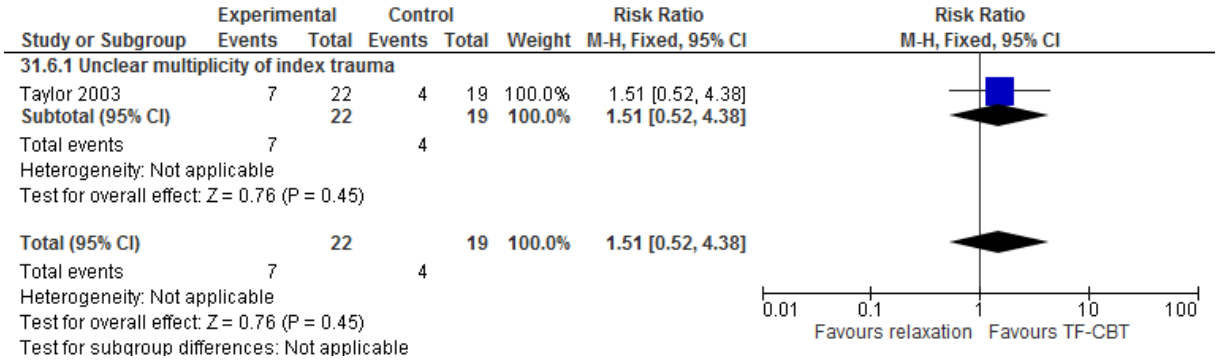


Figure 275: Trauma-focused CBT (±TAU) versus relaxation (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Response (number of people showing ≥30% improvement on CAPS)

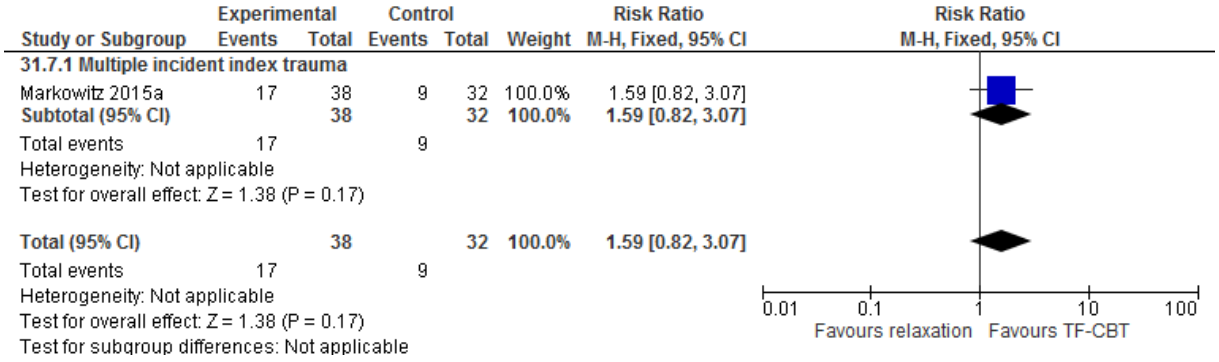


Figure 276: Trauma-focused CBT (±TAU) versus relaxation (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Dissociative symptoms (CAPS dissociation cluster change score); Unclear multiplicity of index trauma

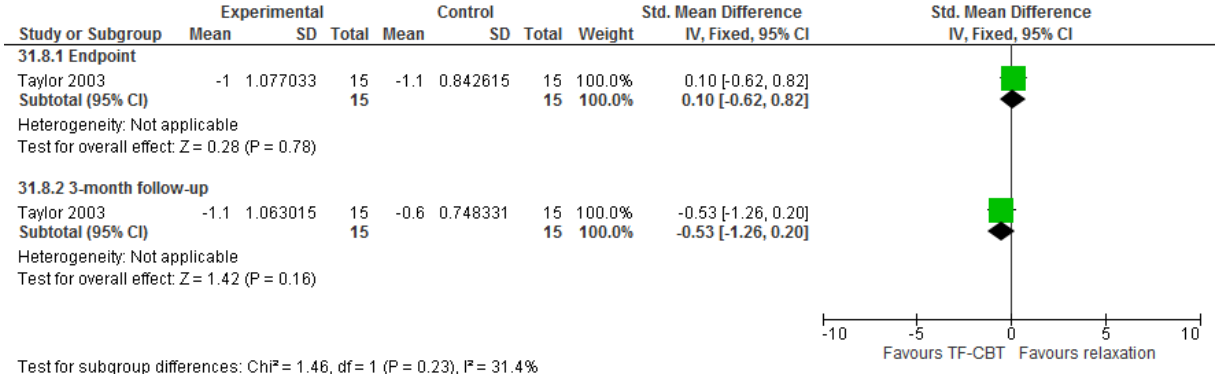


Figure 277: Trauma-focused CBT (±TAU) versus relaxation (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Anxiety

symptoms (SCL-90: Anxiety; change score); unclear multiplicity of index trauma

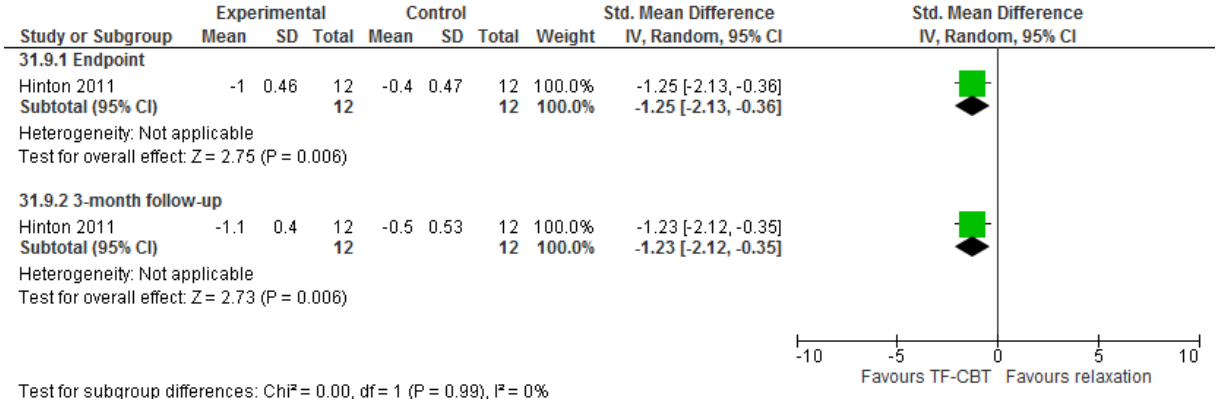


Figure 278: Trauma-focused CBT (±TAU) versus relaxation (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms at endpoint (HAMD/BDI change score)

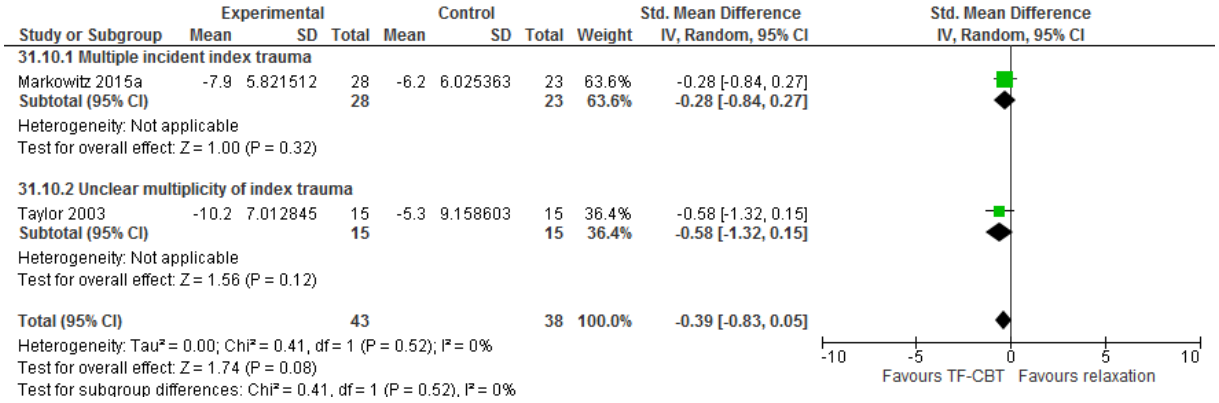


Figure 279: Trauma-focused CBT (±TAU) versus relaxation (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms at 3-month follow-up (BDI change score)

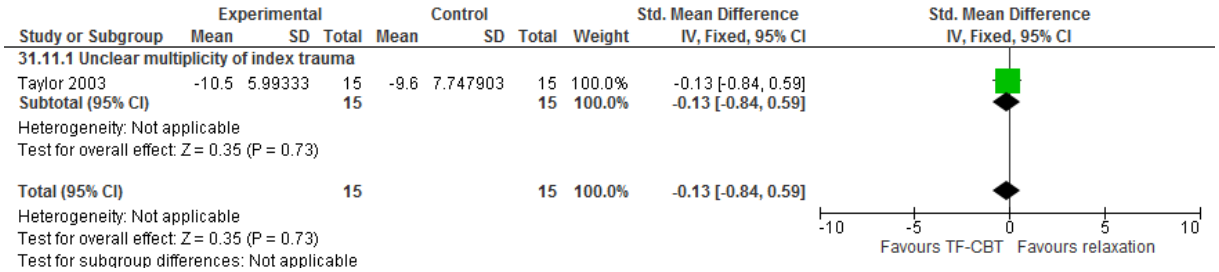


Figure 280: Trauma-focused CBT (±TAU) versus relaxation (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Functional impairment (SAS change score)

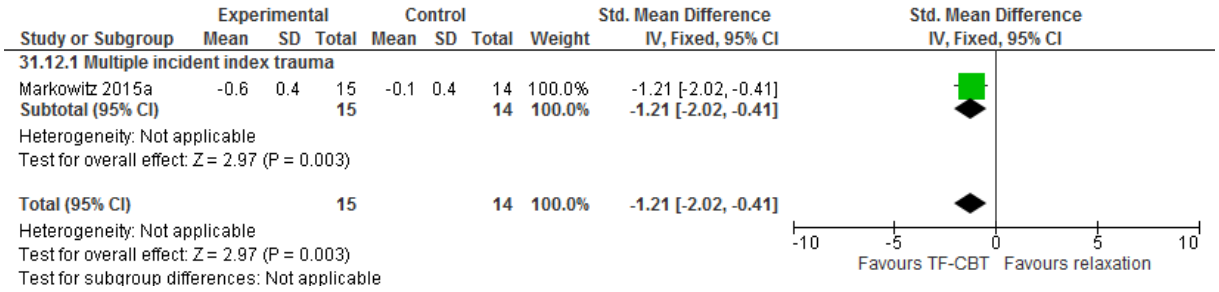


Figure 281: Trauma-focused CBT (±TAU) versus relaxation (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Quality of life (Q-LES-Q-SF change score)

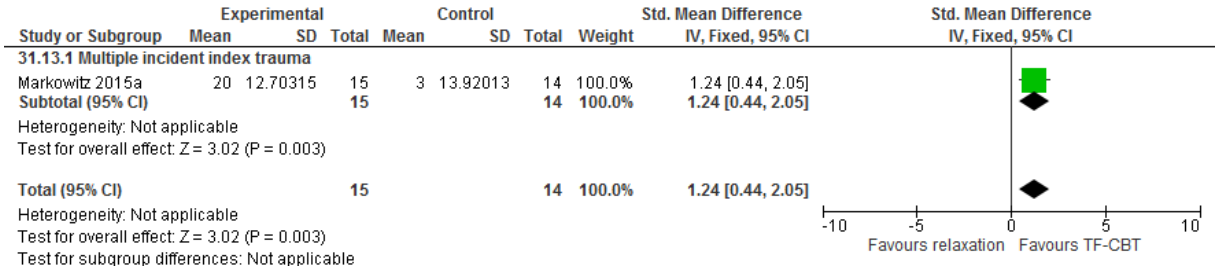


Figure 282: Trauma-focused CBT (±TAU) versus relaxation (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Relationship difficulties (IIP change score)

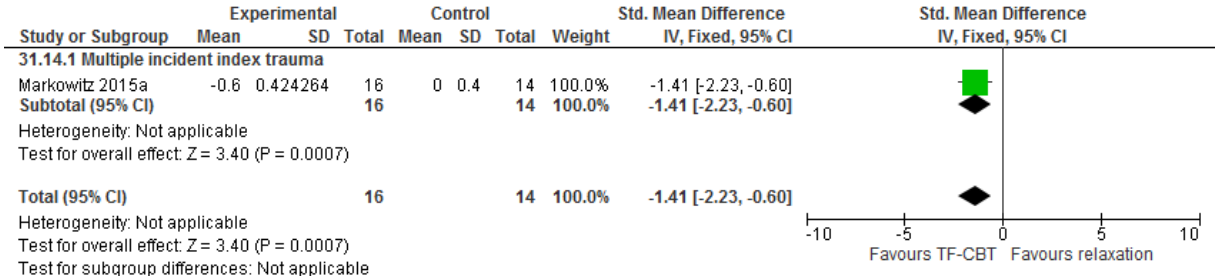


Figure 283: Trauma-focused CBT (±TAU) versus relaxation (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)

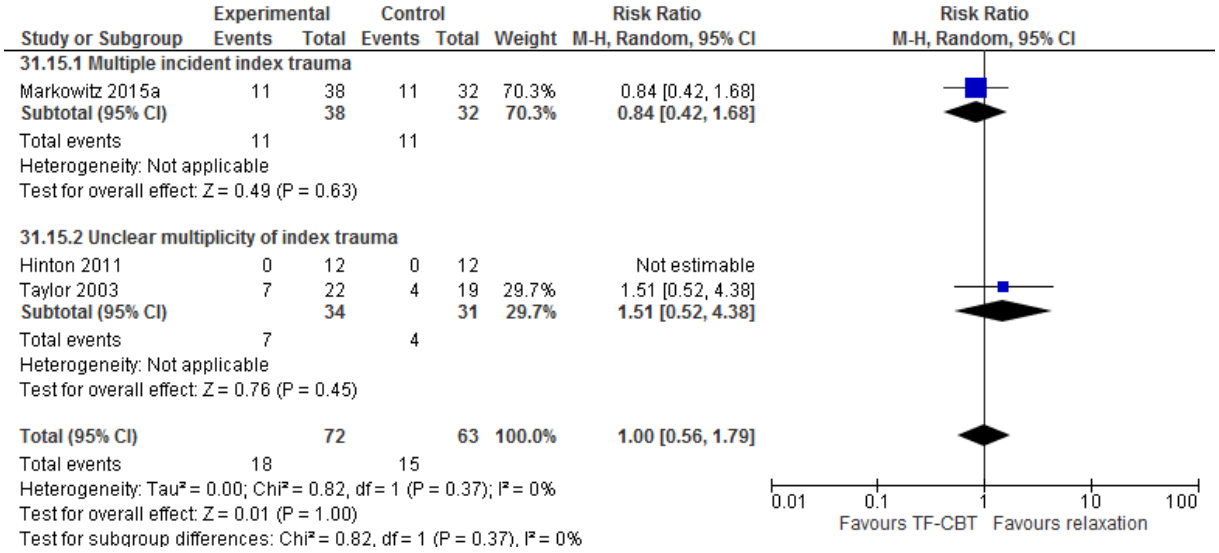


Figure 284: Trauma-focused CBT versus acupuncture for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated (PSS-SR change score); unclear multiplicity of index trauma

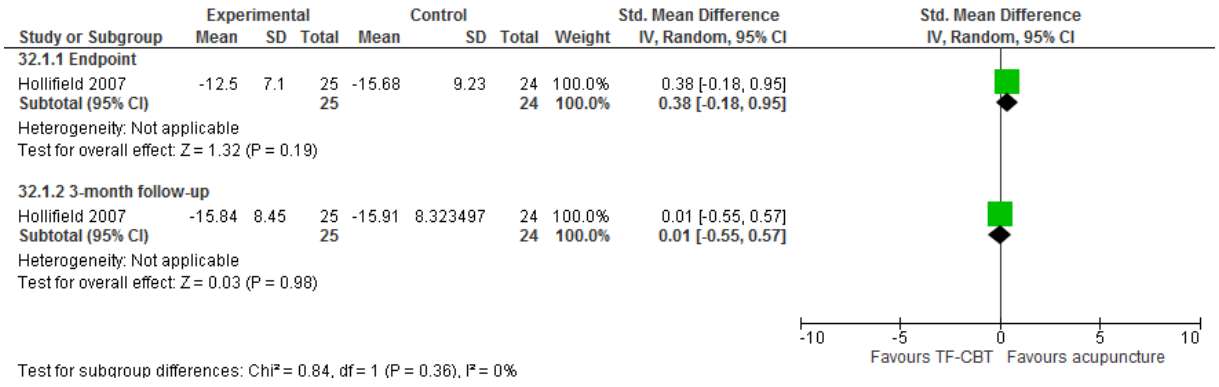


Figure 285: Trauma-focused CBT versus acupuncture for delayed treatment (>3 months) of clinically important symptoms/PTSD: Remission (number of people scoring <16 on PSS-SR); unclear multiplicity of index trauma

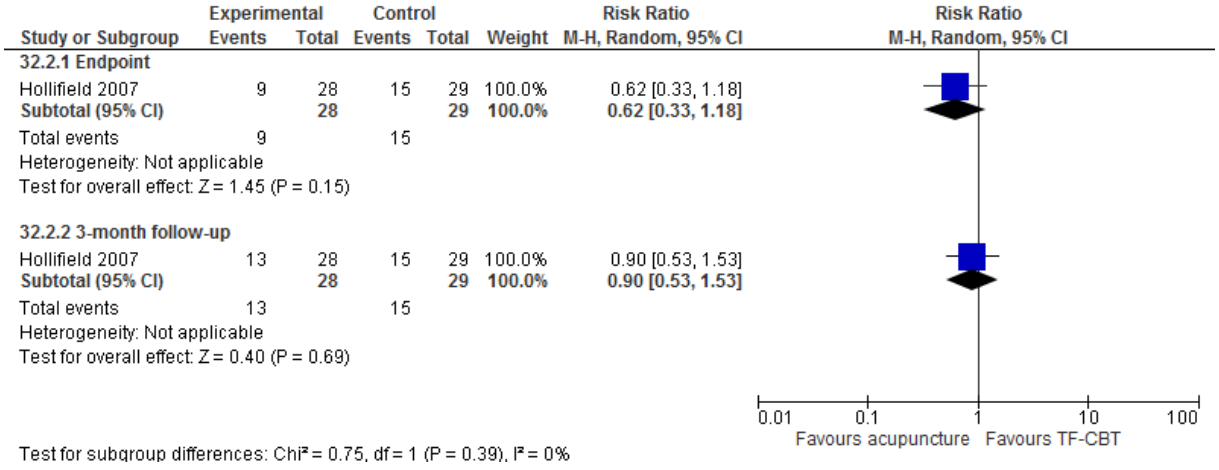


Figure 286: Trauma-focused CBT versus acupuncture for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms (HSCL-25: Depression, change score); unclear multiplicity of index trauma

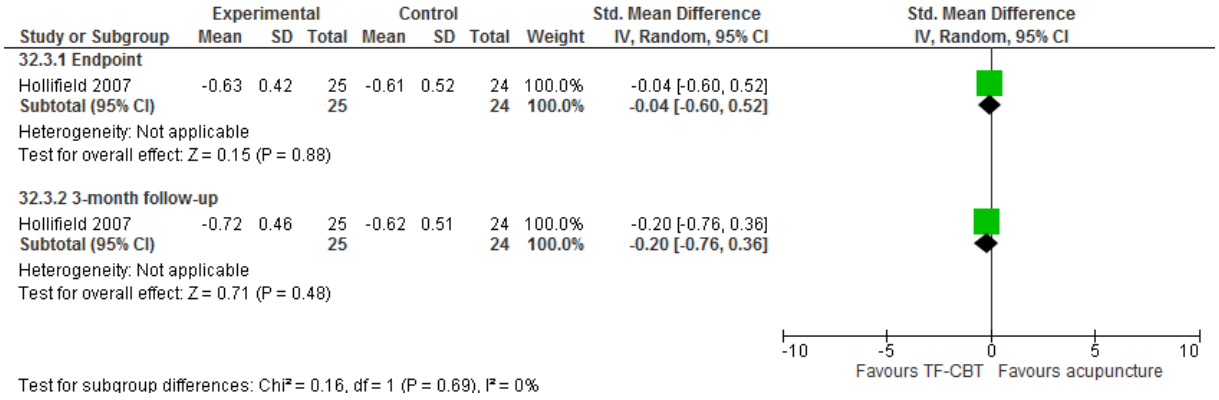


Figure 287: Trauma-focused CBT versus acupuncture for delayed treatment (>3 months) of clinically important symptoms/PTSD: Anxiety symptoms (HSCL-25; Anxiety, change score); unclear multiplicity of index trauma

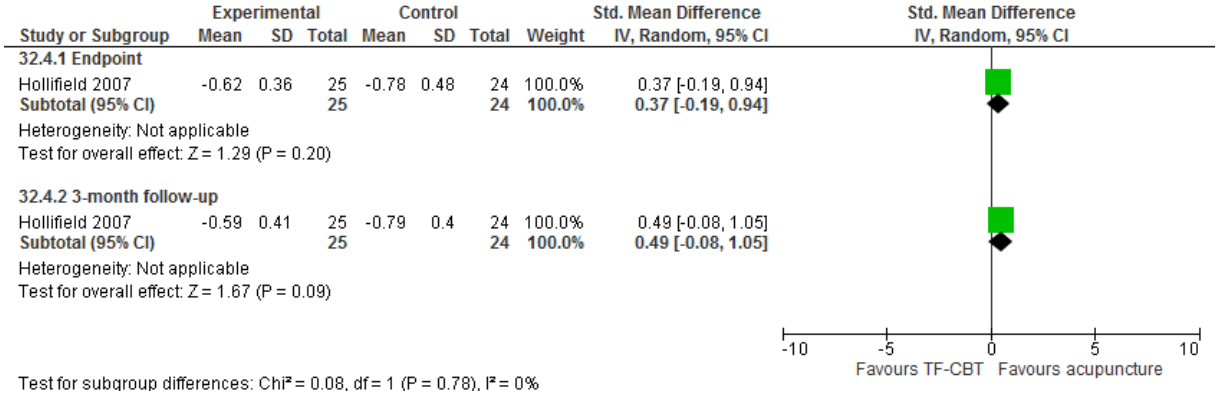


Figure 288: Trauma-focused CBT versus acupuncture for delayed treatment (>3 months) of clinically important symptoms/PTSD: Functional impairment (SDS change score); unclear multiplicity of index trauma

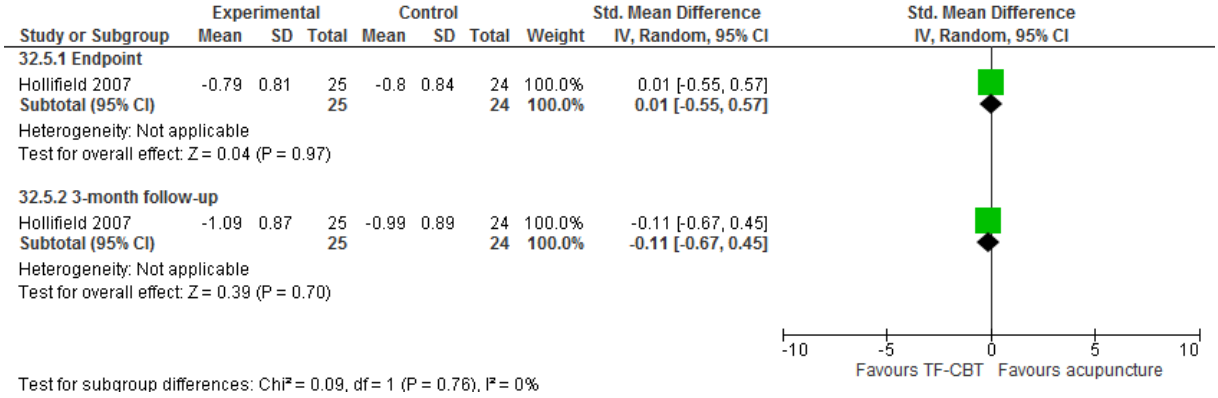


Figure 289: Trauma-focused CBT versus acupuncture for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)

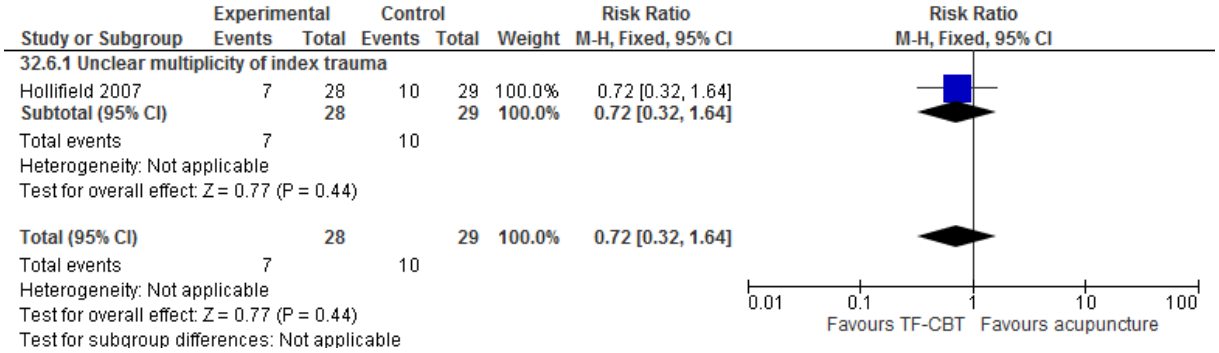


Figure 290: Trauma-focused CBT versus SSRIs for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated at endpoint (HTQ/PDS change score)

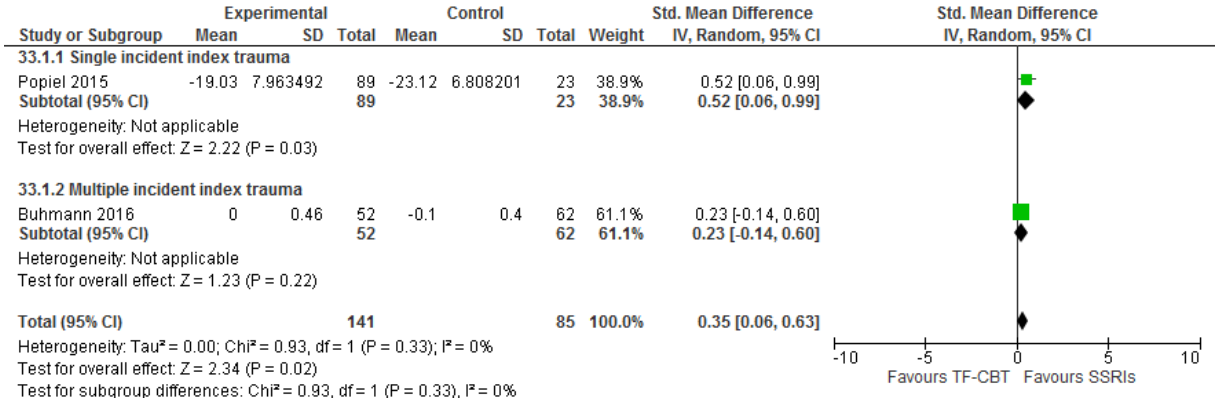


Figure 291: Trauma-focused CBT versus SSRIs for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated at 1-year follow-up (PDS change score)

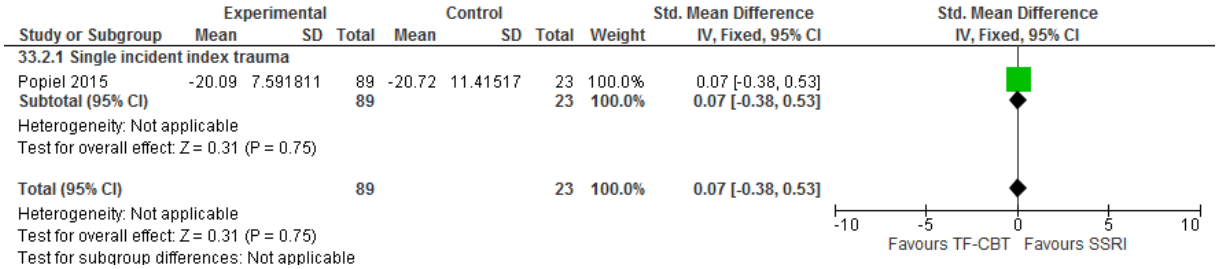


Figure 292: Trauma-focused CBT versus SSRIs for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated (PSS-I/SI-PTSD change score)

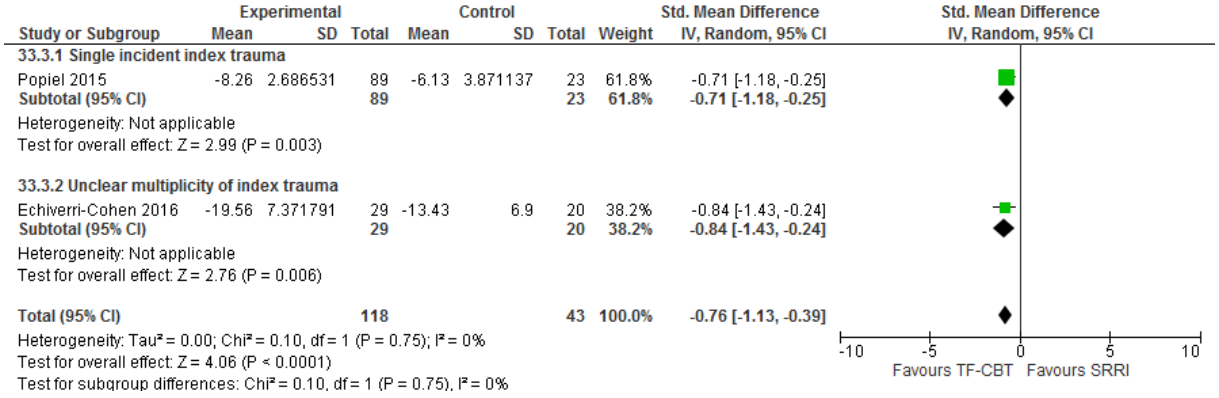


Figure 293: Trauma-focused CBT versus SSRIs for delayed treatment (>3 months) of clinically important symptoms/PTSD: Remission (number of people no longer meeting diagnostic criteria for PTSD)

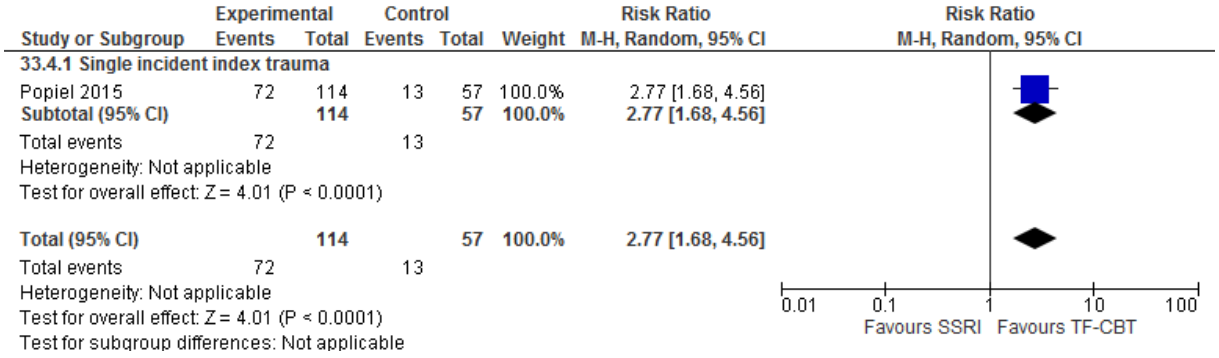


Figure 294: Trauma-focused CBT versus SSRIs for delayed treatment (>3 months) of clinically important symptoms/PTSD: Dissociative symptoms (DES change score)

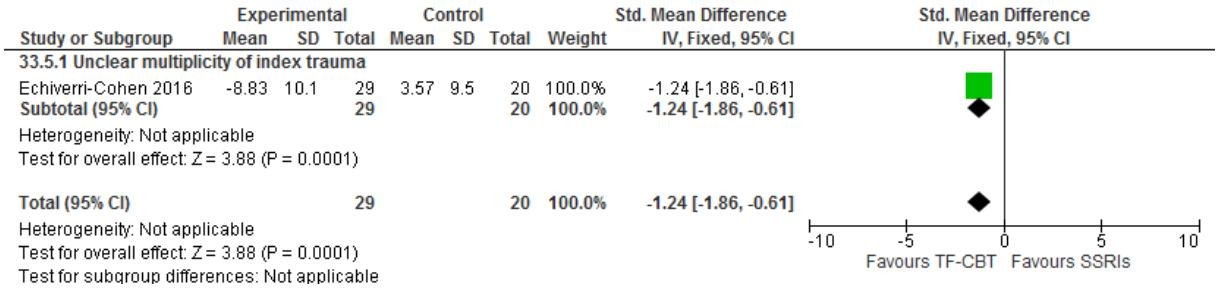


Figure 295: Trauma-focused CBT versus SSRIs for delayed treatment (>3 months) of clinically important symptoms/PTSD: Anxiety symptoms at endpoint (HAM-A/STAI State change score)

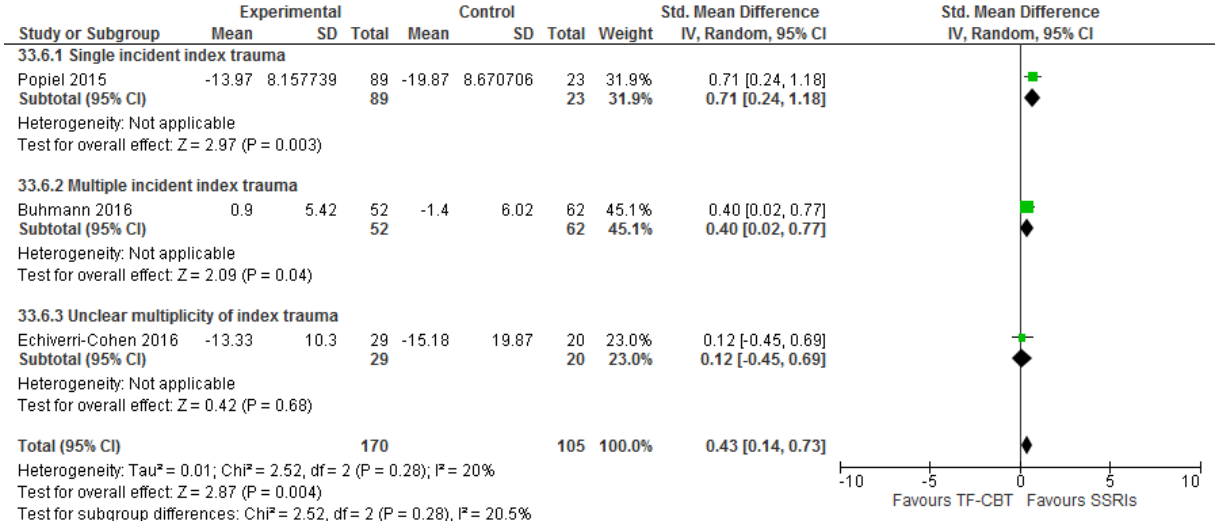


Figure 296: Trauma-focused CBT versus SSRIs for delayed treatment (>3 months) of clinically important symptoms/PTSD: Anxiety symptoms at 1-year follow-up (STAI State change score)

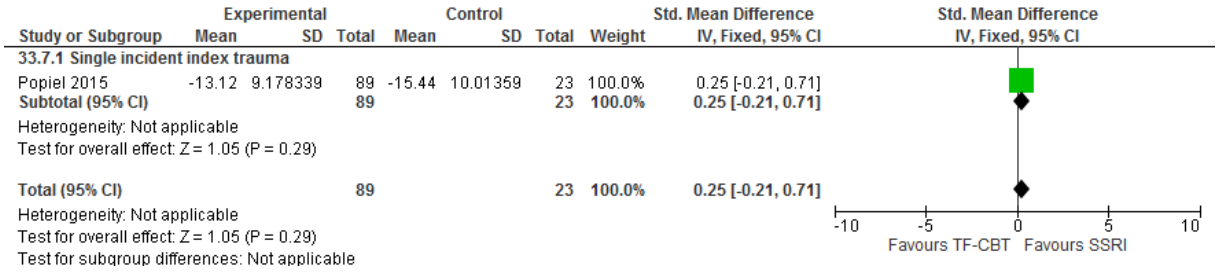


Figure 297: Trauma-focused CBT versus SSRIs for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms at endpoint (HAMD/BDI/BDI-II change score)

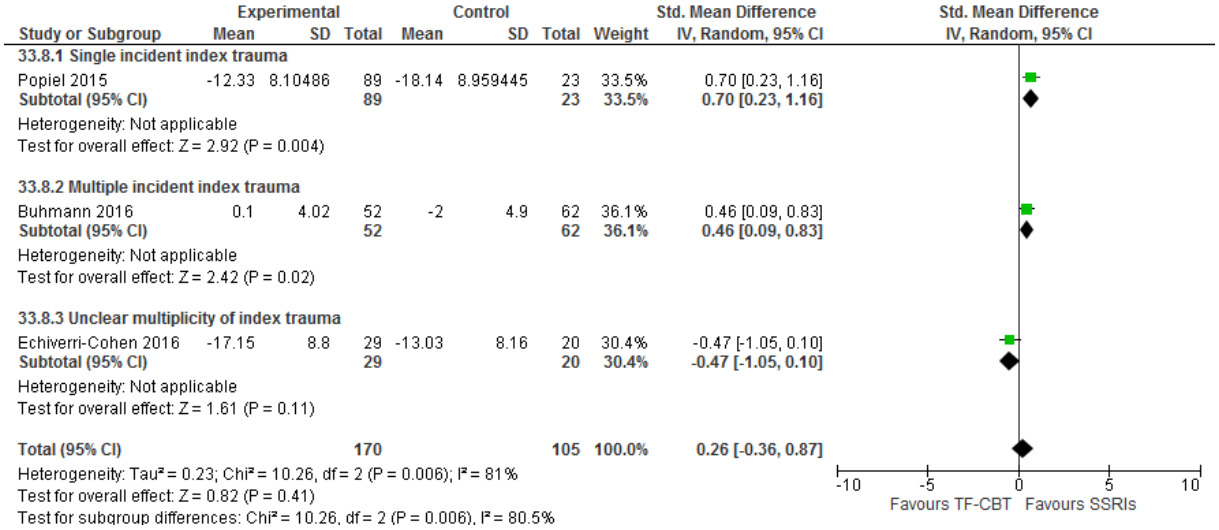


Figure 298: Trauma-focused CBT versus SSRIs for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms at 1-year follow-up (BDI-II change score)

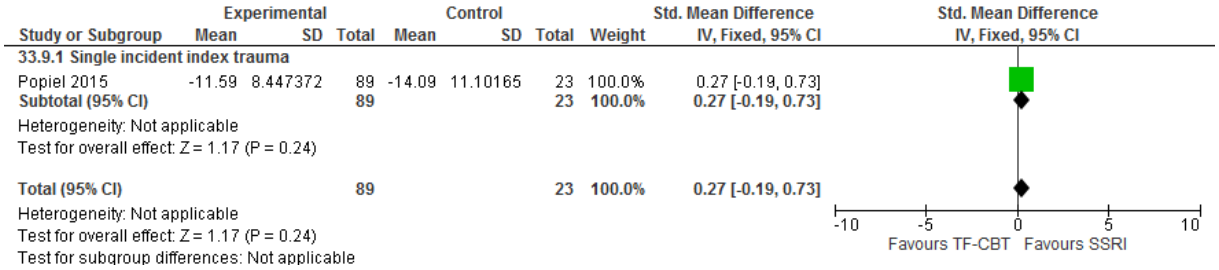


Figure 299: Trauma-focused CBT versus SSRIs for delayed treatment (>3 months) of clinically important symptoms/PTSD: Functional impairment (SDS change score)

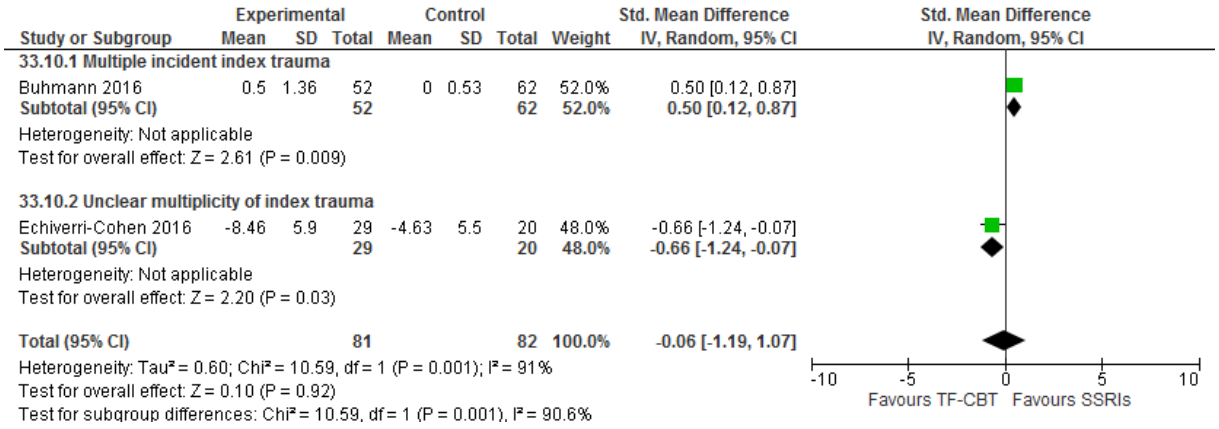


Figure 300: Trauma-focused CBT versus SSRIs for delayed treatment (>3 months) of clinically important symptoms/PTSD: Quality of life (WHO-5 change score)

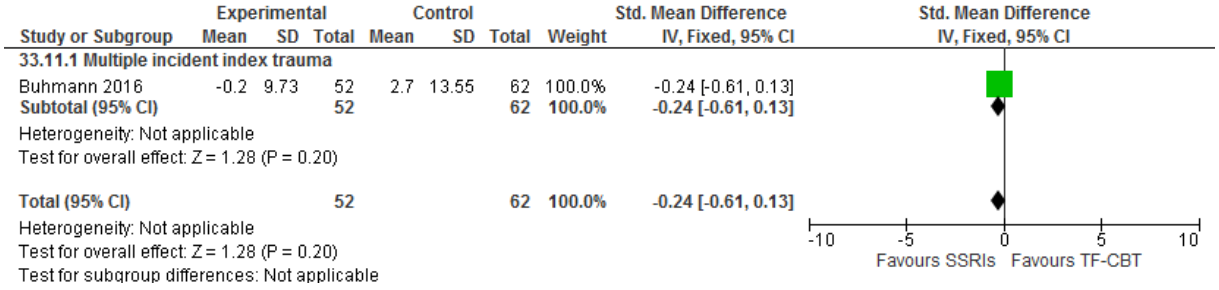


Figure 301: Trauma-focused CBT versus SSRIs for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)

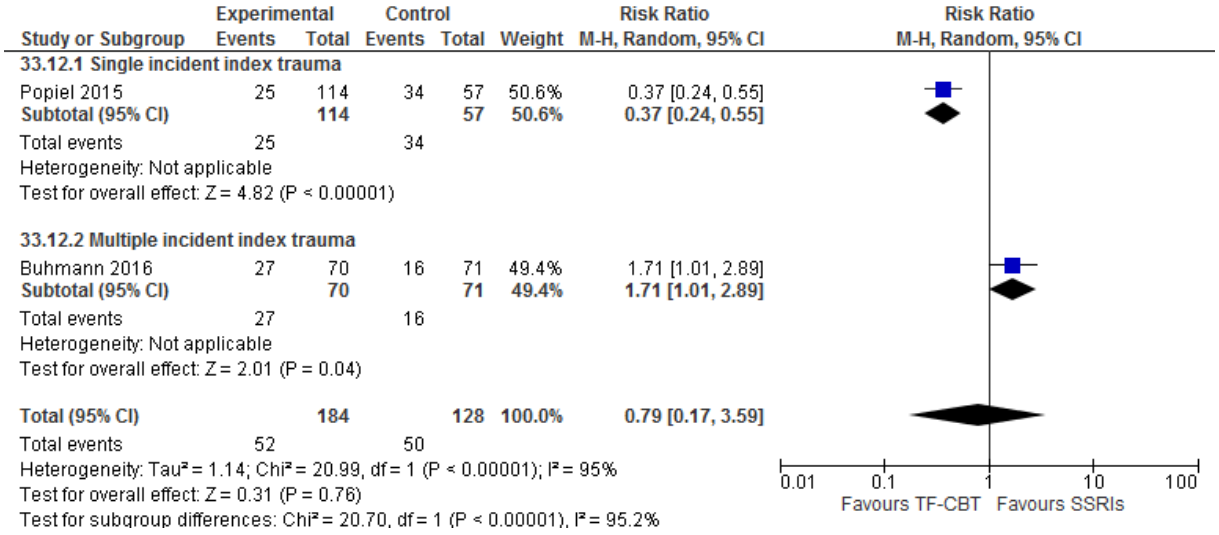


Figure 302: Trauma-focused CBT + SSRIs versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated (HTQ change score)

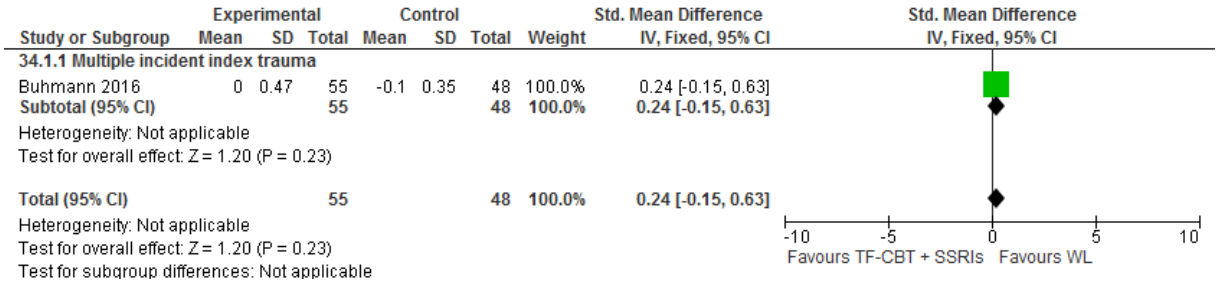


Figure 303: Trauma-focused CBT + SSRIs versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Anxiety symptoms (HAM-A change score)

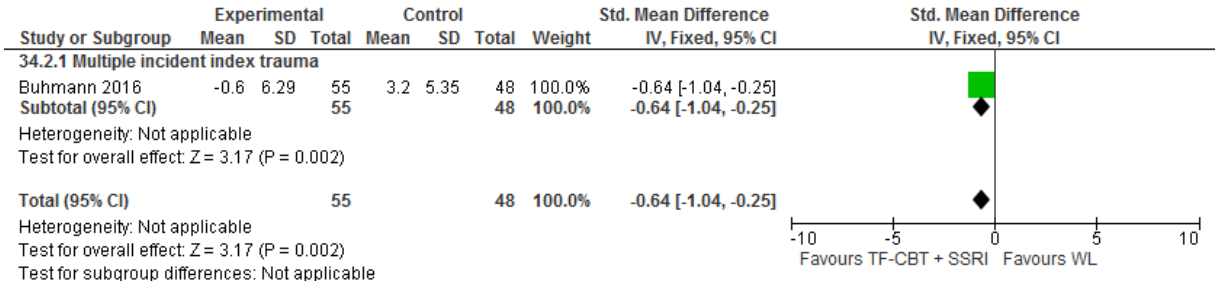


Figure 304: Trauma-focused CBT + SSRIs versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms (HAMD change score)

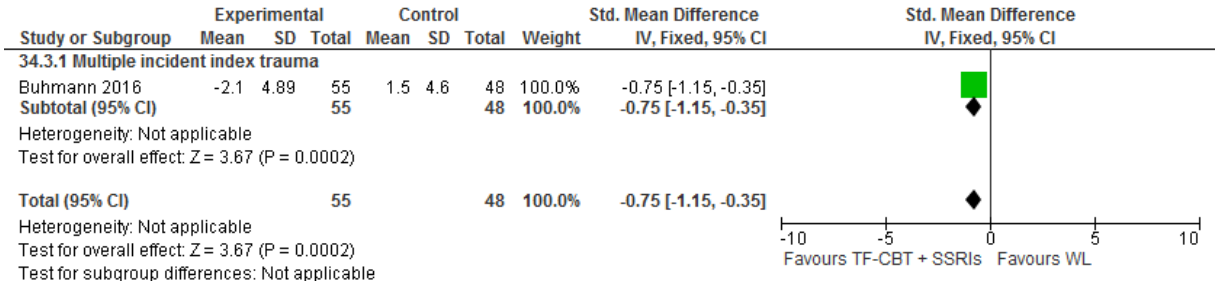


Figure 305: Trauma-focused CBT + SSRIs versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Functional impairment (SDS change score)

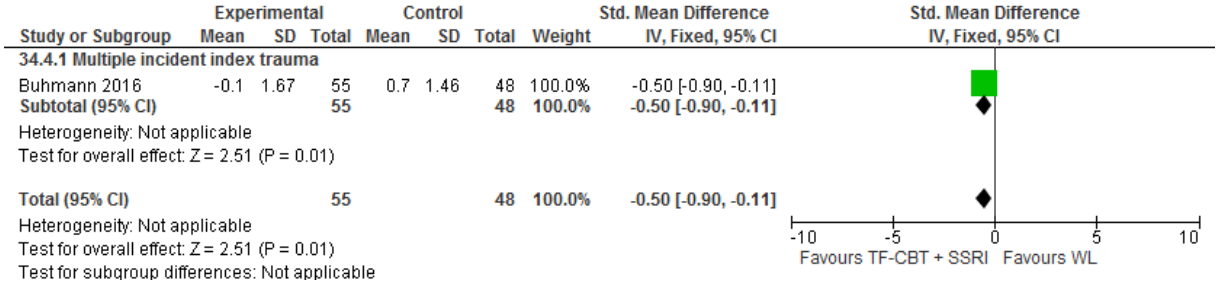


Figure 306: Trauma-focused CBT + SSRIs versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Quality of life (WHO-5 change score)

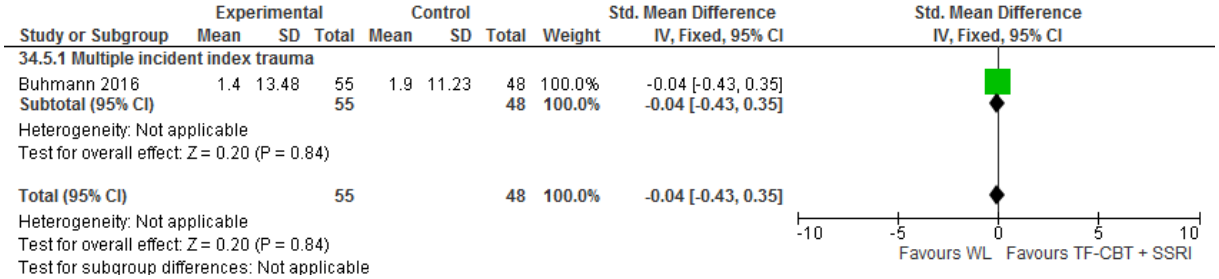
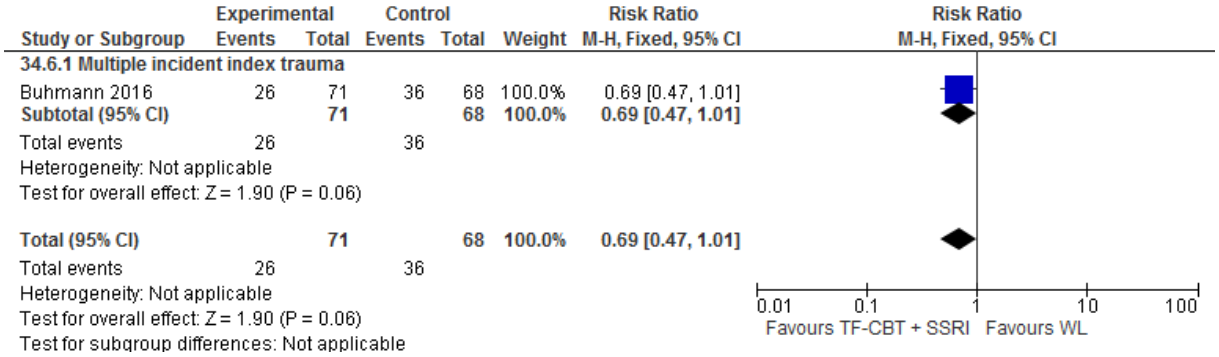


Figure 307: Trauma-focused CBT + SSRIs versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)



Non-trauma-focused CBP

Figure 308: Non-trauma-focused CBT (±TAU) versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-report (PCL/DTS/PDS/PSS-SR/MPSS-SR change score)

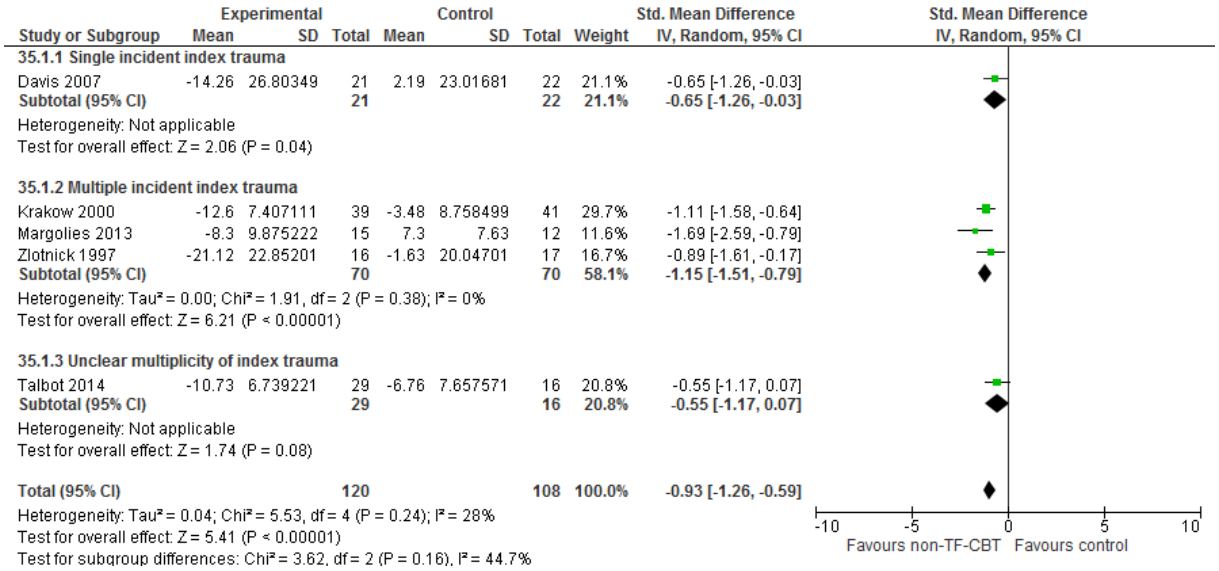


Figure 309: Non-trauma-focused CBT (±TAU) versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated at endpoint (CAPS change score)

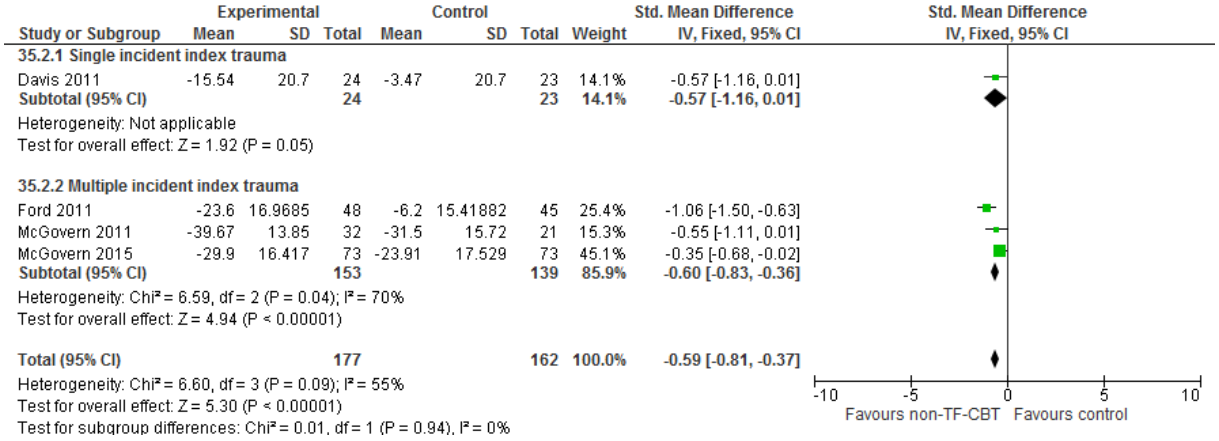


Figure 310: Non-trauma-focused CBT (±TAU) versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated at 3-month follow-up (CAPS change score)

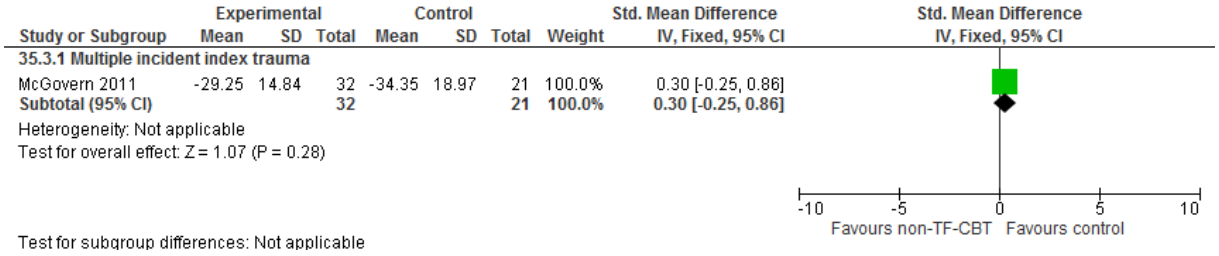


Figure 311: Non-trauma-focused CBT (±TAU) versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Remission at endpoint (number of people no longer meeting diagnostic criteria/above threshold on a scale for PTSD)

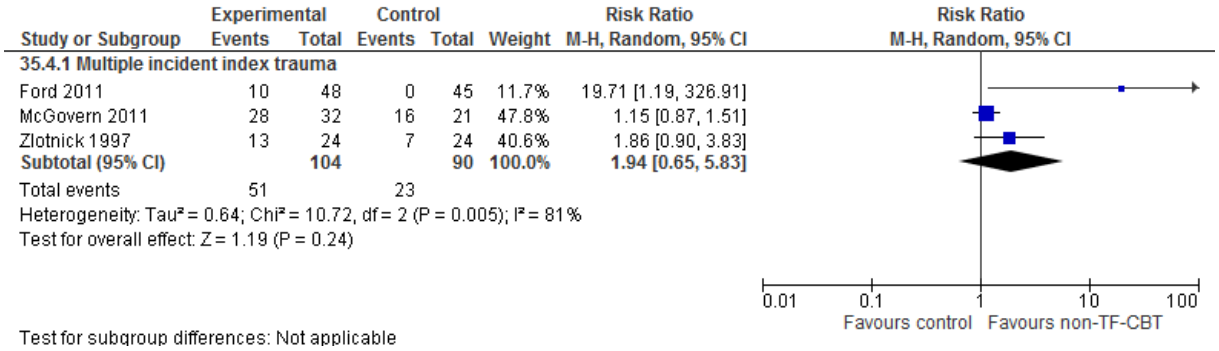


Figure 312: Non-trauma-focused CBT (±TAU) versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Remission at 3-month follow-up (number of people no longer meeting diagnostic criteria)

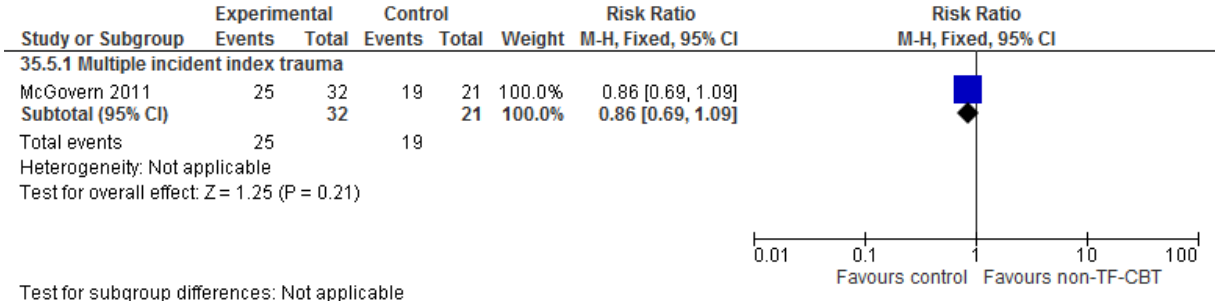


Figure 313: Non-trauma-focused CBT (±TAU) versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Dissociative symptoms (DES; change score)

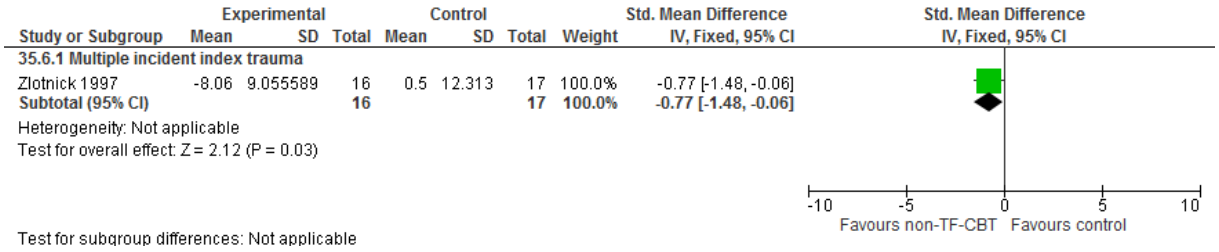


Figure 314: Non-trauma-focused CBT (±TAU) versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Sleeping difficulties (ISI/SQI change score)

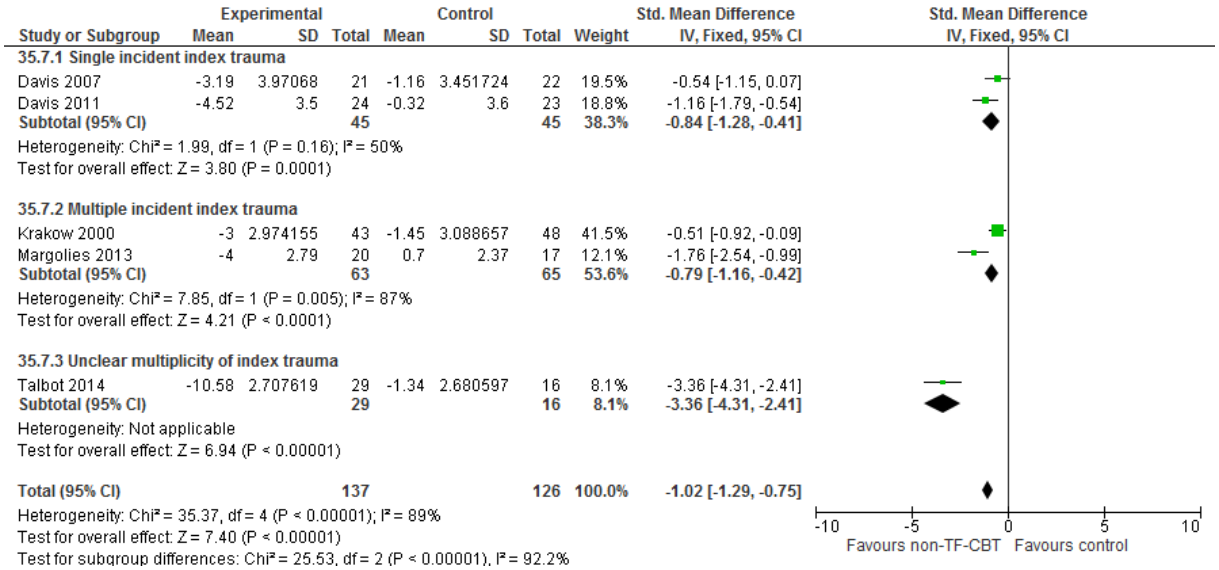


Figure 315: Non-trauma-focused CBT (±TAU) versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptom at endpoint (BDI/BDI-II change score)

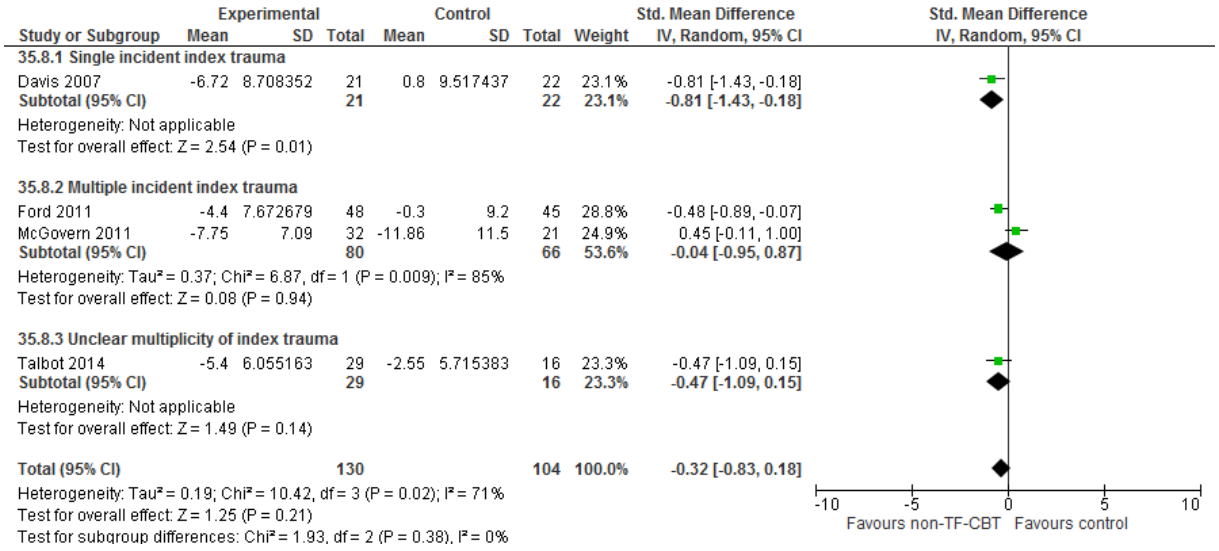


Figure 316: Non-trauma-focused CBT (±TAU) versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms at 3-month follow-up (BDI change score)

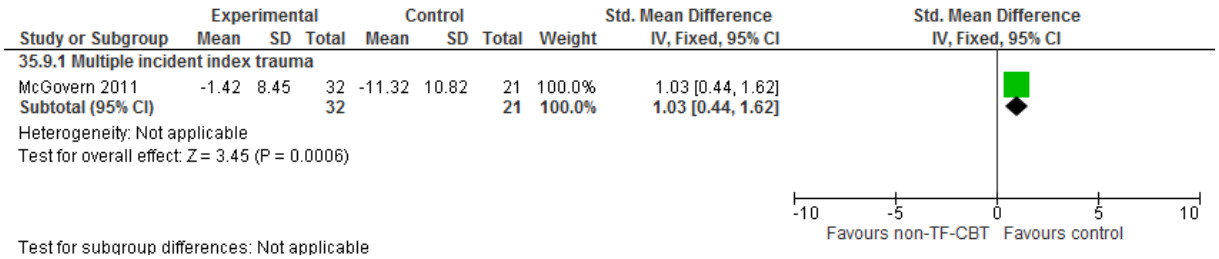


Figure 317: Non-trauma-focused CBT (±TAU) versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Alcohol use (TLFB Number of drinking days; change score); Multiple incident index trauma

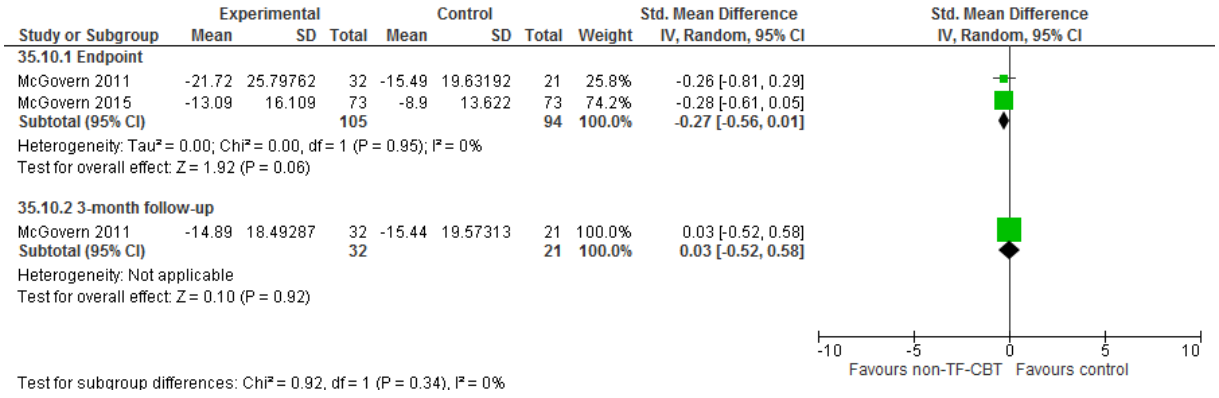


Figure 318: Non-trauma-focused CBT (±TAU) versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Drug use (TLFB Number of drug use days; change score); Multiple incident index trauma

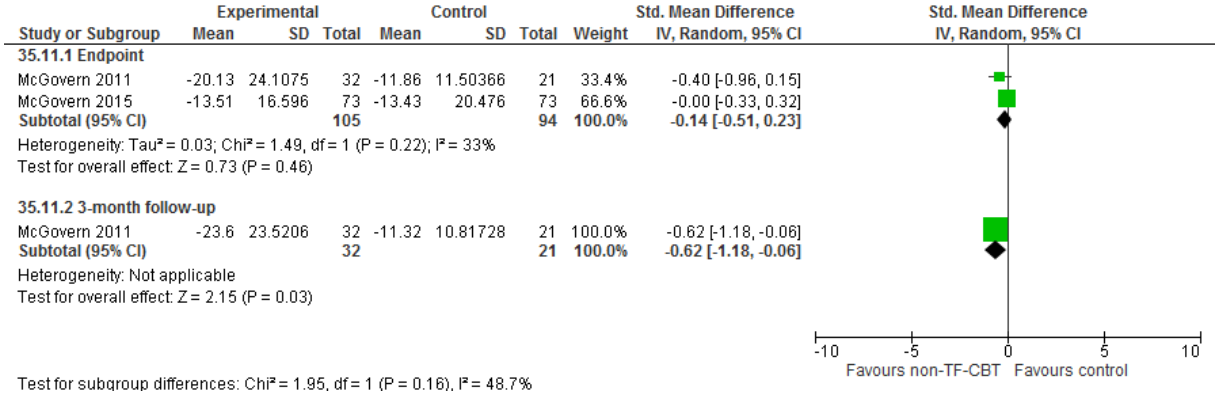
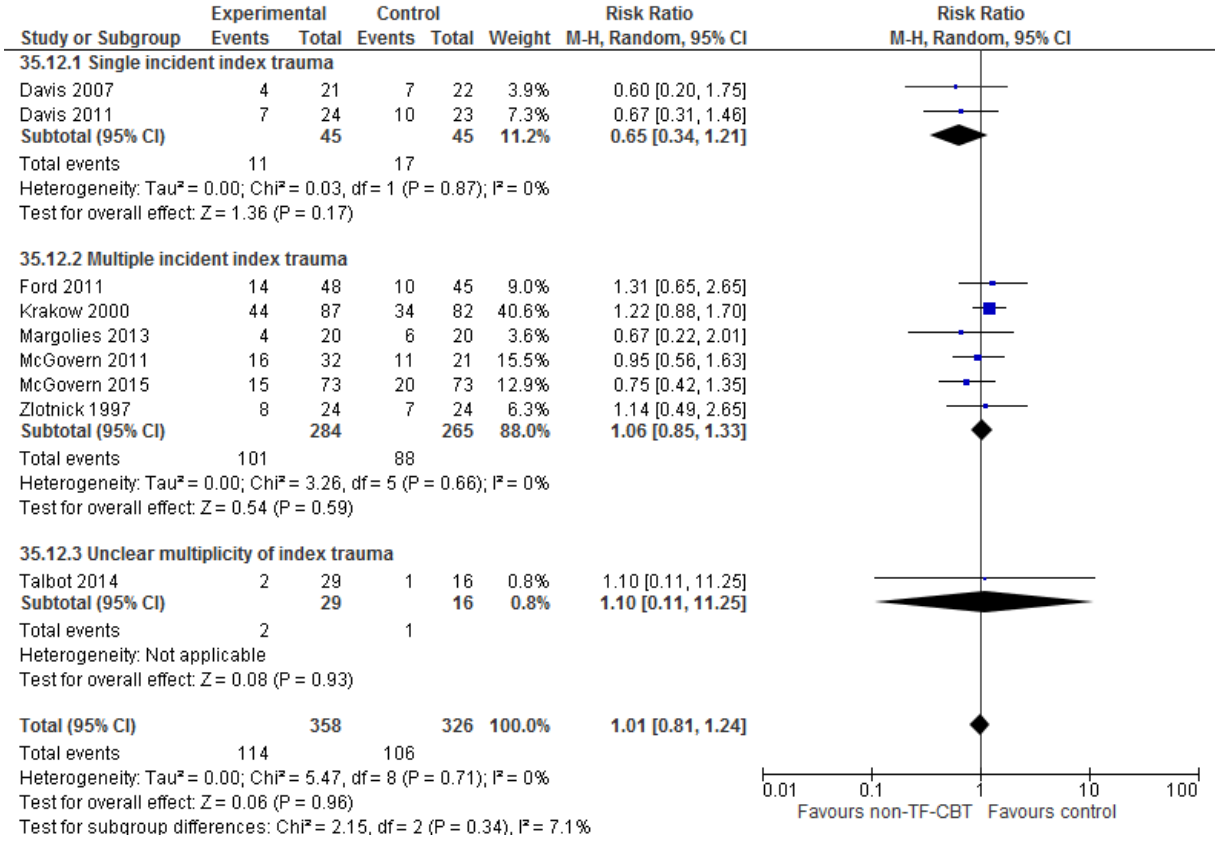


Figure 319: Non-trauma-focused CBT (±TAU) versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)



Sub-analysis by specific intervention: Non-trauma-focused CBT (±TAU) versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD

Figure 320: Non-trauma-focused CBT (±TAU) versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-report (PCL/DTS/PDS/PSS-SR/MPSS-SR change score)

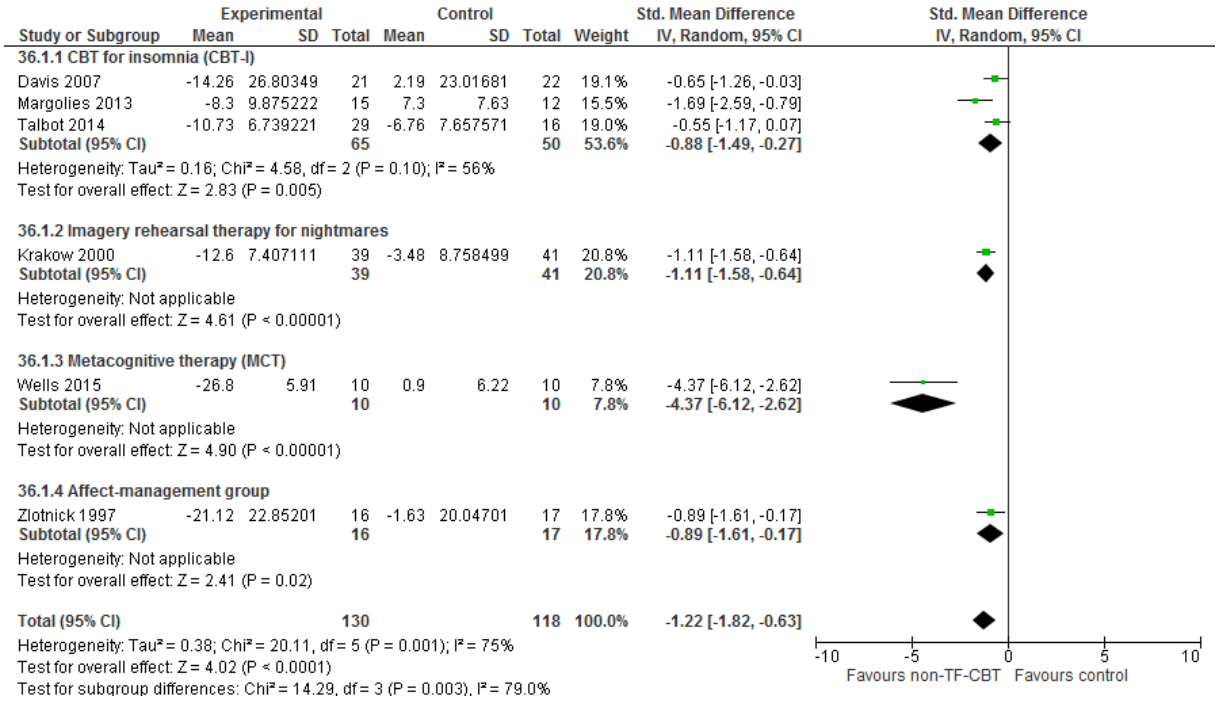


Figure 321: Non-trauma-focused CBT (±TAU) versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated at endpoint (CAPS change score)

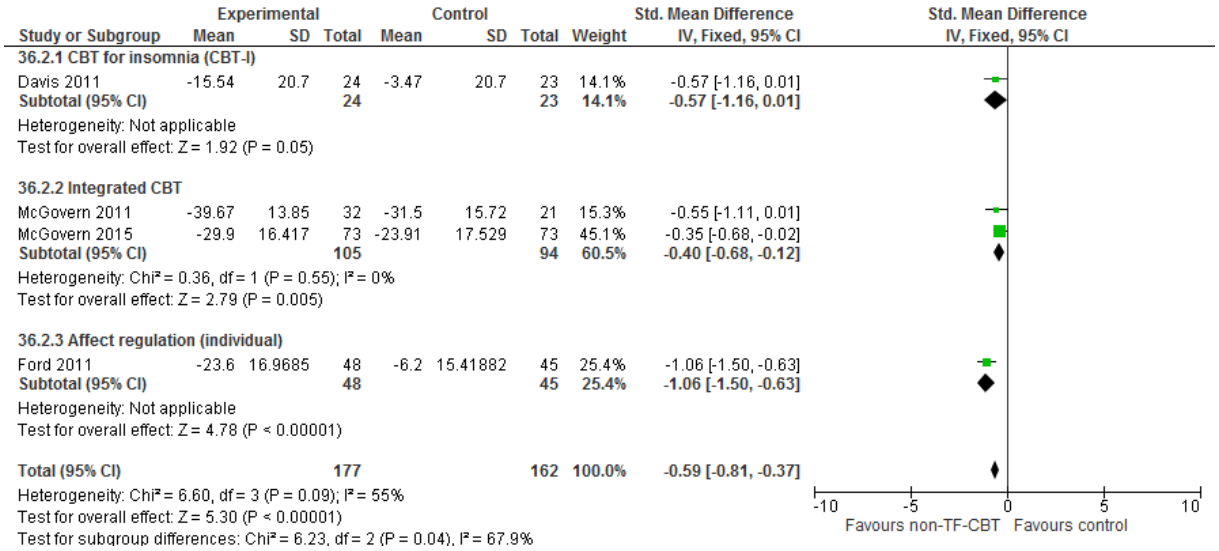
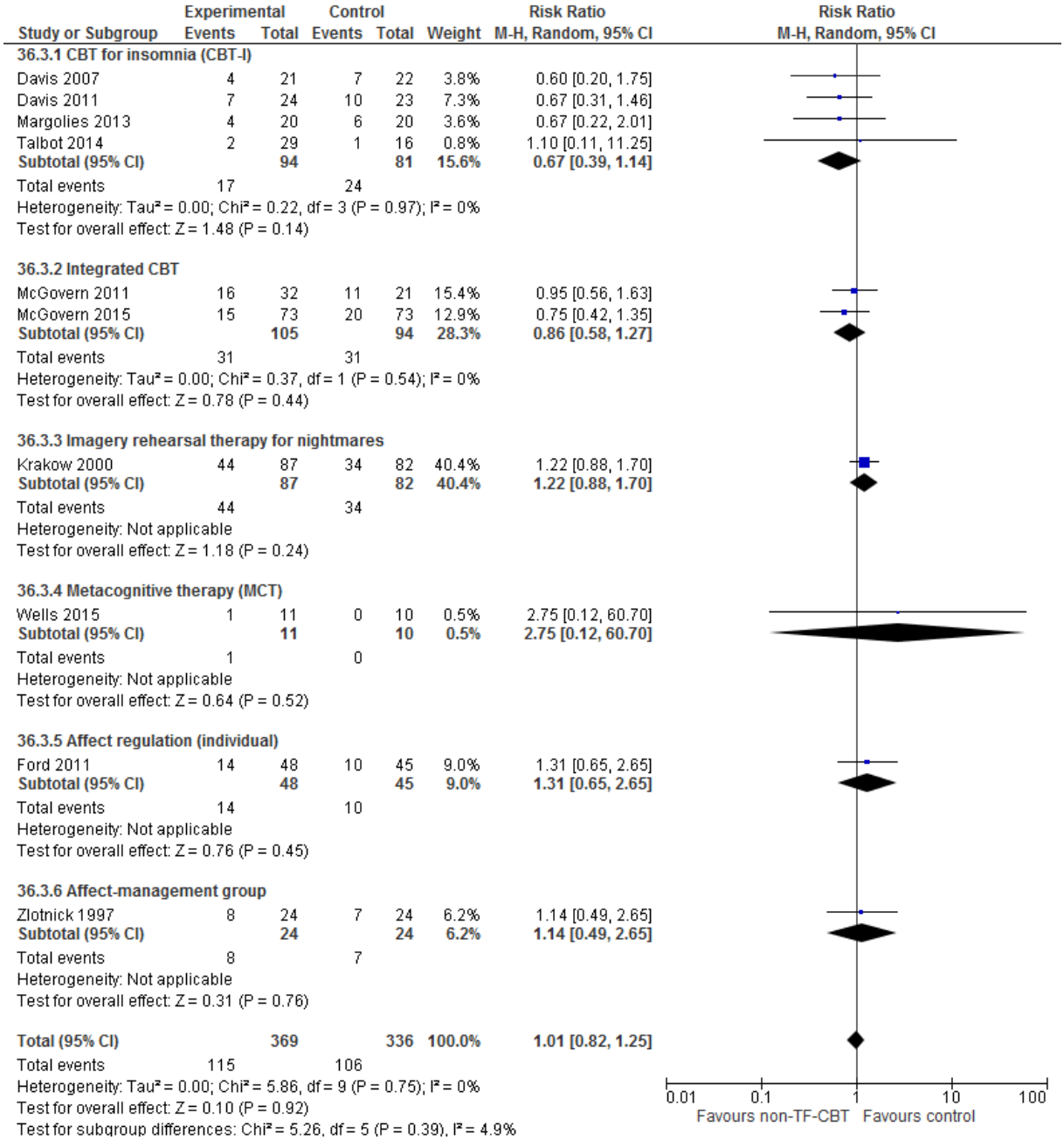


Figure 322: Non-trauma-focused CBT (±TAU) versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)



Sub-analysis by diagnostic status at baseline:

Figure 323: Non-trauma-focused CBT (±TAU) versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-report (PCL/DTS/PDS/PSS-SR/MPSS-SR change score)

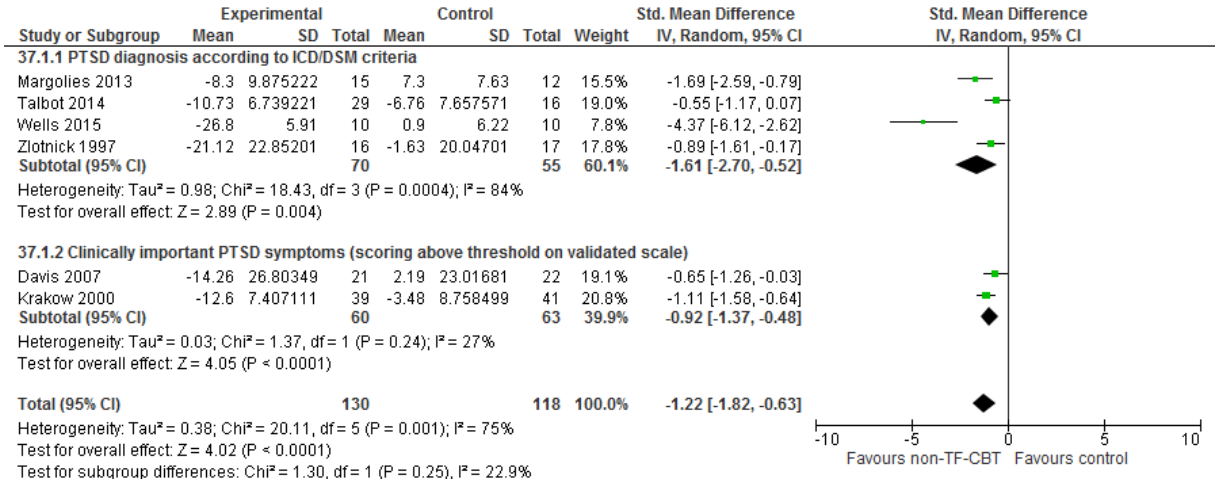


Figure 324: Non-trauma-focused CBT (±TAU) versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated at endpoint (CAPS change score)

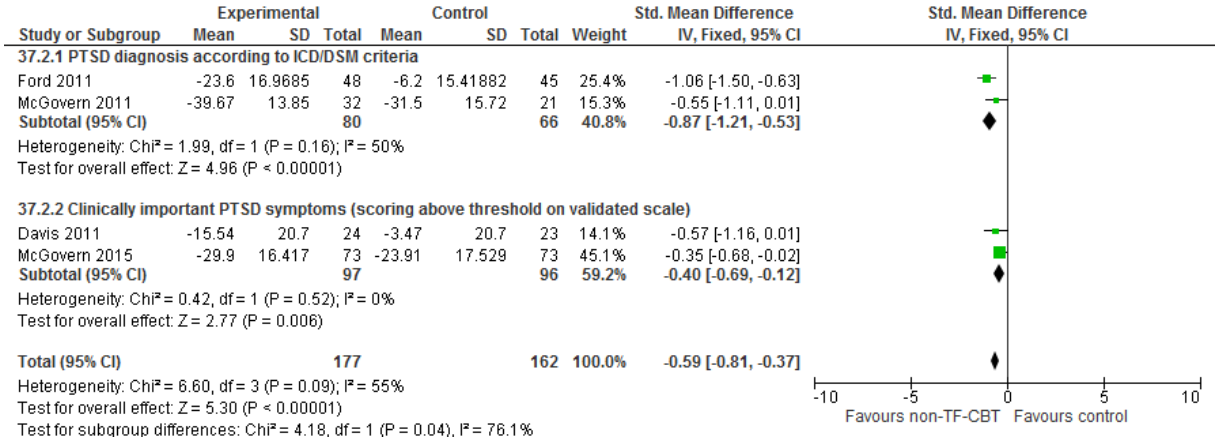
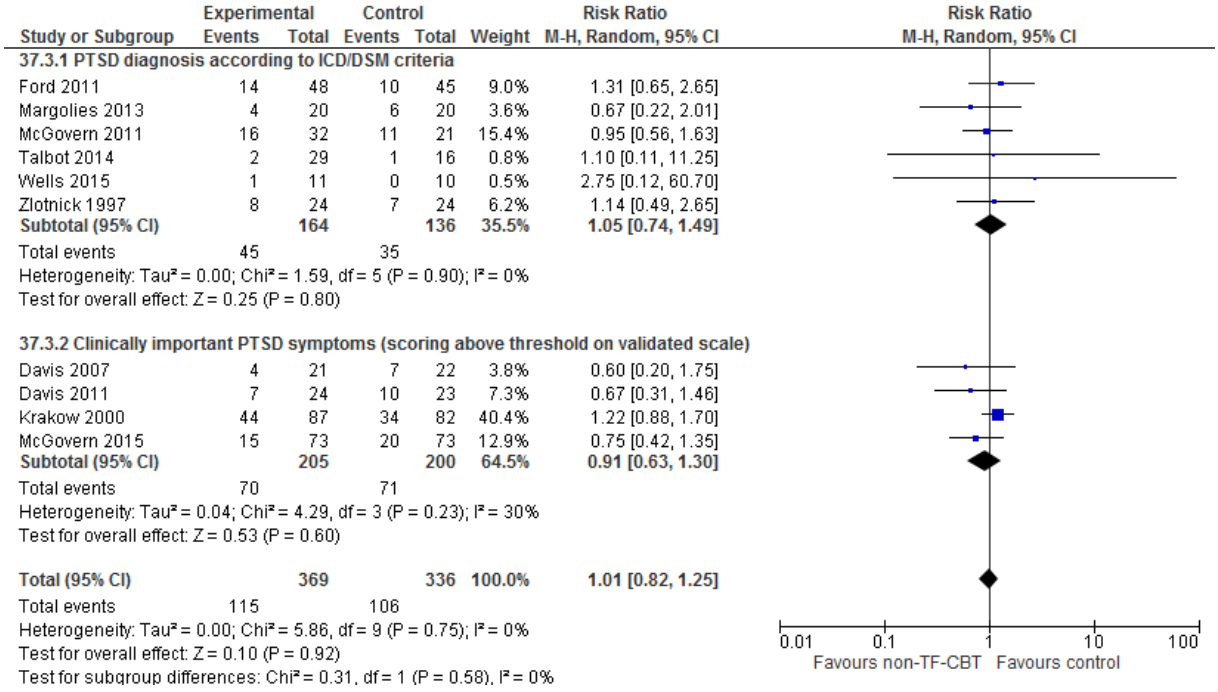


Figure 325: Non-trauma-focused CBT (±TAU) versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)



Sub-analysis by trauma type:

Figure 326: Non-trauma-focused CBT (±TAU) versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-report (PCL/DTS/PDS/PSS-SR/MPSS-SR change score)

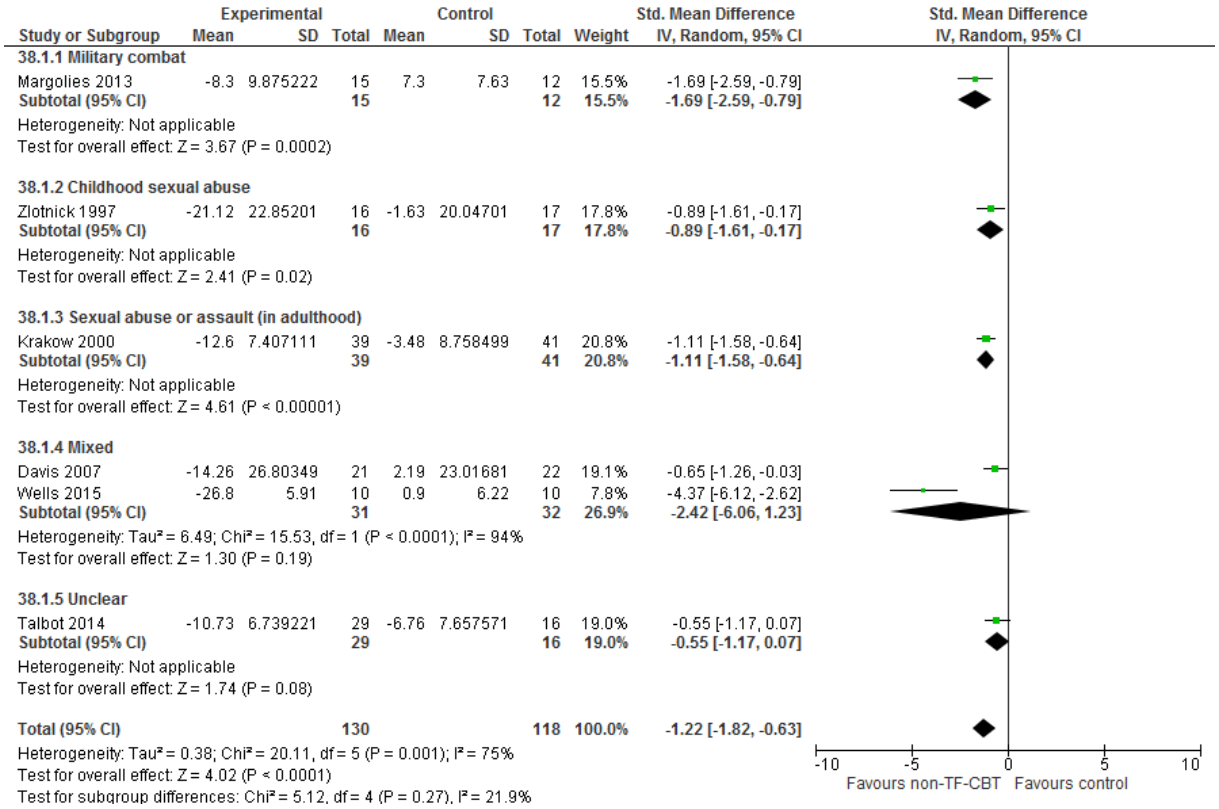


Figure 327: Non-trauma-focused CBT (±TAU) versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated at endpoint (CAPS change score)

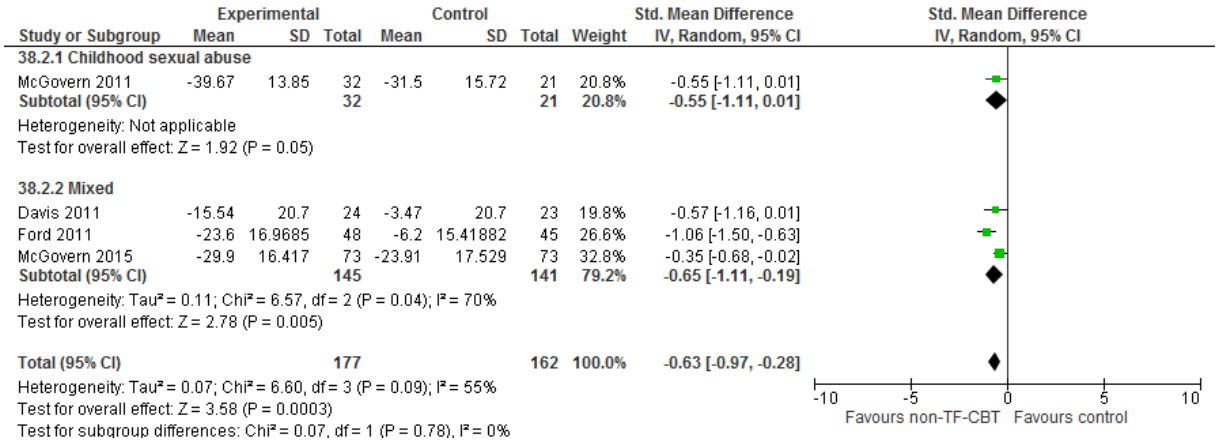


Figure 328: Non-trauma-focused CBT (±TAU) versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)

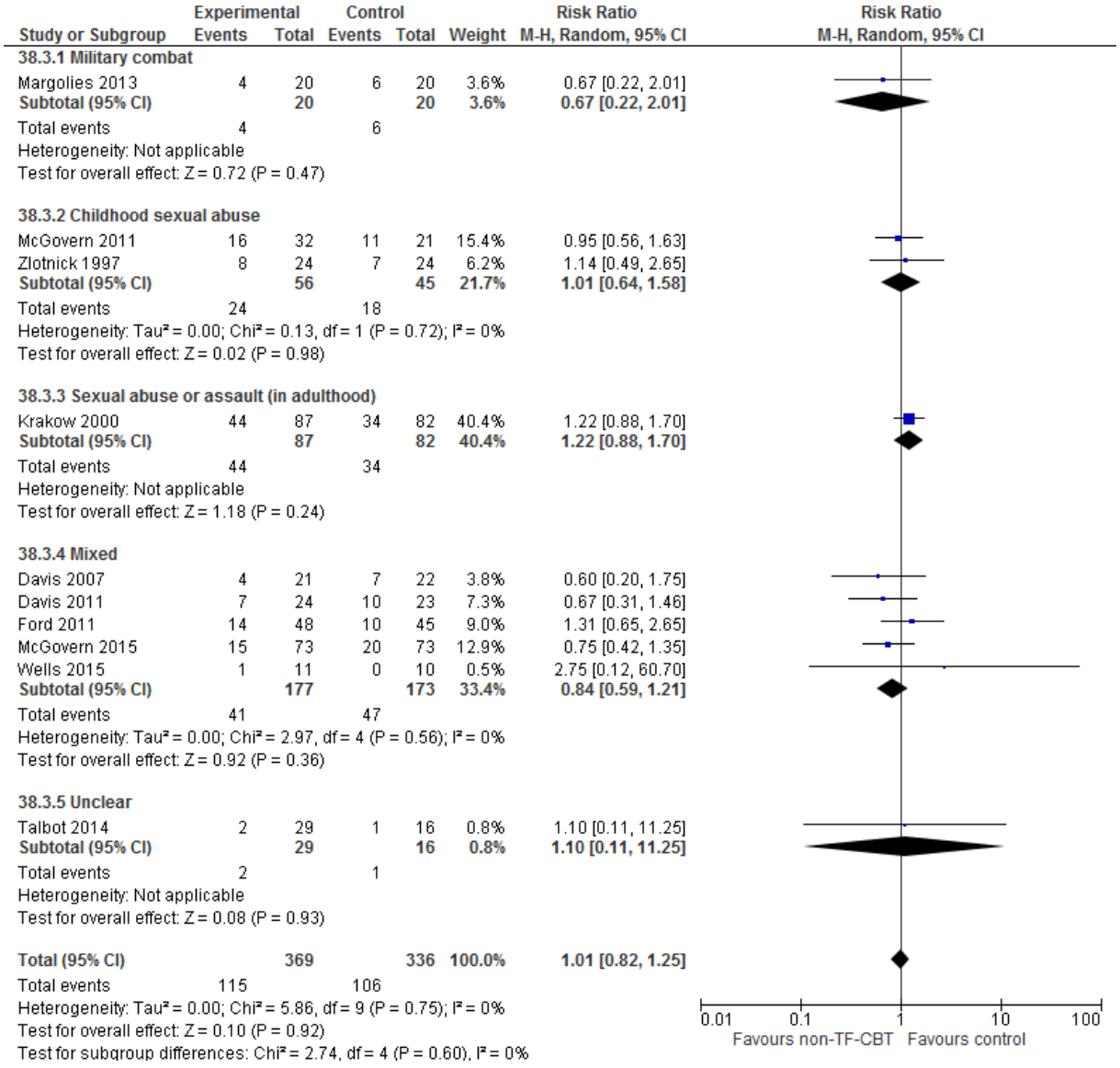


Figure 329: Non-trauma-focused CBT (±TAU) versus attention-placebo (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-report at endpoint (PCL/PSS-SR change score)

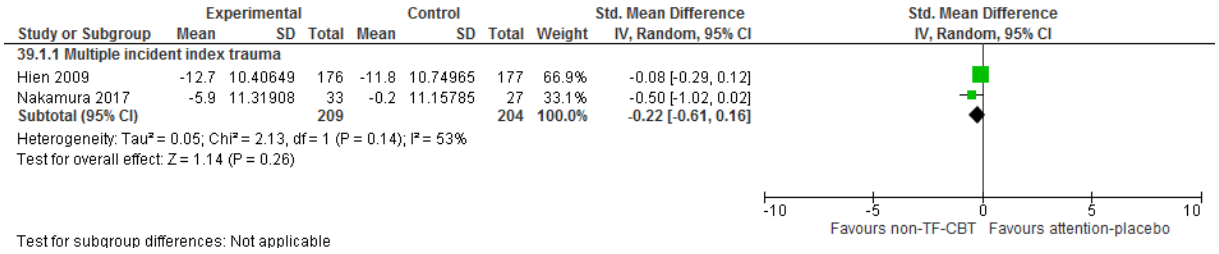


Figure 330: Non-trauma-focused CBT (±TAU) versus attention-placebo (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-report at 3-month follow-up (PCL change score)

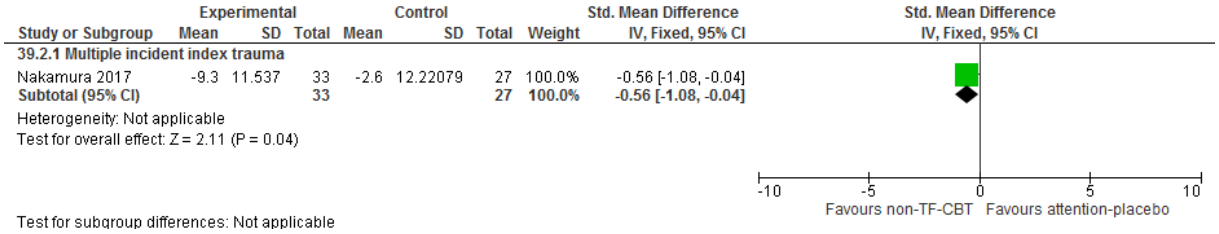


Figure 331: Non-trauma-focused CBT (±TAU) versus attention-placebo (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated (CAPS change score)

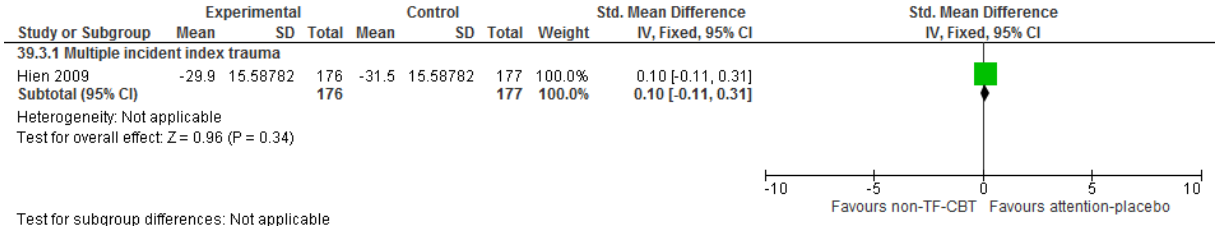


Figure 332: Non-trauma-focused CBT (±TAU) versus attention-placebo (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD:

Response (number of people showing clinically significant improvement, based on reliable change indices [RCI])

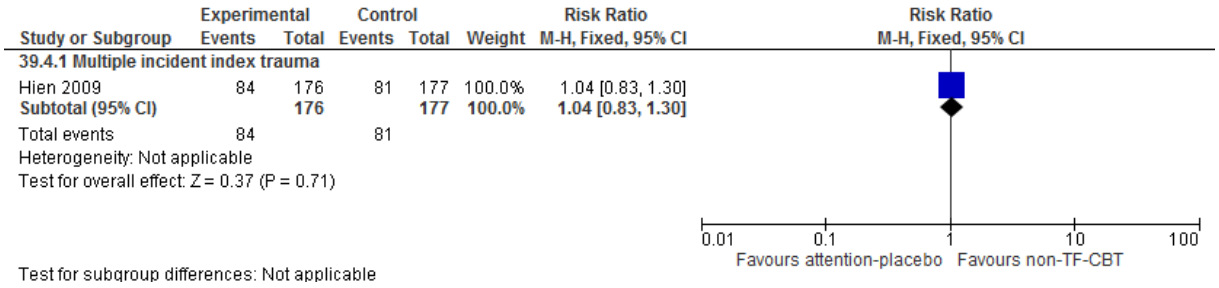


Figure 333: Non-trauma-focused CBT (±TAU) versus attention-placebo (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms (CES-D change score); Multiple incident index trauma

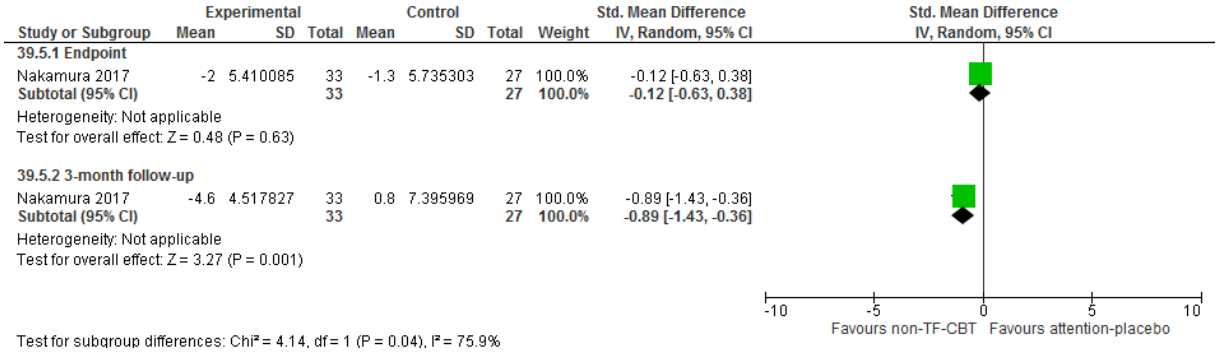


Figure 334: Non-trauma-focused CBT (±TAU) versus attention-placebo (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Drug use (Substance use Inventory: Number of days participants used drugs during the past 7 days; change score)

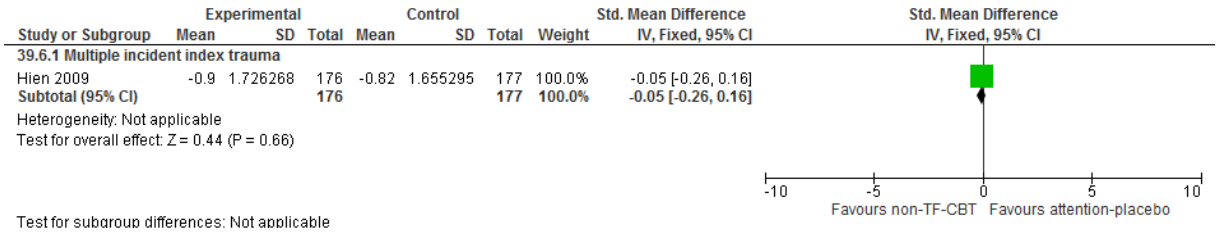


Figure 335: Non-trauma-focused CBT (±TAU) versus attention-placebo (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Quality of life at endpoint (SF-36 change score)

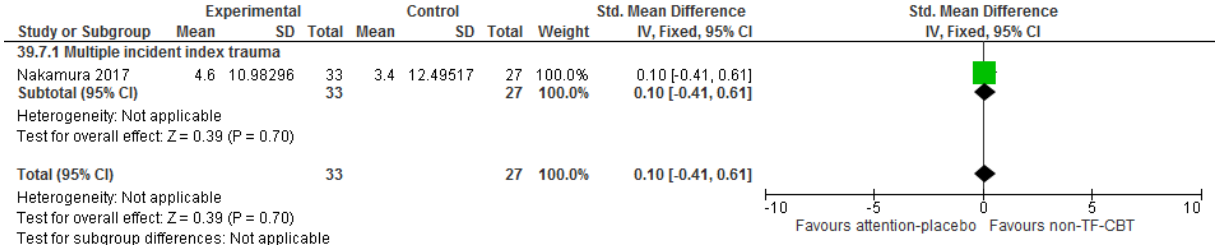


Figure 336: Non-trauma-focused CBT (±TAU) versus attention-placebo (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Quality of life at 3-month follow-up (SF-36 change score)

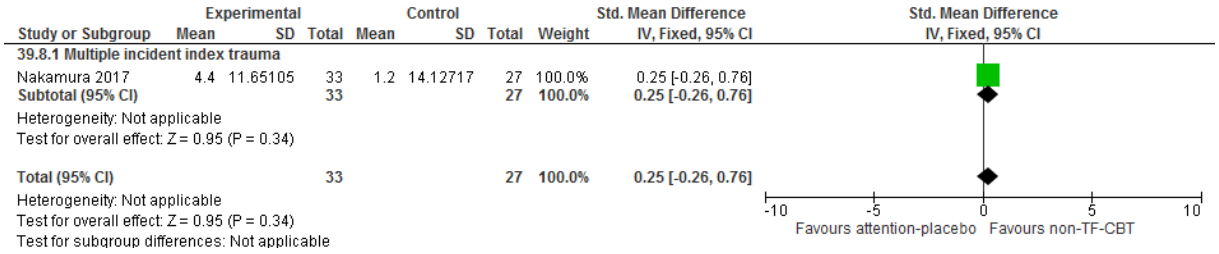


Figure 337: Non-trauma-focused CBT (±TAU) versus attention-placebo (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)

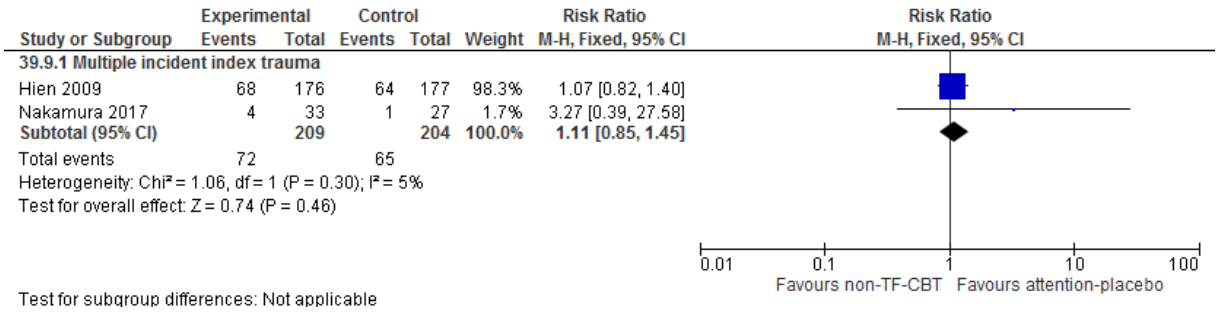


Figure 338: Non-trauma-focused CBT (+TAU) versus psychoeducational group (+TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD:

PTSD symptomatology self-report (DTS change score); Multiple incident index trauma

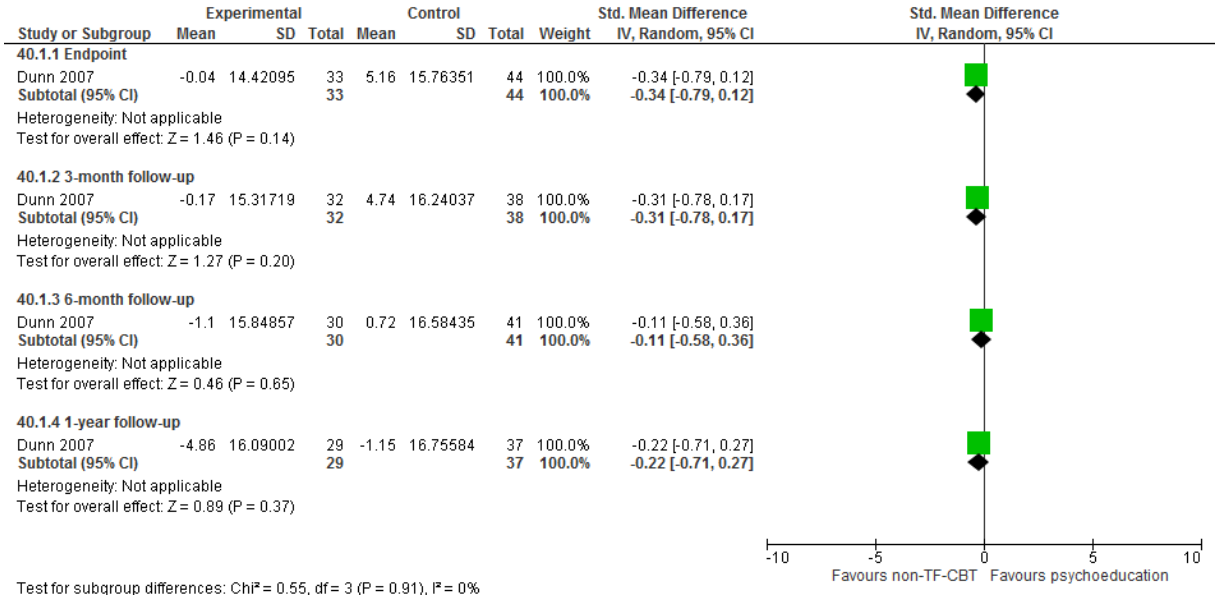


Figure 339: Non-trauma-focused CBT (+TAU) versus psychoeducational group (+TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated (CAPS change score); Multiple incident index trauma

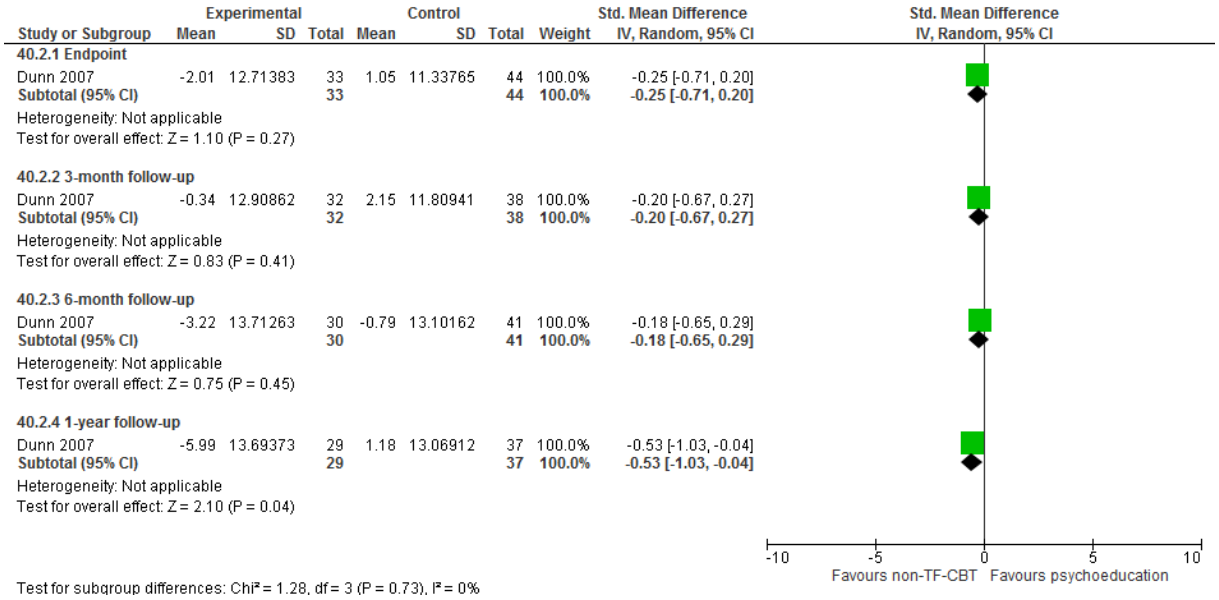


Figure 340: Non-trauma-focused CBT (+TAU) versus psychoeducational group (+TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms (HAMD change score); Multiple incident index trauma

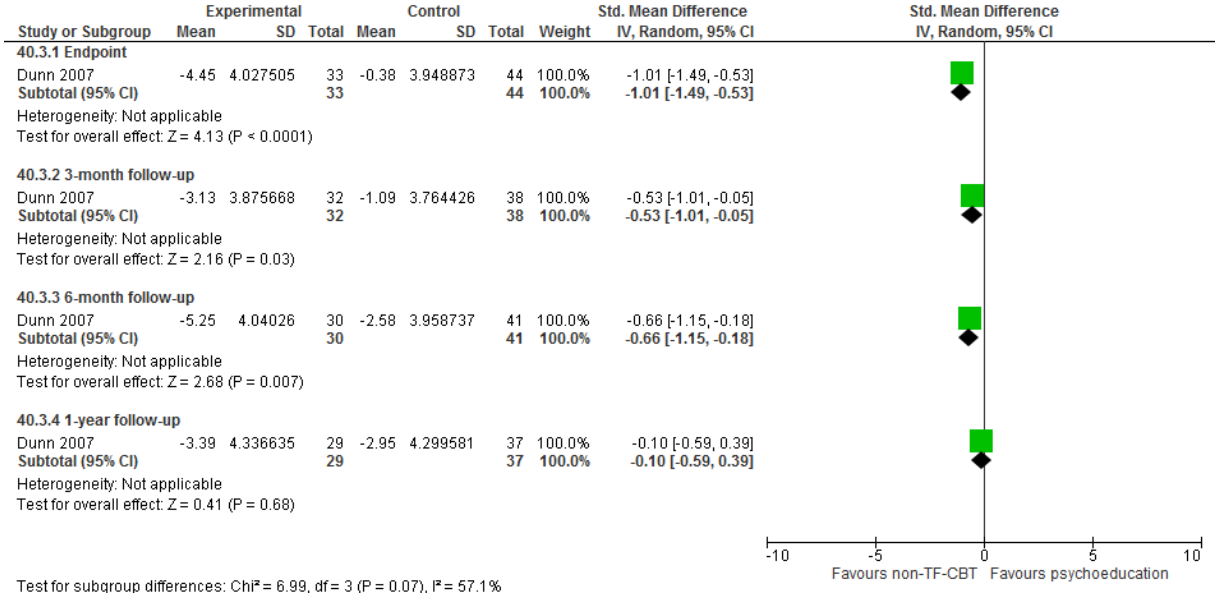


Figure 341: Non-trauma-focused CBT (+TAU) versus psychoeducational group (+TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)

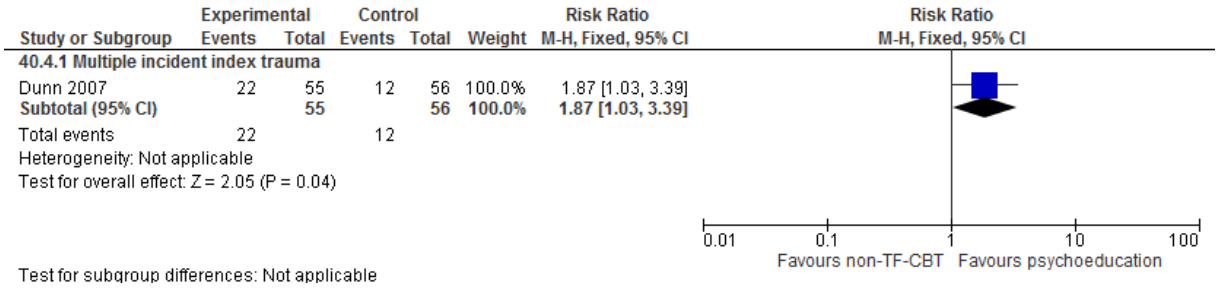


Figure 342: Non-trauma-focused CBT versus counselling for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated (PSS-I change score)

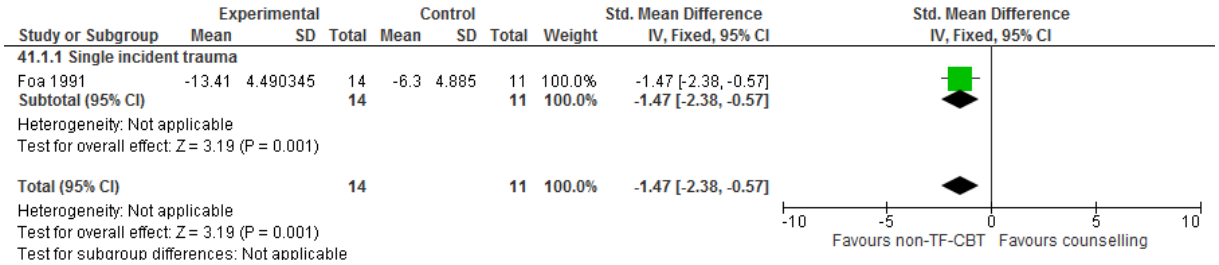


Figure 343: Non-trauma-focused CBT versus counselling for delayed treatment (>3 months) of clinically important symptoms/PTSD: Remission (number of people no longer meeting diagnostic criteria for PTSD)

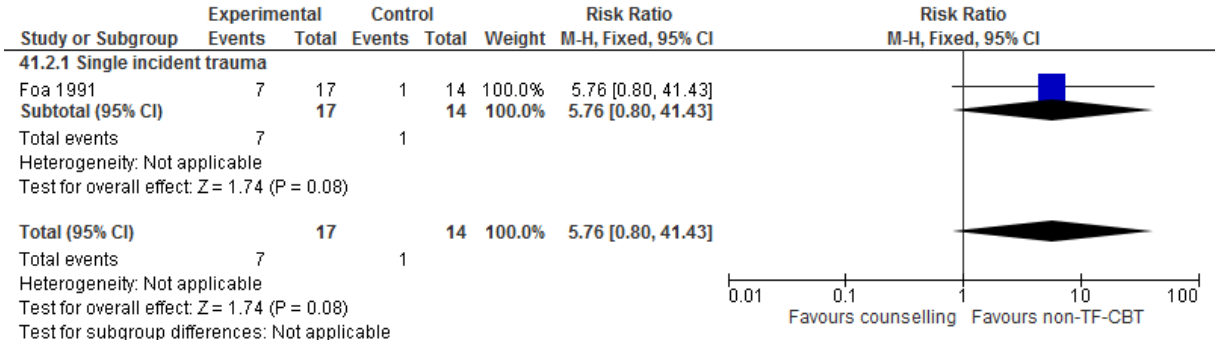


Figure 344: Non-trauma-focused CBT versus counselling for delayed treatment (>3 months) of clinically important symptoms/PTSD: Response (number of people showing clinically significant improvement based on reliable change indices [RCI] on PSS-I)

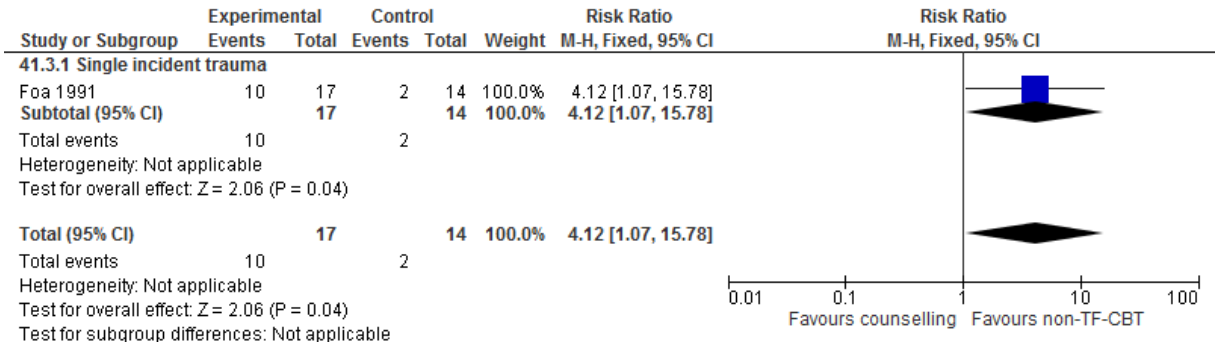


Figure 345: Non-trauma-focused CBT versus counselling for delayed treatment (>3 months) of clinically important symptoms/PTSD: Anxiety symptoms (STAI State change score)

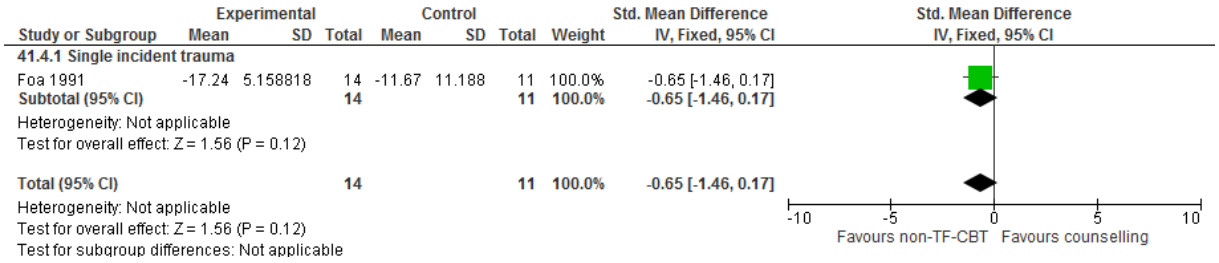


Figure 346: Non-trauma-focused CBT versus counselling for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms (BDI change score)

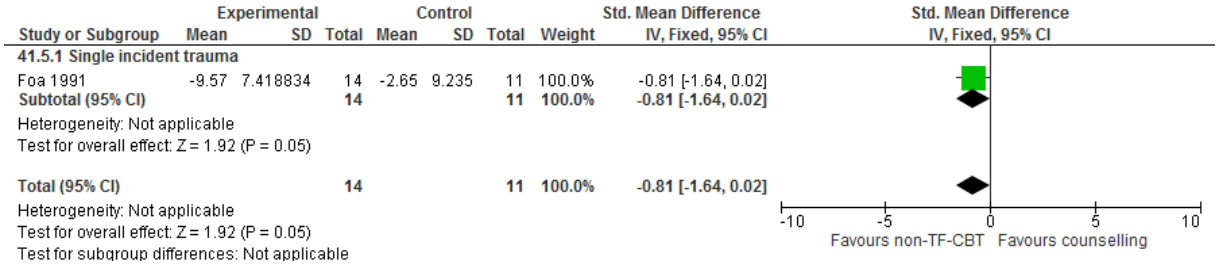


Figure 347: Non-trauma-focused CBT versus counselling for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)

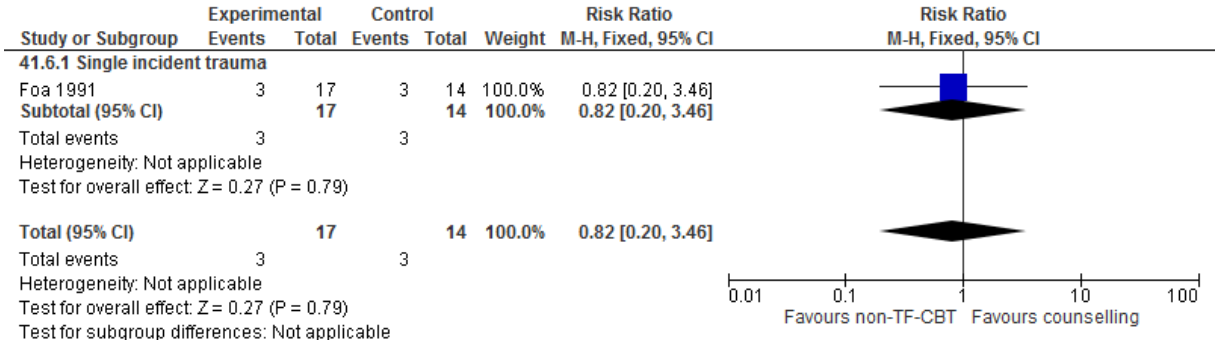


Figure 348: Non-trauma-focused CBT versus present-centered therapy for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD

symptomatology clinician-rated (CAPS change score); Multiple incident index trauma

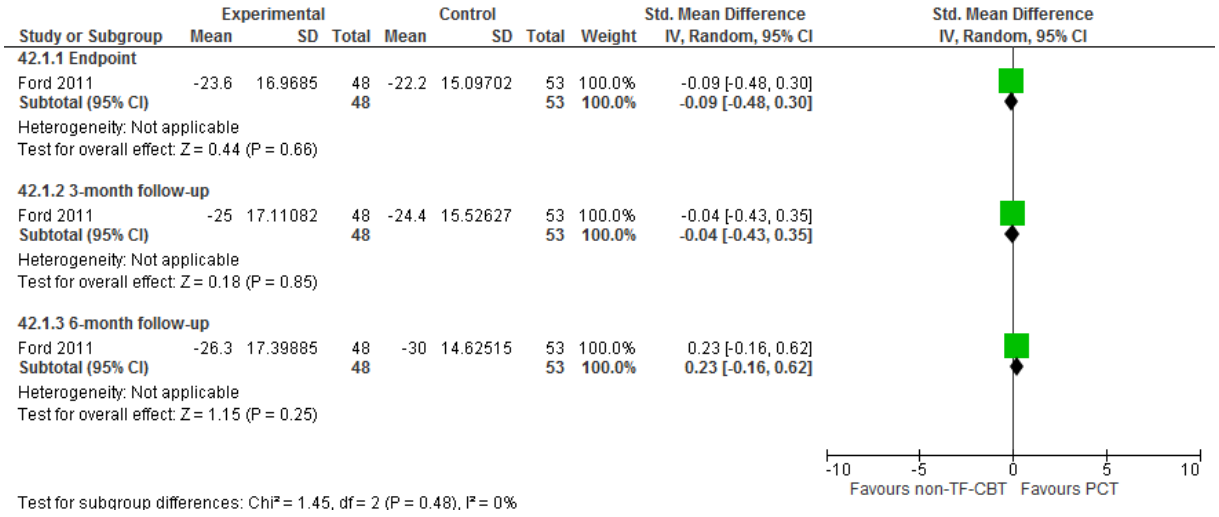


Figure 349: Non-trauma-focused CBT versus present-centered therapy for delayed treatment (>3 months) of clinically important symptoms/PTSD: Remission (number of people no longer meeting diagnostic criteria for PTSD); Multiple incident index trauma

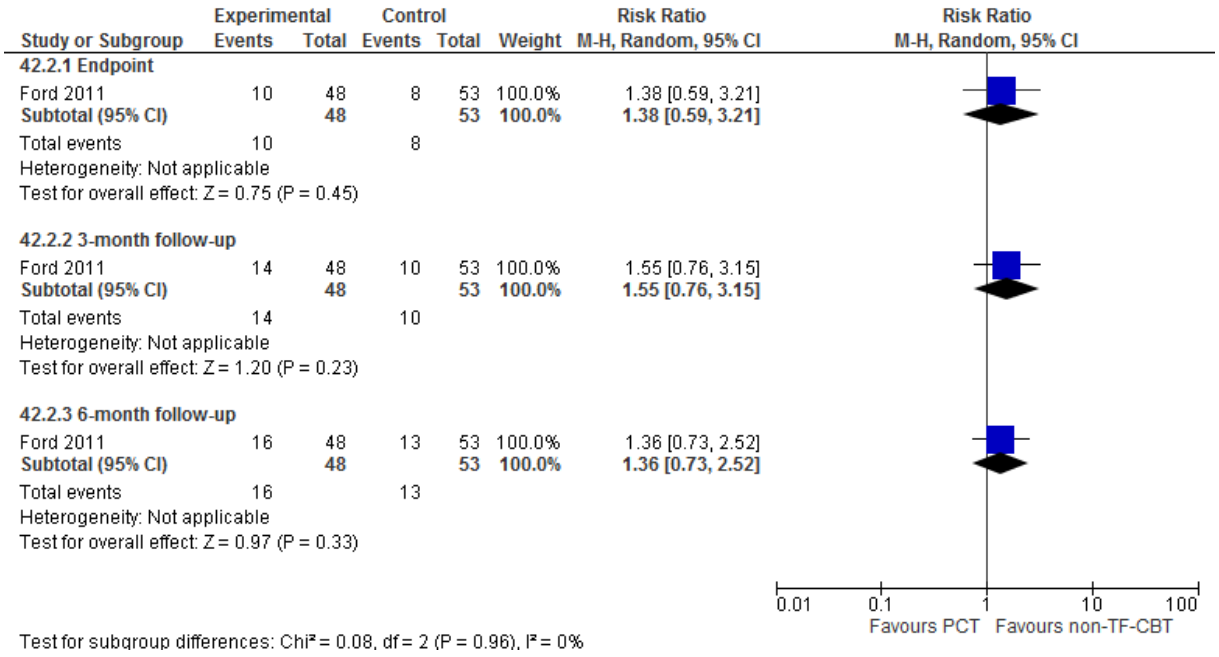


Figure 350: Non-trauma-focused CBT versus present-centered therapy for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms (BDI change score); Multiple incident index trauma

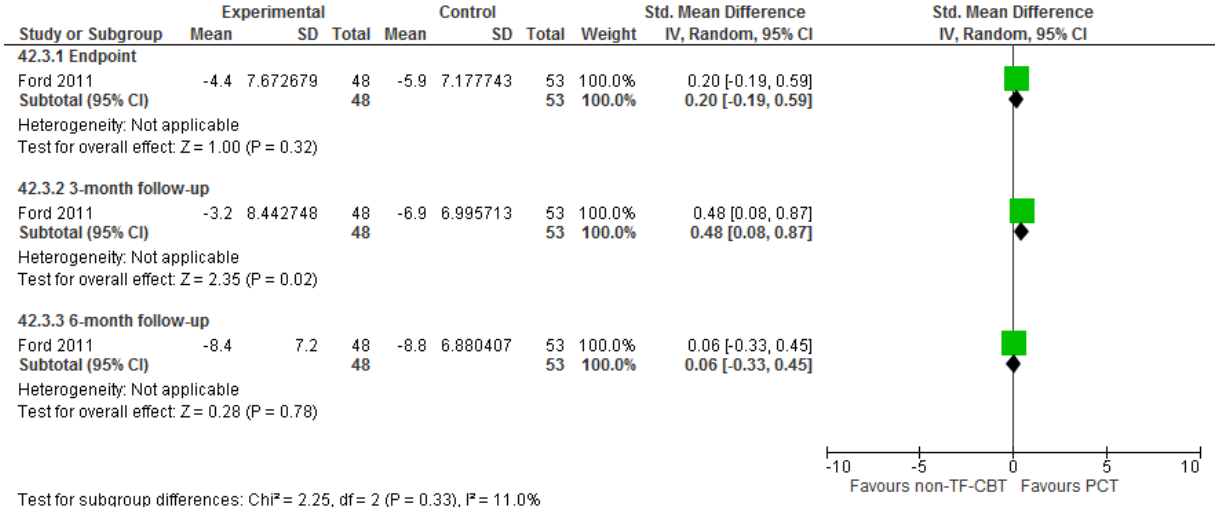
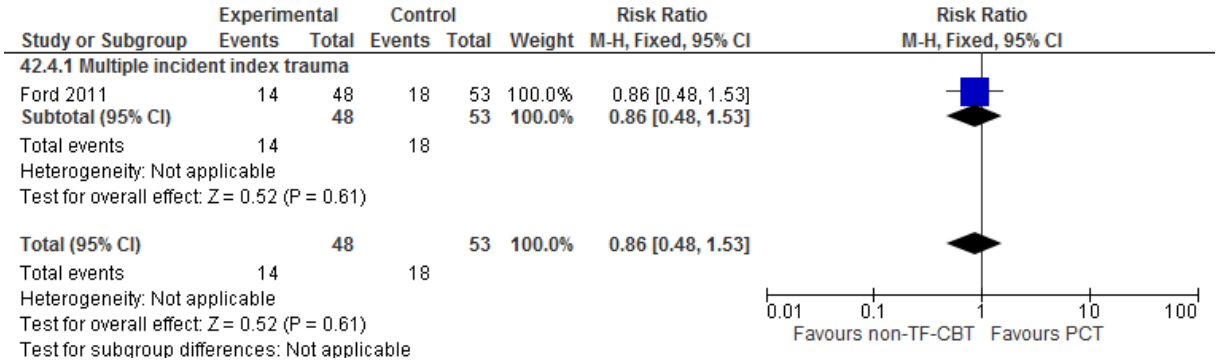


Figure 351: Non-trauma-focused CBT versus present-centered therapy for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)



Present-centered therapy (+TAU)

Figure 352: Present-centered therapy (+TAU) versus TAU for early treatment (1-3 months) clinically important symptoms/PTSD: PTSD symptomatology clinician-rated (CAPS change score); Multiple incident index trauma

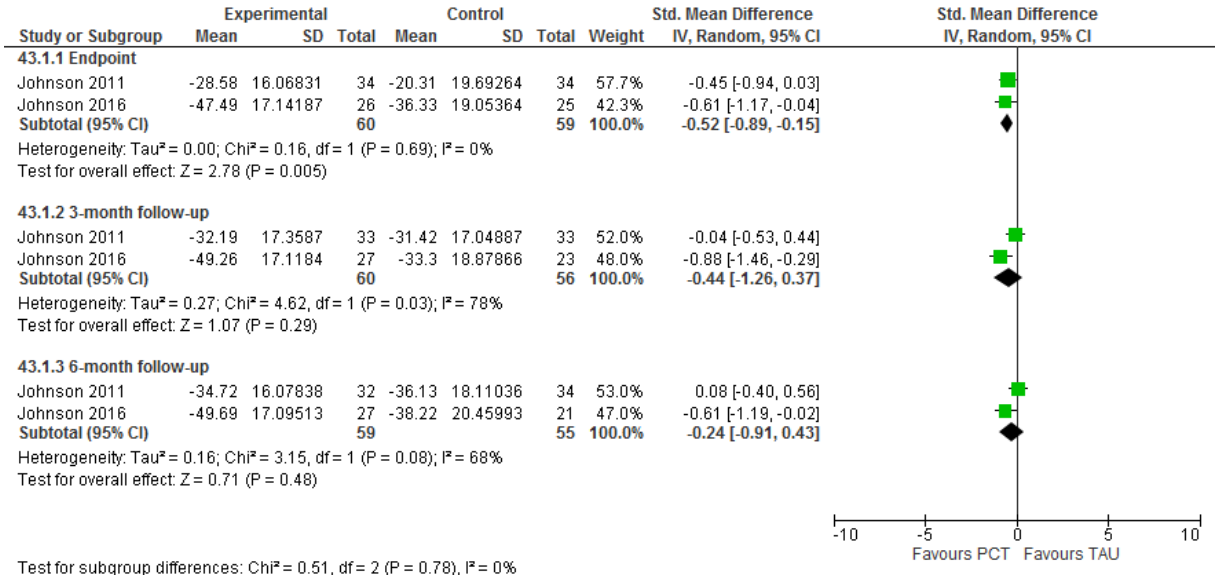


Figure 353: Present-centered therapy (+TAU) versus TAU for early treatment (1-3 months) clinically important symptoms/PTSD: Response (number of people showing improvement of at least 26 points on CAPS); Multiple incident index trauma

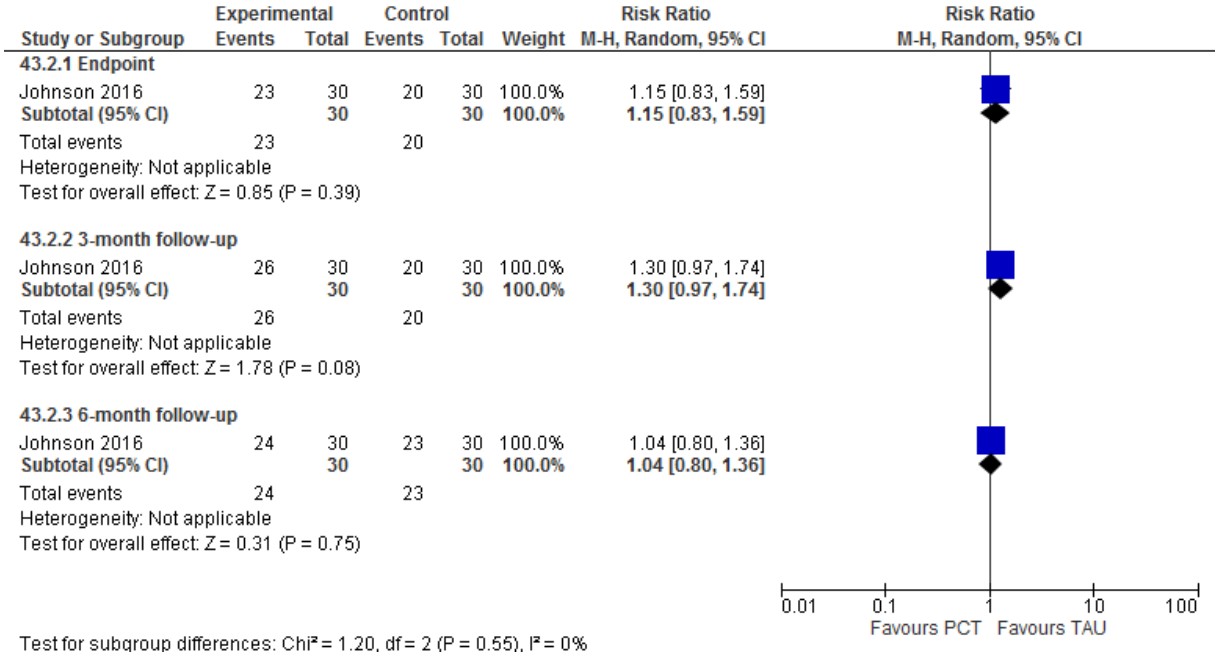


Figure 354: Present-centered therapy (+TAU) versus TAU for early treatment (1-3 months) clinically important symptoms/PTSD: Depression symptoms (BDI change score); Multiple incident index trauma

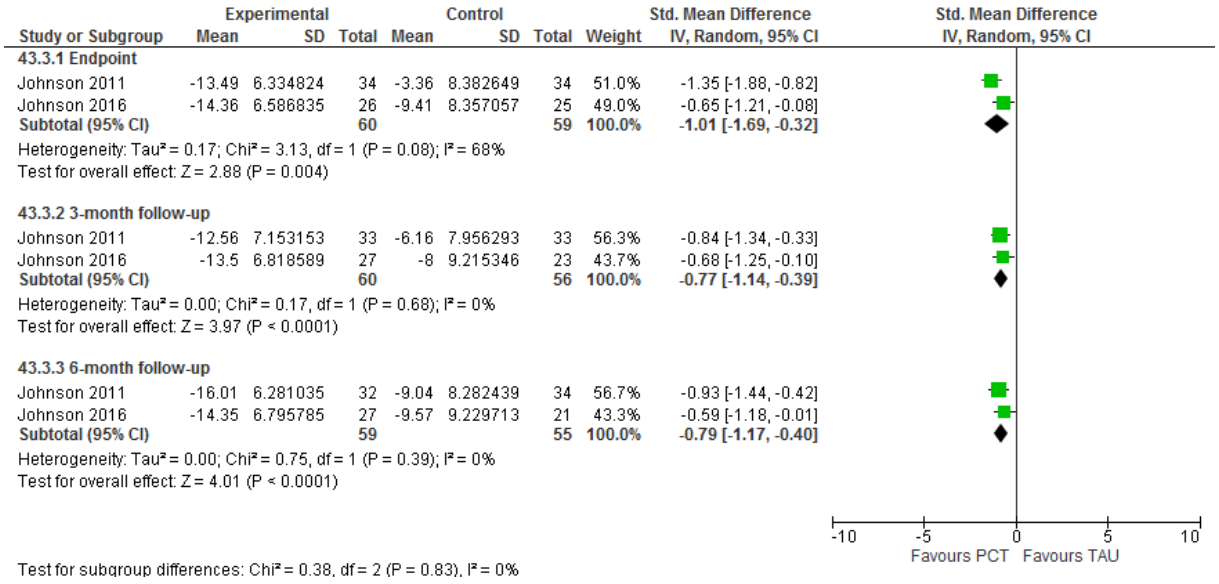


Figure 355: Present-centered therapy (+TAU) versus TAU for early treatment (1-3 months) clinically important symptoms/PTSD: Discontinuation (loss to follow-up)

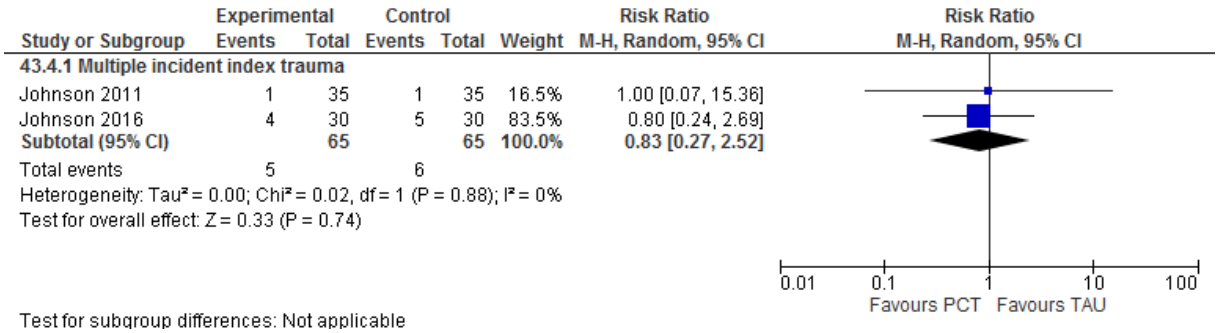


Figure 356: Present-centered therapy versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated (CAPS change score)

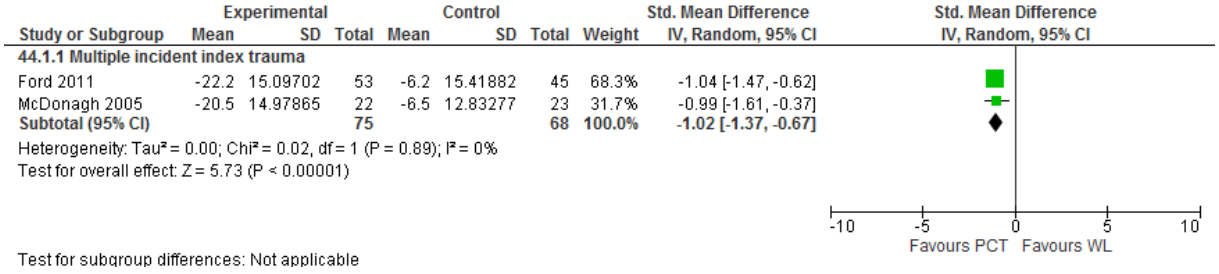


Figure 357: Present-centered therapy versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Remission (number of people no longer meeting diagnostic criteria for PTSD)

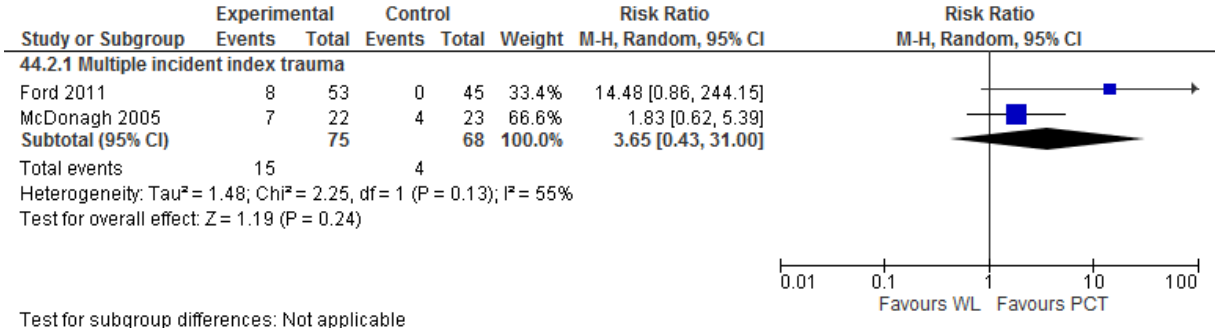


Figure 358: Present-centered therapy versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Dissociative symptoms (DES; change score)

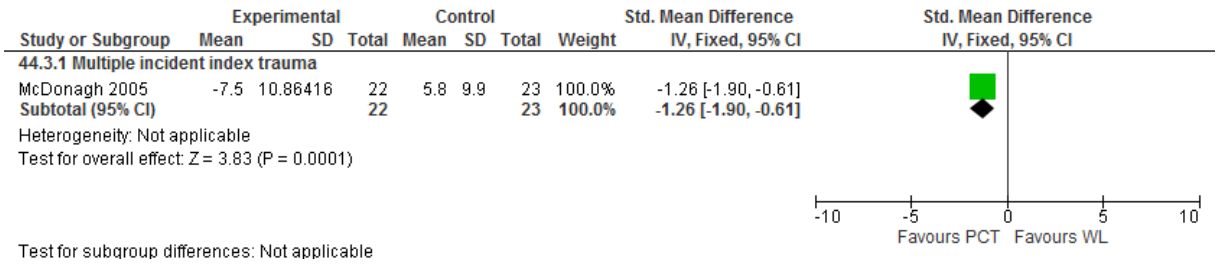


Figure 359: Present-centered therapy versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Anxiety symptoms (STAI state; change score)

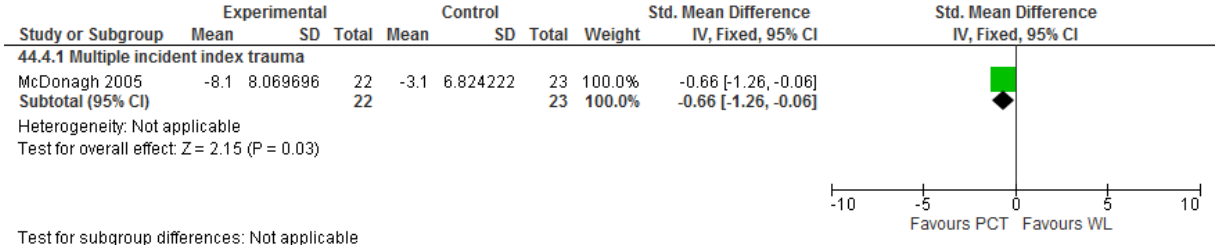


Figure 360: Present-centered therapy versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms (BDI change score)

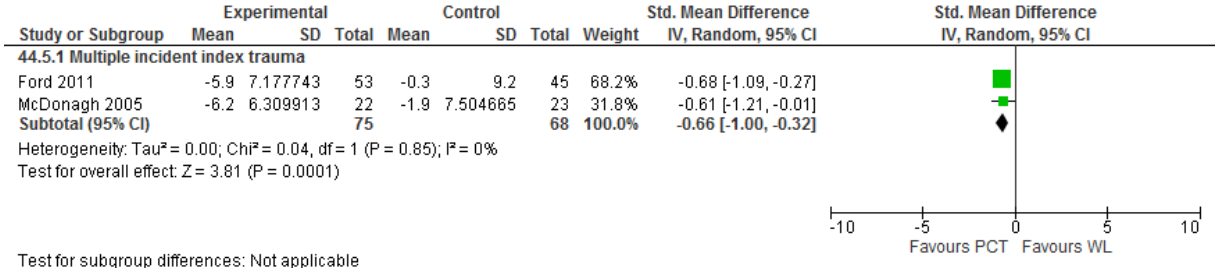


Figure 361: Present-centered therapy versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Emotional and behavioural problems: Anger (STAXI change score)

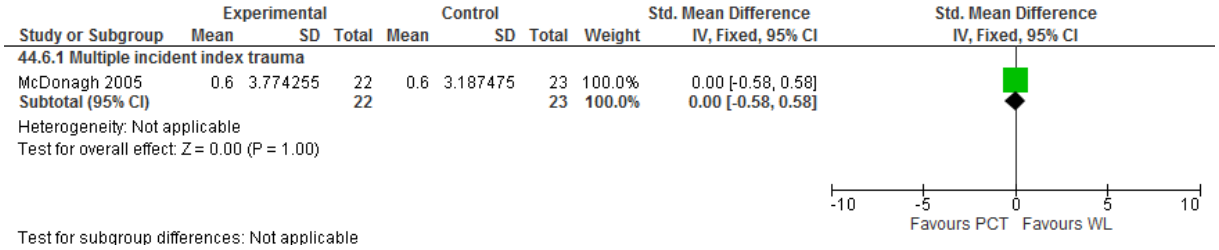


Figure 362: Present-centered therapy versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Quality of life (QOLI change score)

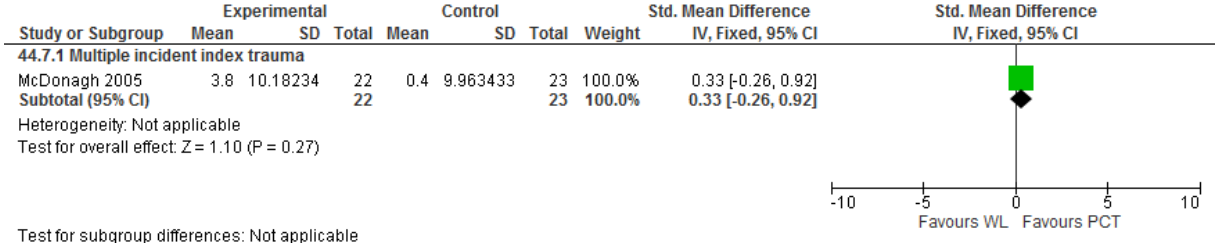
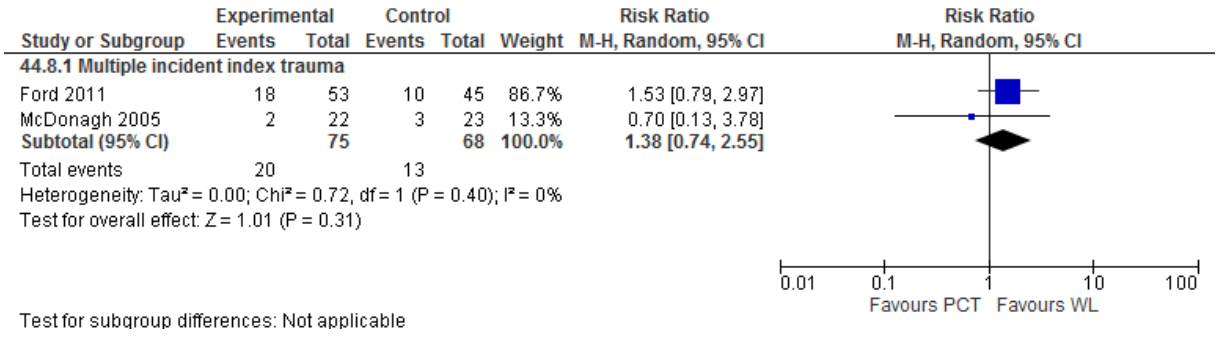


Figure 363: Present-centered therapy versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)



Metacognitive therapy

Figure 364: Metacognitive therapy (±TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated (IES/PDS change score)

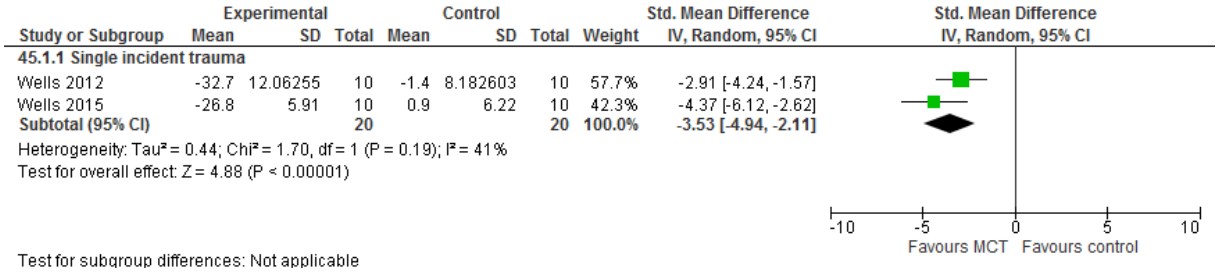


Figure 365: Metacognitive therapy (±TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: Response self-rated at endpoint (number of people showing clinically significant improvement based on at least 10-point improvement on IES)

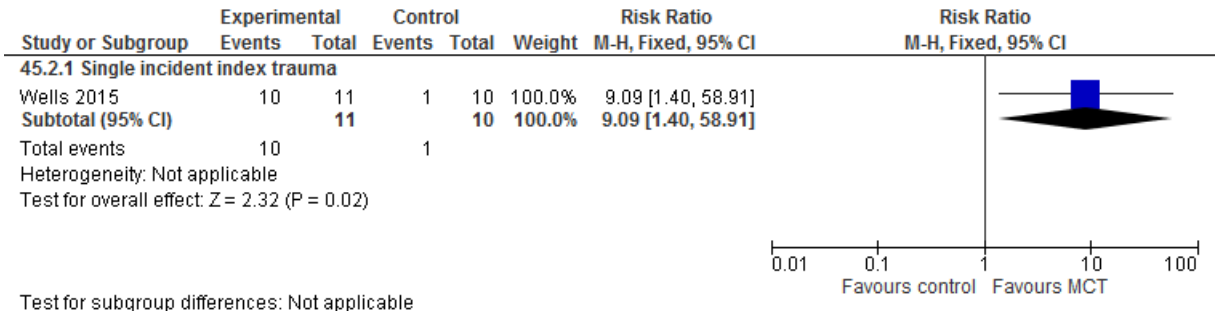


Figure 366: Metacognitive therapy (±TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: Anxiety symptoms (BAI change score)

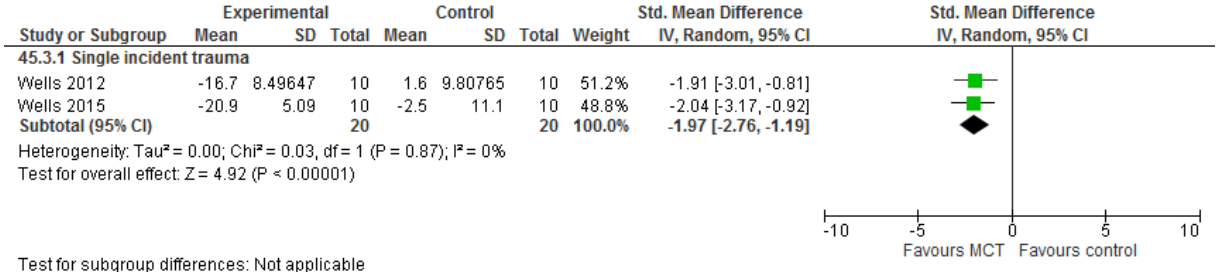


Figure 367: Metacognitive therapy (±TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms (BDI-II change score)

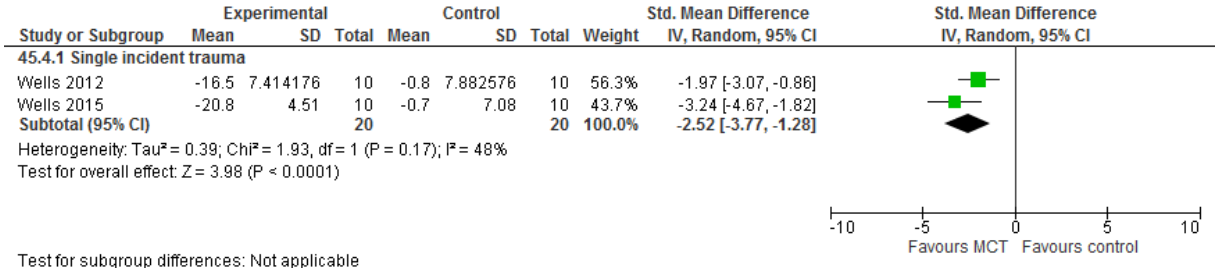
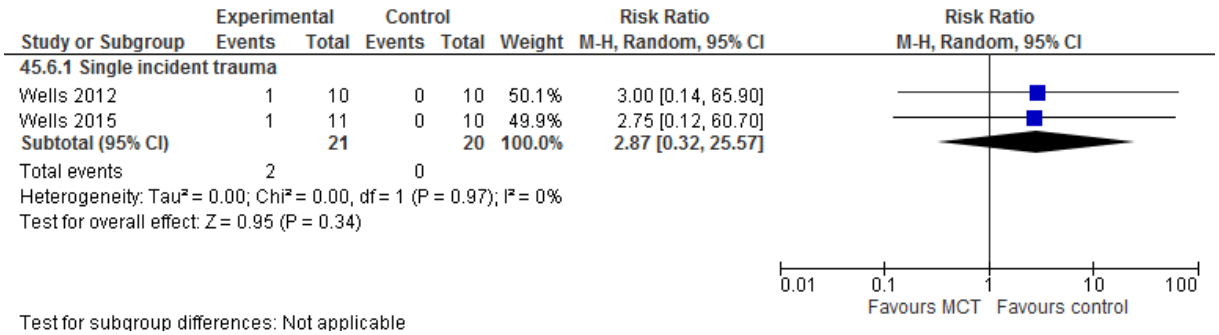


Figure 368: Metacognitive therapy (±TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)



Single-session behavioural therapy

Figure 369: Single-session behavioural therapy versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated at 6-week follow-up (TSSC change score)

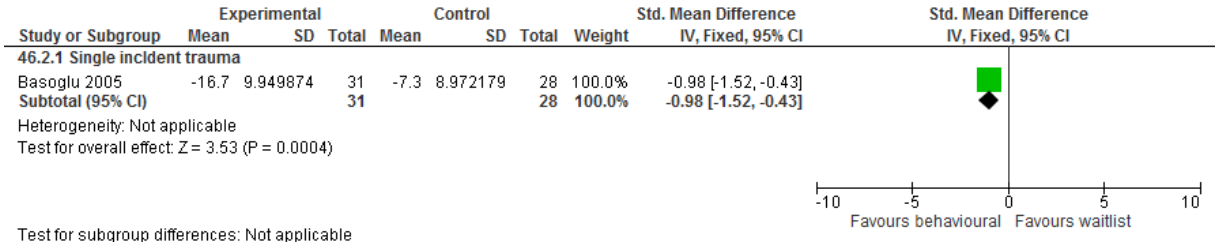


Figure 370: Single-session behavioural therapy versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated at 6-8 week follow-up (CAPS change score)

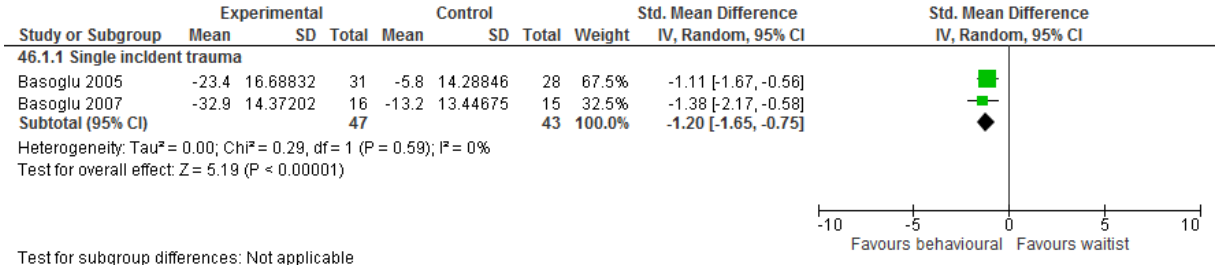


Figure 371: Single-session behavioural therapy versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: Response at 6-week follow-up (number of people rated as 'much' or 'very much' improved on CGI-I)

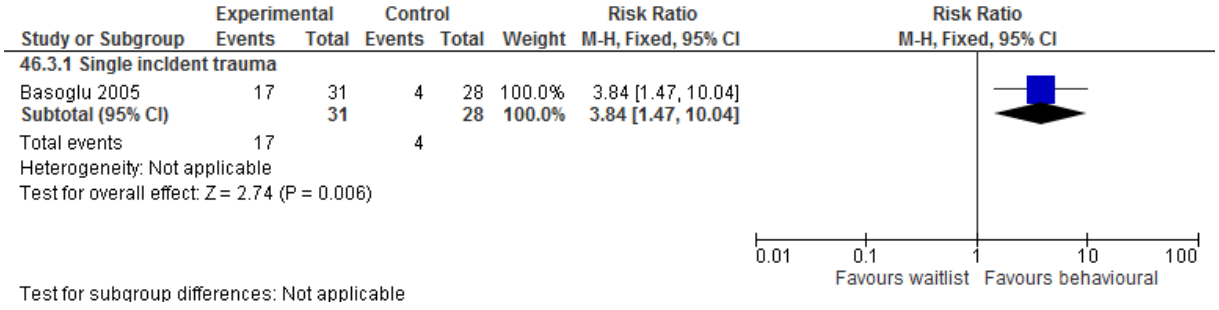


Figure 372: Single-session behavioural therapy versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: Functional impairment at 6-8 week follow-up (WSA change score)

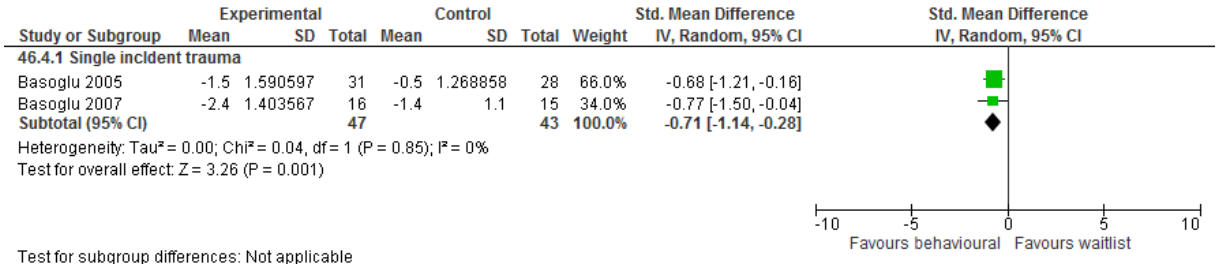
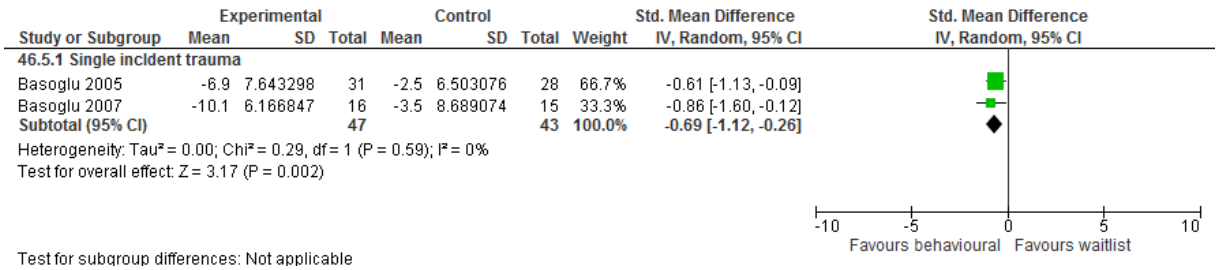


Figure 373: Single-session behavioural therapy versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms at 6-8 week follow-up (BDI change score)



Problem solving

Figure 374: Problem solving versus supportive counselling for early treatment (1-3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-report (IES-R endpoint score); Single incident trauma

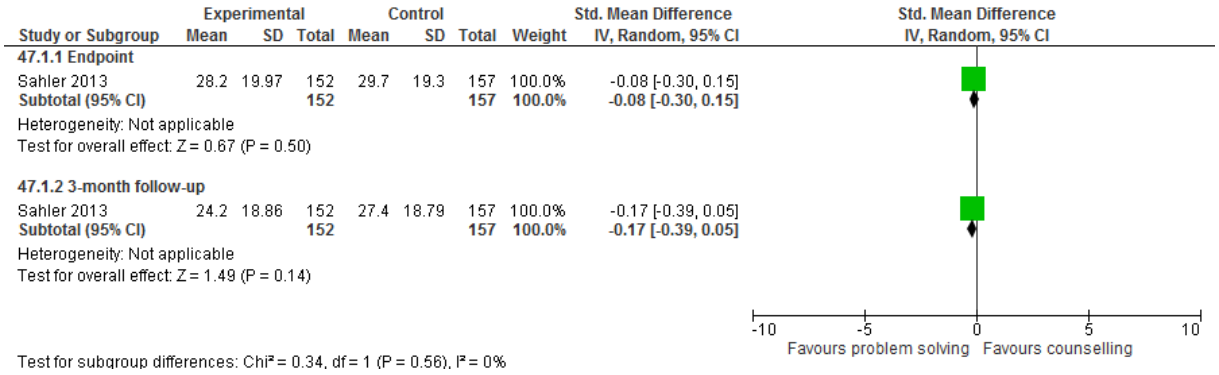
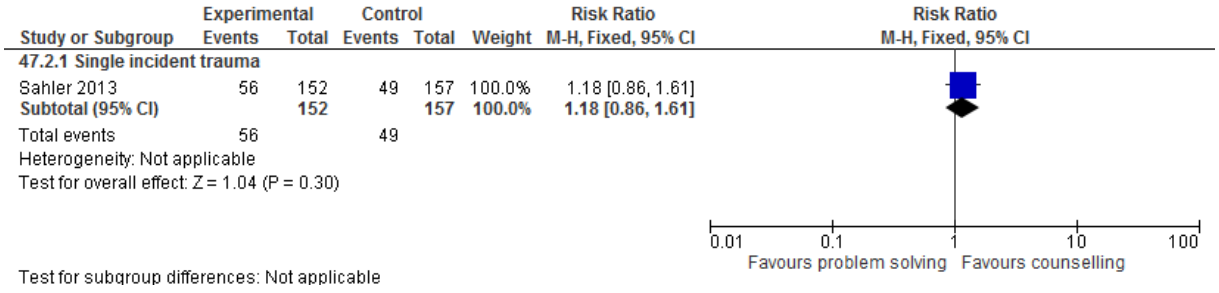


Figure 375: Problem solving versus supportive counselling for early treatment (1-3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)



Eye movement desensitisation and reprocessing (EMDR)

Figure 376: Eye movement desensitisation and reprocessing (EMDR) versus supportive counselling for early treatment (1-3 months) of clinically

important symptoms/PTSD: PTSD symptomatology clinician-rated (SPRINT change score); Multiple incident index trauma

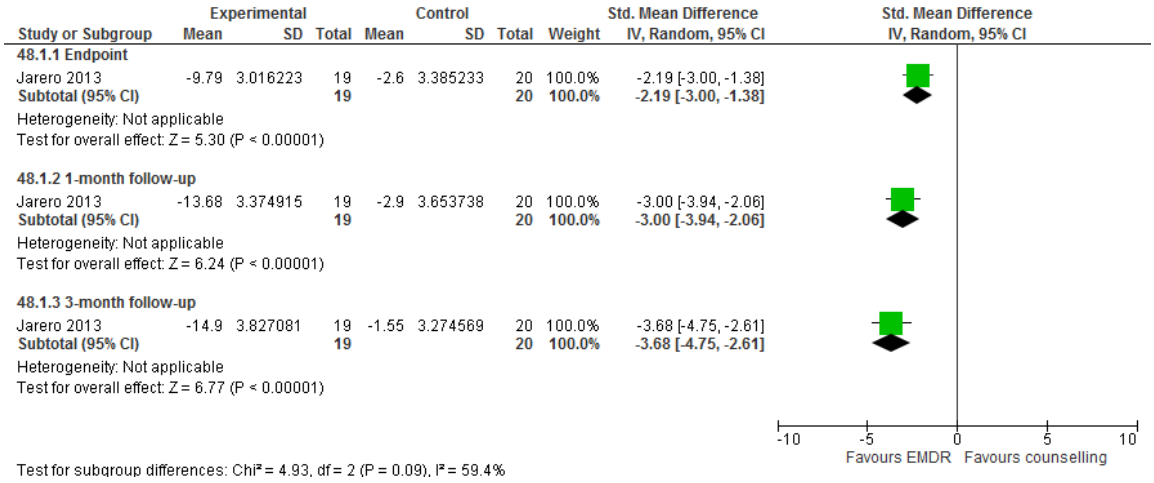


Figure 377: Eye movement desensitisation and reprocessing (EMDR; ±TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-report at endpoint (IES/IES-R/Trauma Symptoms Inventory/PDS/PSS-SR change scores/M-PTSD endpoint)

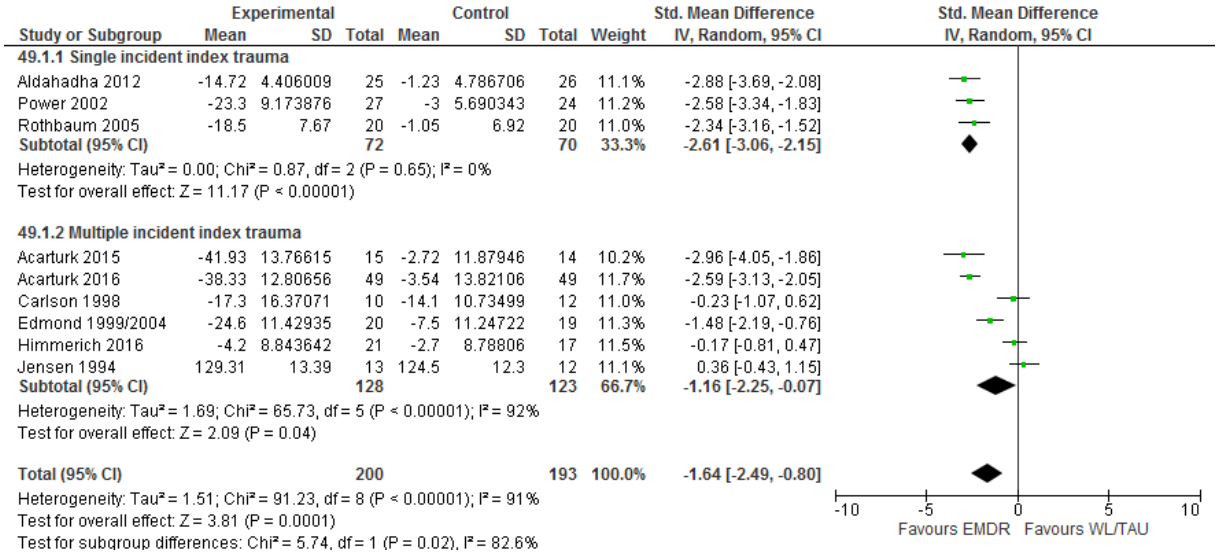


Figure 378: Eye movement desensitisation and reprocessing (EMDR; ±TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important

symptoms/PTSD: PTSD symptomatology self-report at 1-month follow-up (IES-R change score)

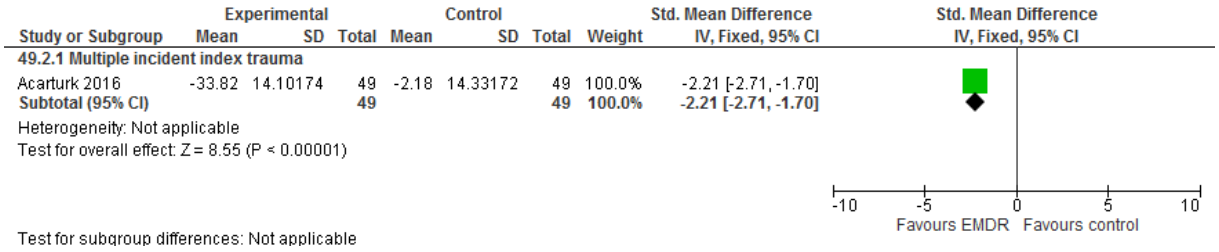


Figure 379: Eye movement desensitisation and reprocessing (EMDR; ±TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated (SI-PTSD/CAPS change score)

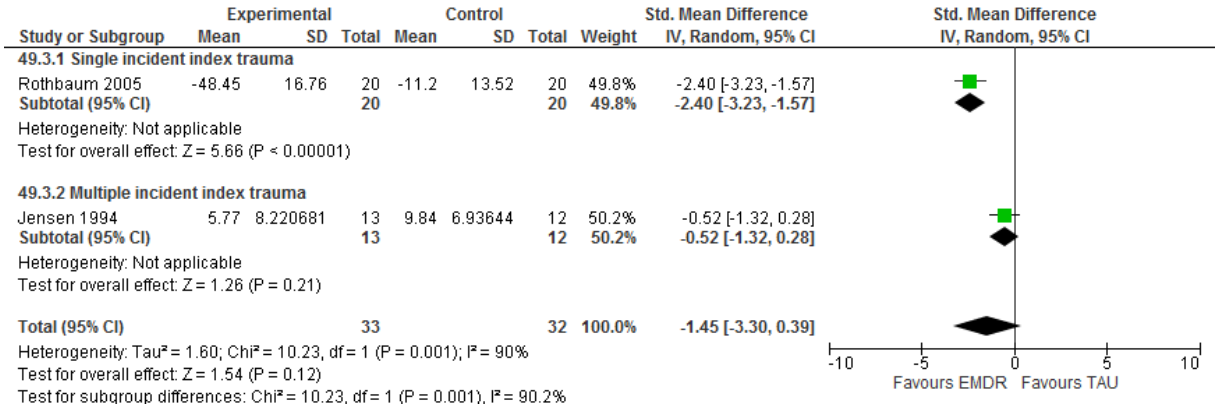


Figure 380: Eye movement desensitisation and reprocessing (EMDR; ±TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important

symptoms/PTSD: Remission at endpoint (number of people no longer meeting diagnostic criteria for PTSD)

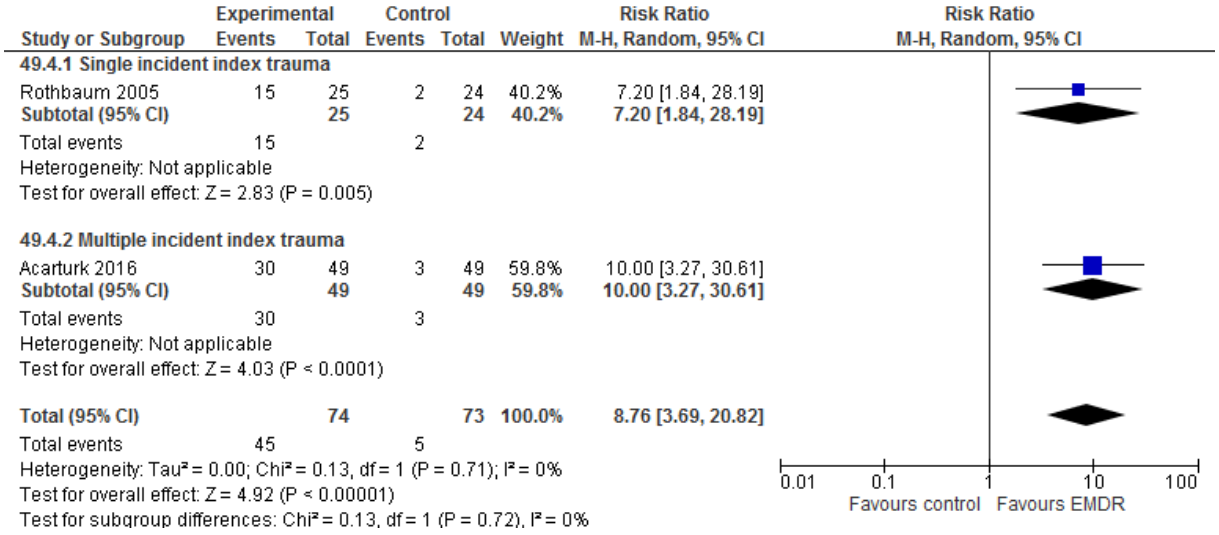


Figure 381: Eye movement desensitisation and reprocessing (EMDR; ±TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: Remission at 1-month follow-up (number of people no longer meeting diagnostic criteria for PTSD)

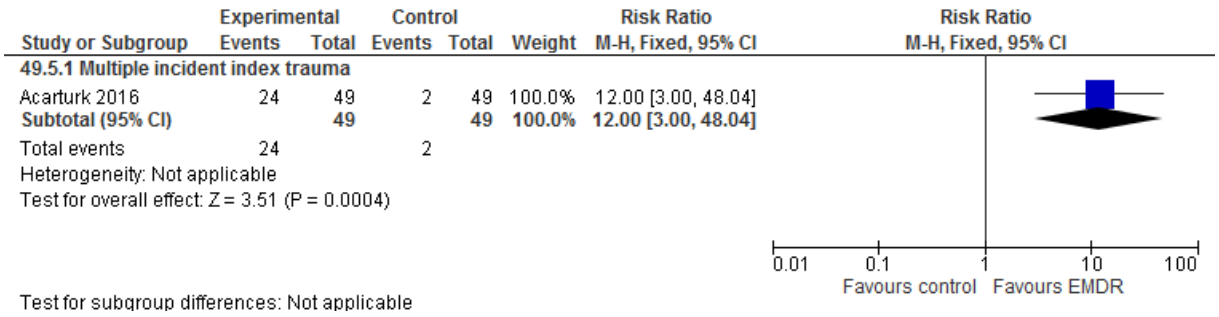


Figure 382: Eye movement desensitisation and reprocessing (EMDR; ±TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important

symptoms/PTSD: Response self-rated (number of people showing clinically significant improvement, based on reliable change indices [RCI] on IES)

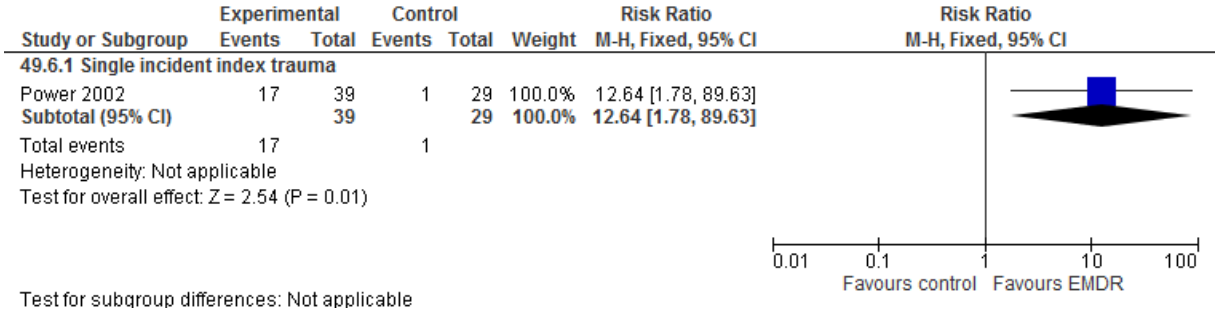


Figure 383: Eye movement desensitisation and reprocessing (EMDR; ±TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: Dissociative symptoms (DES change score)

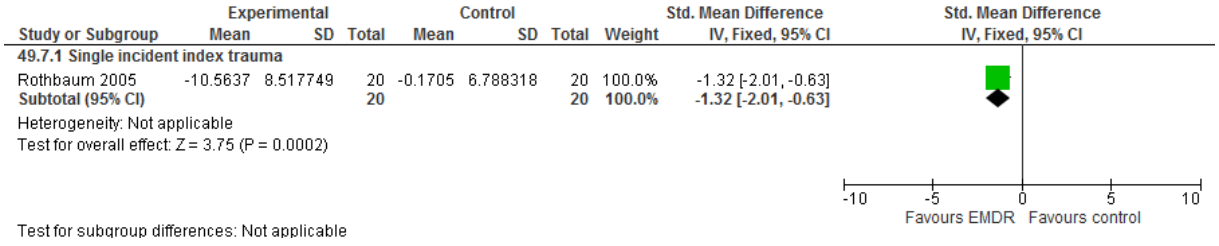


Figure 384: Eye movement desensitisation and reprocessing (EMDR; ±TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: Anxiety symptoms (STAI State/HAM-A change score)

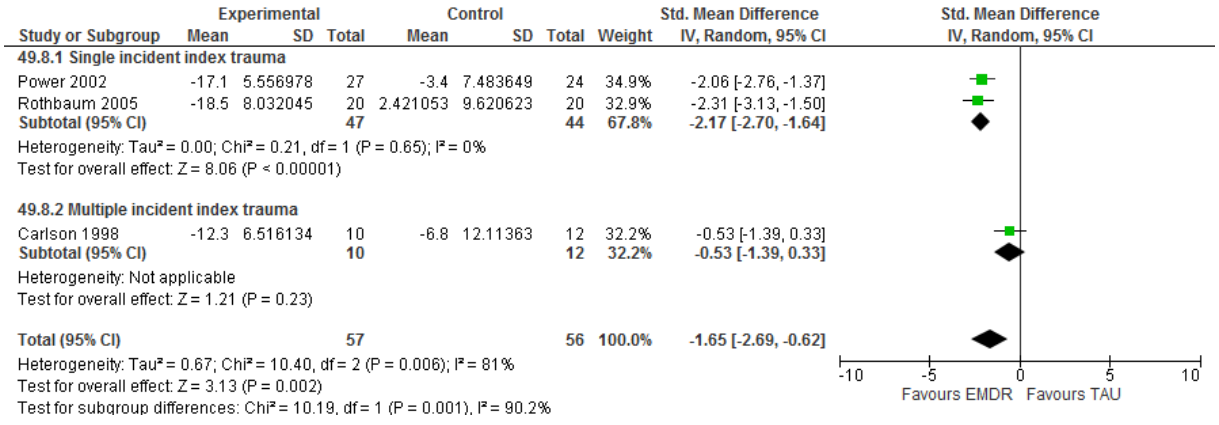


Figure 385: Eye movement desensitisation and reprocessing (EMDR; ±TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important

symptoms/PTSD: Depression symptoms at endpoint (BDI/BDI-II /MADRS change score)

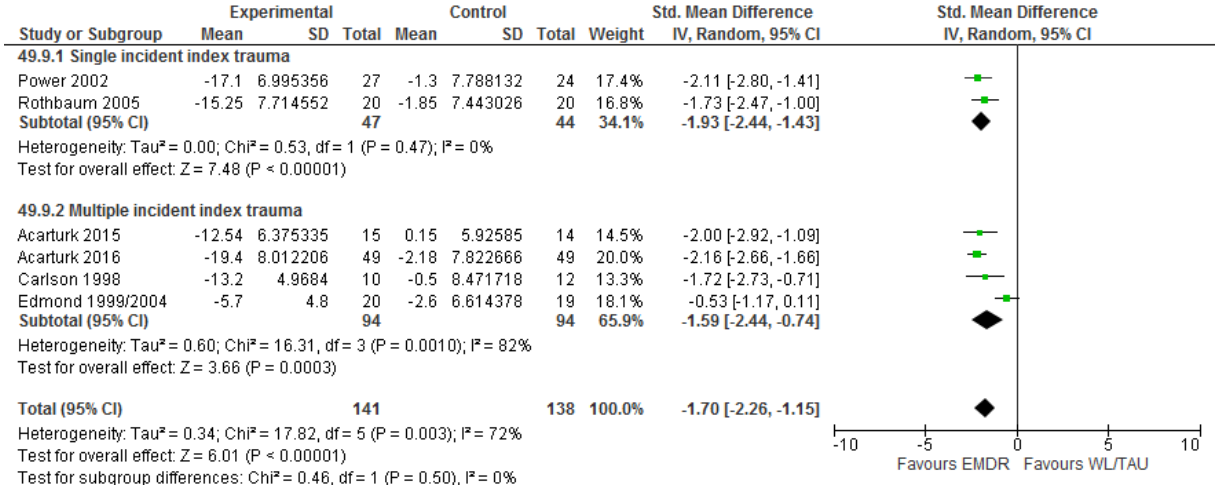


Figure 386: Eye movement desensitisation and reprocessing (EMDR; ±TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms at 1-month follow-up (BDI-II change score)

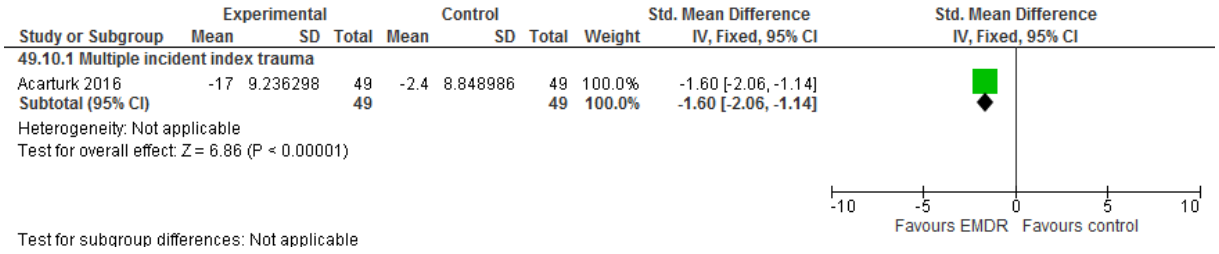


Figure 387: Eye movement desensitisation and reprocessing (EMDR; ±TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: Functional impairment (SDS change score)

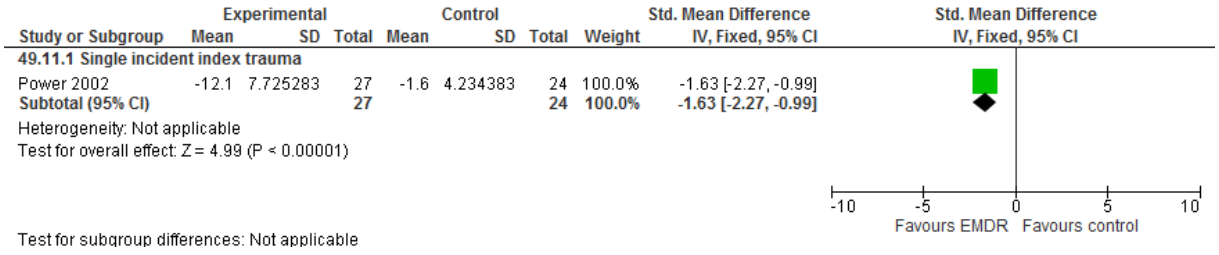
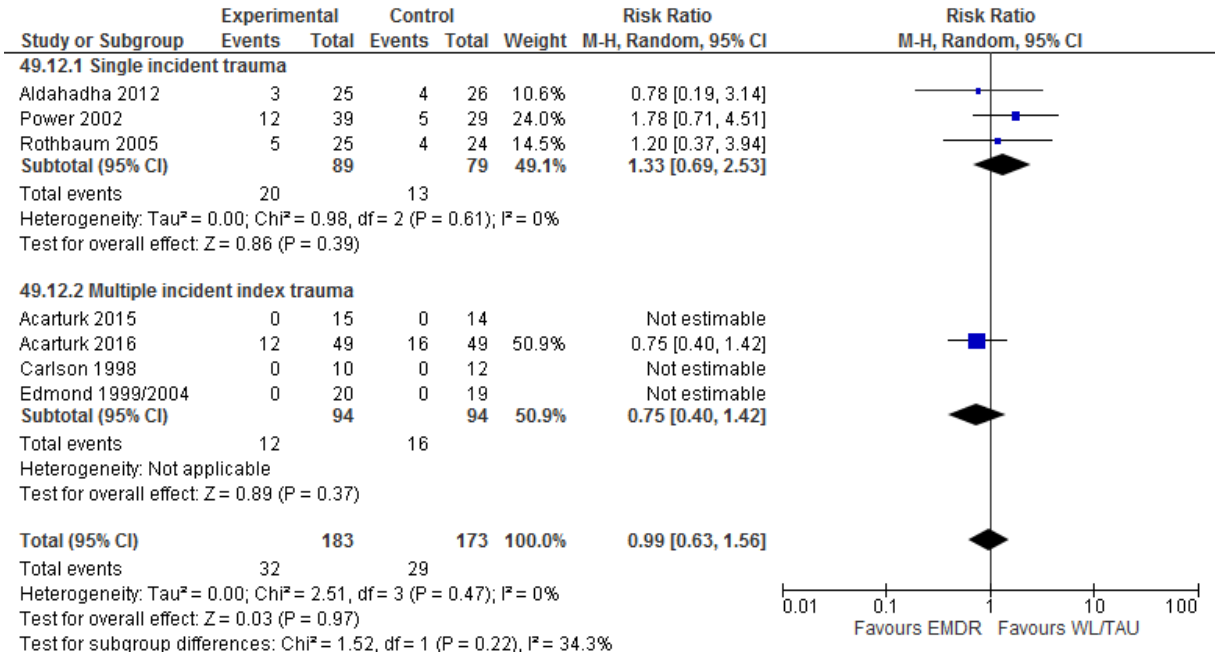


Figure 388: Eye movement desensitisation and reprocessing (EMDR; ±TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)



Sub-analysis by diagnostic status at baseline: Eye movement desensitisation and reprocessing (EMDR; ±TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD

Figure 389: Eye movement desensitisation and reprocessing (EMDR; ±TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-report at endpoint (IES/IES-

R/Trauma Symptoms Inventory/PDS/PSS-SR change scores/M-PTSD endpoint)

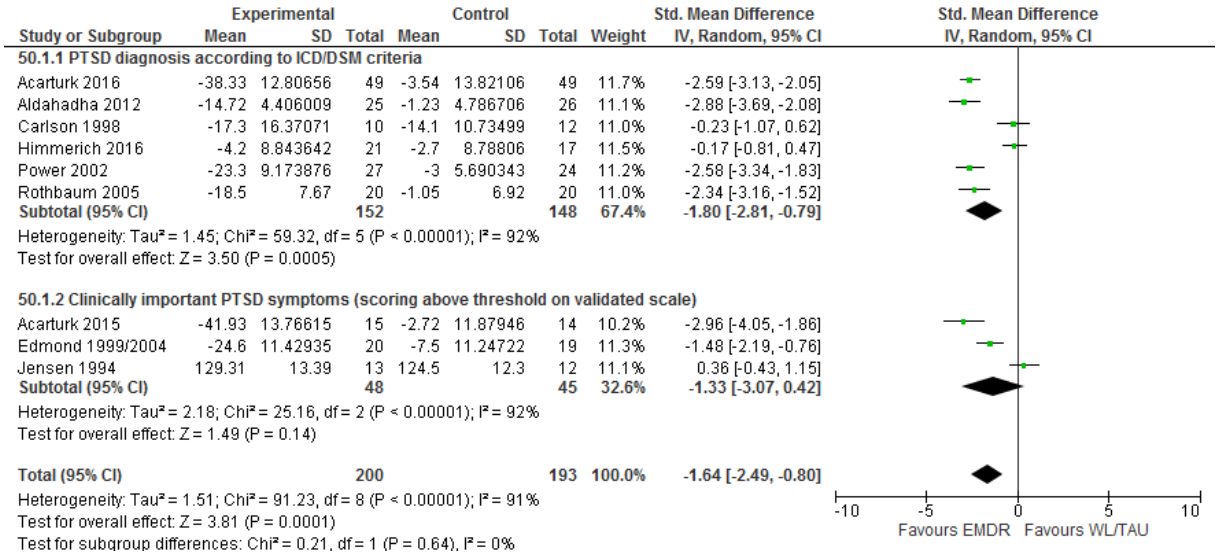


Figure 390: Eye movement desensitisation and reprocessing (EMDR; ±TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated (SI-PTSD/CAPS change score)

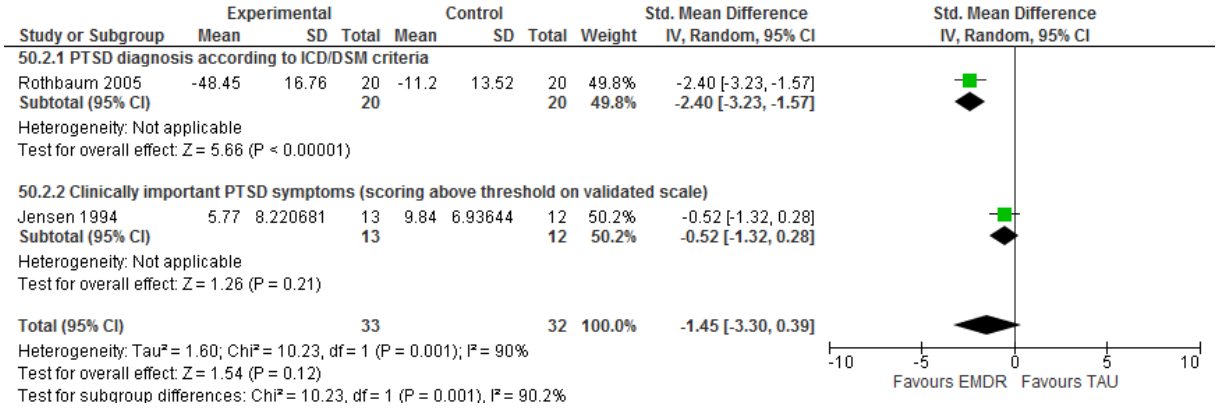
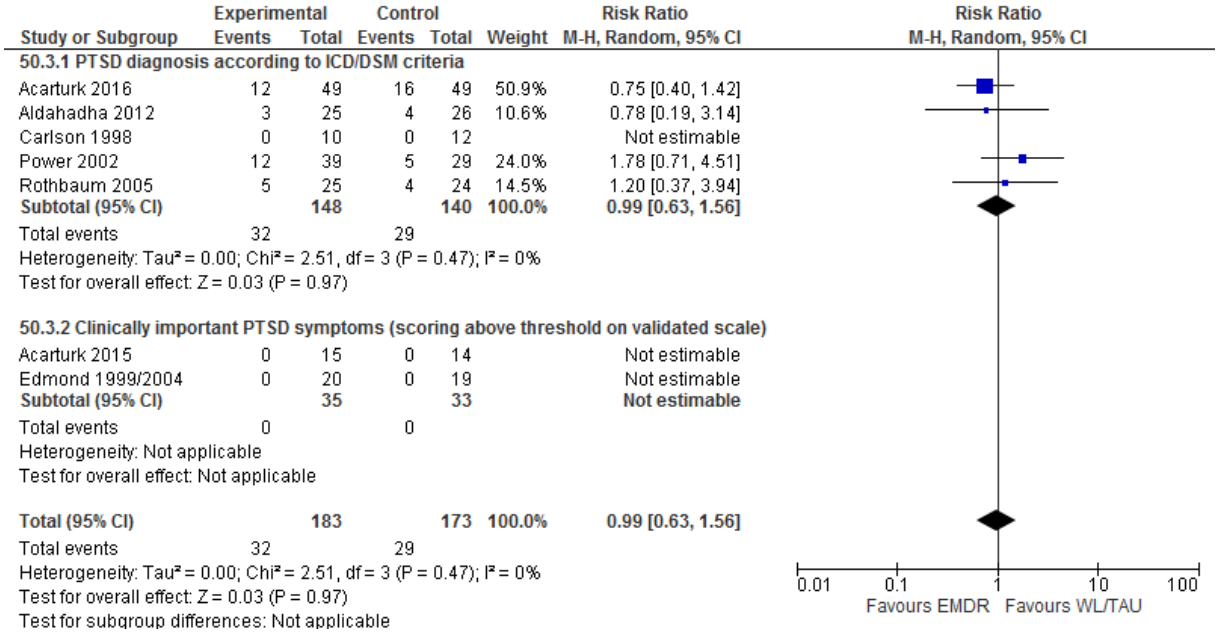


Figure 391: Eye movement desensitisation and reprocessing (EMDR; ±TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)



Sub-analysis by trauma type:

Figure 392: Eye movement desensitisation and reprocessing (EMDR; ±TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-report at endpoint (IES/IES-

R/Trauma Symptoms Inventory/PDS/PSS-SR change scores/M-PTSD endpoint)

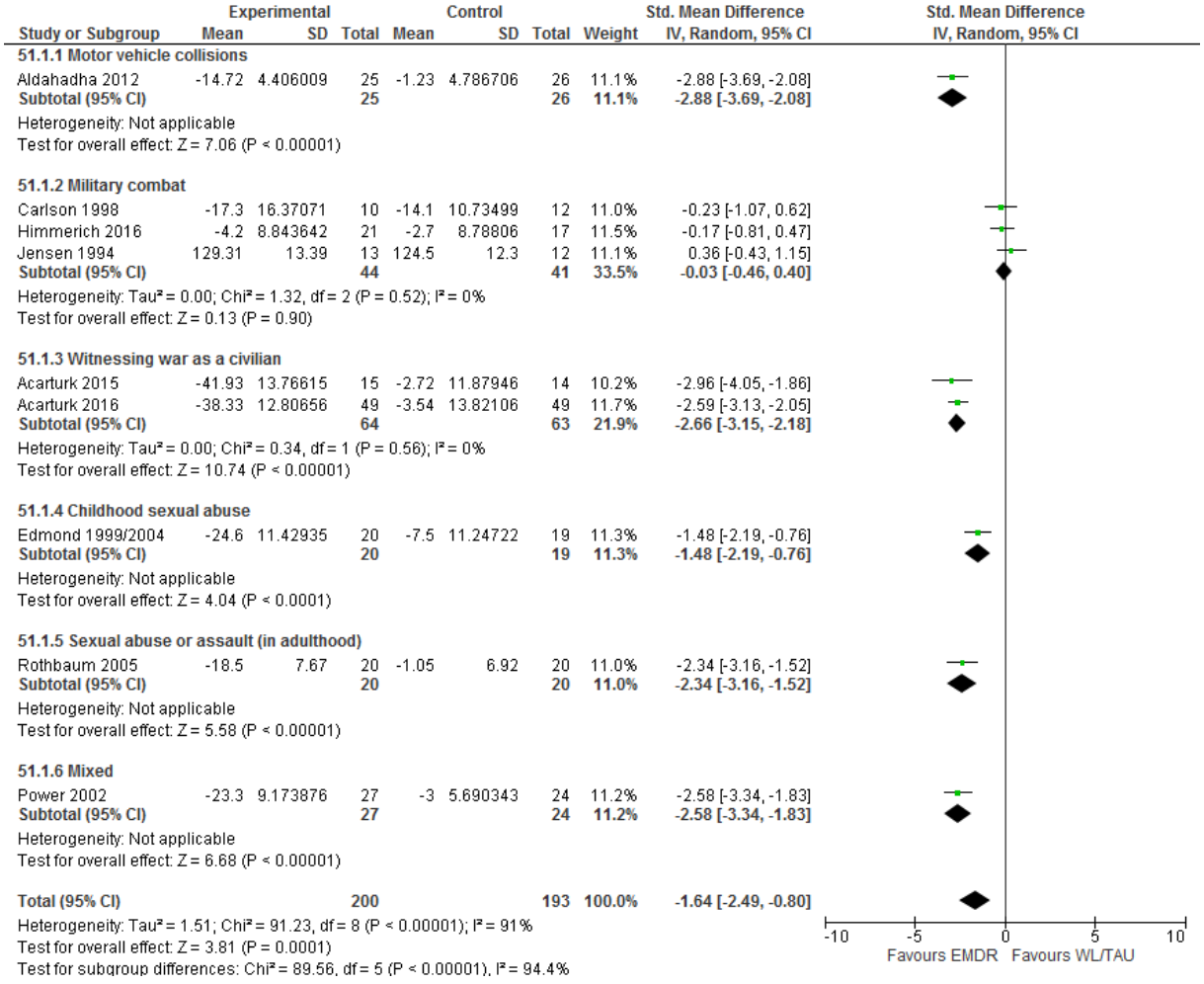


Figure 393: Eye movement desensitisation and reprocessing (EMDR; ±TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important

symptoms/PTSD: PTSD symptomatology clinician-rated (SI-PTSD/CAPS change score)

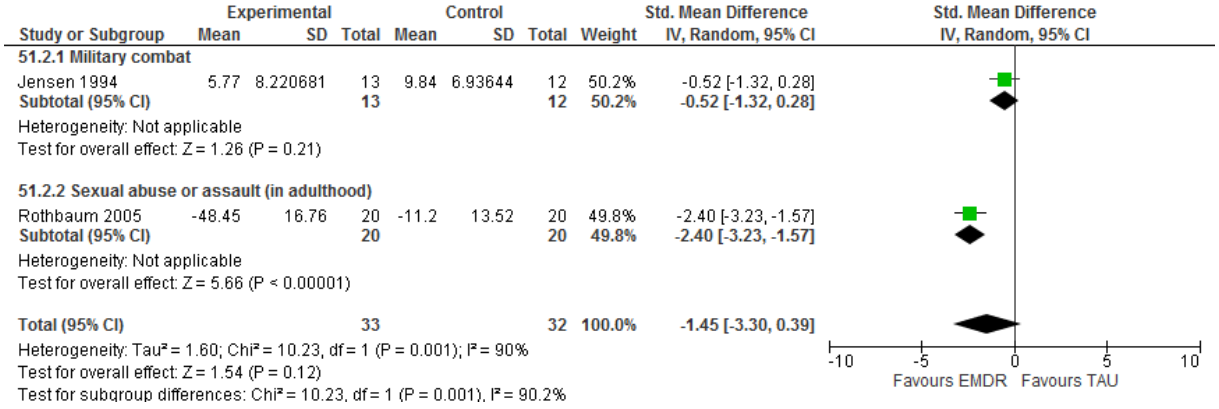


Figure 394: Eye movement desensitisation and reprocessing (EMDR; ±TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)

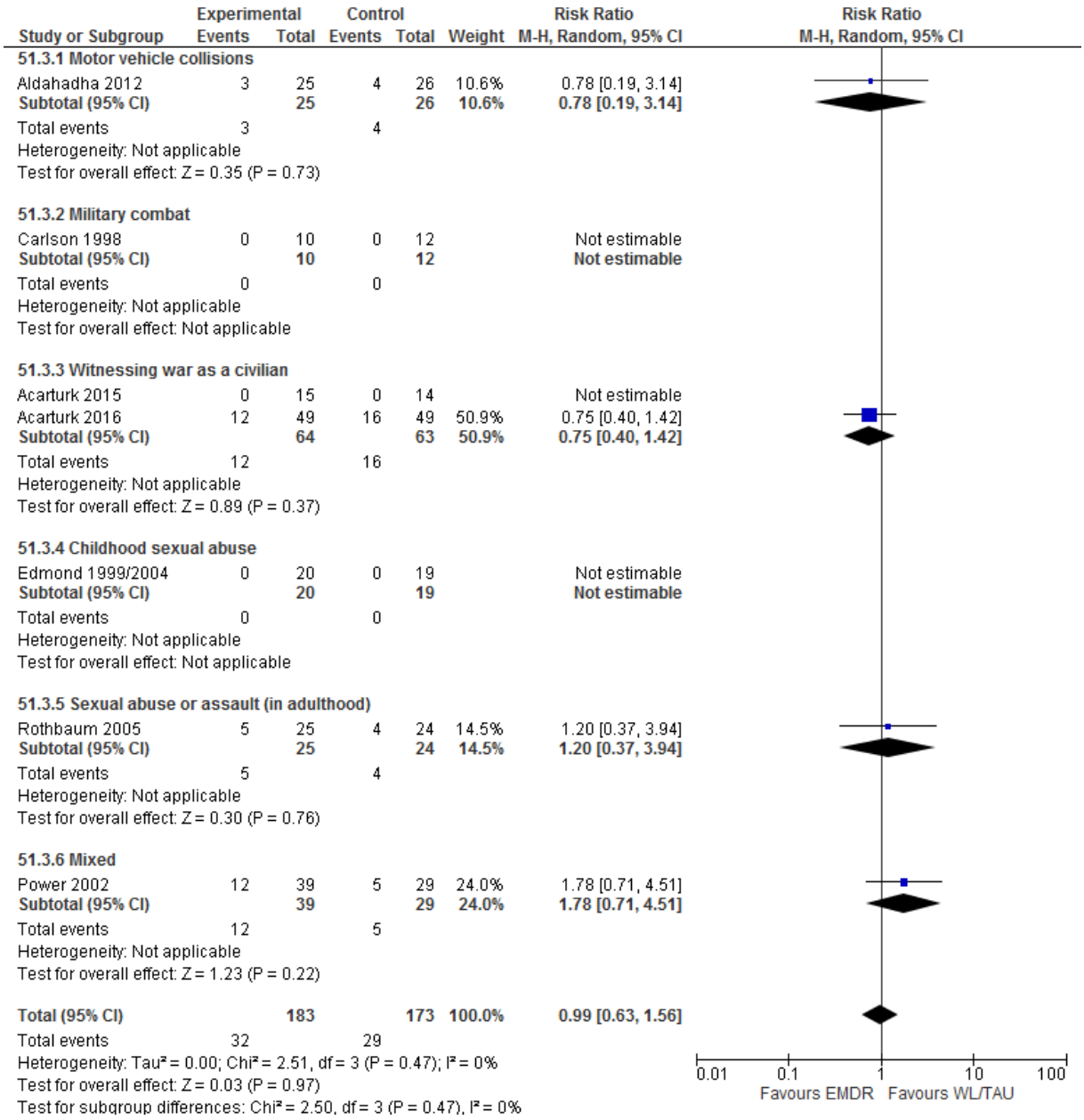


Figure 395: Eye movement desensitisation and reprocessing (EMDR) versus pill placebo for delayed treatment (>3 months) of clinically important

symptoms/PTSD: PTSD symptomatology clinician-rated (CAPS change score)

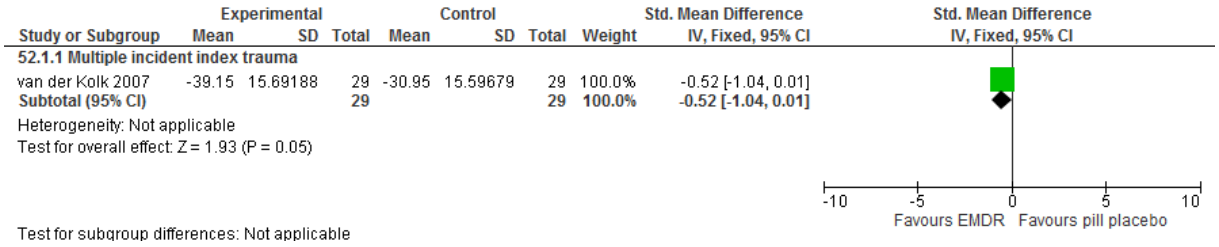


Figure 396: Eye movement desensitisation and reprocessing (EMDR) versus pill placebo for delayed treatment (>3 months) of clinically important symptoms/PTSD: Remission (number of people scoring <20 on CAPS)

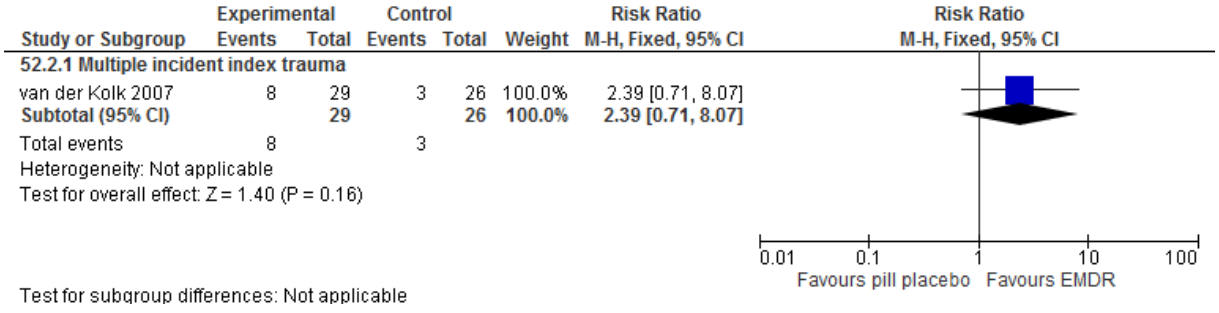


Figure 397: Eye movement desensitisation and reprocessing (EMDR) versus pill placebo for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms (BDI-II; change score)

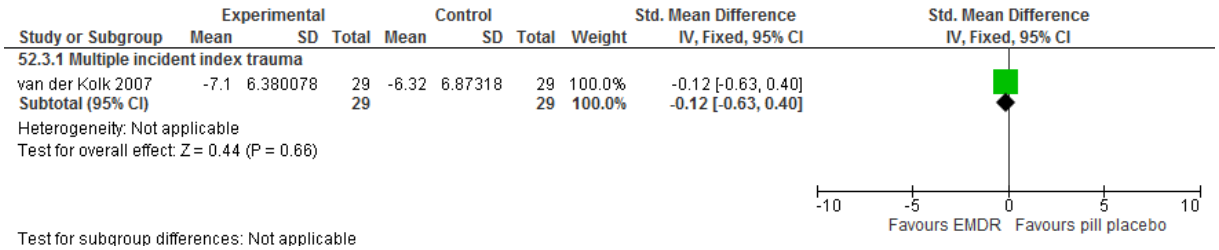


Figure 398: Eye movement desensitisation and reprocessing (EMDR) versus pill placebo for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)

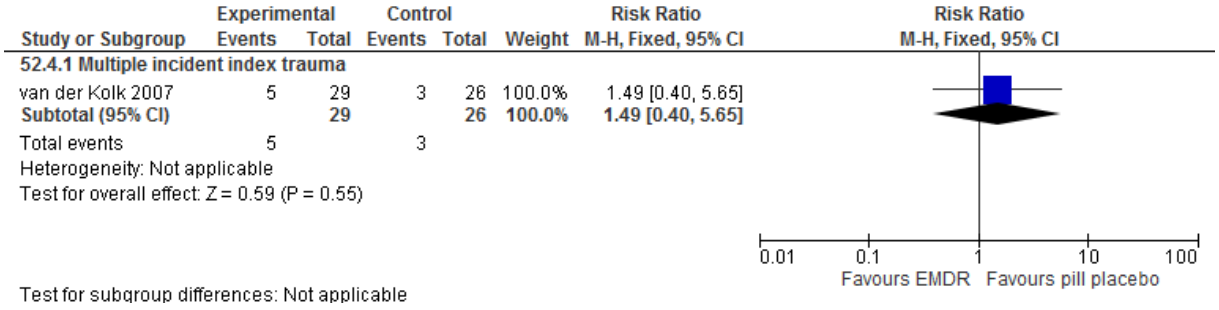


Figure 399: Eye movement desensitisation and reprocessing (EMDR) versus supportive counselling for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated (IES change score)

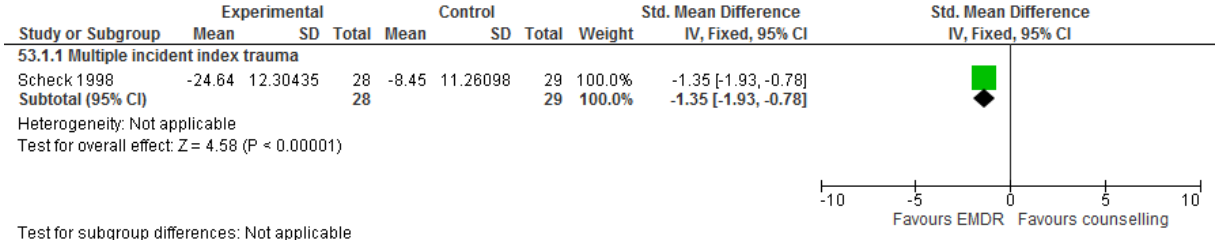


Figure 400: Eye movement desensitisation and reprocessing (EMDR) versus supportive counselling for delayed treatment (>3 months) of clinically important symptoms/PTSD: Anxiety symptoms (STAI State; change score)

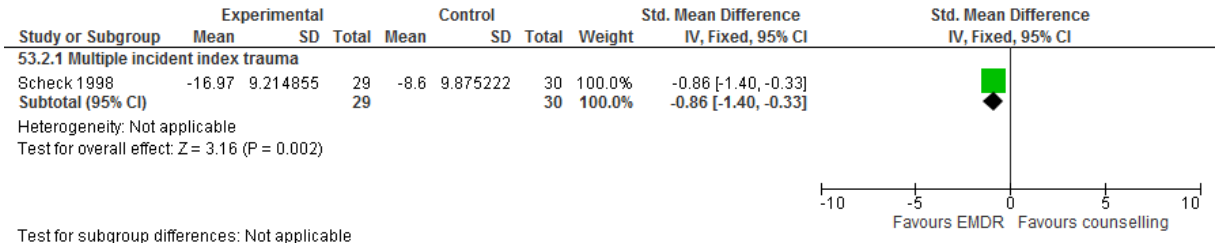


Figure 401: Eye movement desensitisation and reprocessing (EMDR) versus supportive counselling for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms (BDI change score)

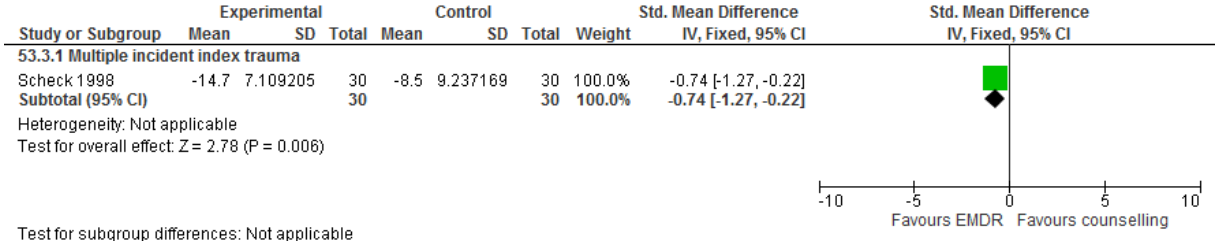


Figure 402: Eye movement desensitisation and reprocessing (EMDR) versus supportive counselling for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)

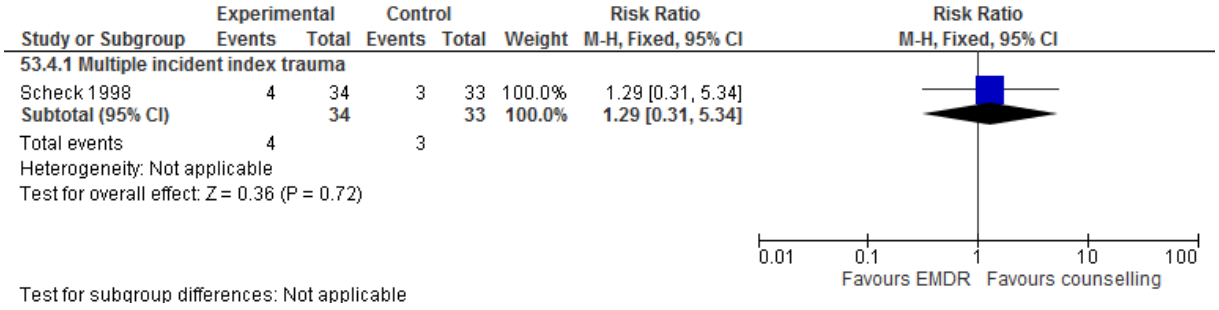


Figure 403: Eye movement desensitisation and reprocessing (EMDR) versus non-trauma-focused CBT for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated (CAPS change score); Multiple incident index trauma

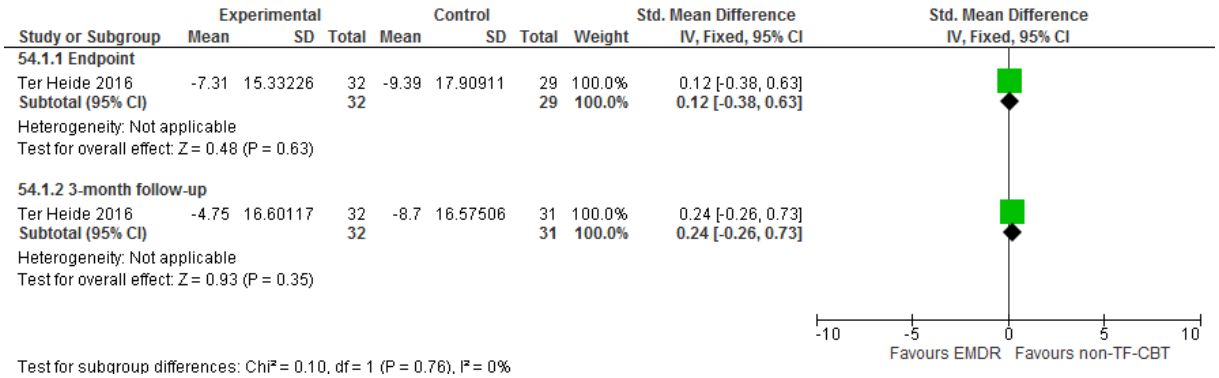


Figure 404: Eye movement desensitisation and reprocessing (EMDR) versus non-trauma-focused CBT for delayed treatment (>3 months) of clinically

important symptoms/PTSD: PTSD symptomatology self-rated (HTQ change score); Multiple incident index trauma

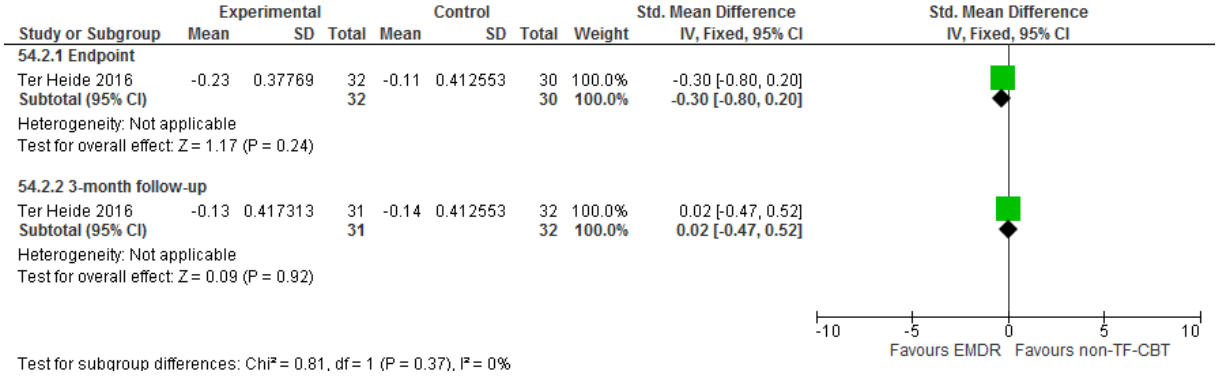


Figure 405: Eye movement desensitisation and reprocessing (EMDR) versus non-trauma-focused CBT for delayed treatment (>3 months) of clinically important symptoms/PTSD: Response (number of people showing improvement of at least 10 points on CAPS at 3-month follow-up)

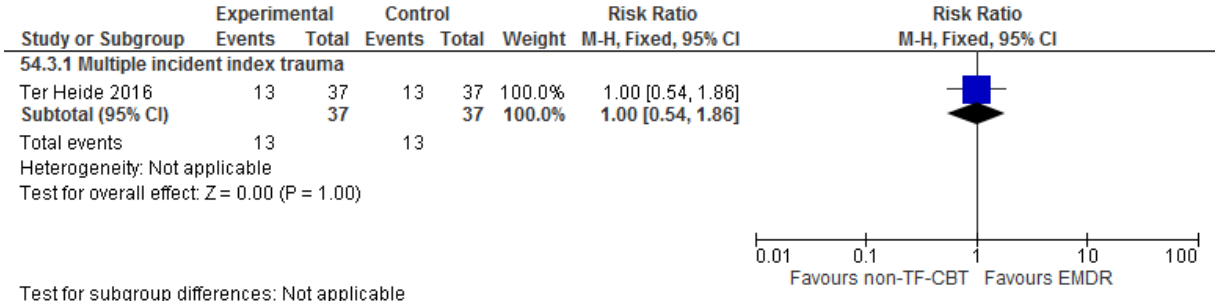


Figure 406: Eye movement desensitisation and reprocessing (EMDR) versus non-trauma-focused CBT for delayed treatment (>3 months) of clinically important symptoms/PTSD: Anxiety symptoms (HSCL-25: Anxiety, change score); Multiple incident index trauma

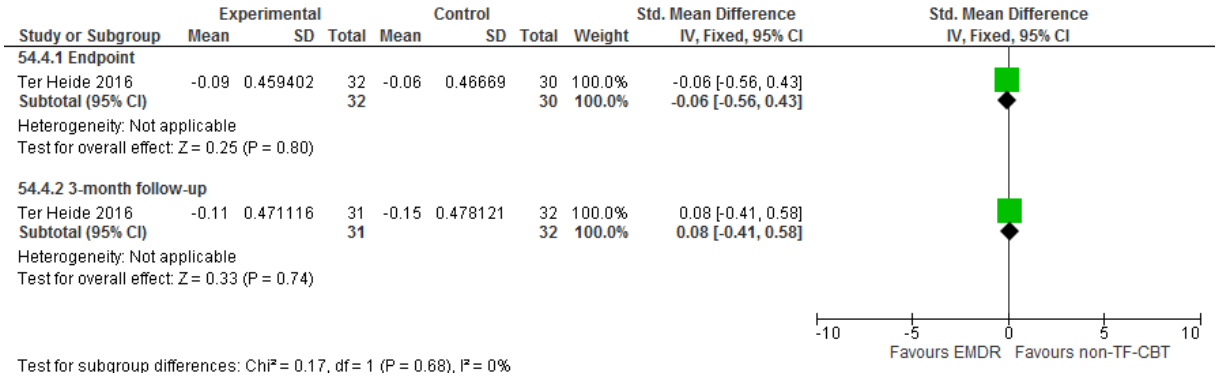


Figure 407: Eye movement desensitisation and reprocessing (EMDR) versus non-trauma-focused CBT for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms (HSCL-25: Depression; Change score); Multiple incident index trauma

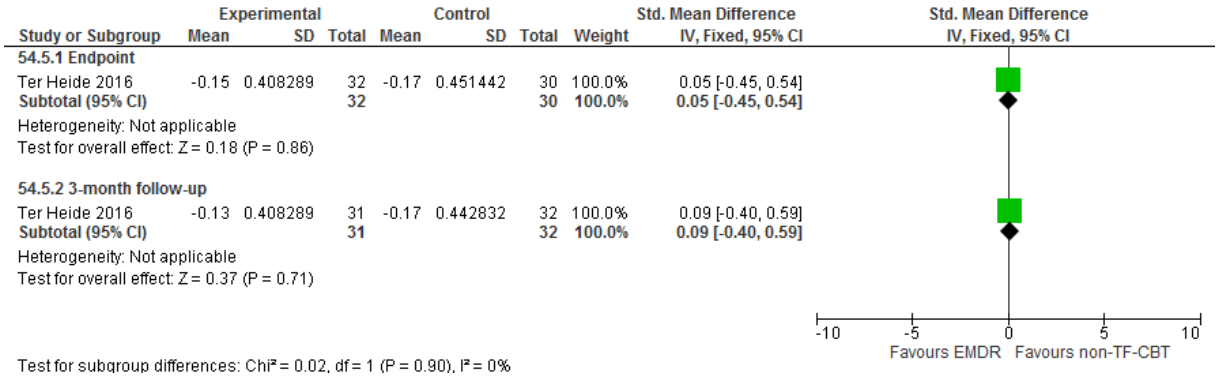


Figure 408: Eye movement desensitisation and reprocessing (EMDR) versus non-trauma-focused CBT for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)

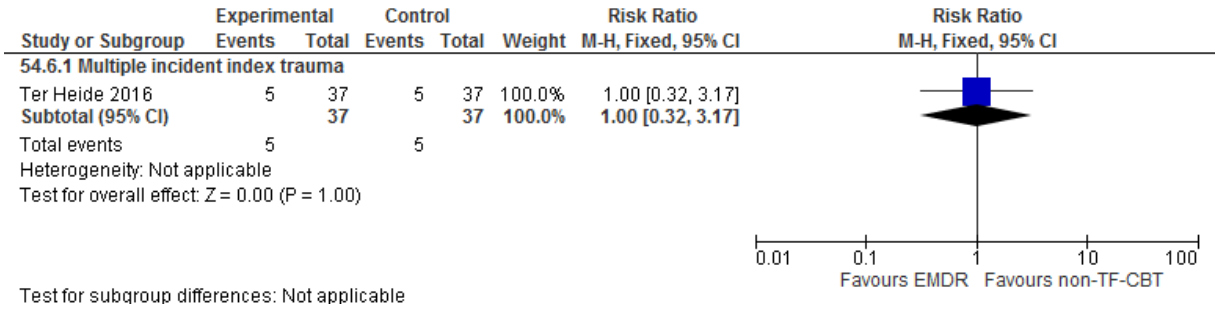


Figure 409: Eye movement desensitisation and reprocessing (EMDR) versus 'other active psych intervention' for delayed treatment (>3 months) of clinically

important symptoms/PTSD: PTSD symptomatology self-rated (IES change score); Multiple incident index trauma

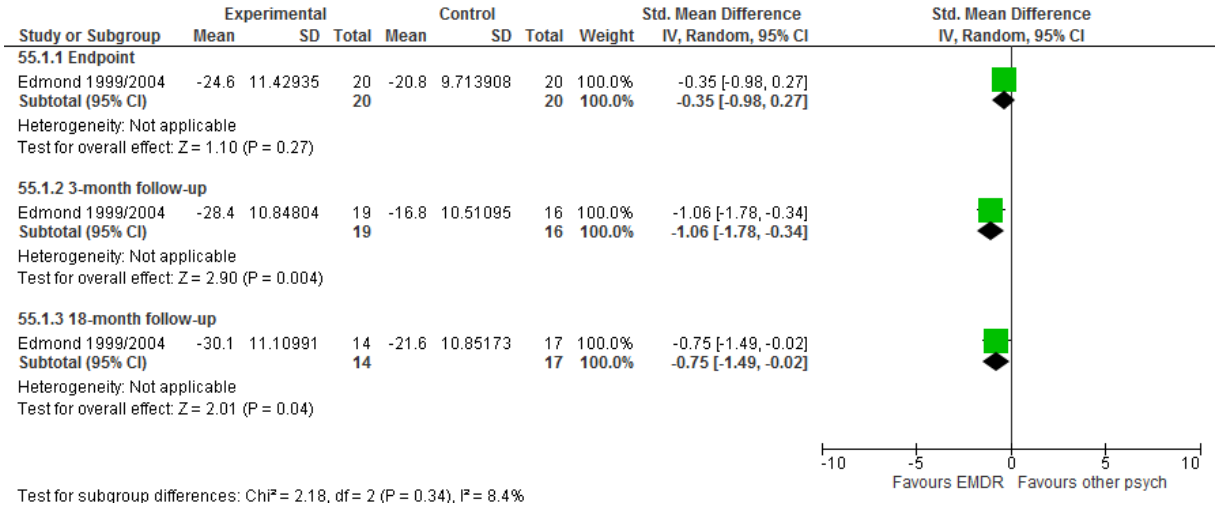


Figure 410: Eye movement desensitisation and reprocessing (EMDR) versus 'other active psych intervention' for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms (BDI change score); Multiple incident index trauma

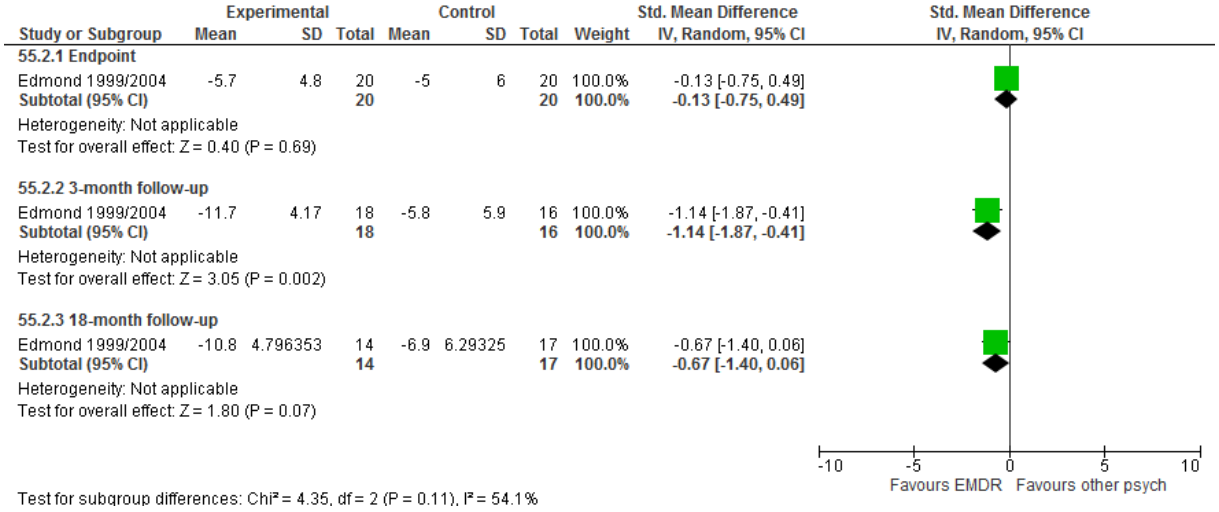


Figure 411: Eye movement desensitisation and reprocessing (EMDR; ±TAU) versus relaxation (±TAU) for delayed treatment (>3 months) of clinically important

symptoms/PTSD: PTSD symptomatology self-rated at endpoint (IES/PSS-SR change score at endpoint/follow-up)

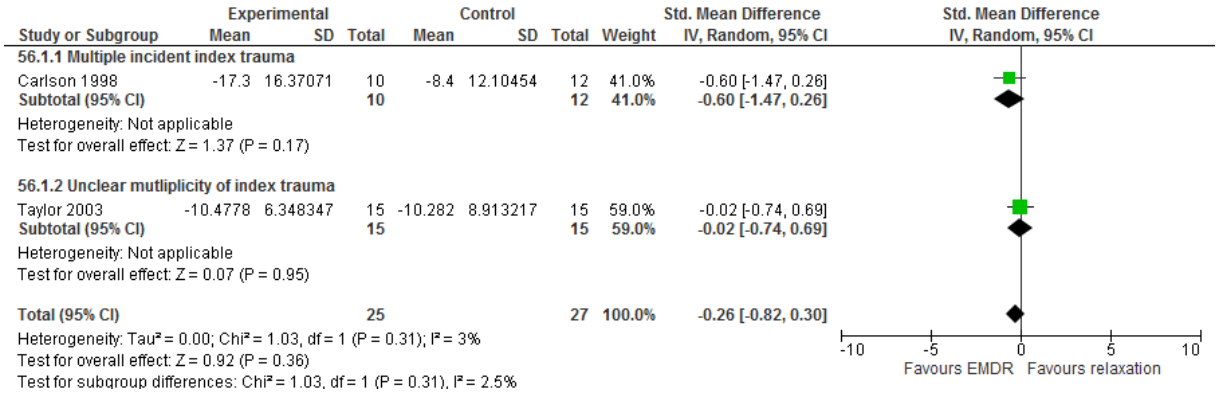


Figure 412: Eye movement desensitisation and reprocessing (EMDR; ±TAU) versus relaxation (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated at 3-month follow-up (PSS-SR change score at endpoint/follow-up)

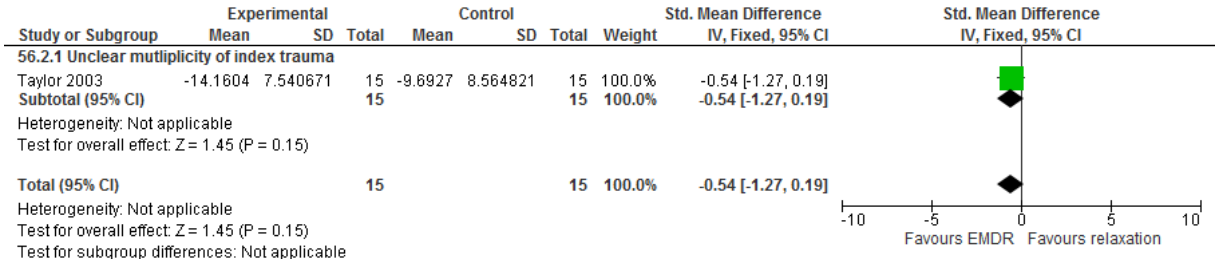


Figure 413: Eye movement desensitisation and reprocessing (EMDR; ±TAU) versus relaxation (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated at 6-month follow-up (IES-R change score)

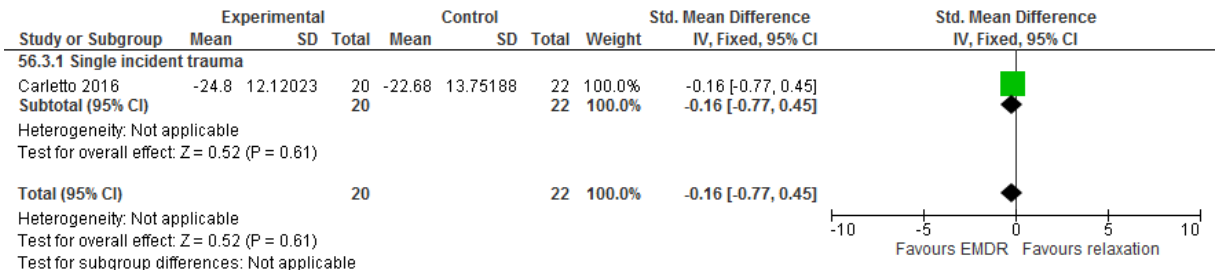


Figure 414: Eye movement desensitisation and reprocessing (EMDR; ±TAU) versus relaxation (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated at endpoint (CAPS change score)

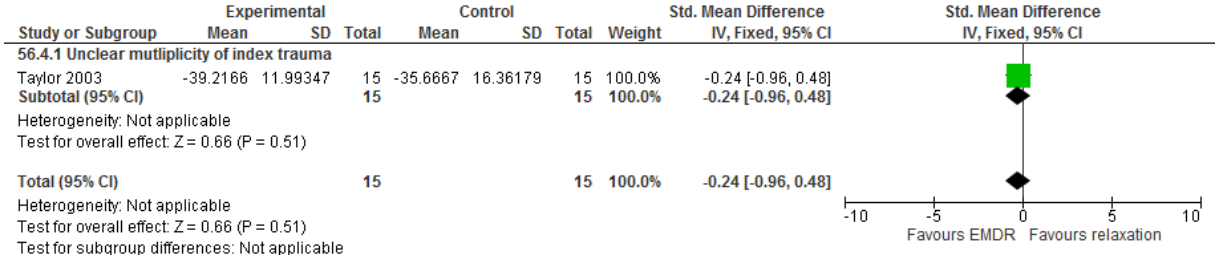


Figure 415: Eye movement desensitisation and reprocessing (EMDR; ±TAU) versus relaxation (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated at 3-month follow-up (CAPS change score)

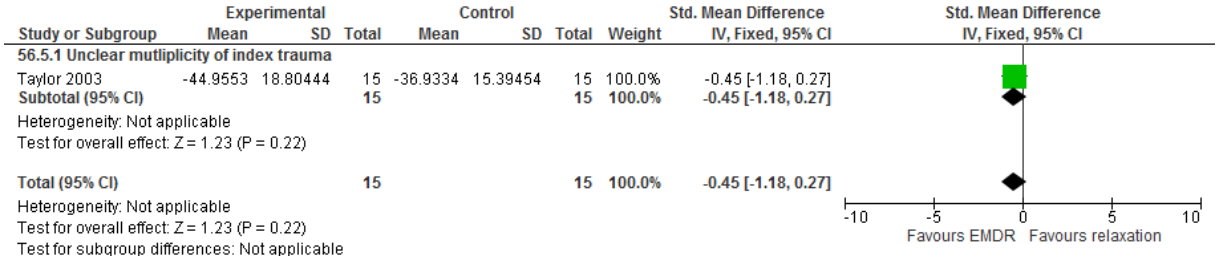


Figure 416: Eye movement desensitisation and reprocessing (EMDR; ±TAU) versus relaxation (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated at 6-month follow-up (CAPS change score)

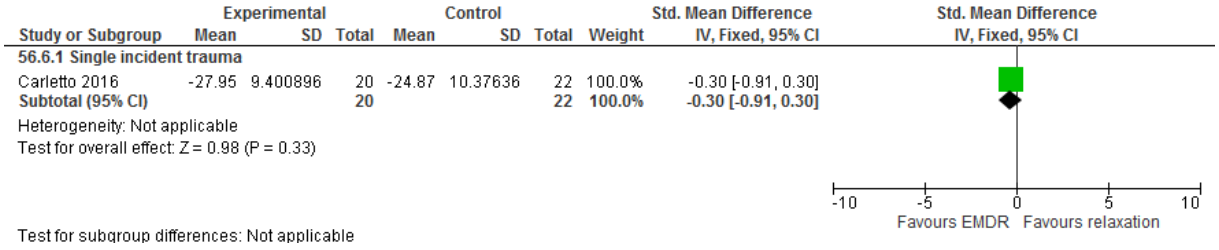


Figure 417: Eye movement desensitisation and reprocessing (EMDR; ±TAU) versus relaxation (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Remission at endpoint (number of people no longer

meeting diagnostic criteria or no longer above clinical threshold on a scale for PTSD)

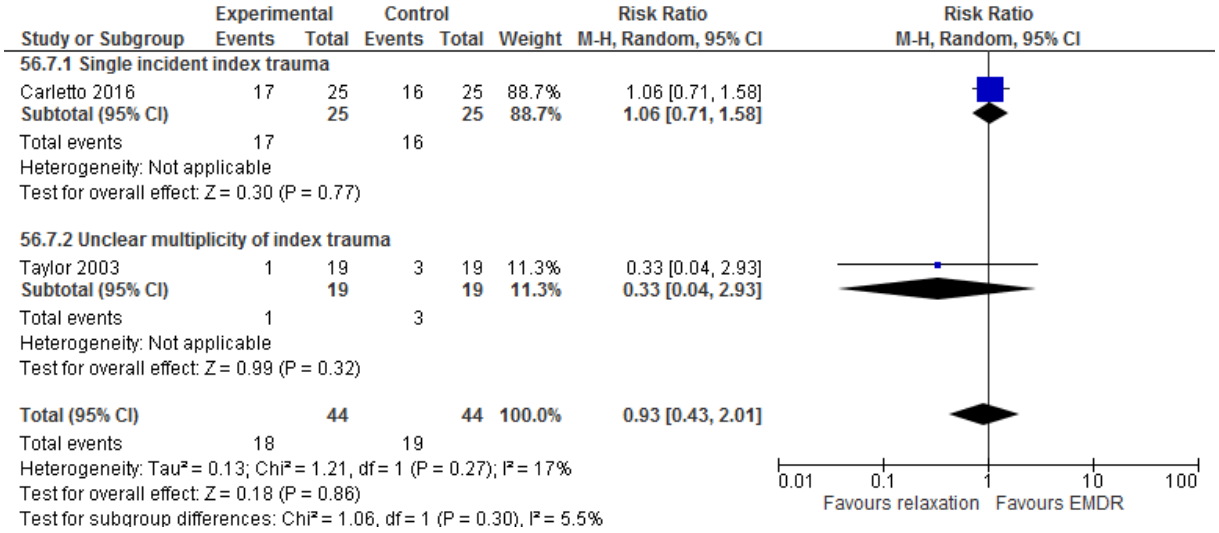


Figure 418: Eye movement desensitisation and reprocessing (EMDR; ±TAU) versus relaxation (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Remission at 3-month follow-up (number of people no longer above clinical threshold on a scale for PTSD)

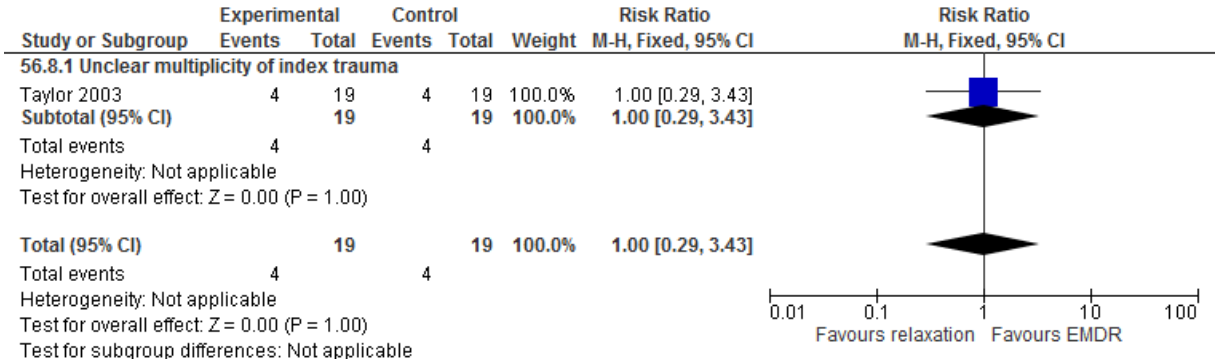


Figure 419: Eye movement desensitisation and reprocessing (EMDR; ±TAU) versus relaxation (±TAU) for delayed treatment (>3 months) of clinically important

symptoms/PTSD: Remission at 6-month follow-up (number of people no longer meeting diagnostic criteria for PTSD)

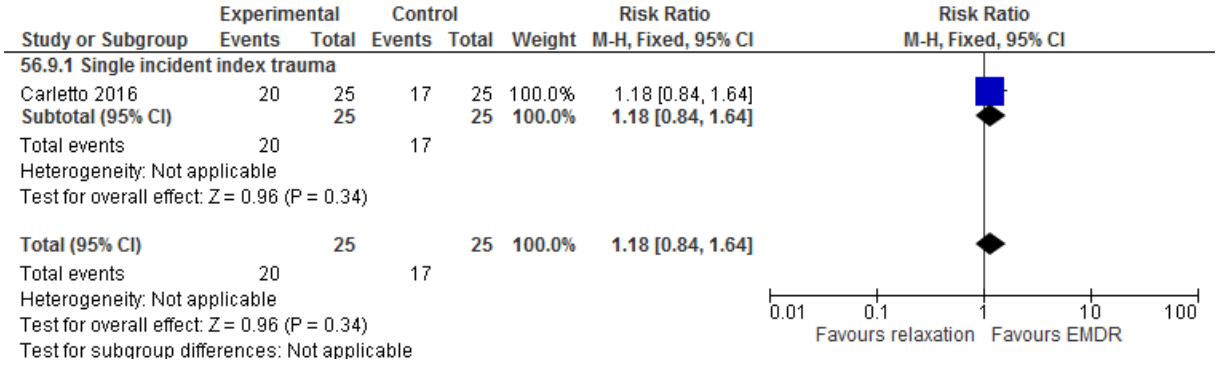


Figure 420: Eye movement desensitisation and reprocessing (EMDR; ±TAU) versus relaxation (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Dissociative symptoms (CAPS dissociation cluster change score); Unclear multiplicity of index trauma

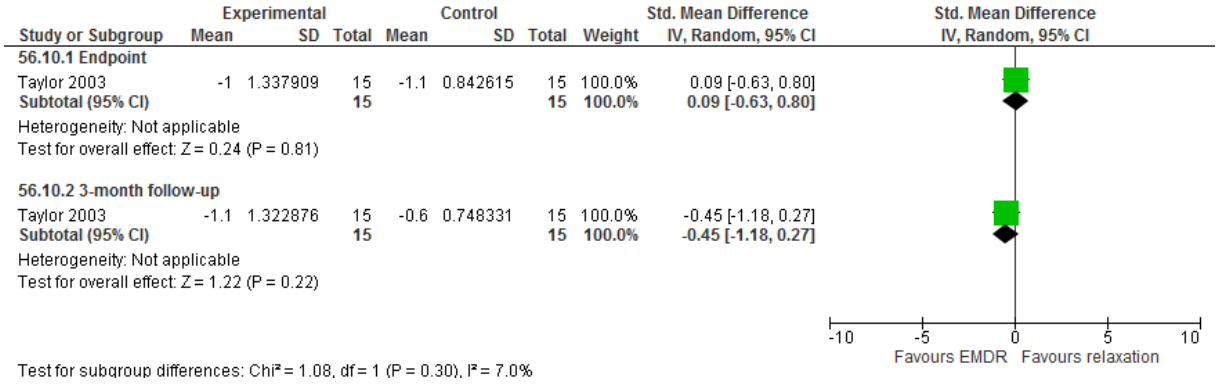


Figure 421: Eye movement desensitisation and reprocessing (EMDR; ±TAU) versus relaxation (±TAU) for delayed treatment (>3 months) of clinically important

symptoms/PTSD: Anxiety symptoms (HADS-A/STAI state change score at endpoint/follow-up)

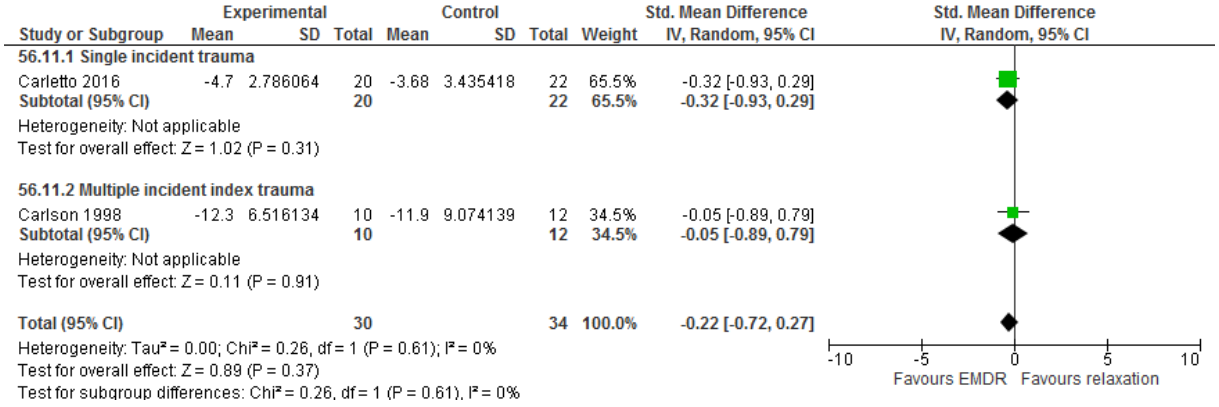


Figure 422: Depression symptoms ar endpoint (BDI change score)

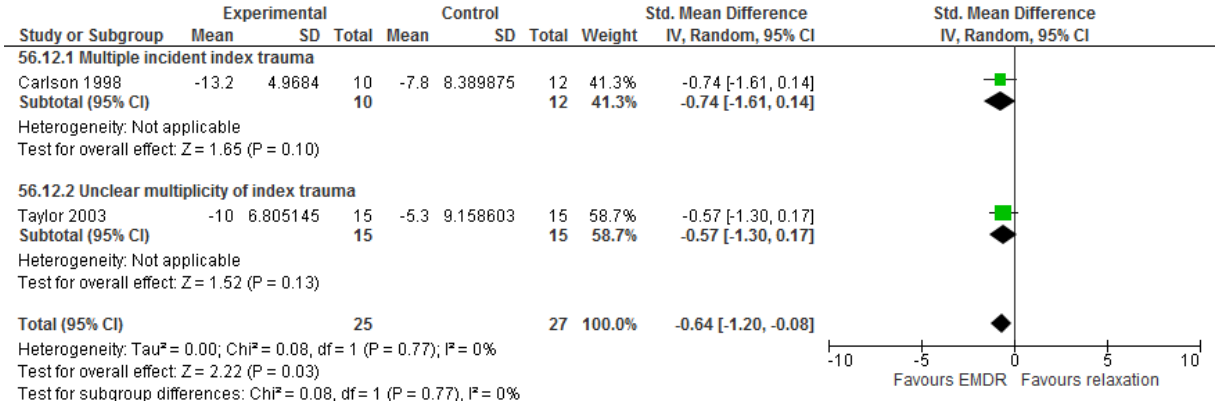


Figure 423: Eye movement desensitisation and reprocessing (EMDR; ±TAU) versus relaxation (±TAU) for delayed treatment (>3 months) of clinically important

symptoms/PTSD: Depression symptoms at 3-6 month follow-up (BDI/HADS-D change score)

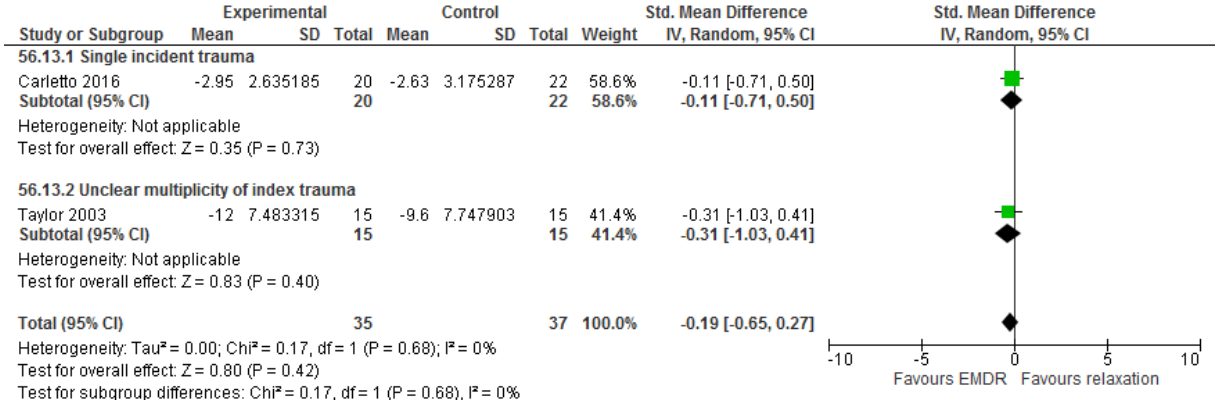


Figure 424: Eye movement desensitisation and reprocessing (EMDR; ±TAU) versus relaxation (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Quality of life (Functional Assessment of Quality of Life in MS; change score)

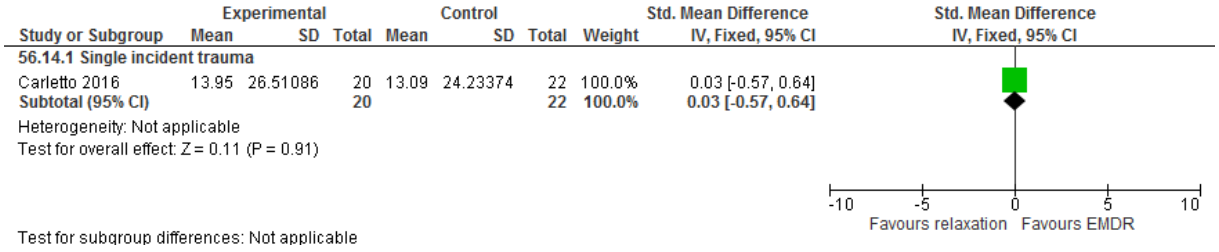


Figure 425: Eye movement desensitisation and reprocessing (EMDR; ±TAU) versus relaxation (±TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)

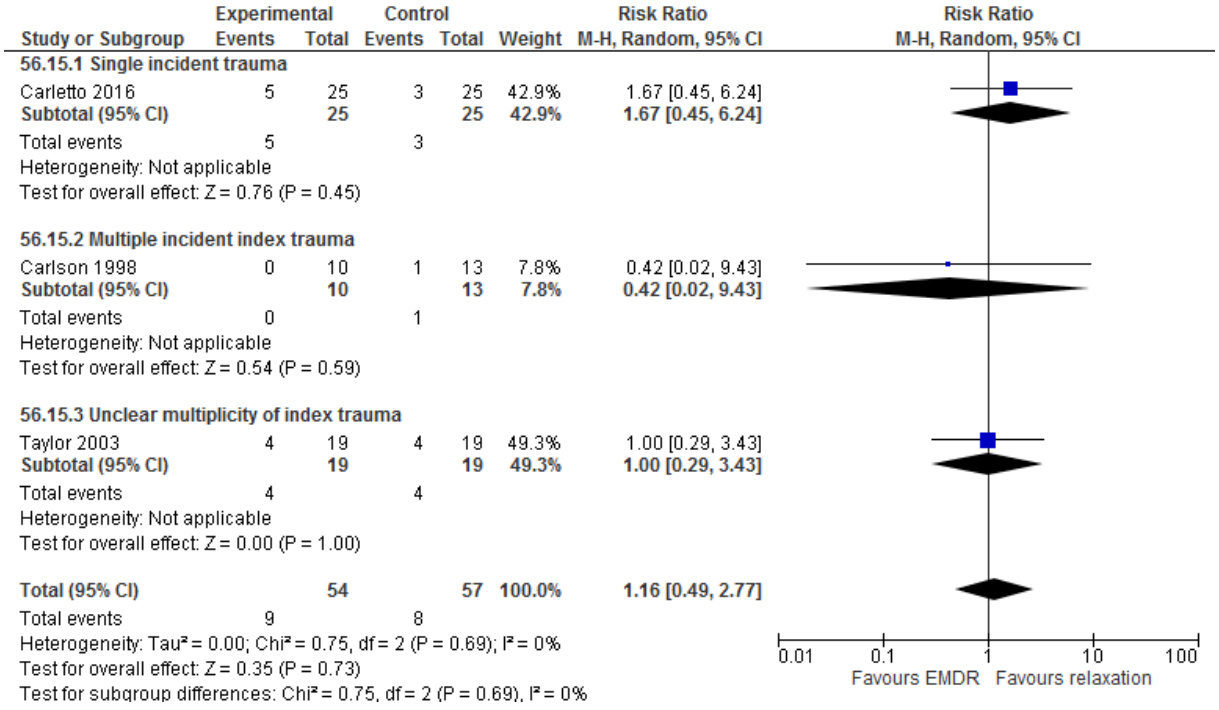


Figure 426: Eye movement desensitisation and reprocessing (EMDR) versus combined somatic and cognitive therapies for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-report (PCL-C change score); Single incident trauma

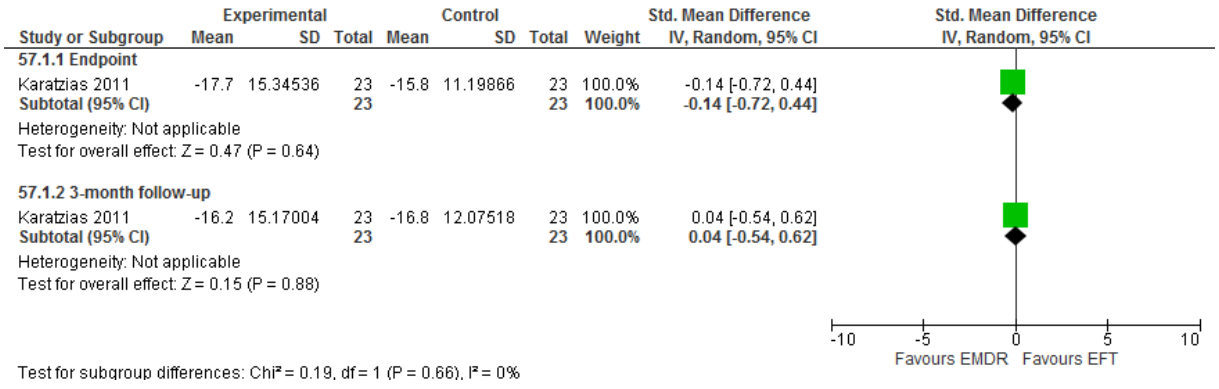


Figure 427: Eye movement desensitisation and reprocessing (EMDR) versus combined somatic and cognitive therapies for delayed treatment (>3 months)

of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated (CAPS change score); Single incident trauma

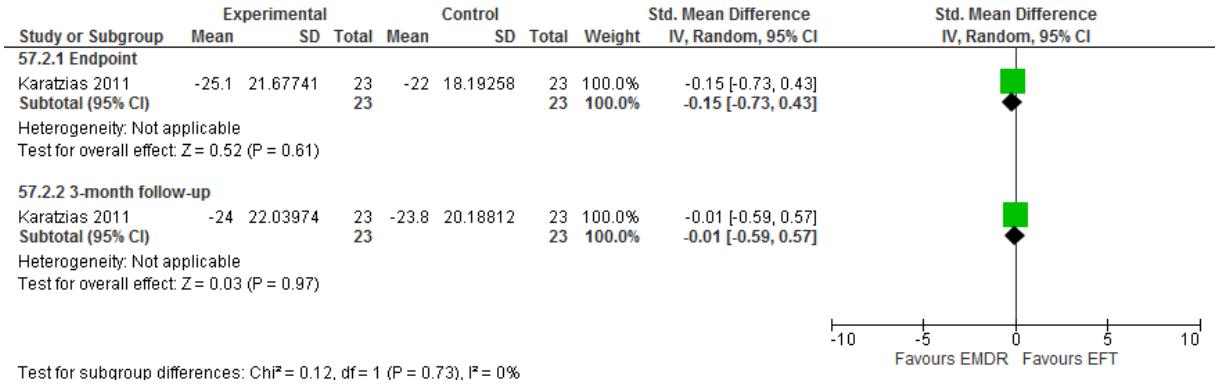


Figure 428: Eye movement desensitisation and reprocessing (EMDR) versus combined somatic and cognitive therapies for delayed treatment (>3 months) of clinically important symptoms/PTSD: Response self-rated (number of people showing clinically significant improvement (based on reliable change indices [RCI]) on PCL-C); Single incident trauma

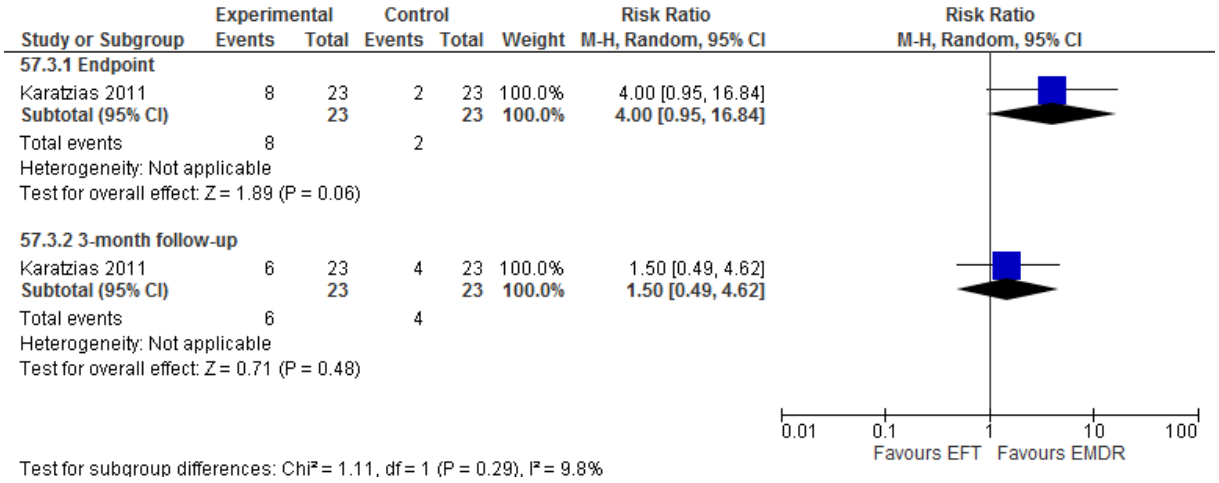


Figure 429: Eye movement desensitisation and reprocessing (EMDR) versus combined somatic and cognitive therapies for delayed treatment (>3 months) of clinically important symptoms/PTSD: Response clinician-rated (number of

people showing clinically significant improvement [based on RCI] on CAPS); Single incident trauma

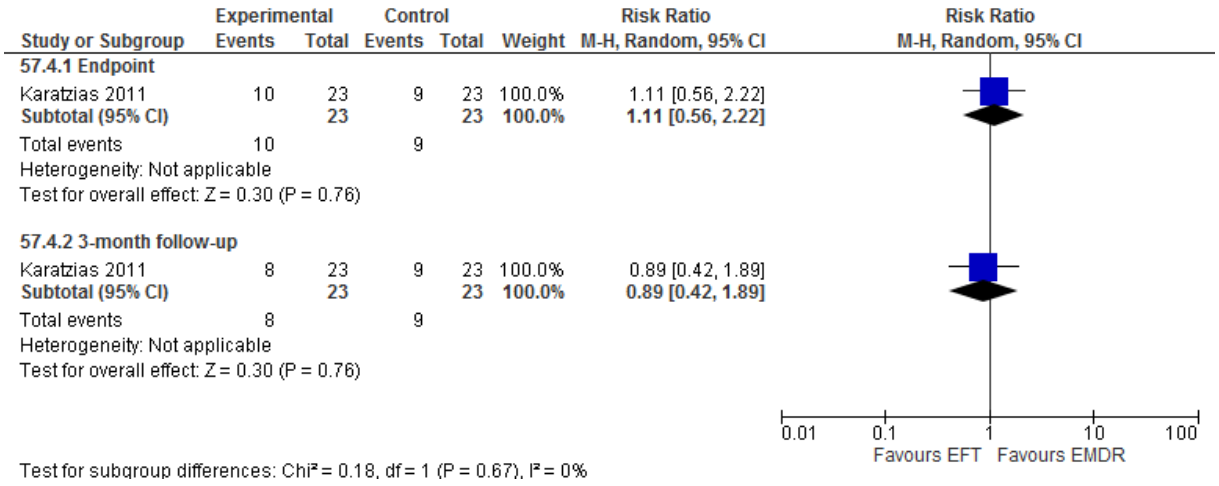


Figure 430: Eye movement desensitisation and reprocessing (EMDR) versus combined somatic and cognitive therapies for delayed treatment (>3 months) of clinically important symptoms/PTSD: Anxiety symptoms (HADS-A change score); Single incident trauma

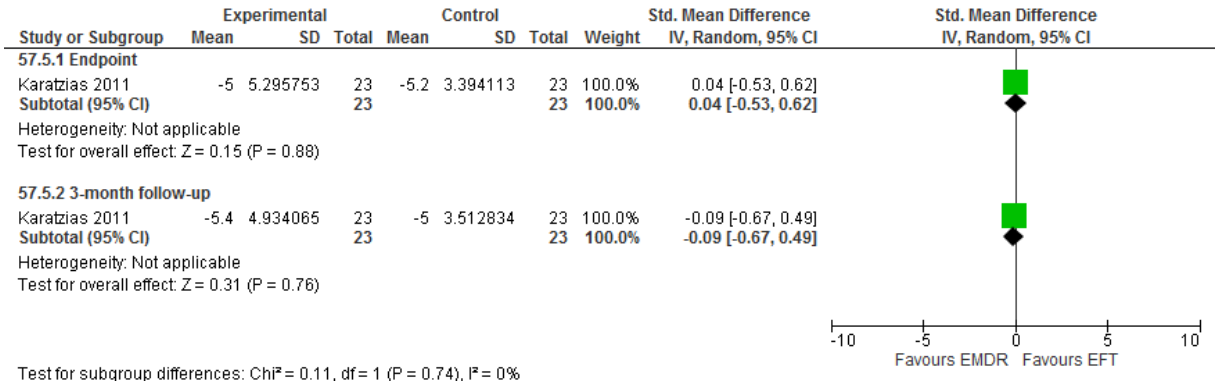


Figure 431: Eye movement desensitisation and reprocessing (EMDR) versus combined somatic and cognitive therapies for delayed treatment (>3 months)

of clinically important symptoms/PTSD: Depression symptoms (HADS-D change score); Single incident trauma

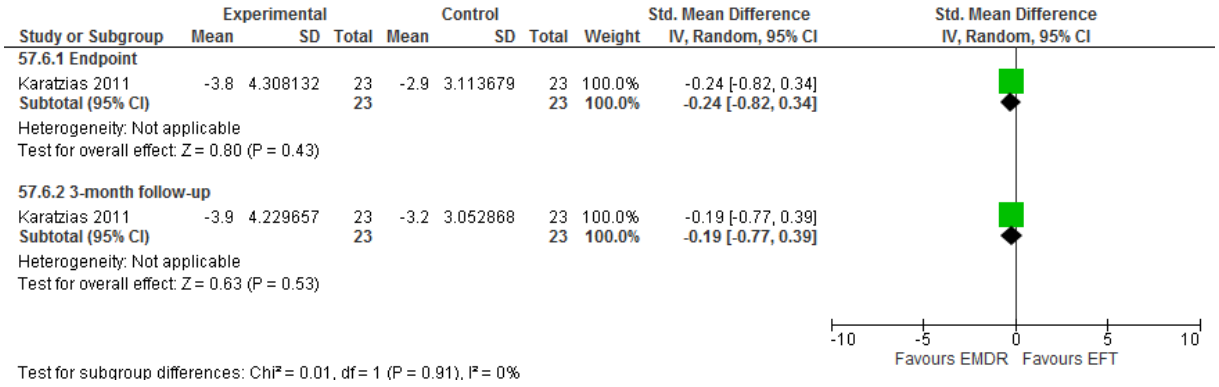


Figure 432: Eye movement desensitisation and reprocessing (EMDR) versus combined somatic and cognitive therapies for delayed treatment (>3 months) of clinically important symptoms/PTSD: Quality of life (Satisfaction with Life Scale; change score); Single incident trauma

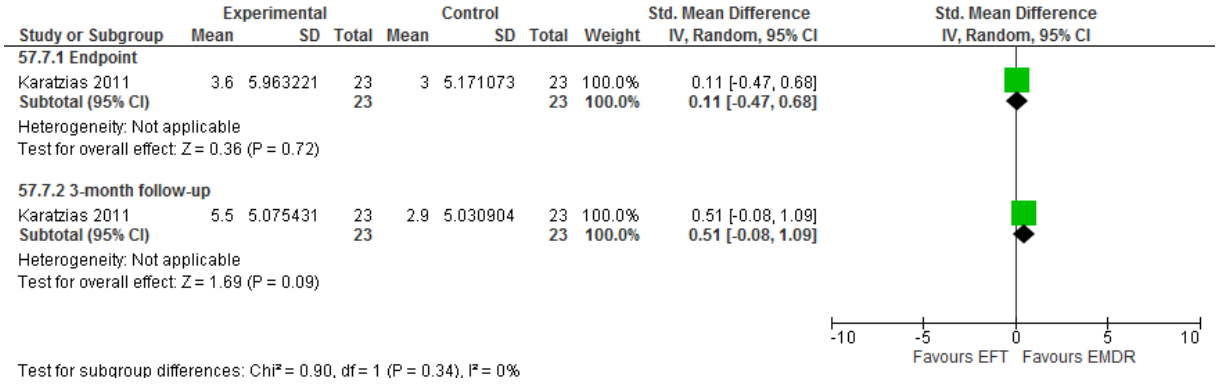


Figure 433: Eye movement desensitisation and reprocessing (EMDR) versus combined somatic and cognitive therapies for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)

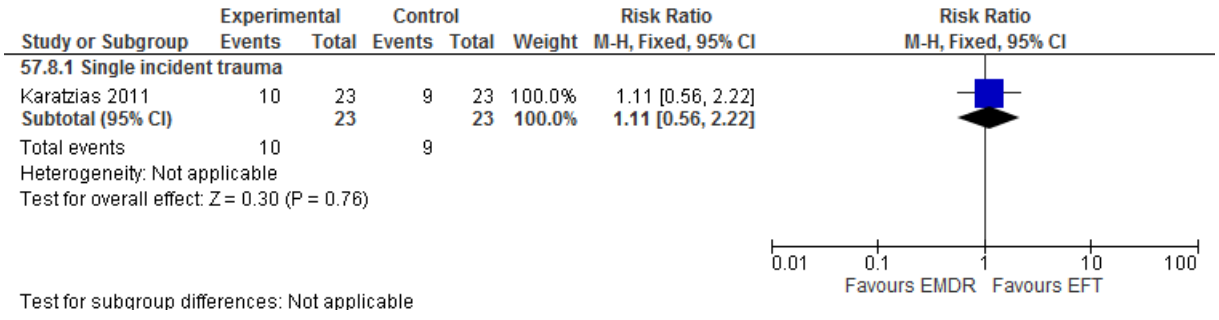


Figure 434: Eye movement desensitisation and reprocessing (EMDR) versus fluoxetine for delayed treatment (>3 months) of clinically important

symptoms/PTSD: PTSD symptomatology clinician-rated (CAPS change score); Multiple incident index trauma

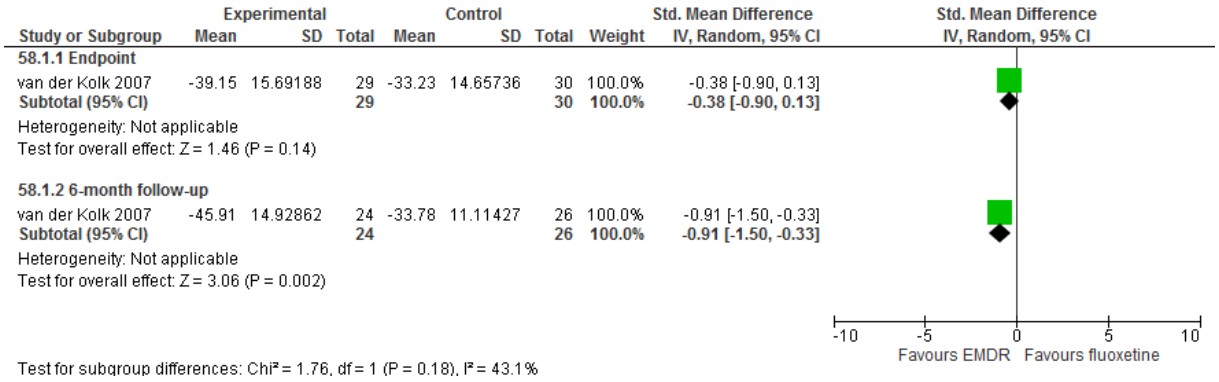


Figure 435: Eye movement desensitisation and reprocessing (EMDR) versus fluoxetine for delayed treatment (>3 months) of clinically important symptoms/PTSD: Remission (number of people scoring <20 on CAPS); Multiple incident index trauma

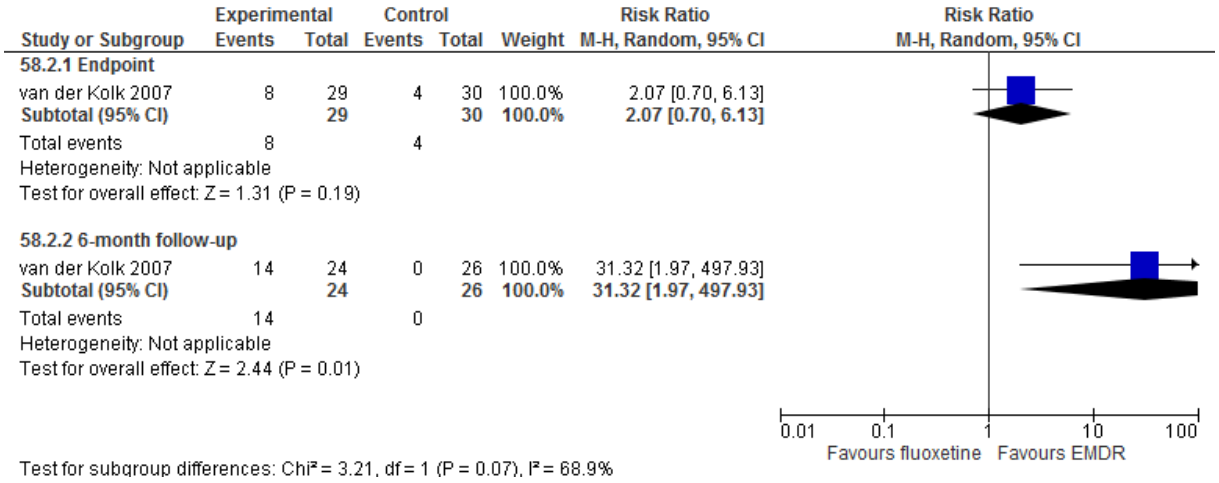


Figure 436: Eye movement desensitisation and reprocessing (EMDR) versus fluoxetine for delayed treatment (>3 months) of clinically important

symptoms/PTSD: Depression symptoms (BDI-II change score); Multiple incident index trauma

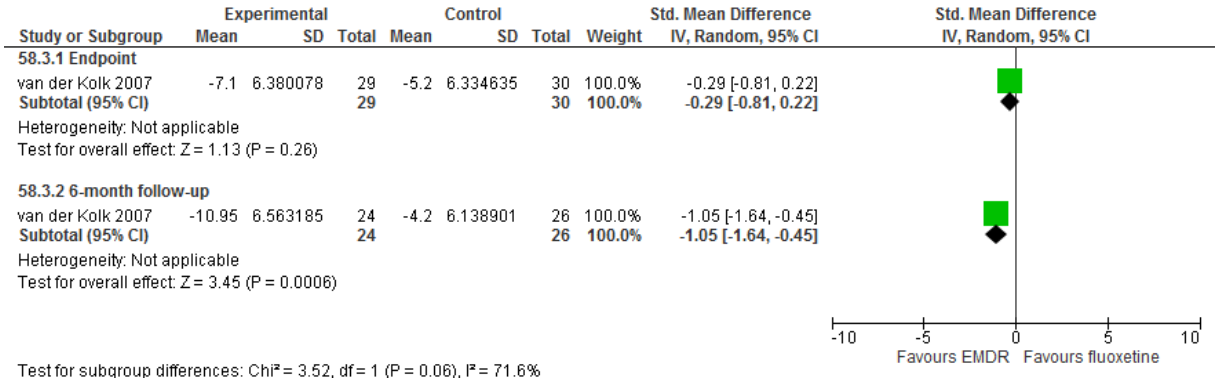
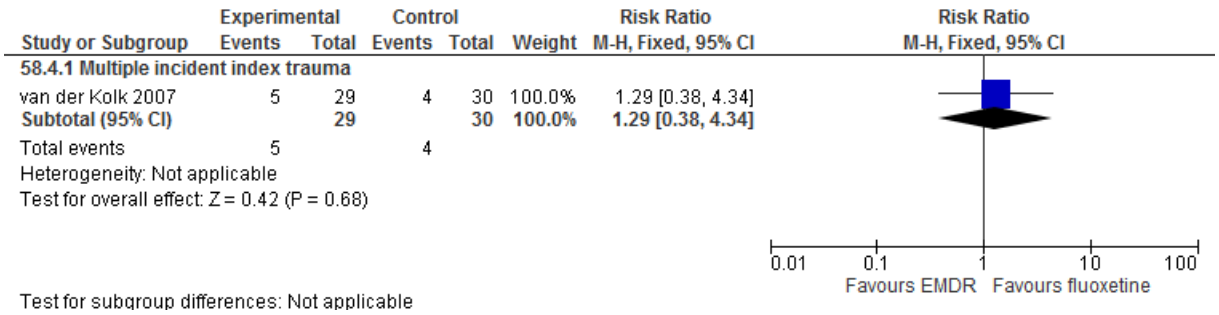


Figure 437: Eye movement desensitisation and reprocessing (EMDR) versus fluoxetine for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)



Hypnotherapy

Figure 438: Hypnotherapy + TAU versus TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated (IES change score)

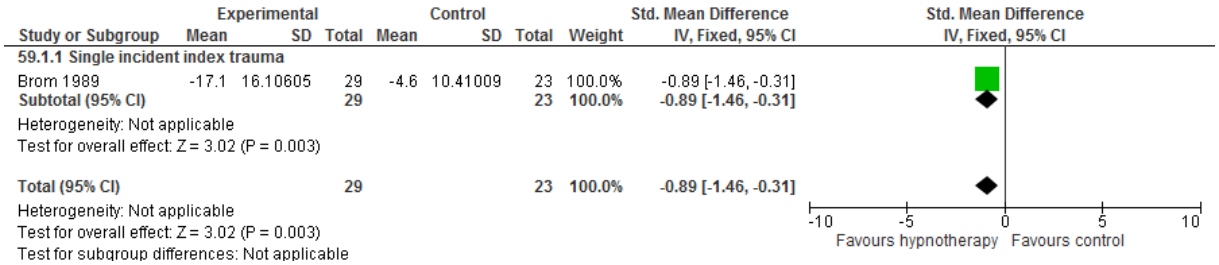


Figure 439: Hypnotherapy followed by trauma-focused CBT versus symptom monitoring followed by trauma-focused CBT for delayed treatment (>3

months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated (CAPS change score); Multiple incident index trauma

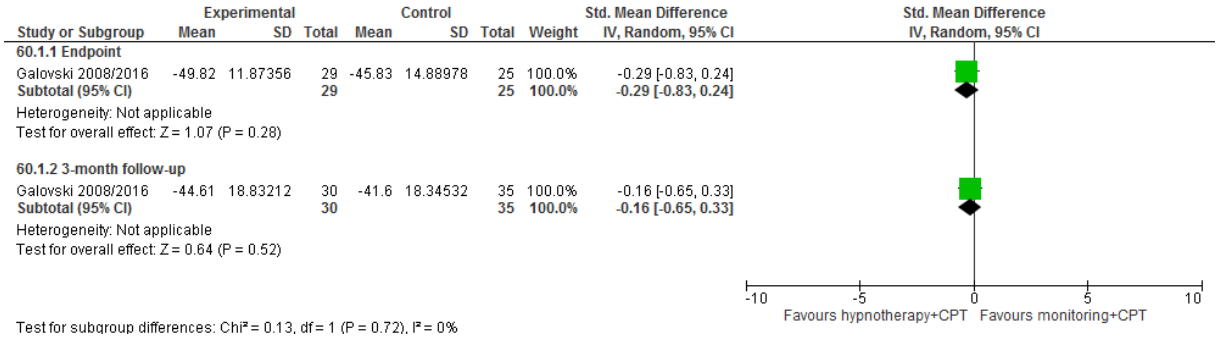


Figure 440: Hypnotherapy followed by trauma-focused CBT versus symptom monitoring followed by trauma-focused CBT for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms (BDI-II change score); Multiple incident index trauma

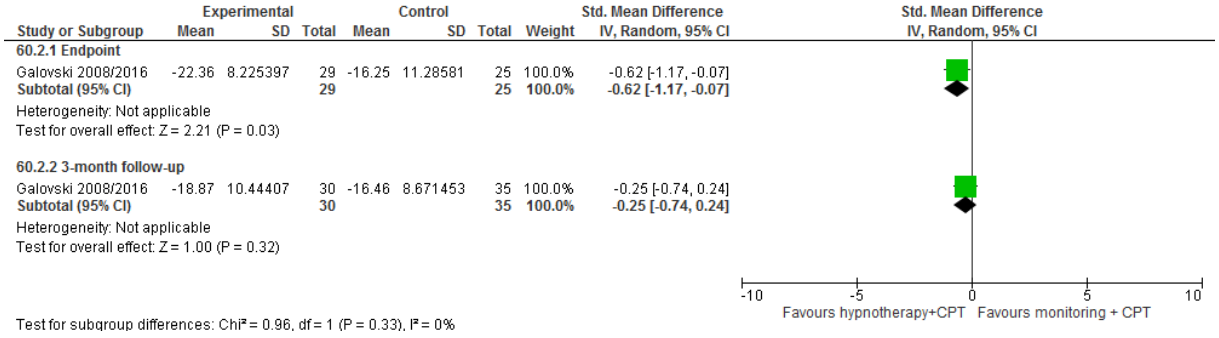


Figure 441: Hypnotherapy followed by trauma-focused CBT versus symptom monitoring followed by trauma-focused CBT for delayed treatment (>3 months) of clinically important symptoms/PTSD: Sleeping difficulties (PSQI change score); Multiple incident index trauma

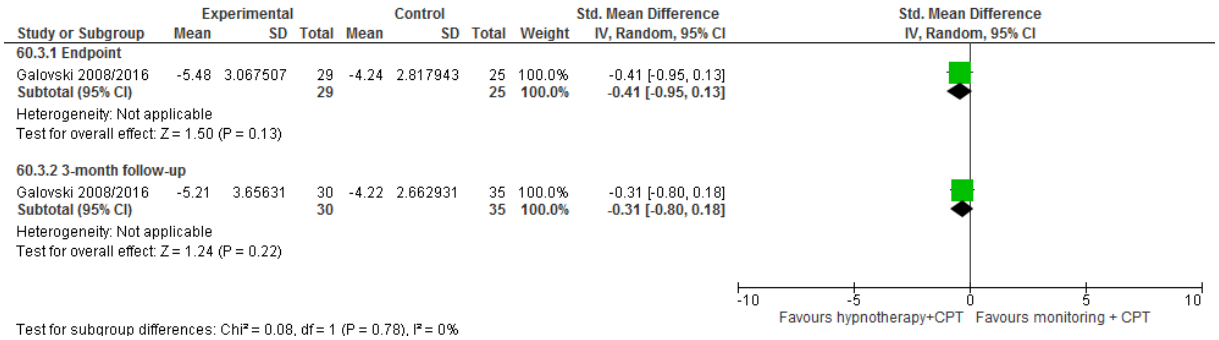


Figure 442: Hypnotherapy followed by trauma-focused CBT versus symptom monitoring followed by trauma-focused CBT for delayed treatment (>3

months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)

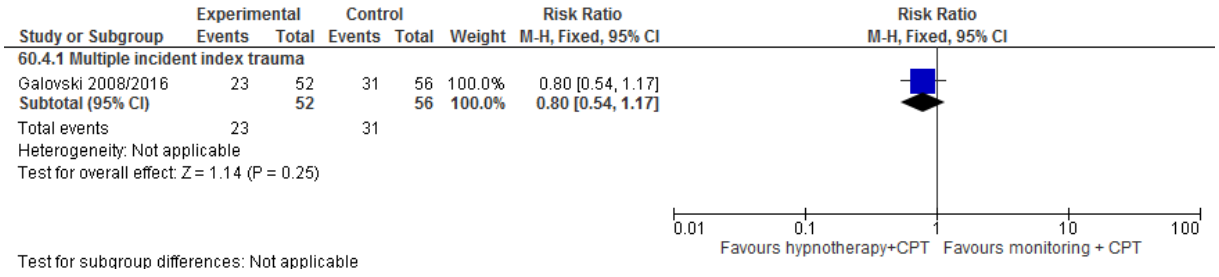


Figure 443: Hypnotherapy (+ TAU) versus zolpidem (+ TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-report (IES change score); Multiple incident index trauma

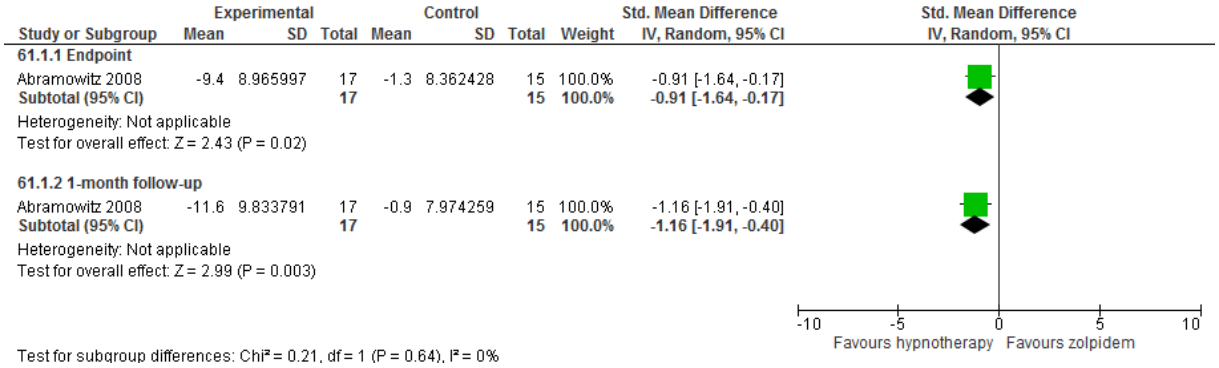


Figure 444: Hypnotherapy (+ TAU) versus zolpidem (+ TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms (BDI change score); Multiple incident index trauma

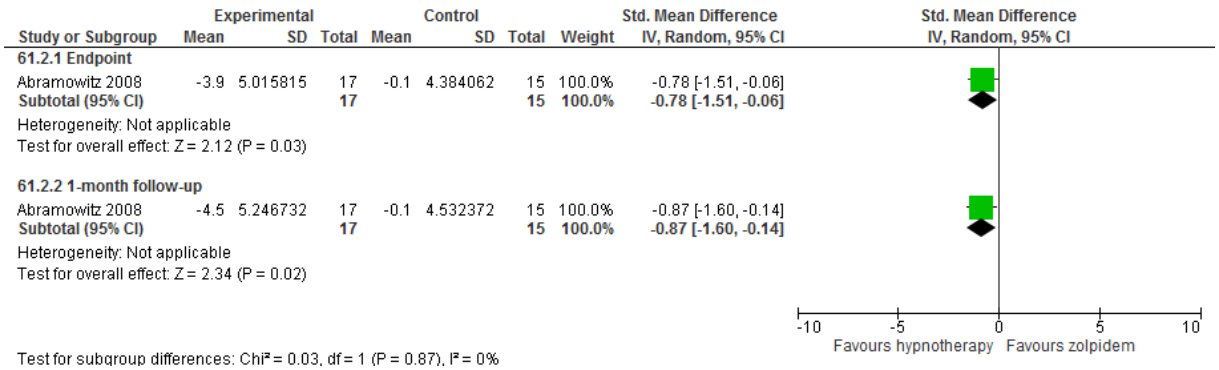
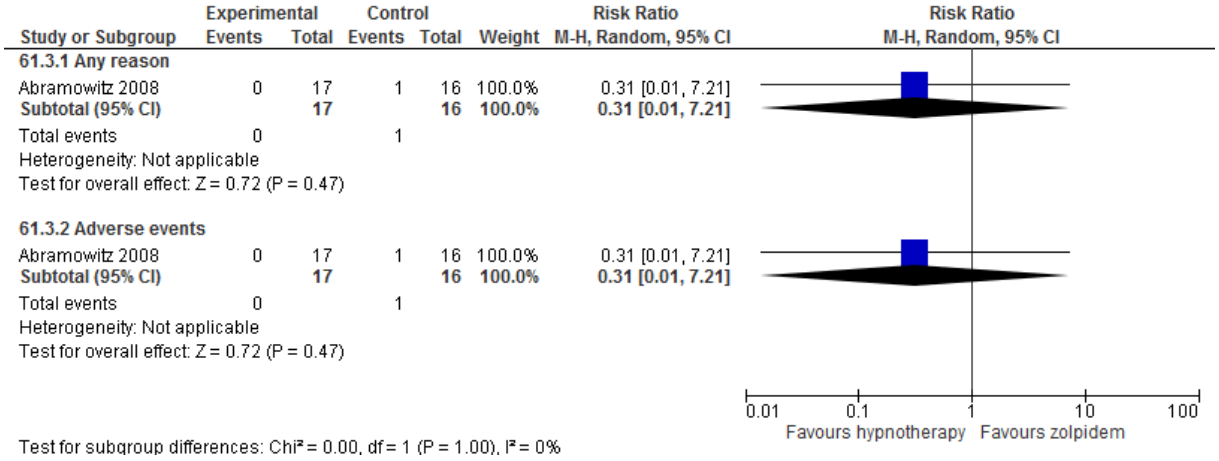


Figure 445: Hypnotherapy (+ TAU) versus zolpidem (+ TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up); Multiple incident index trauma



Psychodynamic therapy

Figure 446: Psychodynamic therapy (± TAU) versus waitlist (+ TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated (IES change score)

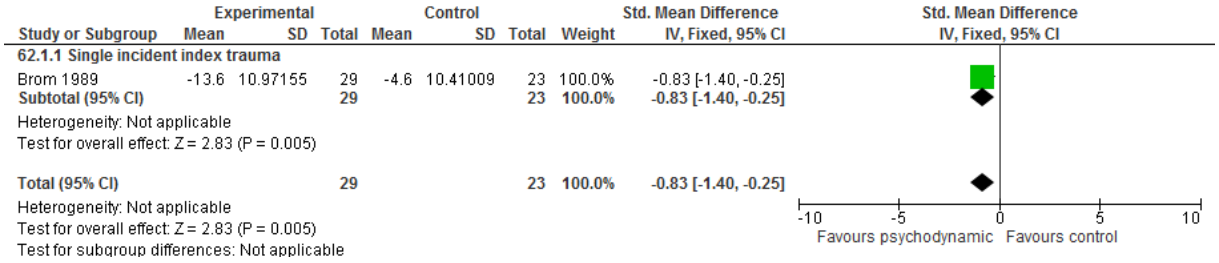


Figure 447: Psychodynamic therapy (± TAU) versus waitlist (+ TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Remission (number of people no longer met criteria for PTSD based on HTQ DSM-IV PTSD algorithm)

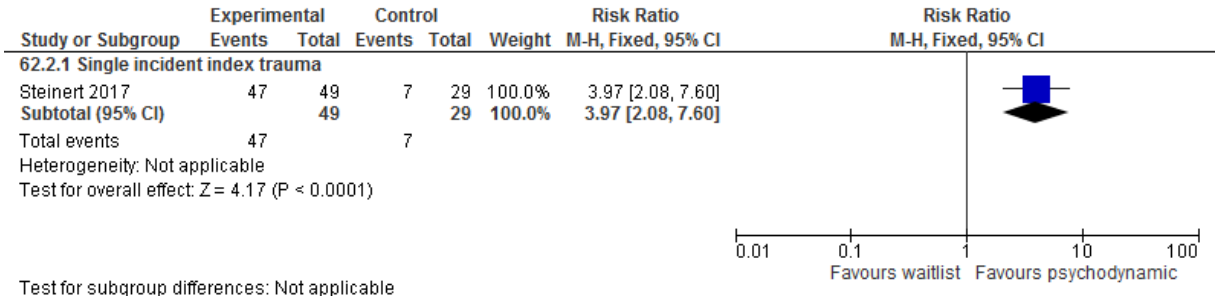


Figure 448: Psychodynamic therapy (± TAU) versus waitlist (+ TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Anxiety symptoms (HSCL-25: Anxiety; change score)

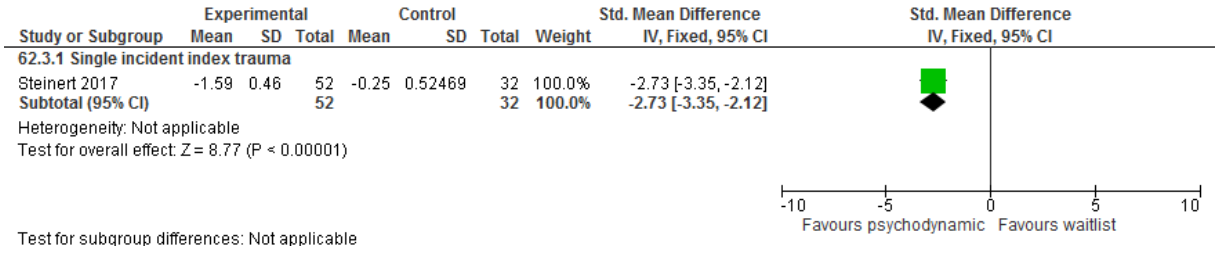


Figure 449: Psychodynamic therapy (± TAU) versus waitlist (+ TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms (HSCL-25: Depression; change score)

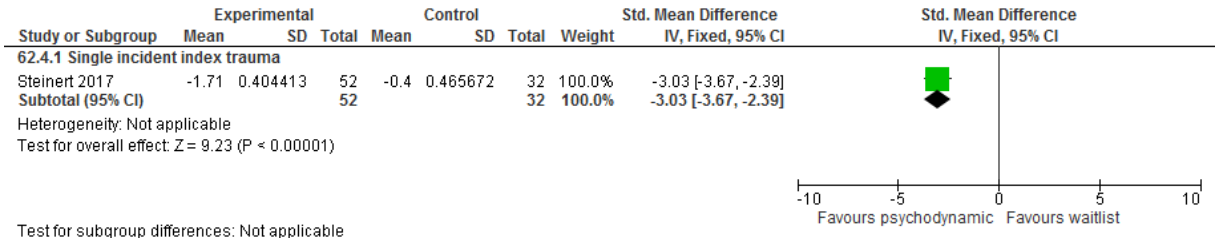
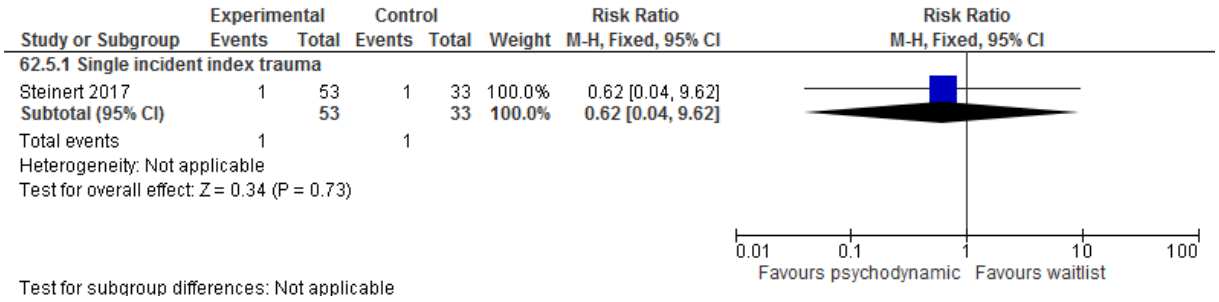


Figure 450: Psychodynamic therapy (± TAU) versus waitlist (+ TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)



Interpersonal psychotherapy

Figure 451: Interpersonal psychotherapy (IPT) versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated (CAPS change score); Multiple incident index trauma

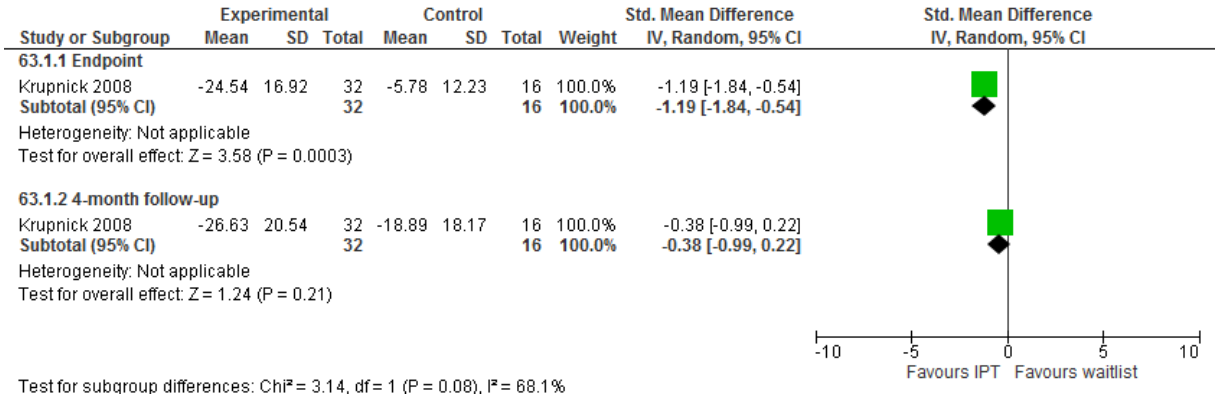


Figure 452: Interpersonal psychotherapy (IPT) versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Remission (number of people no longer meeting diagnostic criteria for PTSD)

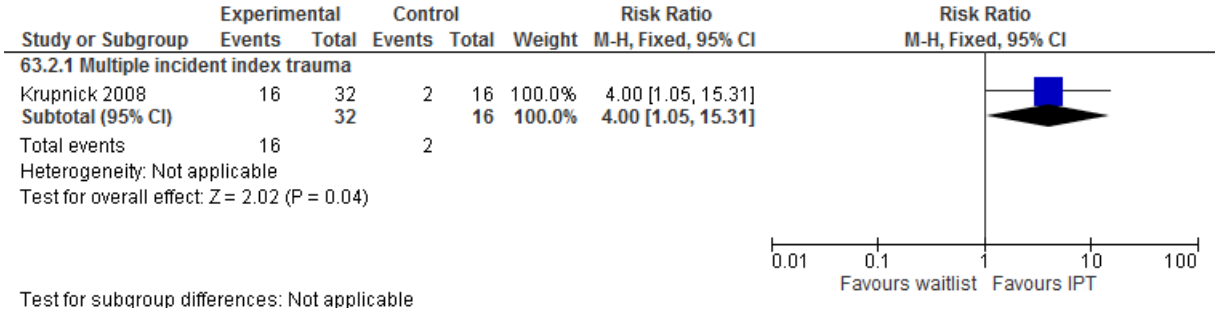


Figure 453: Interpersonal psychotherapy (IPT) versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms (HAMD change score); Multiple incident index trauma

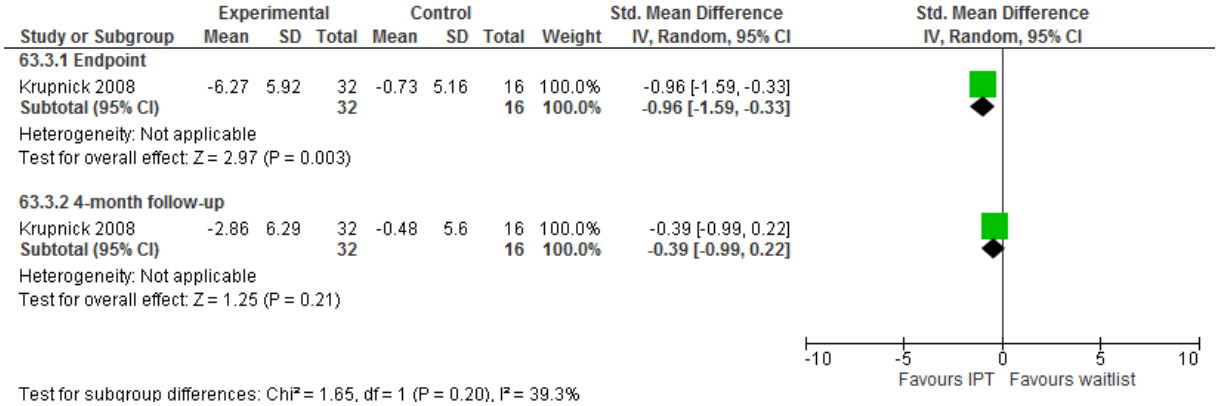


Figure 454: Interpersonal psychotherapy (IPT) versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)

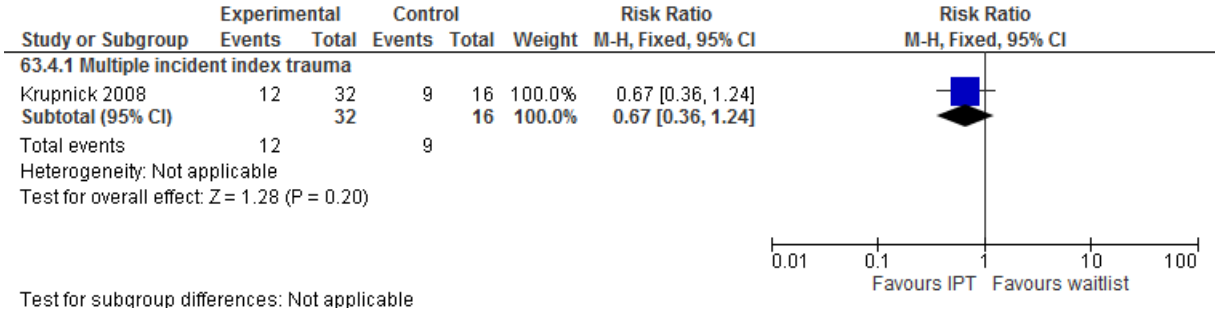


Figure 455: Interpersonal psychotherapy (IPT) versus relaxation for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated (CAPS change score)

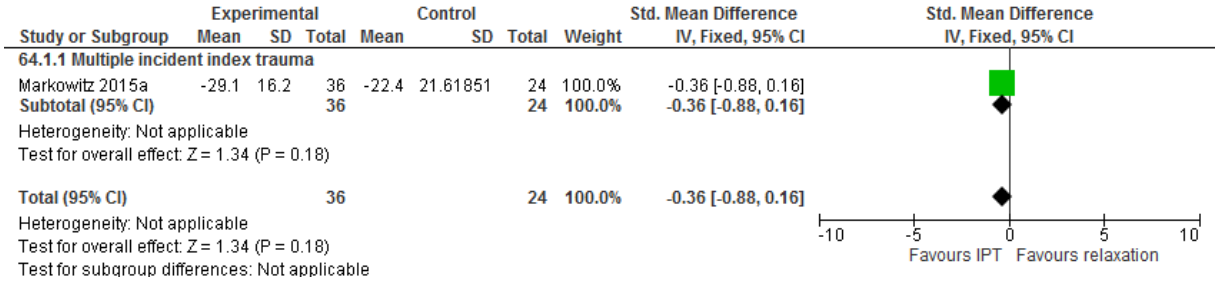


Figure 456: Interpersonal psychotherapy (IPT) versus relaxation for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated (PSS-SR change score)

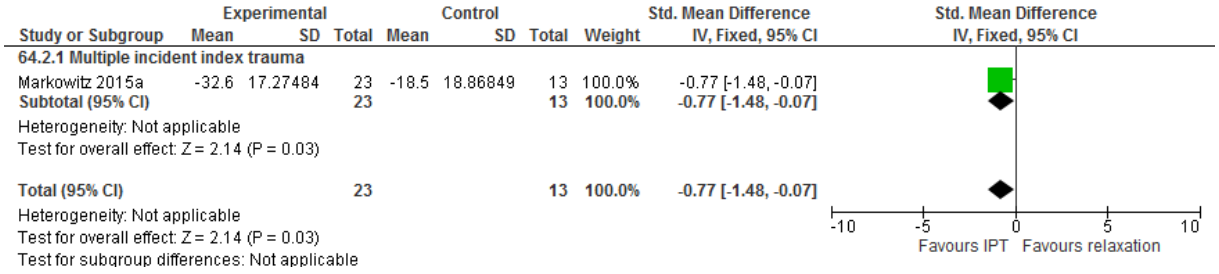


Figure 457: Interpersonal psychotherapy (IPT) versus relaxation for delayed treatment (>3 months) of clinically important symptoms/PTSD: Remission (number of people scoring <20 on CAPS)

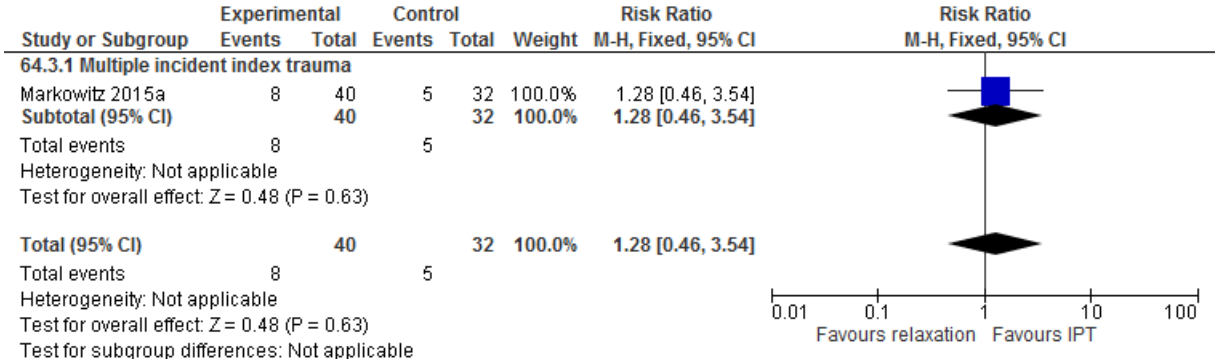


Figure 458: Interpersonal psychotherapy (IPT) versus relaxation for delayed treatment (>3 months) of clinically important symptoms/PTSD: Response (number of people showing ≥30% improvement on CAPS)

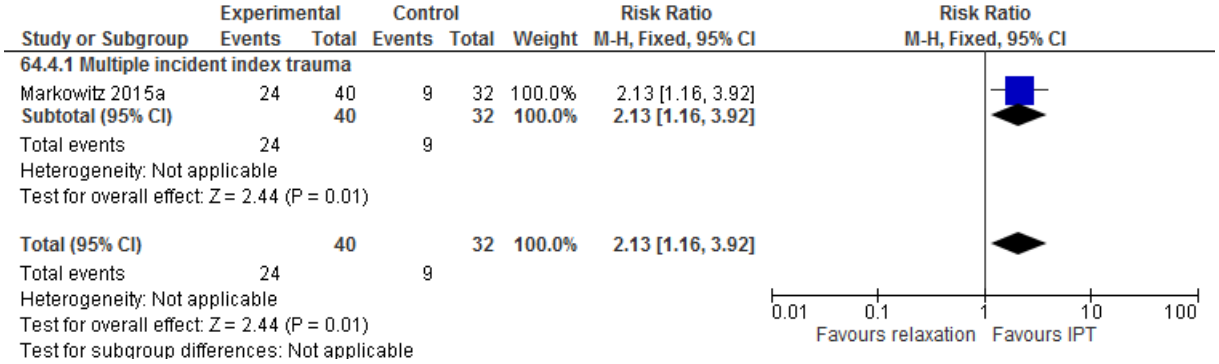


Figure 459: Interpersonal psychotherapy (IPT) versus relaxation for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms (HAMD change score)

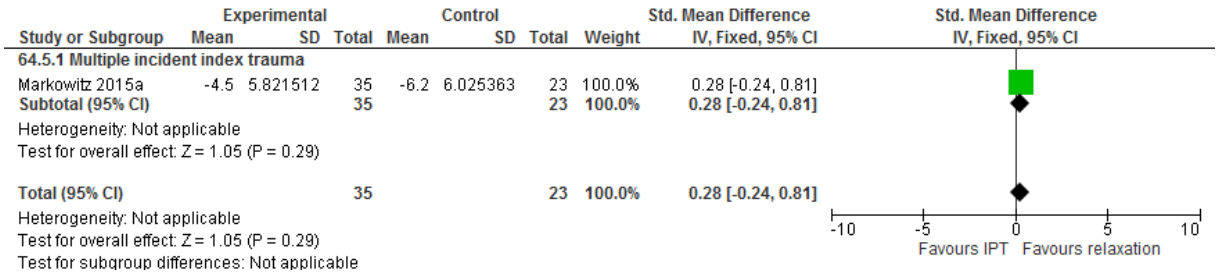


Figure 460: Interpersonal psychotherapy (IPT) versus relaxation for delayed treatment (>3 months) of clinically important symptoms/PTSD: Functional impairment (SAS change score)

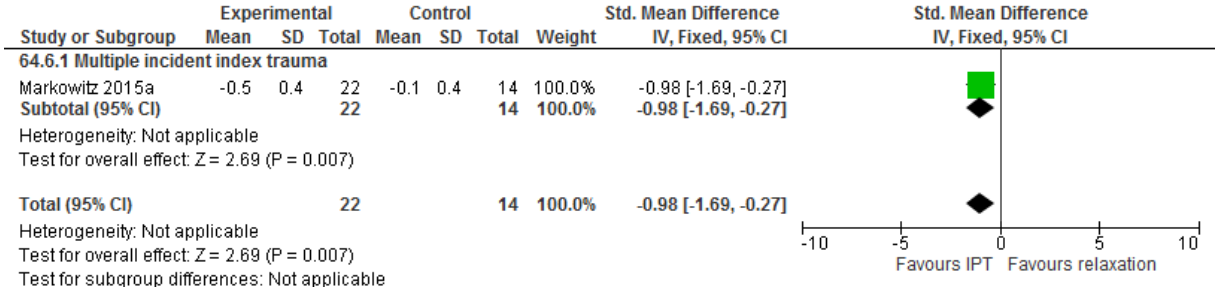


Figure 461: Interpersonal psychotherapy (IPT) versus relaxation for delayed treatment (>3 months) of clinically important symptoms/PTSD: Quality of life (Q-LES-Q-SF change score)

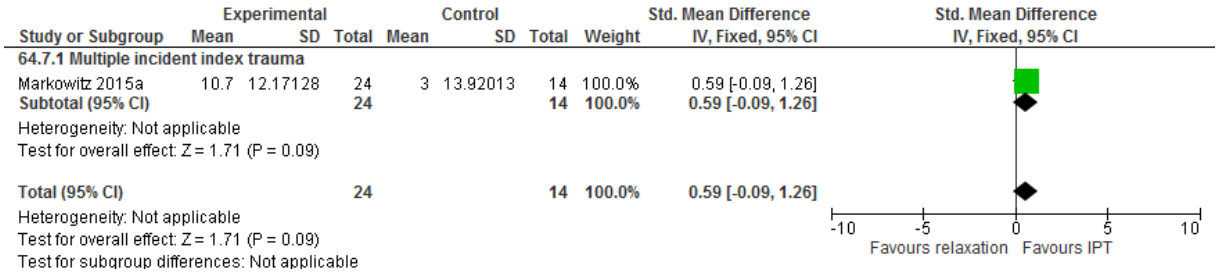


Figure 462: Interpersonal psychotherapy (IPT) versus relaxation for delayed treatment (>3 months) of clinically important symptoms/PTSD: Relationship difficulties (IIP change score)

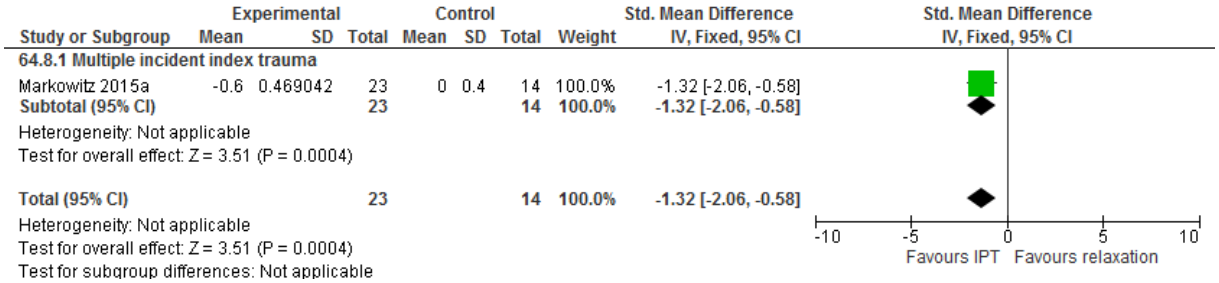
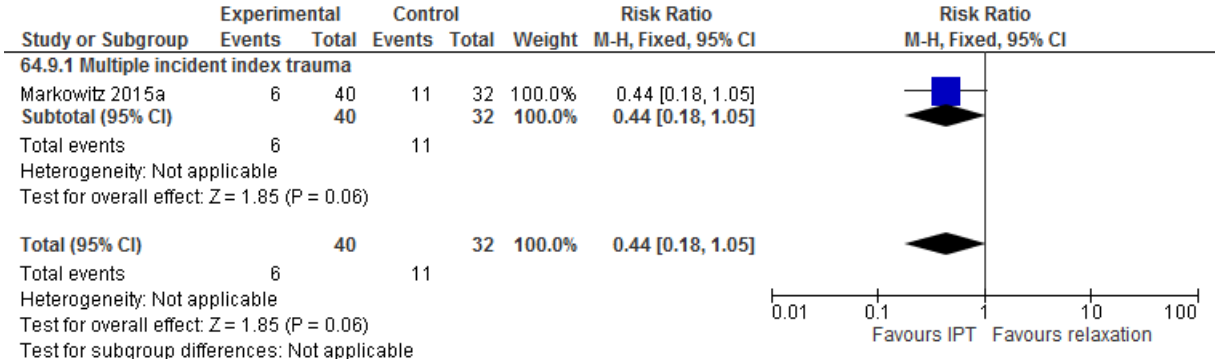


Figure 463: Interpersonal psychotherapy (IPT) versus relaxation for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)



Counselling

Figure 464: Counselling (± TAU) versus TAU or waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated at endpoint (PCL/PDS/HTQ change score)

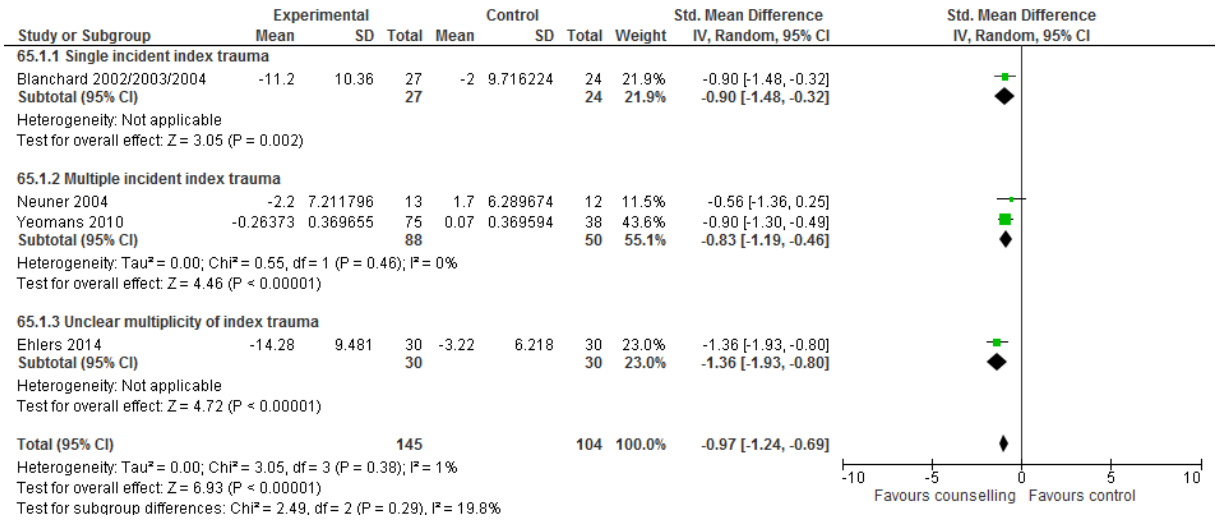


Figure 465: Counselling (± TAU) versus TAU or waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated at 1-4 month follow-up (HTQ/PDS change score)

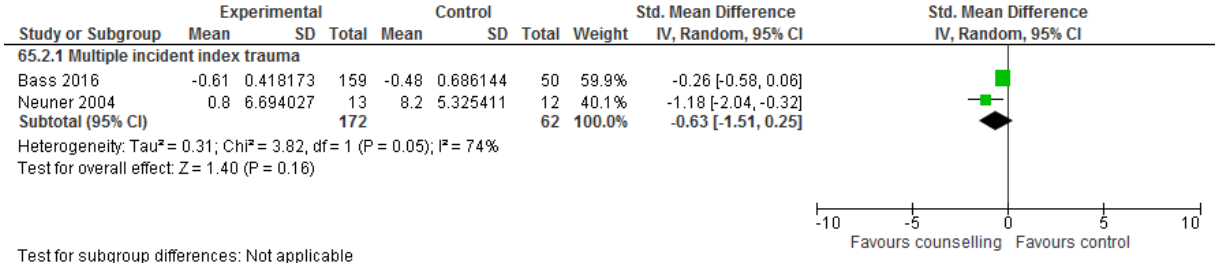


Figure 466: Counselling (± TAU) versus TAU or waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated at 8-12 month follow-up (PDS change score)

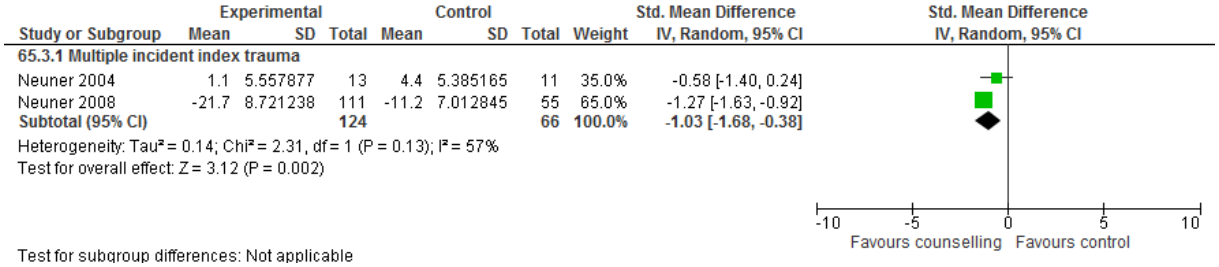


Figure 467: Counselling (± TAU) versus TAU or waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated at endpoint (CAPS change score)

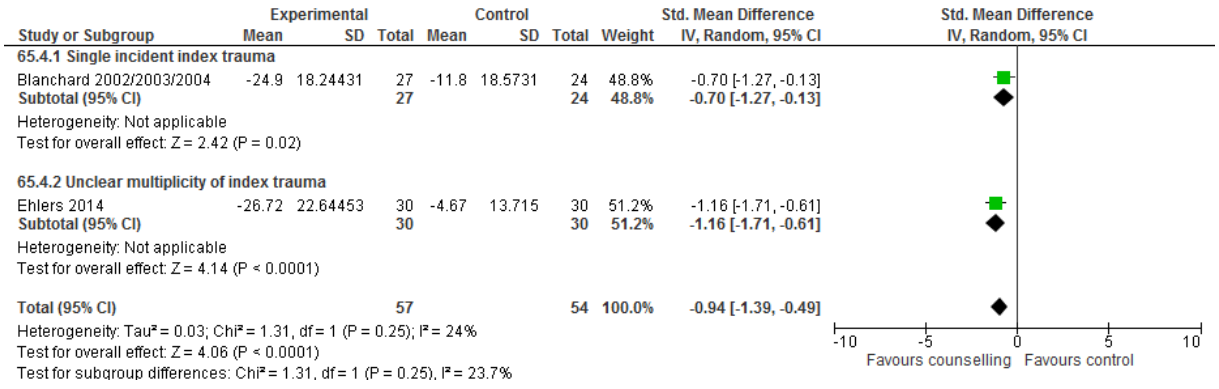


Figure 468: Counselling (± TAU) versus TAU or waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated at 1-year follow-up (CIDI-PTSD change score)

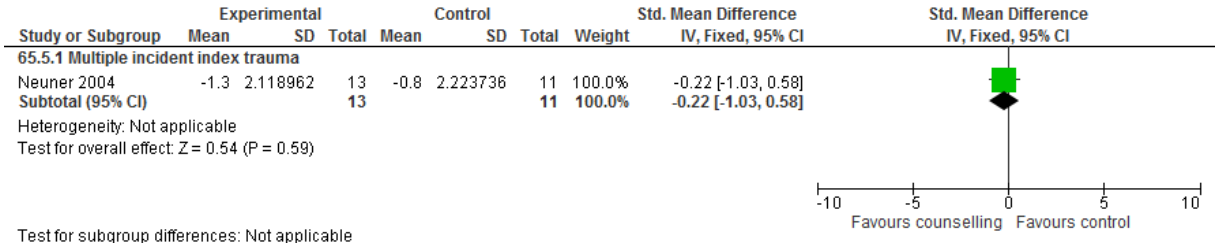


Figure 469: Counselling (± TAU) versus TAU or waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Remission at endpoint (number of people no longer meeting diagnostic criteria or no longer above clinical threshold on a scalefor PTSD)

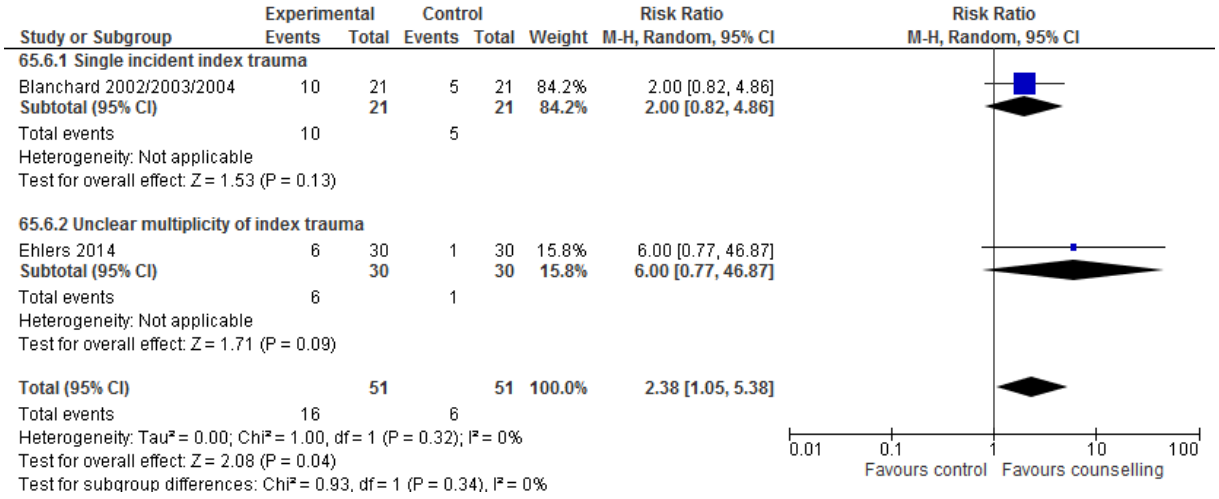


Figure 470: Counselling (± TAU) versus TAU or waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Remission at 8-12 month follow-up (number of people no longer meeting diagnostic criteria for PTSD)

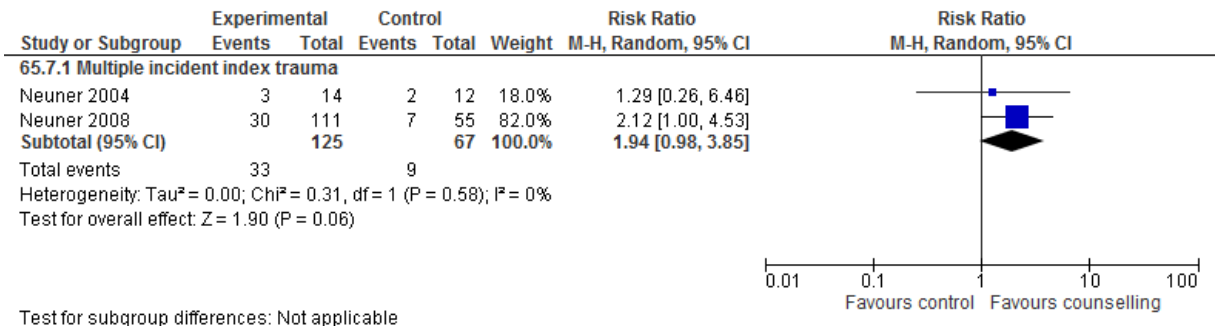


Figure 471: Counselling (± TAU) versus TAU or waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Anxiety symptoms at endpoint (BAI/STAI State change score)

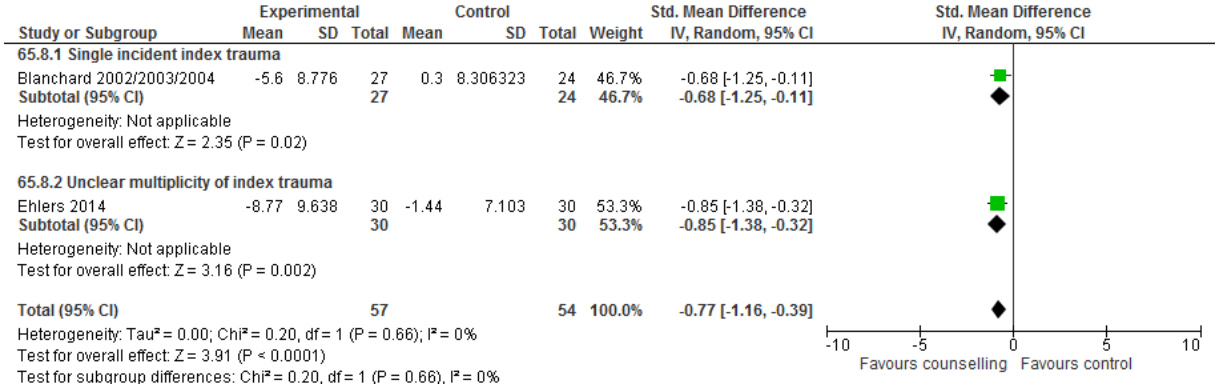


Figure 472: Counselling (± TAU) versus TAU or waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Anxiety symptoms at 1-month follow-up (HSCL Anxiety change score)

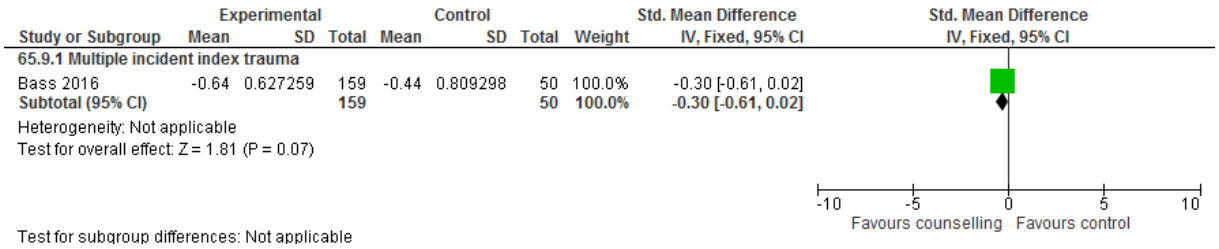


Figure 473: Counselling (± TAU) versus TAU or waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms at endpoint (BDI change score)

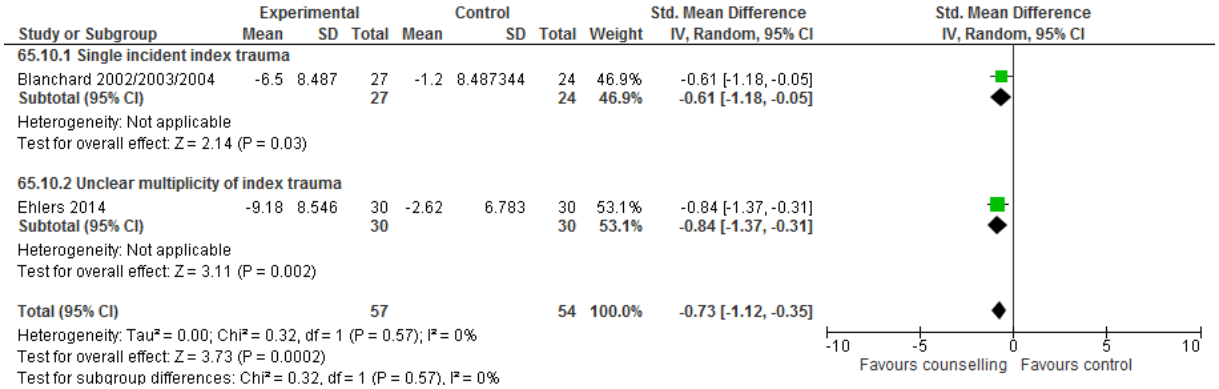


Figure 474: Counselling (± TAU) versus TAU or waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms at 1-month follow-up (HSCL Depression change score)

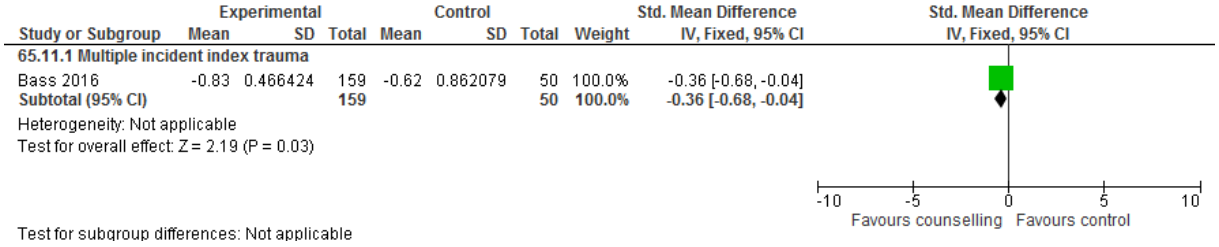


Figure 475: Counselling (± TAU) versus TAU or waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Functional impairment (SDS change score)

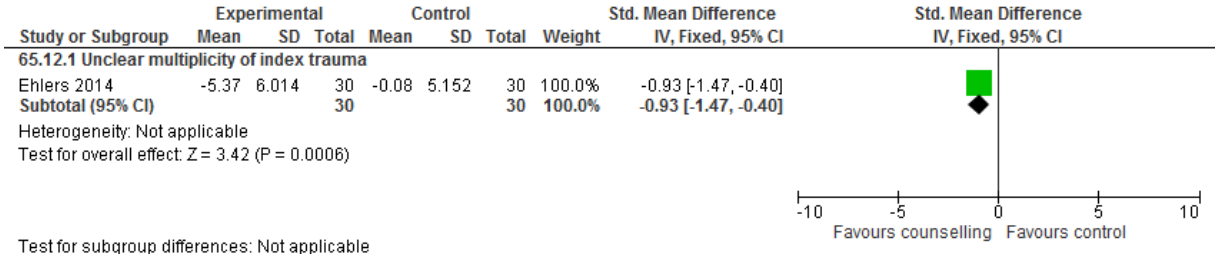


Figure 476: Counselling (± TAU) versus TAU or waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Global functioning (GAF change score)

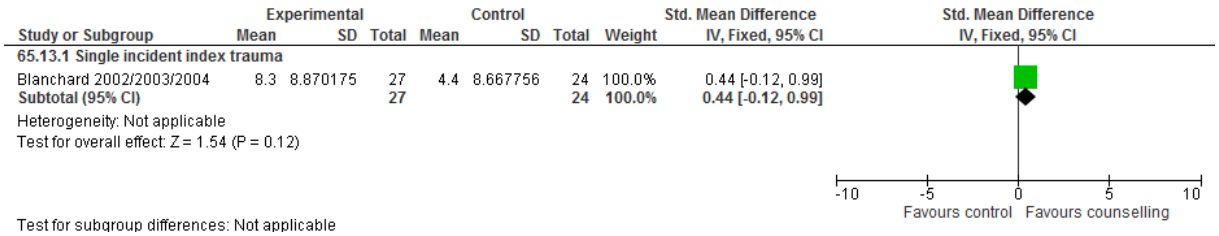


Figure 477: Counselling (± TAU) versus TAU or waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Quality of life at endpoint (Q-LES-Q-SF/SF-12 change score)

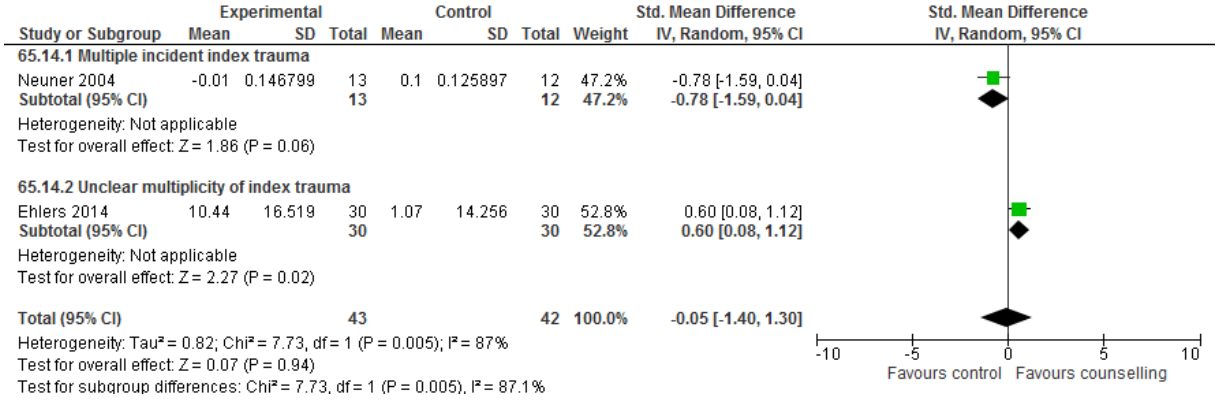


Figure 478: Counselling (± TAU) versus TAU or waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Quality of life at follow-up (SF-12 change score); Multiple incident index trauma

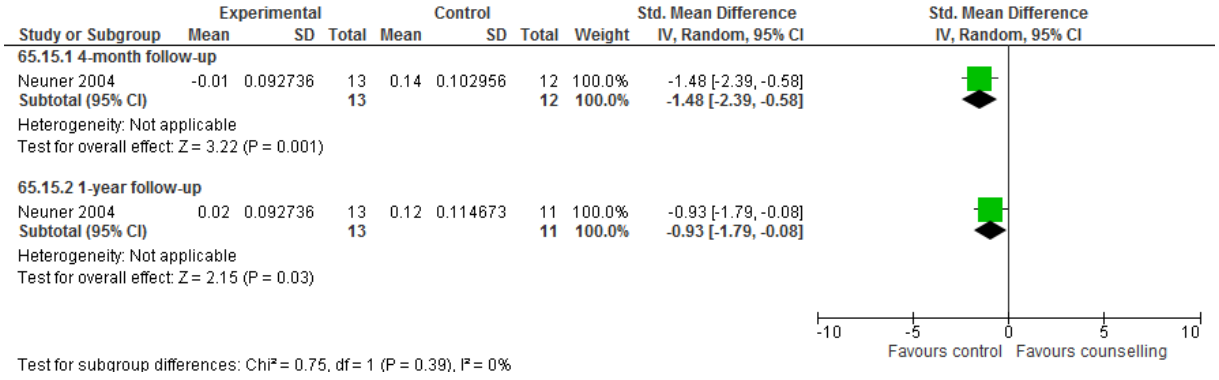
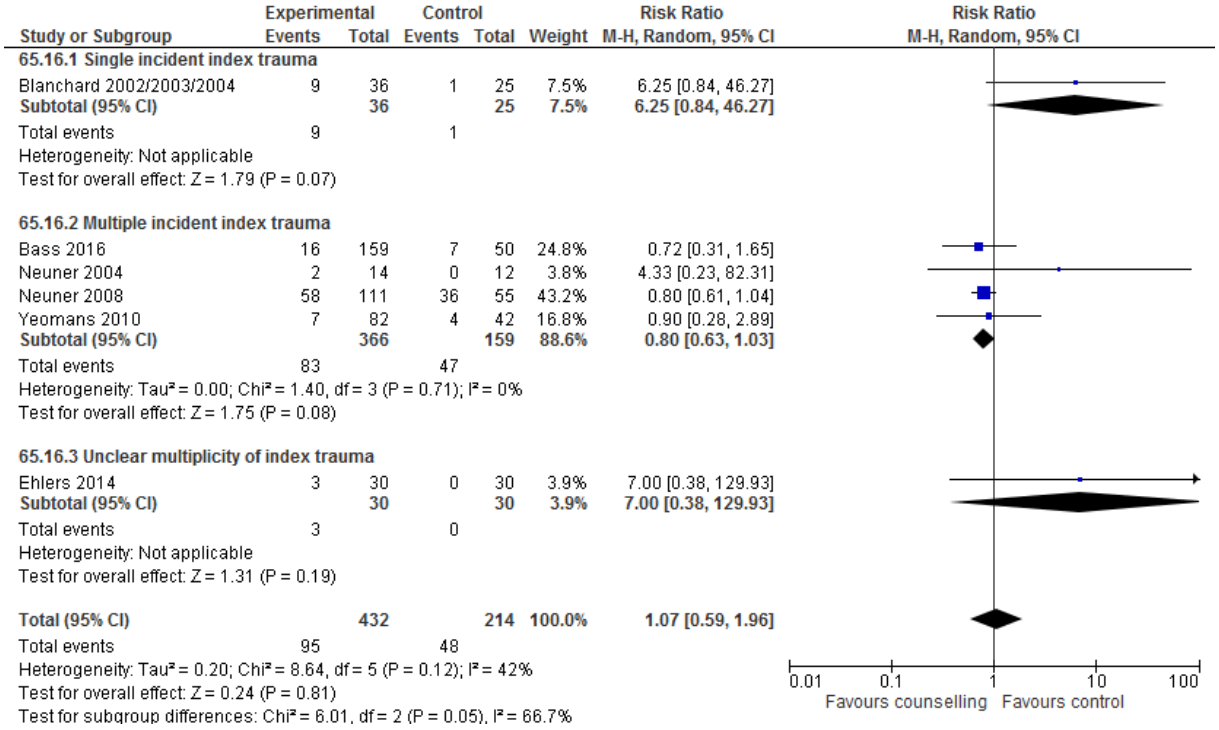


Figure 479: Counselling (± TAU) versus TAU or waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)



Combined somatic and cognitive therapies

Figure 480: Combined somatic and cognitive therapies (± TAU) versus waitlist (± TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated (PCL/PDS/MPSS change score)

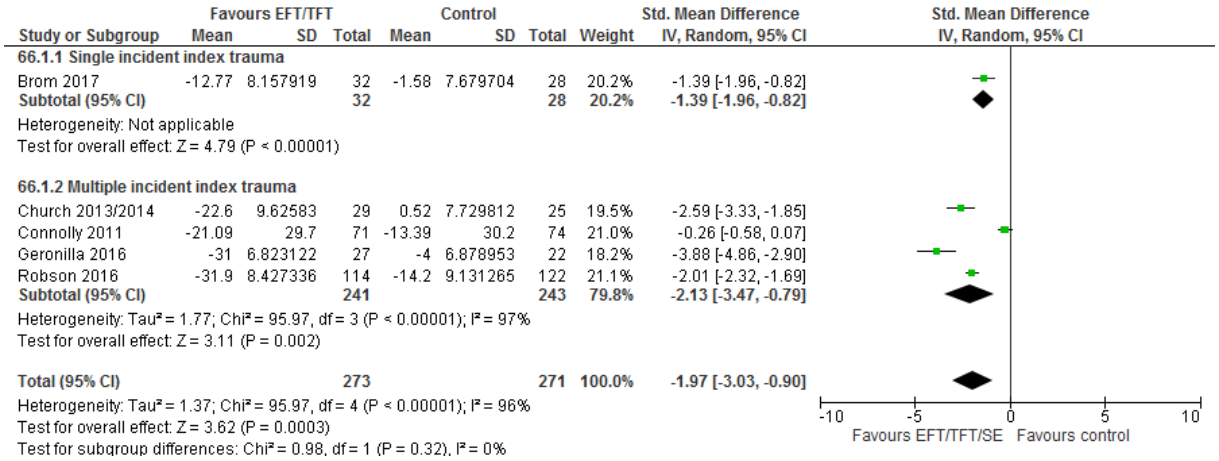


Figure 481: Combined somatic and cognitive therapies (± TAU) versus waitlist (± TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated (CAPS change score)

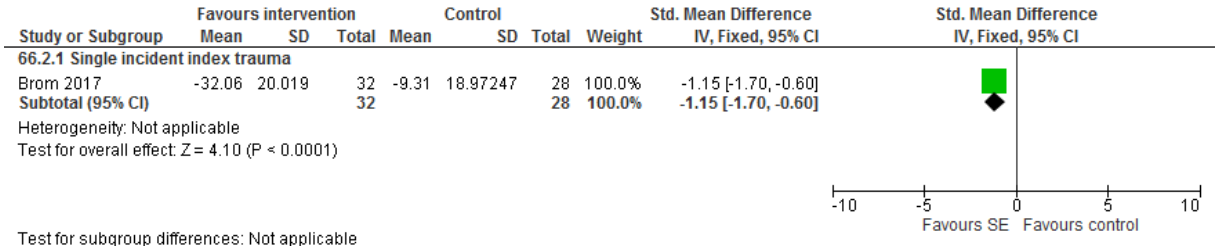


Figure 482: Combined somatic and cognitive therapies (± TAU) versus waitlist (± TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Remission (number of people scoring <50 on PCL)

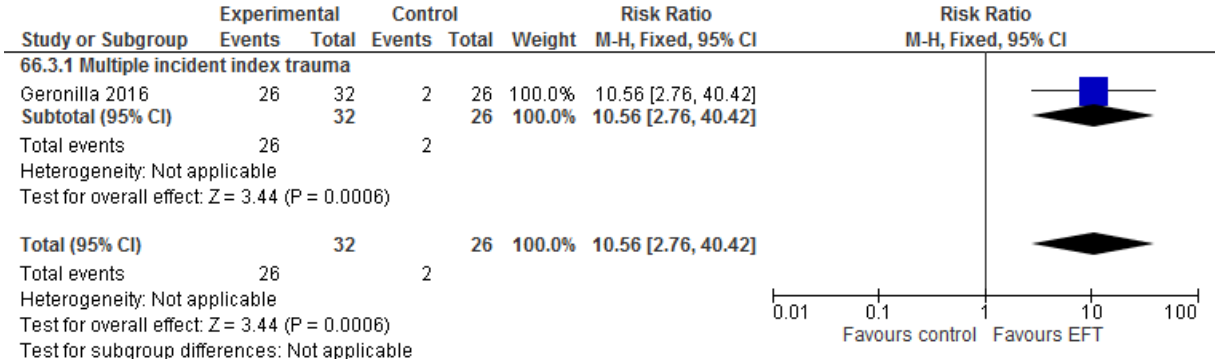


Figure 483: Combined somatic and cognitive therapies (± TAU) versus waitlist (± TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Anxiety symptoms (SA-45 Anxiety T-score; change score)

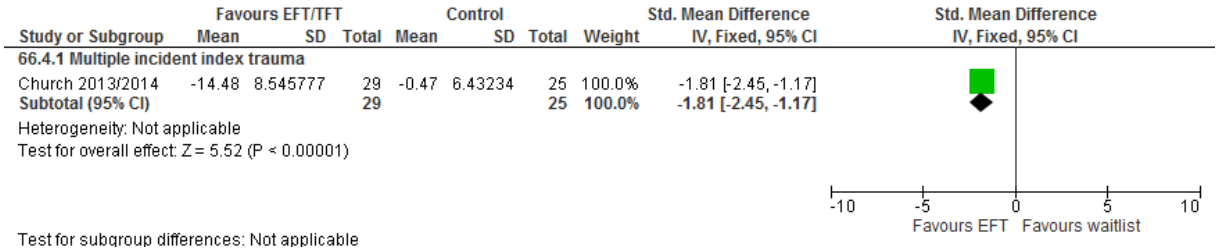


Figure 484: Combined somatic and cognitive therapies (± TAU) versus waitlist (± TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms (CES-D/SA-45 Depression T-score change score)

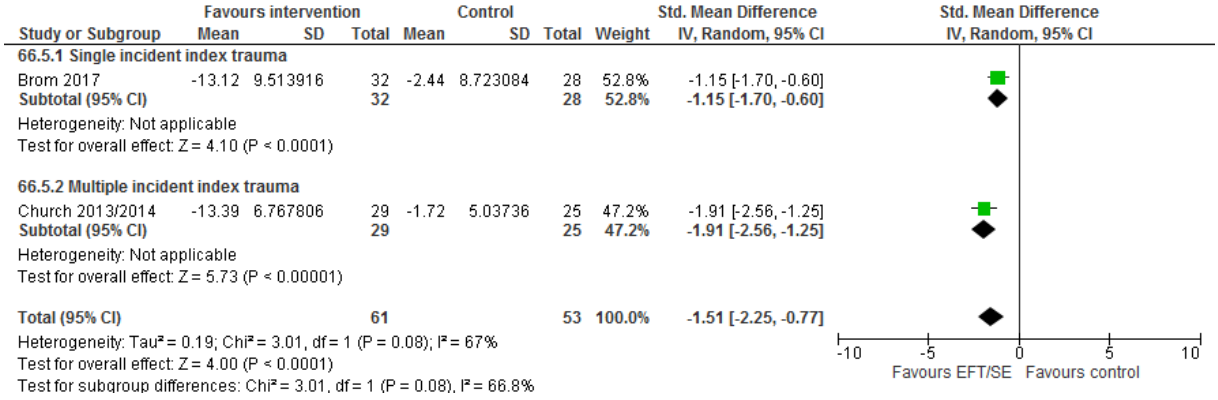


Figure 485: Combined somatic and cognitive therapies (± TAU) versus waitlist (± TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Sleeping difficulties (ISI change score)

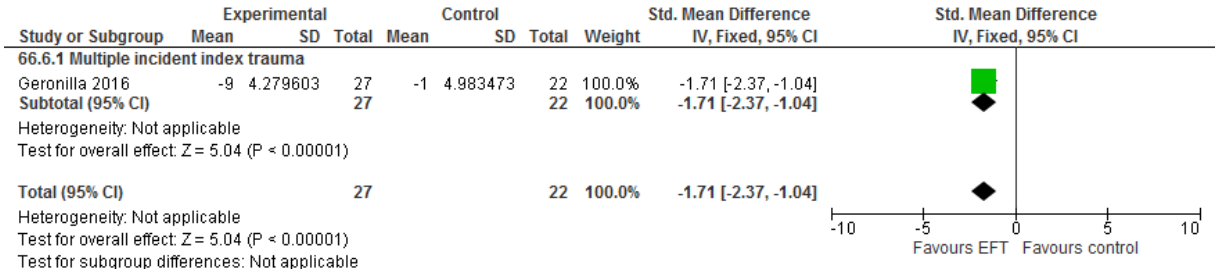
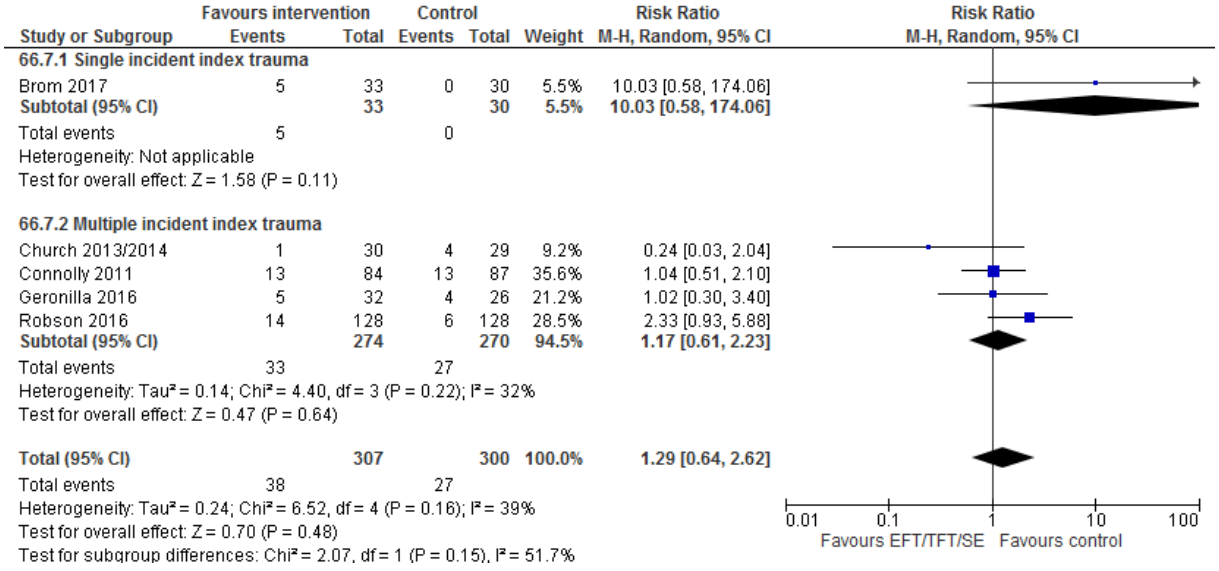


Figure 486: Combined somatic and cognitive therapies (± TAU) versus waitlist (± TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)



Sub-analysis by specific intervention: Combined somatic and cognitive therapies (± TAU) versus waitlist (± TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD

Figure 487: Combined somatic and cognitive therapies (± TAU) versus waitlist (± TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated (PCL/PDS/MPSS change score)

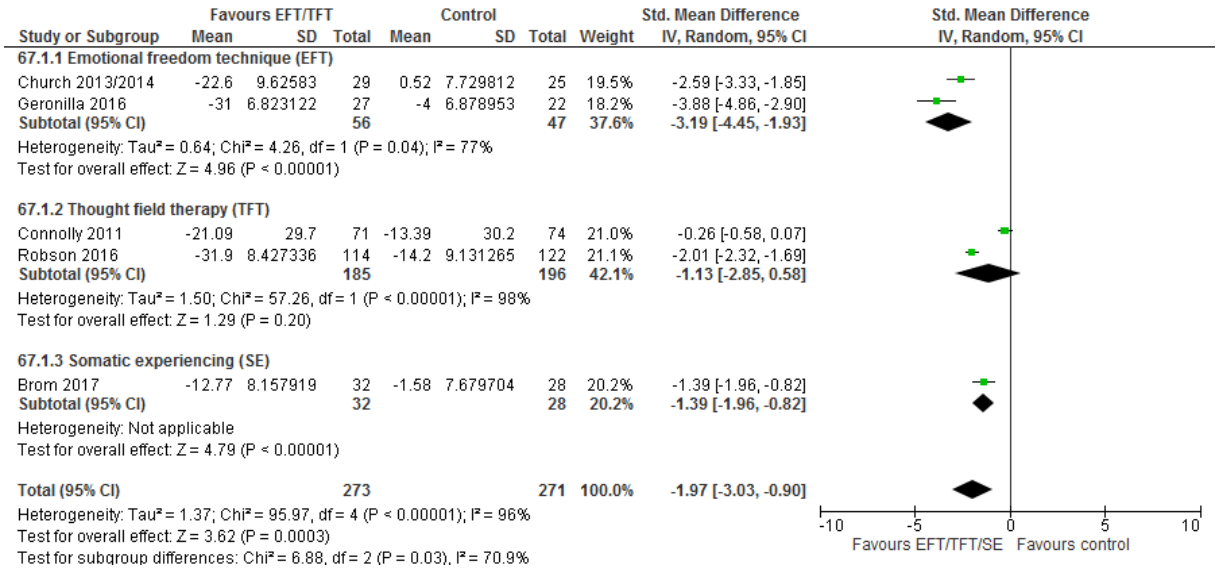


Figure 488: Combined somatic and cognitive therapies (± TAU) versus waitlist (± TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated (CAPS change score)

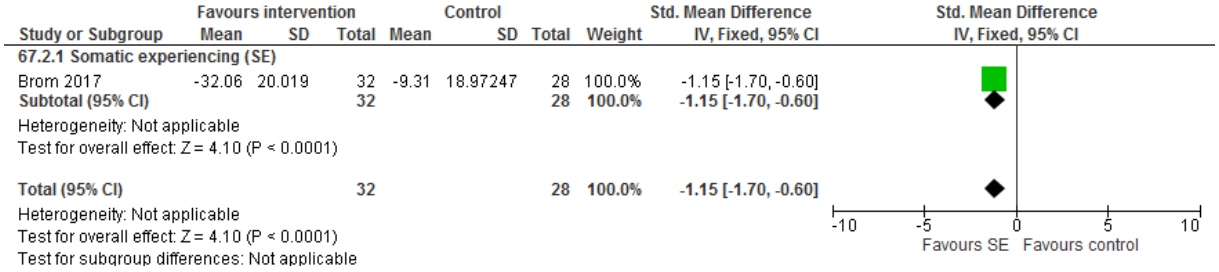
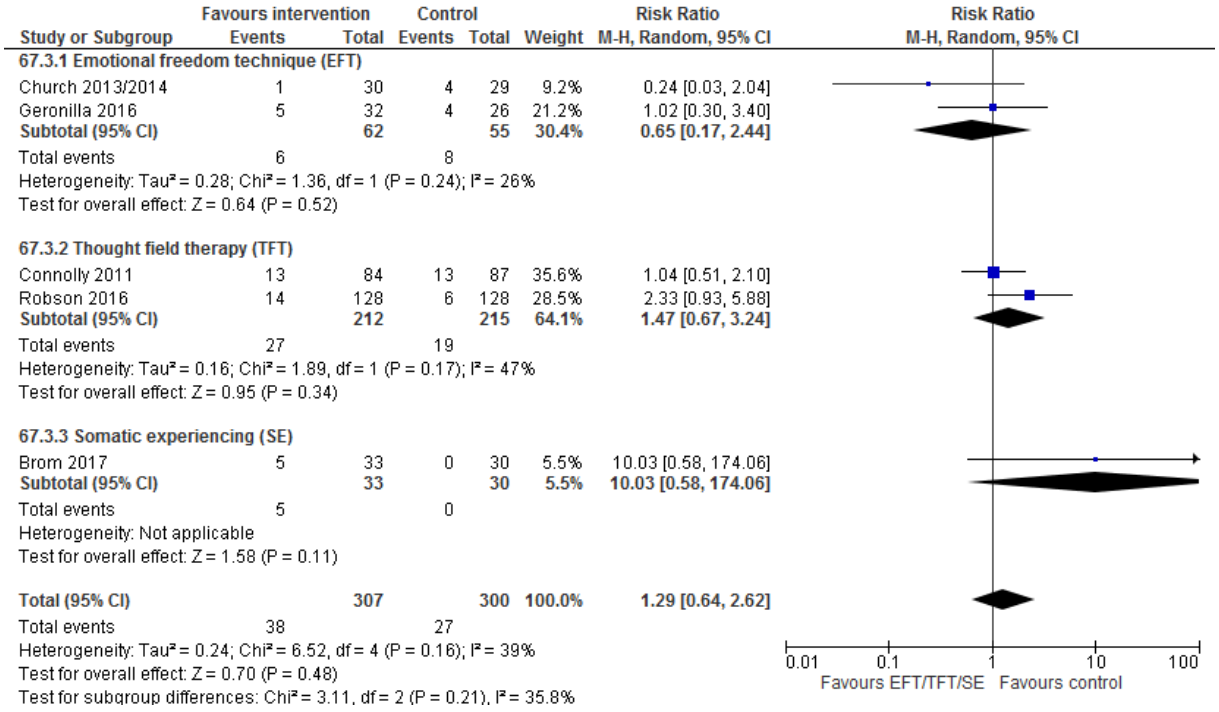


Figure 489: Combined somatic and cognitive therapies (± TAU) versus waitlist (± TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)



Sub-analysis by diagnostic status at baseline: Combined somatic and cognitive therapies (± TAU) versus waitlist (± TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD

Figure 490: Combined somatic and cognitive therapies (± TAU) versus waitlist (± TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated (PCL/PDS/MPSS change score)

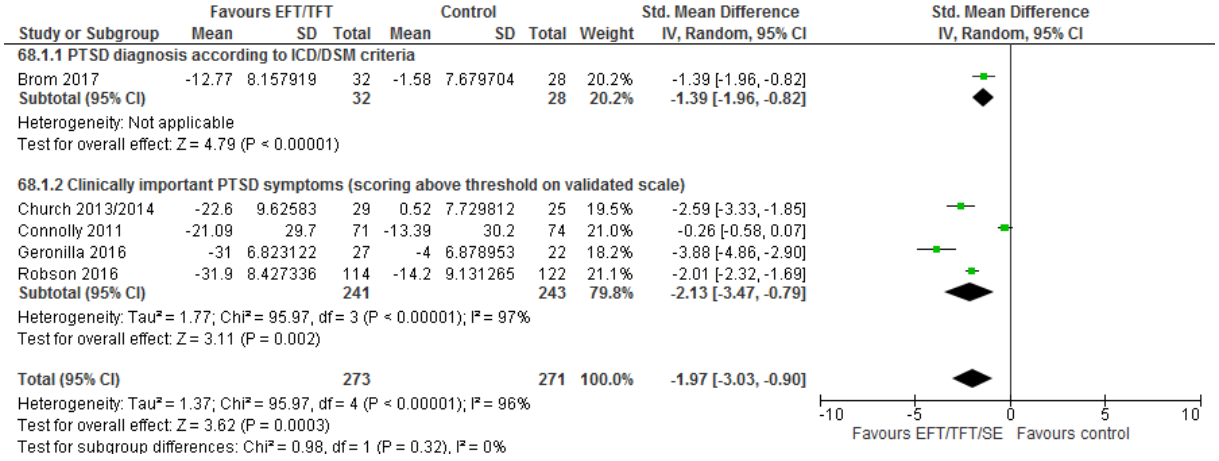


Figure 491: Combined somatic and cognitive therapies (± TAU) versus waitlist (± TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated (CAPS change score)

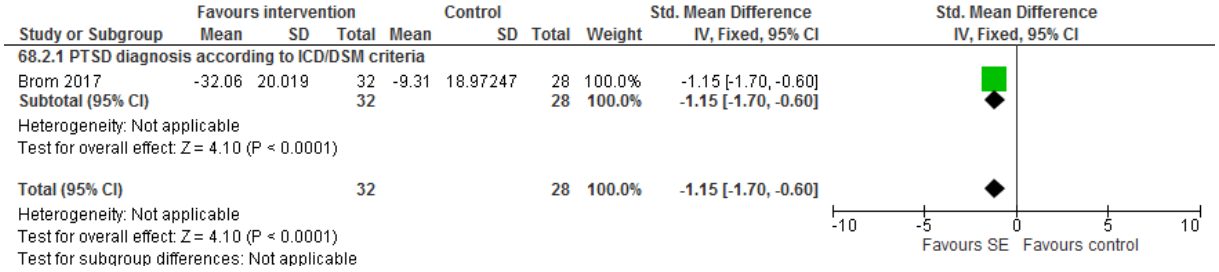
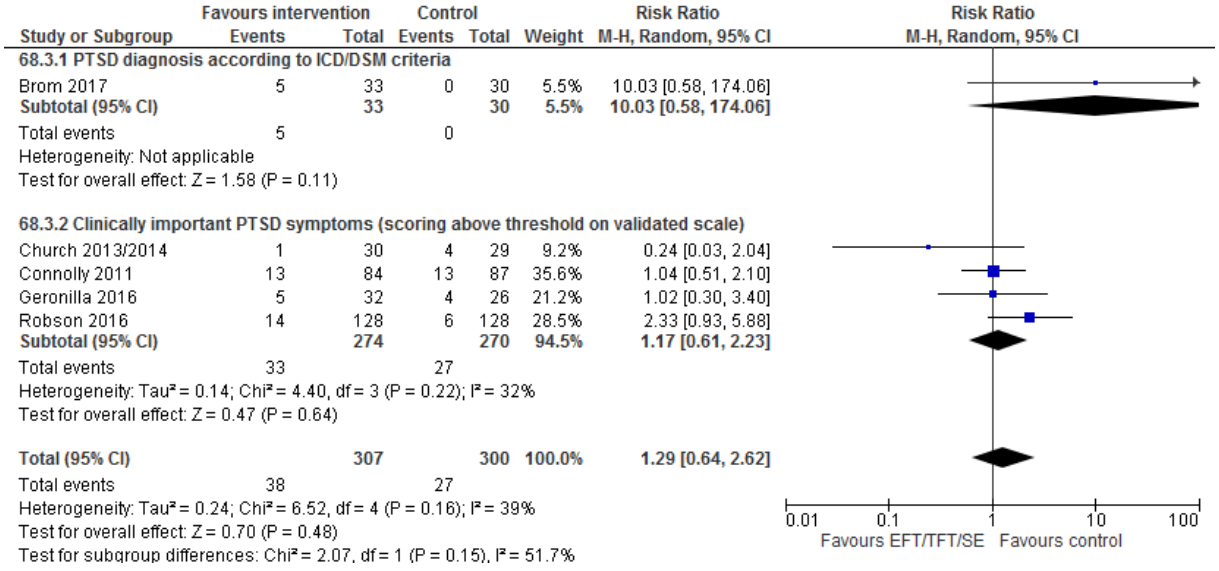


Figure 492: Combined somatic and cognitive therapies (± TAU) versus waitlist (± TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)



Sub-analysis by trauma type: Combined somatic and cognitive therapies (± TAU) versus waitlist (± TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD

Figure 493: Combined somatic and cognitive therapies (± TAU) versus waitlist (± TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated (PCL/PDS/MPSS change score)

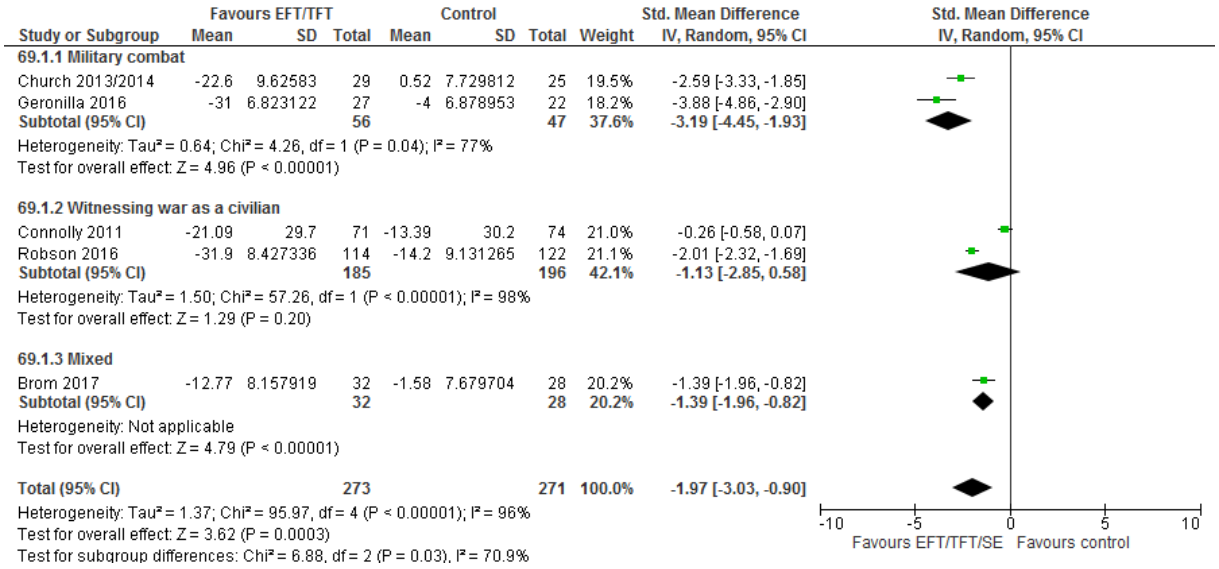


Figure 494: Combined somatic and cognitive therapies (± TAU) versus waitlist (± TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated (CAPS change score)

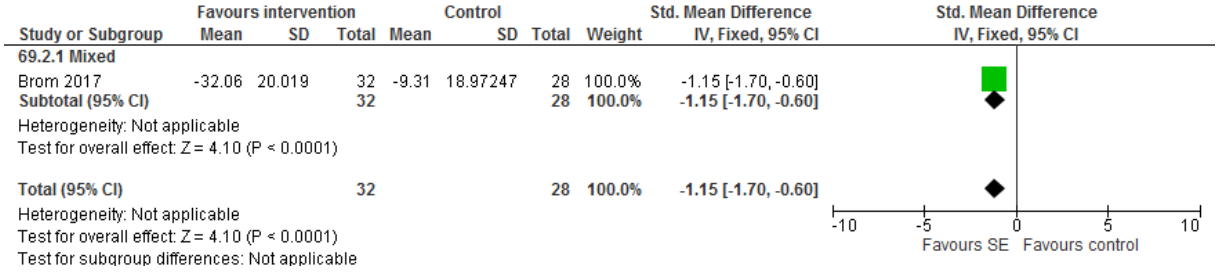
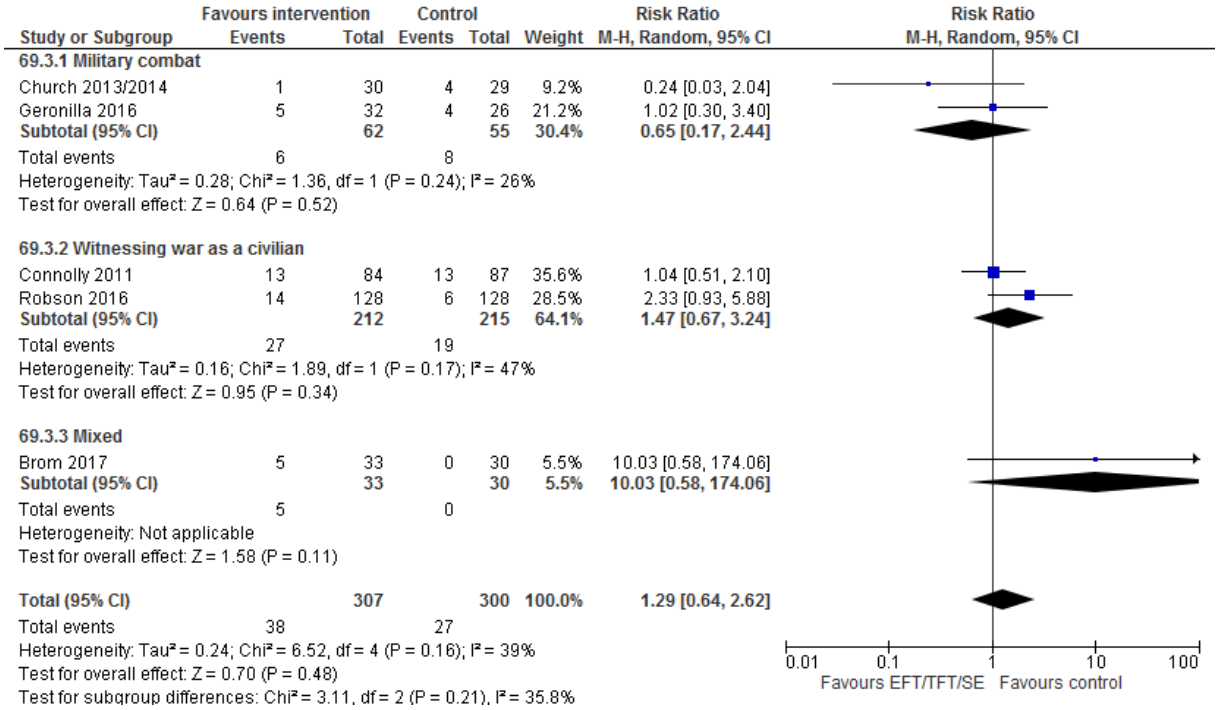


Figure 495: Combined somatic and cognitive therapies (± TAU) versus waitlist (± TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)



Resilience-oriented treatment

Figure 496: Resilience-oriented treatment versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-report (PDS change score)

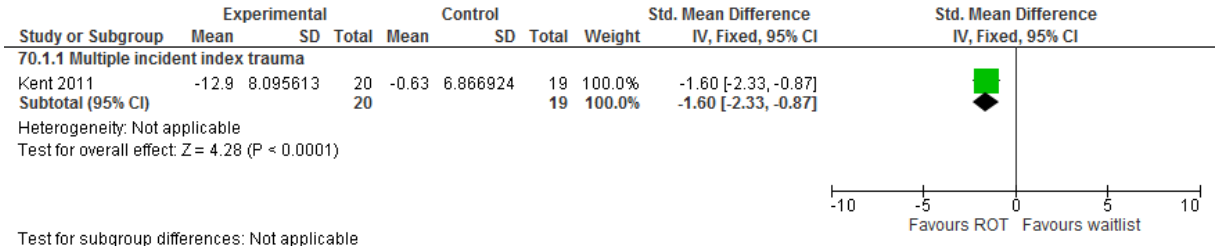


Figure 497: Resilience-oriented treatment versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Anxiety symptoms (STAI state change score)

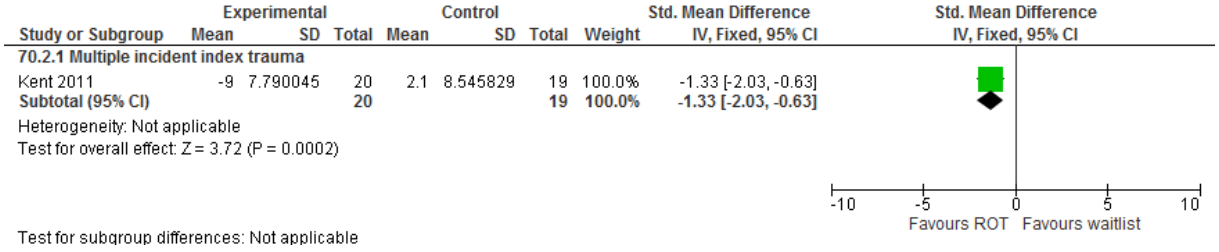


Figure 498: Resilience-oriented treatment versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms (BDI-II change score)

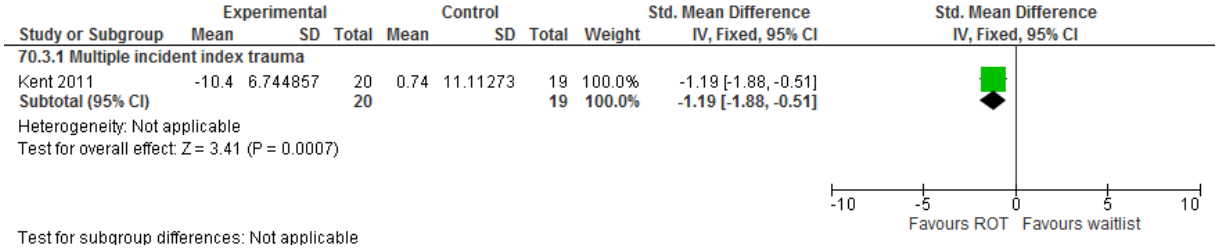
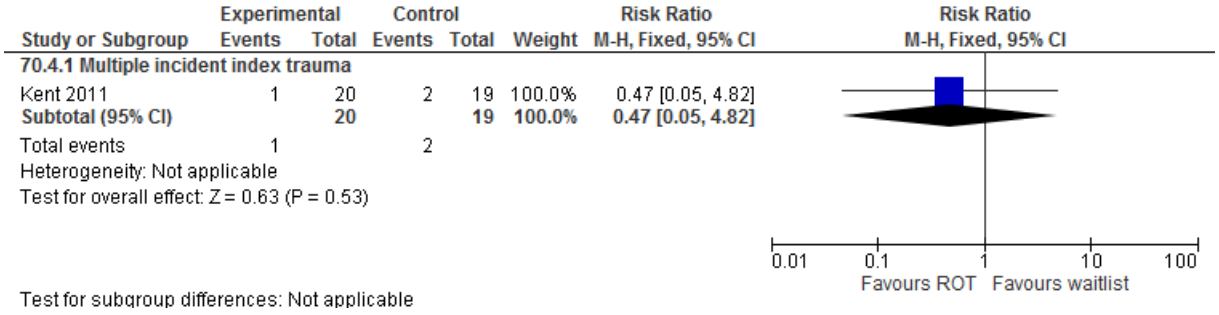


Figure 499: Resilience-oriented treatment versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)



Attention bias modification

Figure 500: Attrition bias modification versus attention-placebo for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-report (PCL/SRIP; change score)

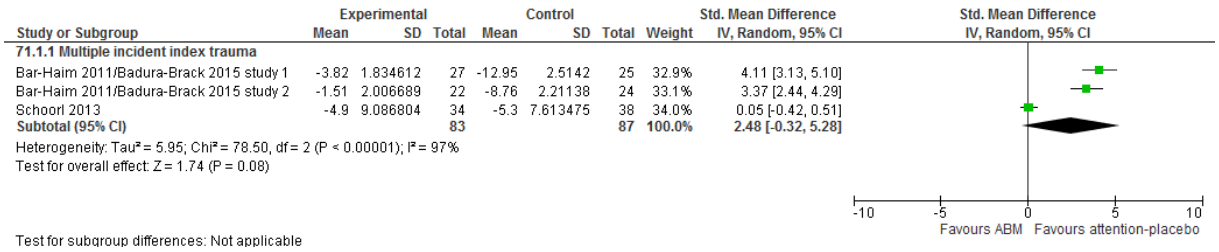


Figure 501: Attrition bias modification versus attention-placebo for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated (CAPS change score); Multiple incident index trauma

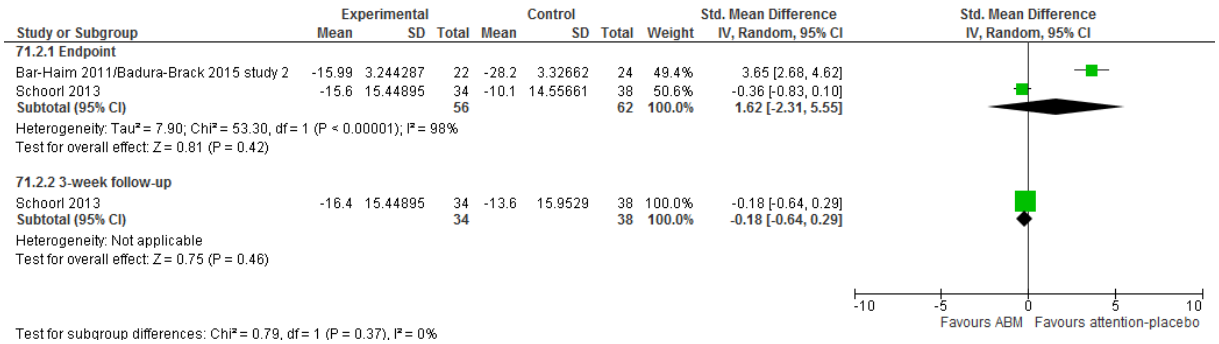


Figure 502: Attrition bias modification versus attention-placebo for delayed treatment (>3 months) of clinically important symptoms/PTSD: Anxiety symptoms (HADS-A change score); Multiple incident index trauma

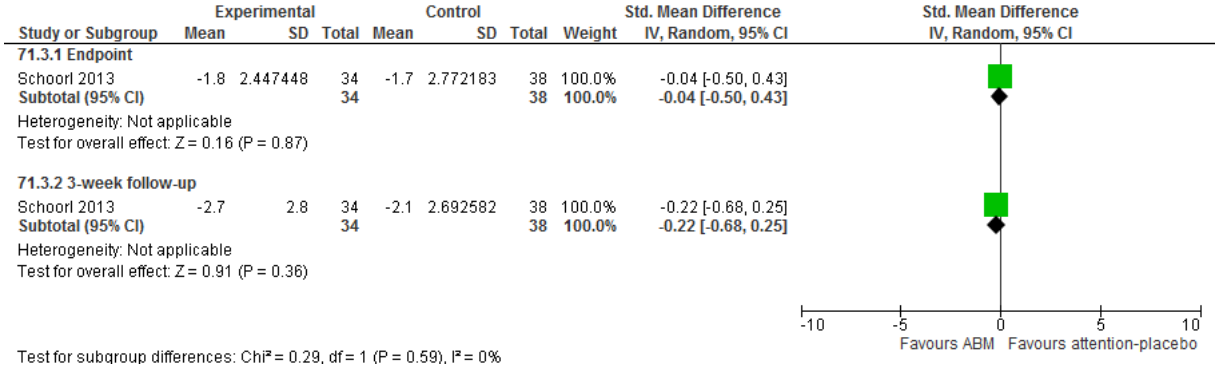


Figure 503: Attrition bias modification versus attention-placebo for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms (PHQ-9/HADS-D change score); Multiple incident index trauma

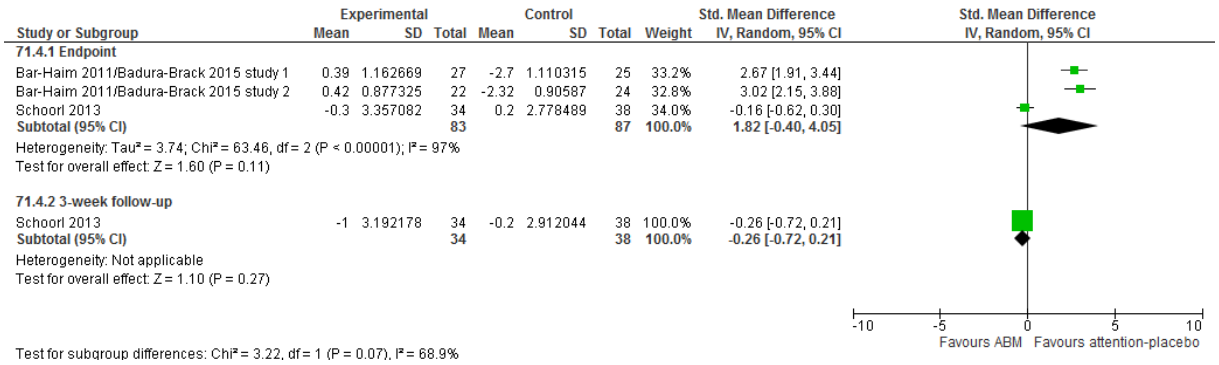
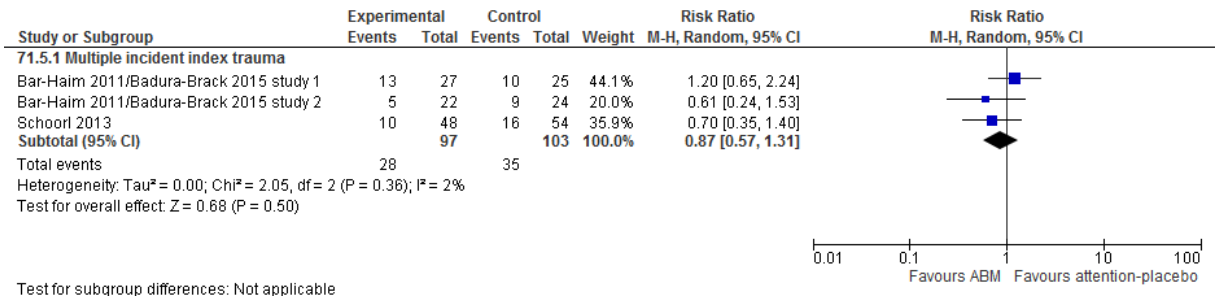


Figure 504: Attrition bias modification versus attention-placebo for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)



Couple intervention

Figure 505: Couple intervention versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Response (number of people showing improvement of at least 10 points on CAPS)

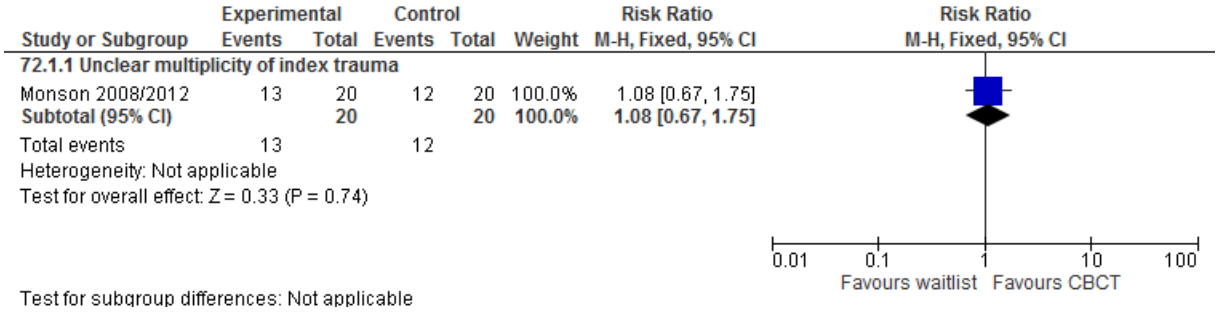


Figure 506: Couple intervention versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Remission (number of people who no longer met DSM-IV-TR diagnostic criteria and CAPS score<45)

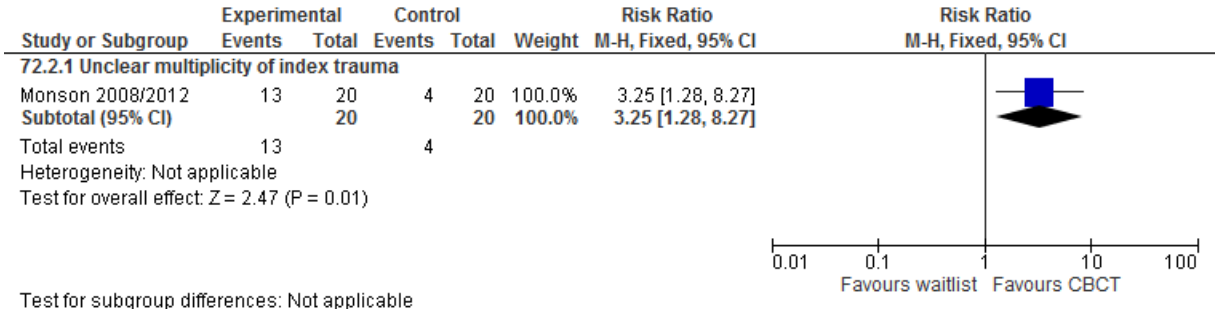


Figure 507: Couple intervention versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Response for relationship difficulties (number of participants showing improvement of at least 10 points on DAS)

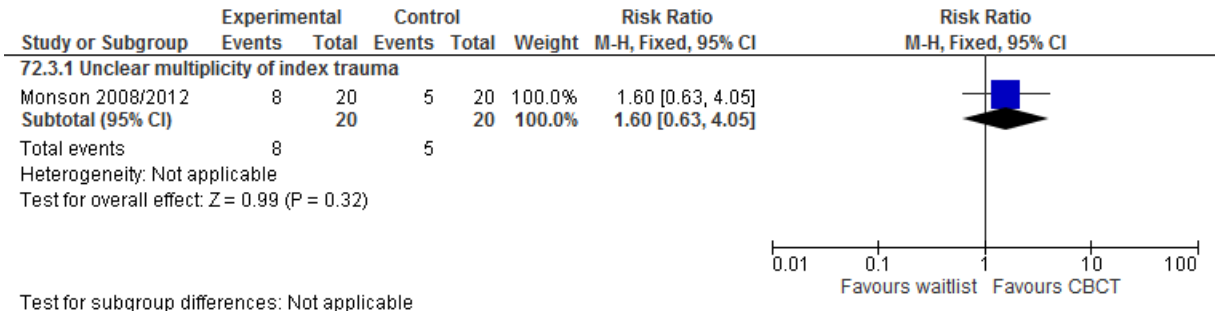


Figure 508: Couple intervention versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Remission for relationship difficulties (number of participants scoring ≥98 on DAS)

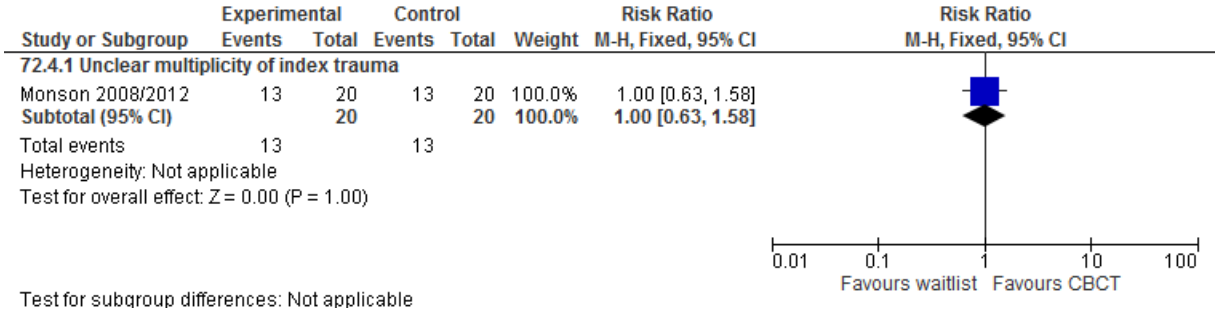


Figure 509: Couple intervention versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)

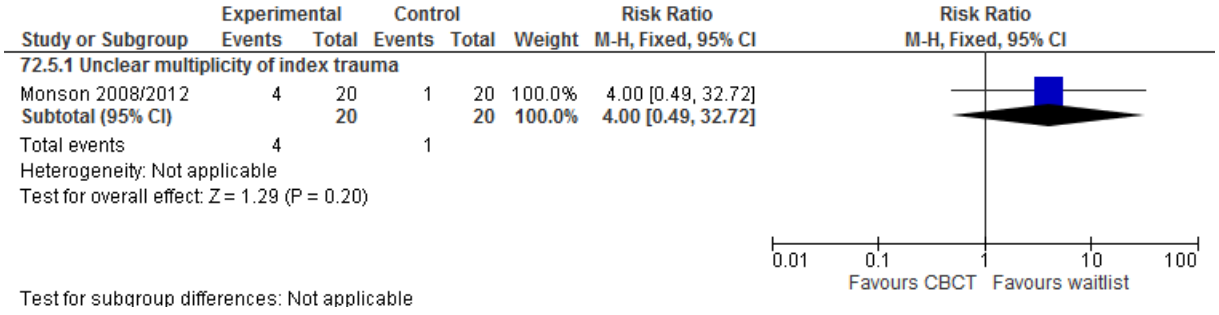


Figure 510: Couple intervention versus psycho-education sessions for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated (CAPS change score); Multiple incident index trauma

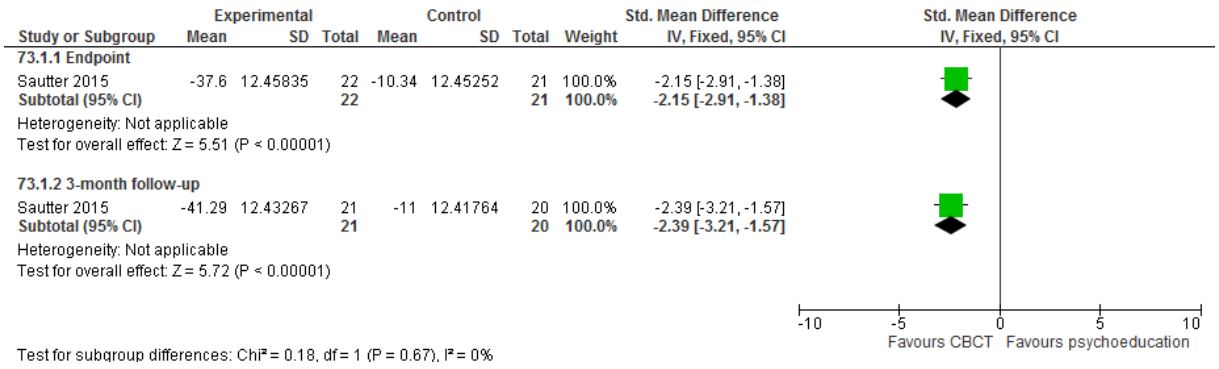


Figure 511: Couple intervention versus psycho-education sessions for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD

symptomatology self-rated (PCL-M change score); Multiple incident index trauma

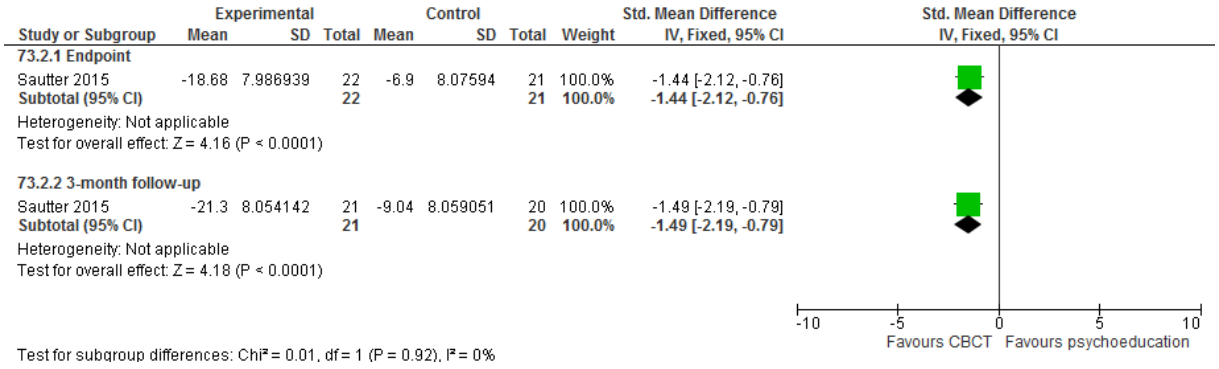


Figure 512: Couple intervention versus psycho-education sessions for delayed treatment (>3 months) of clinically important symptoms/PTSD: Remission (number of people scoring <45 on CAPS at endpoint)

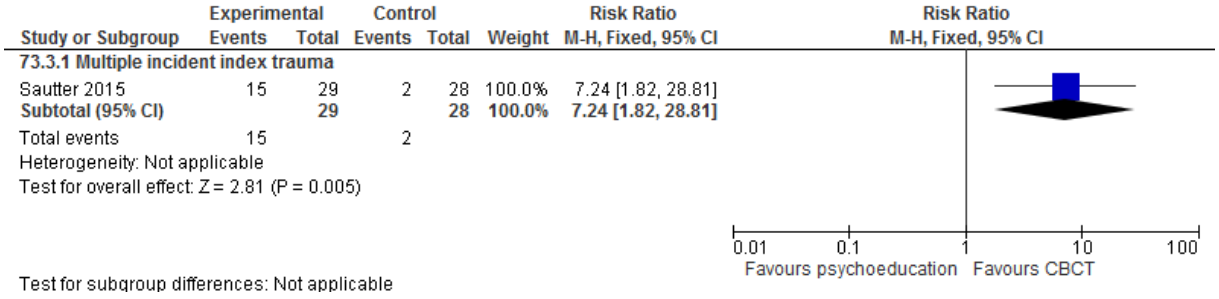


Figure 513: Couple intervention versus psycho-education sessions for delayed treatment (>3 months) of clinically important symptoms/PTSD: Anxiety symptoms (STAI: State change score); Multiple incident index trauma

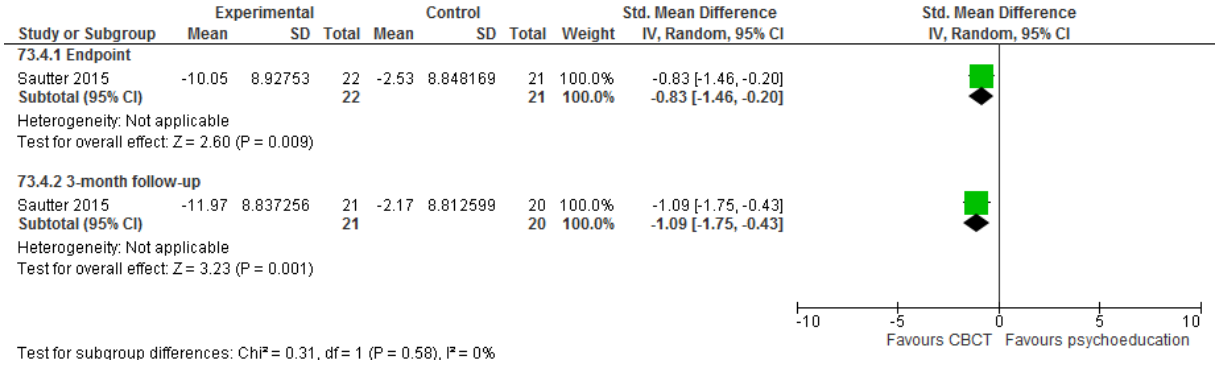


Figure 514: Couple intervention versus psycho-education sessions for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms (CES-D change score); Multiple incident index trauma

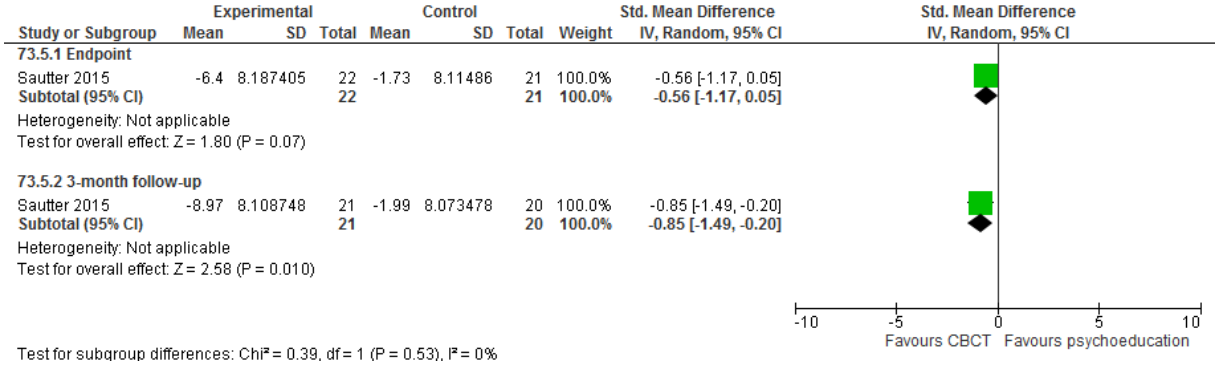


Figure 515: Couple intervention versus psycho-education sessions for delayed treatment (>3 months) of clinically important symptoms/PTSD: Relationship difficulties (DAS change score); Multiple incident index trauma

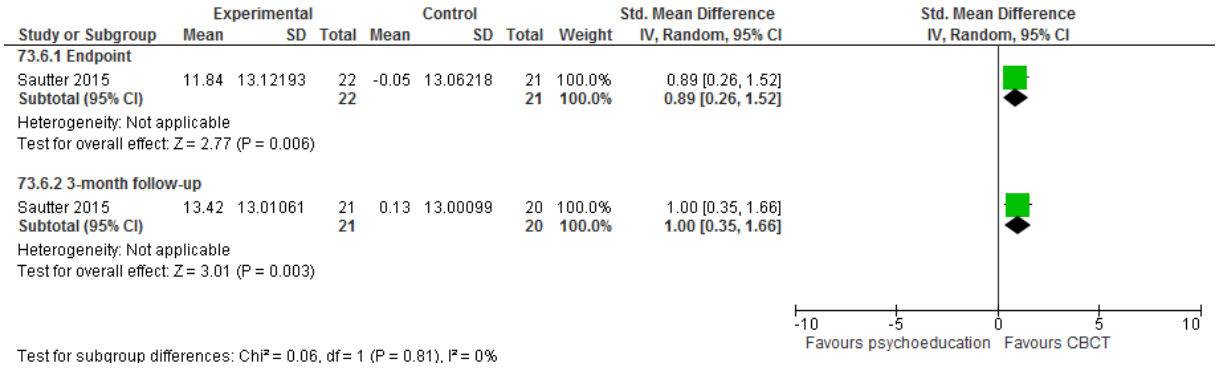
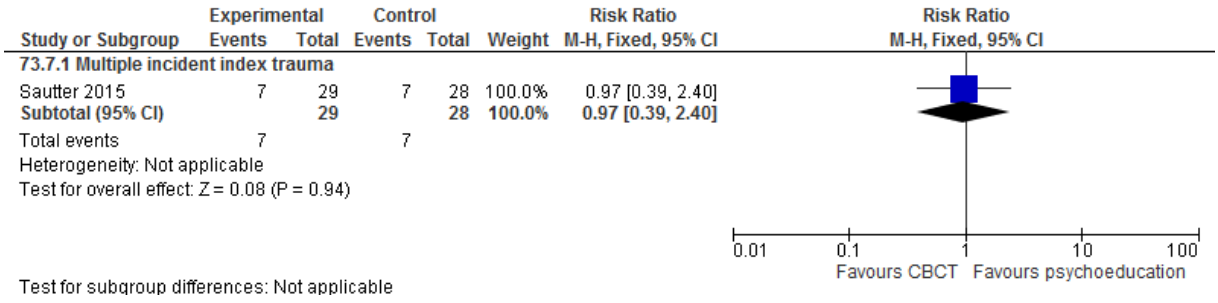


Figure 516: Couple intervention versus psycho-education sessions for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)



Family therapy

Figure 517: Family therapy versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-report at 4-month follow-up (UCLA PTSD-RI; change score)

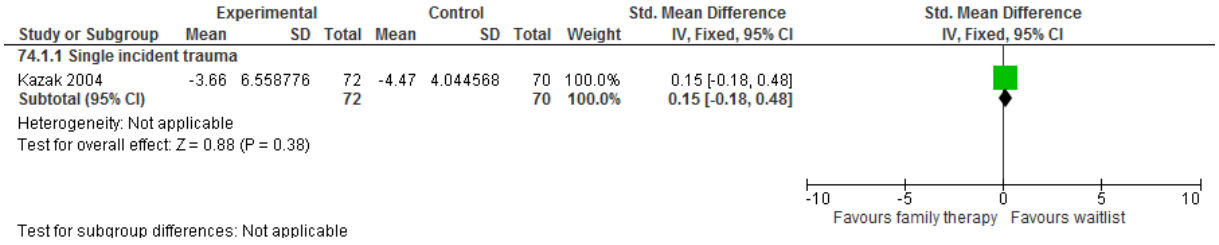
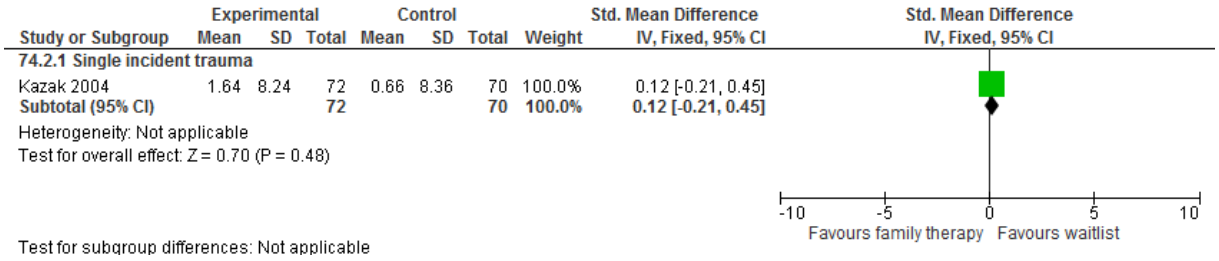


Figure 518: Family therapy versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Anxiety symptoms at 4-month follow-up (STAI: State; change score)



Child-parent psychotherapy

Figure 519: Child-parent psychotherapy (using play) versus case management and individual treatment (for parent only) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated (CAPS change score)

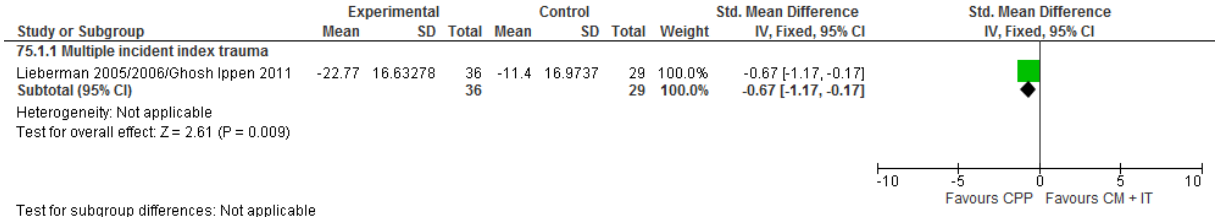


Figure 520: Child-parent psychotherapy (using play) versus case management and individual treatment (for parent only) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Remission (number of people no longer meeting diagnostic criteria for PTSD)

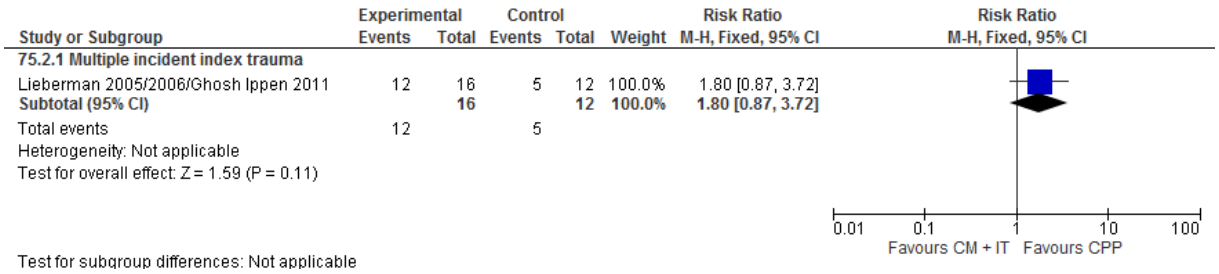
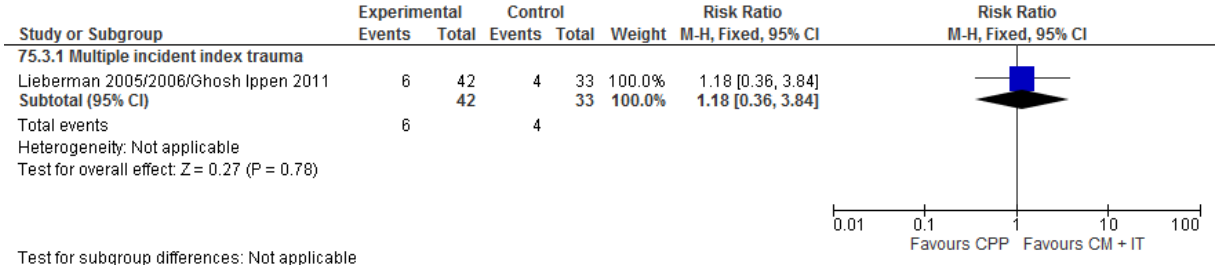


Figure 521: Child-parent psychotherapy (using play) versus case management and individual treatment (for parent only) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)



Self-help with support

Figure 522: Self-help with support (± TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated at endpoint (IES endpoint/IES-R/PDS/PCL-5 change score)

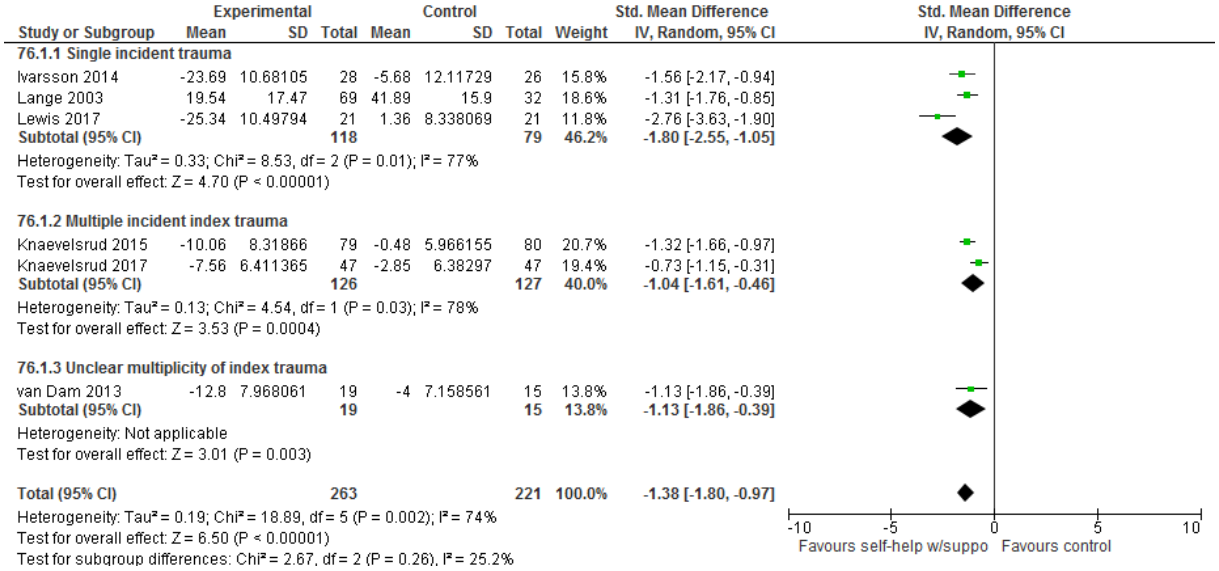


Figure 523: Self-help with support (± TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated at 1-3 month follow-up (IES/PCL-5/PDS change score)

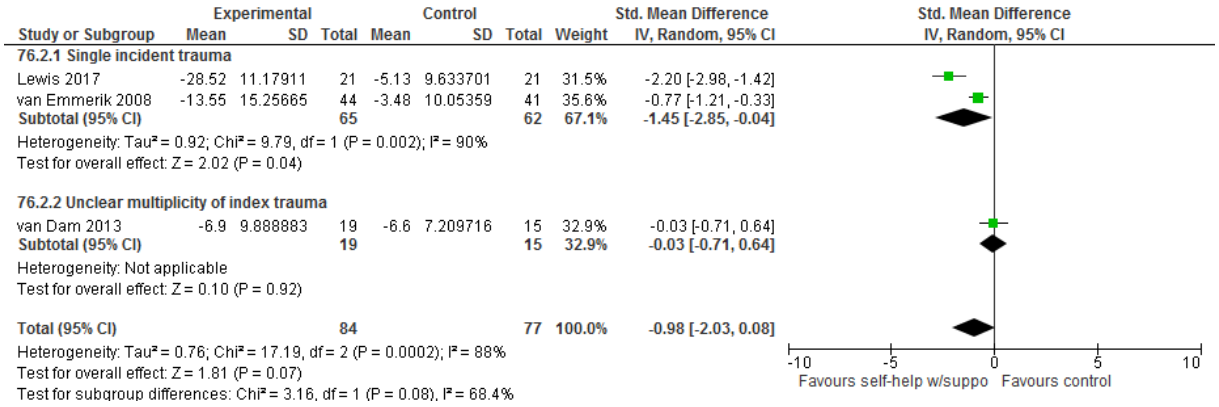


Figure 524: Self-help with support (± TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated at 1-year follow-up (IES change score)

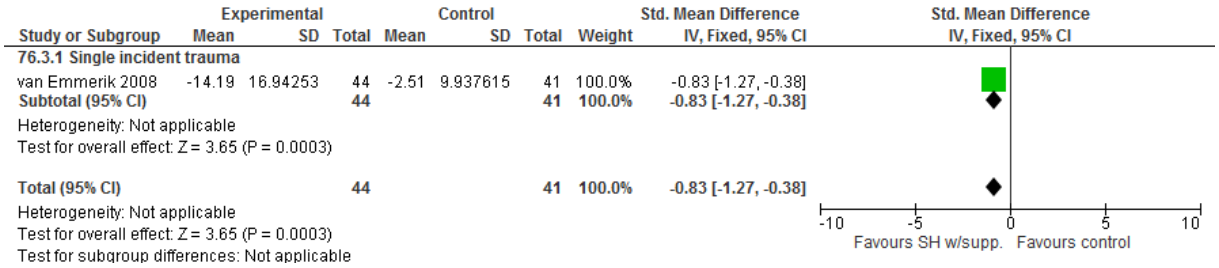


Figure 525: Self-help with support (± TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated (CAPS change score); Single incident trauma

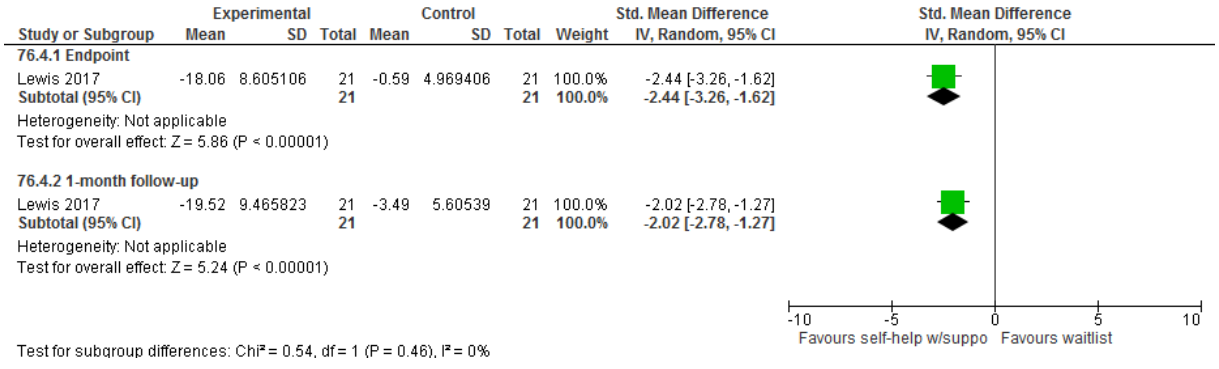


Figure 526: Self-help with support (± TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: Response (number of

people showing clinically significant improvement, based on reliable change indices [RCI], on IES-R/PDS)

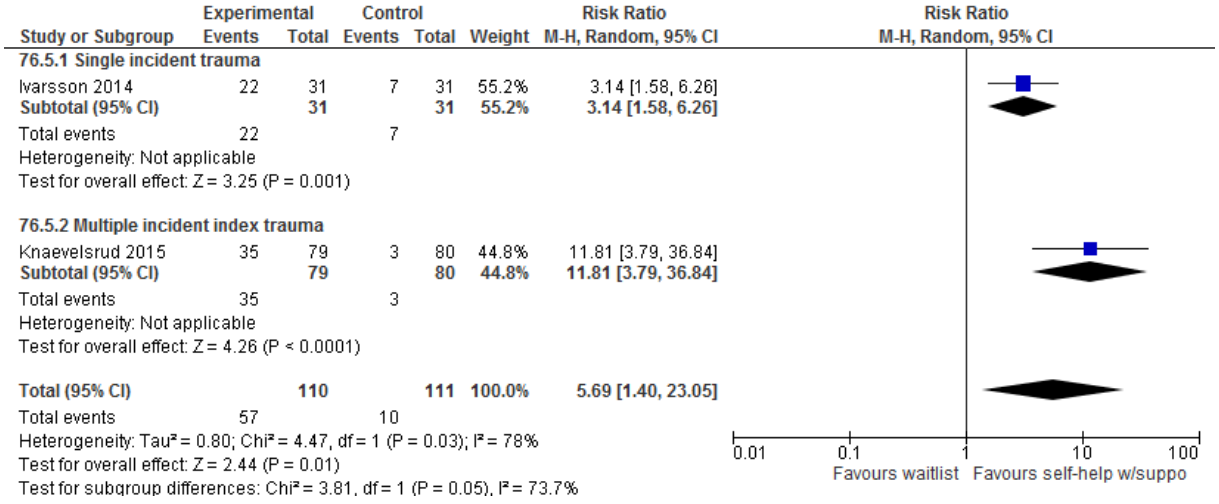


Figure 527: Self-help with support (± TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: Remission (number of people no longer above threshold on CAPS/<20 on PDS)

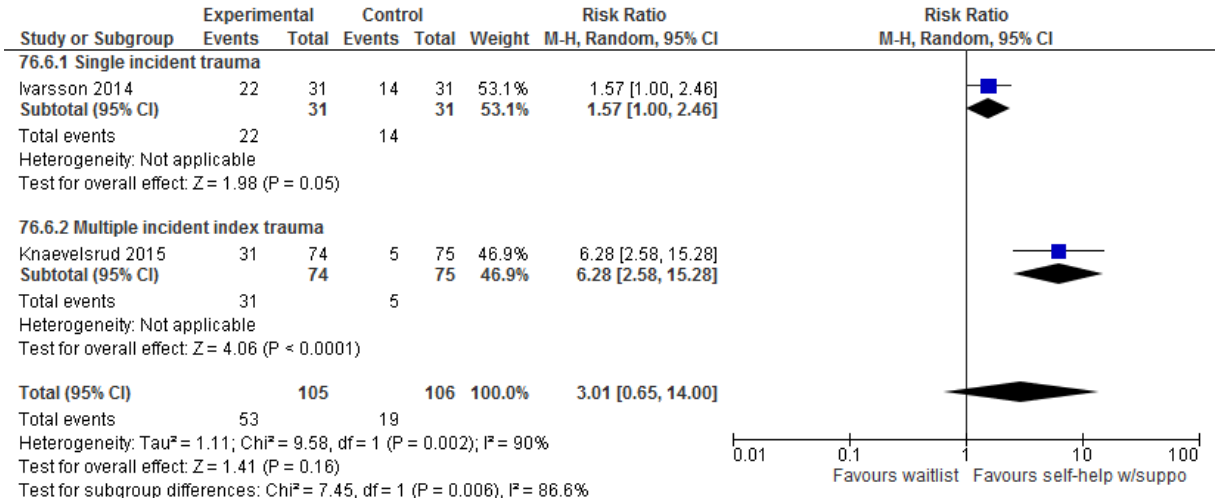


Figure 528: Self-help with support (± TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: Functional impairment (SDS change score); Single incident trauma

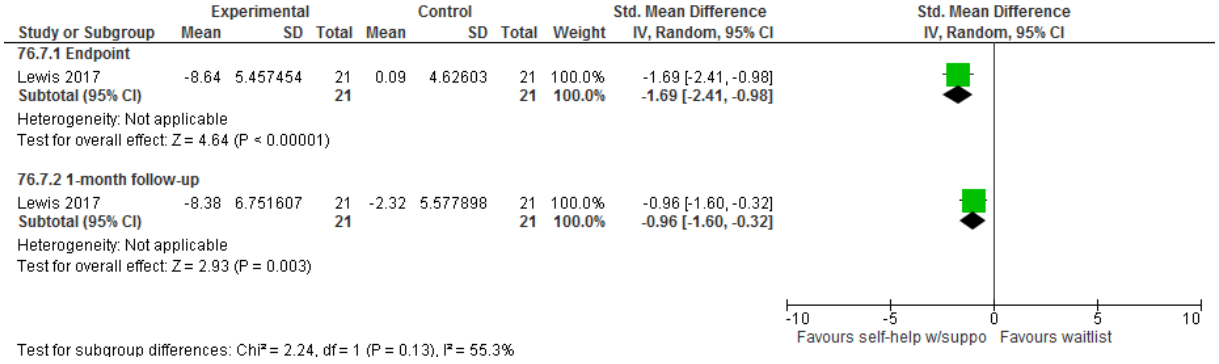


Figure 529: Self-help with support (± TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: Quality of life (QOLI/EUROHIS-QOL change score)

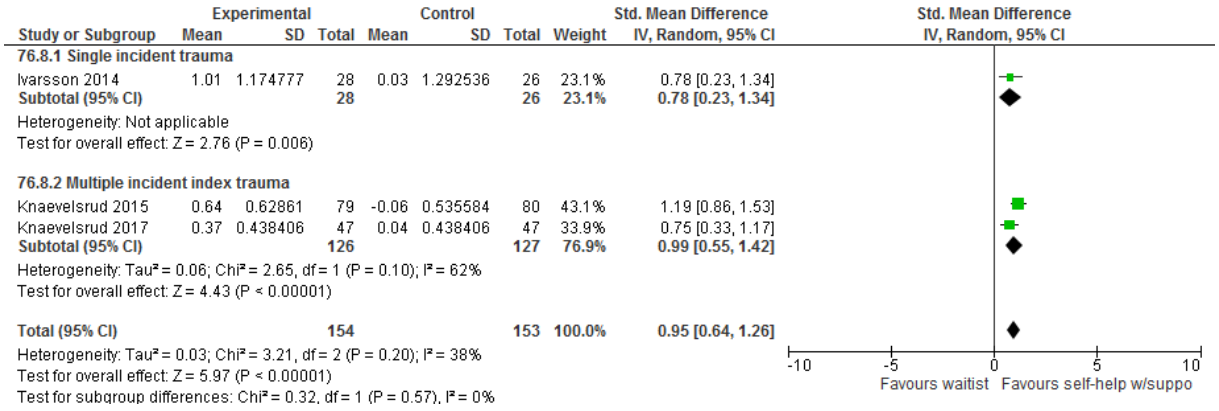


Figure 530: Self-help with support (± TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: Sleeping difficulties (SCL-90: Sleeping problems; change score)

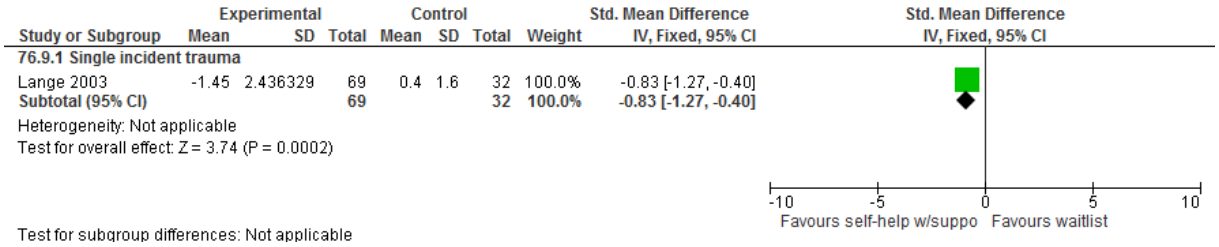


Figure 531: Self-help with support (± TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: Anxiety symptoms at endpoint (BAI/BSI: Anxiety/HSCL-25: Anxiety/SCL-90: Anxiety change score)

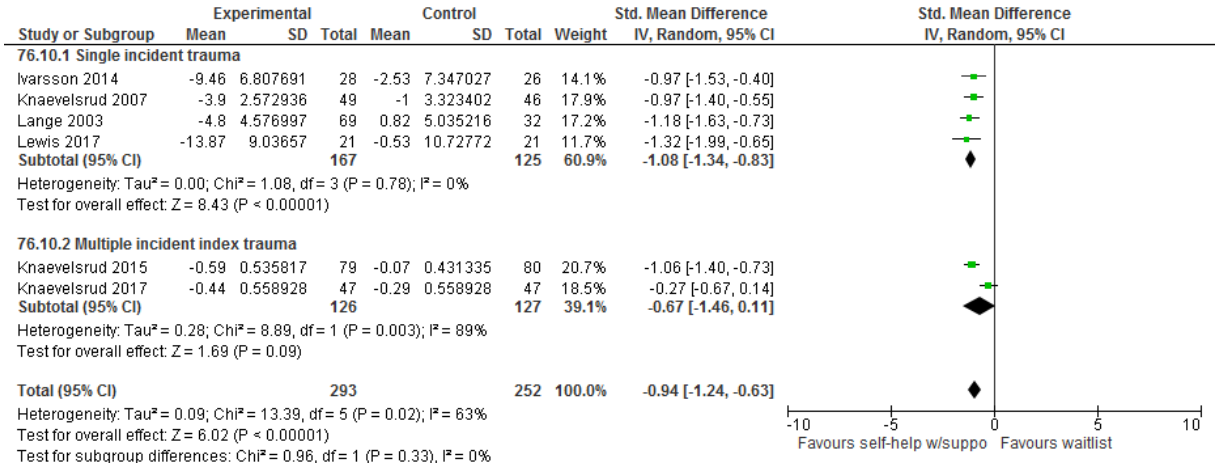


Figure 532: Self-help with support (± TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: Anxiety symptoms at 1-2 month follow-up (BAI/STAI State change score)

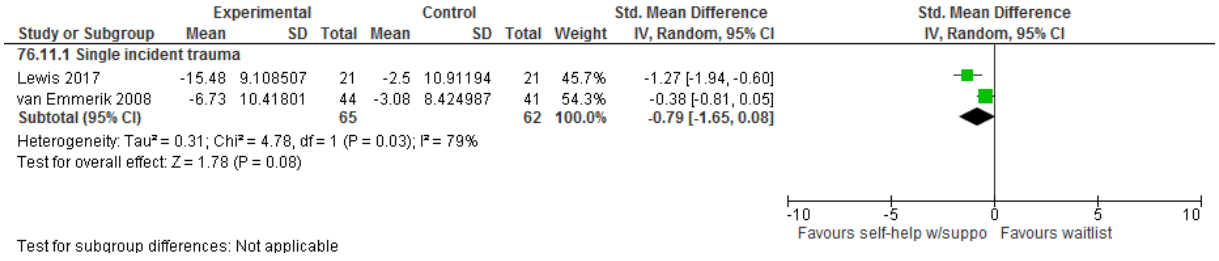


Figure 533: Self-help with support (± TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: Anxiety symptoms at 1-year follow-up (STAI State change score)

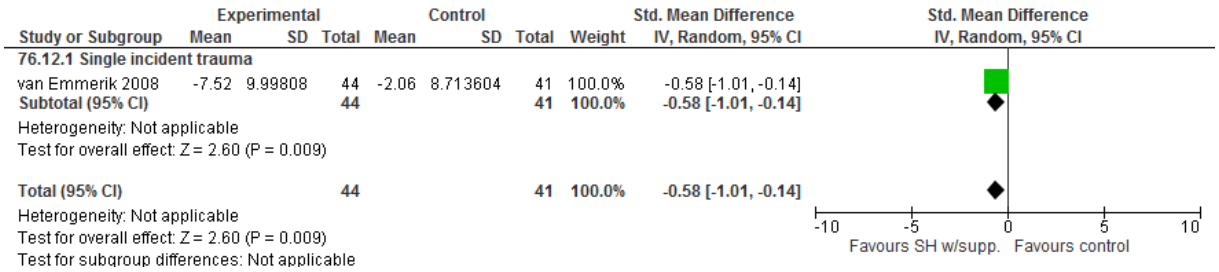


Figure 534: Self-help with support (± TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms

at endpoint (BDI/BDI-II/BSI: Depression/HSCL-25: Depression/SCL-90: Depression change score)

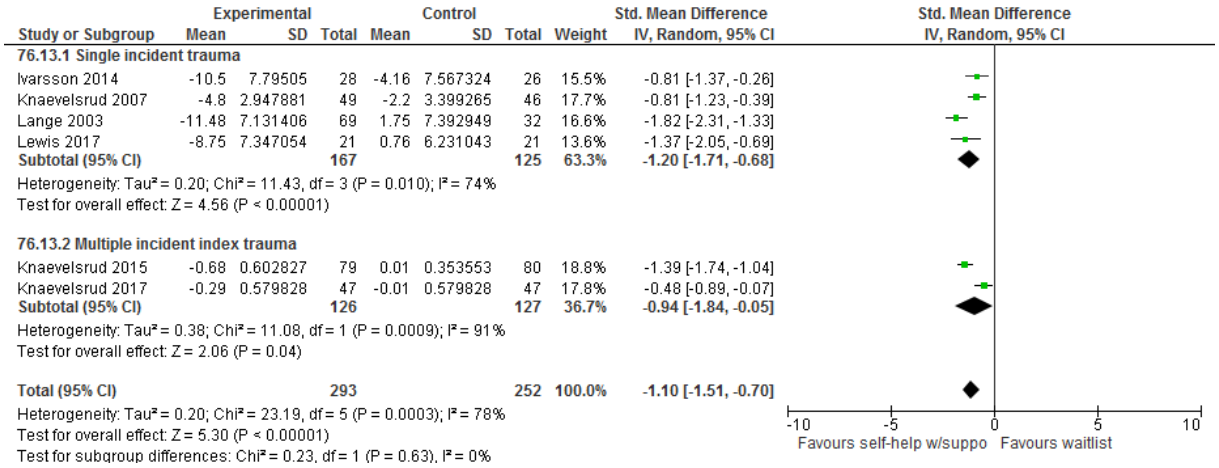


Figure 535: Self-help with support (± TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms at 1-2 month follow-up (BDI change score)

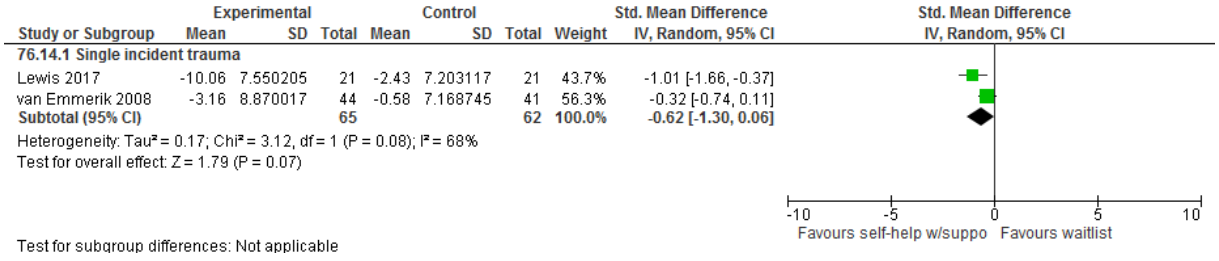


Figure 536: Self-help with support (± TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms at 1-year follow-up (BDI change score)

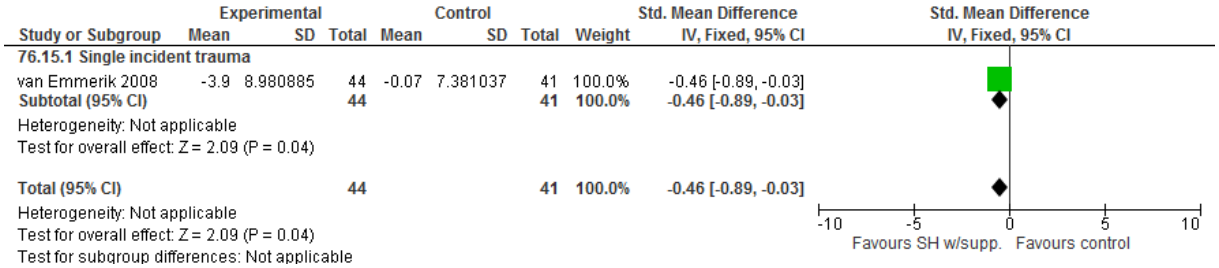


Figure 537: Self-help with support (± TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: Alcohol use disorder symptoms (AUDIT change score); Single incident trauma

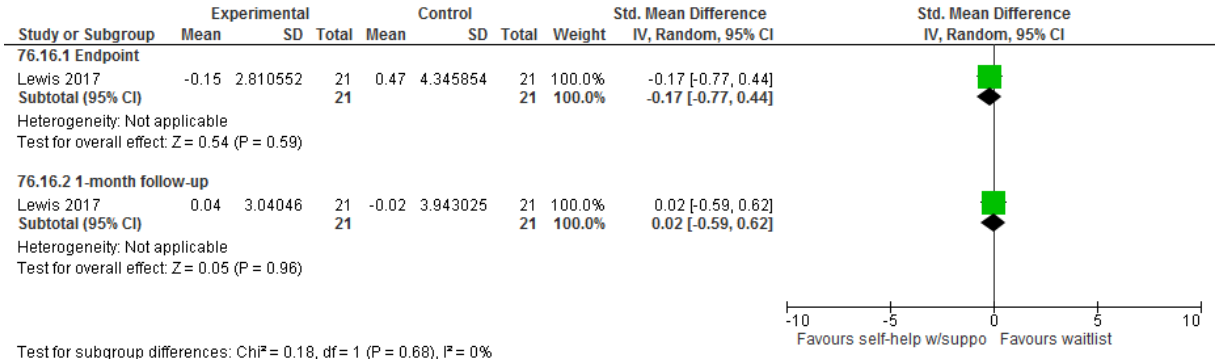


Figure 538: Self-help with support (± TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: Substance use disorder symptoms (TLFB: Number of days abstinent from alcohol in the last 90 days; change score); Unclear multiplicity of index trauma

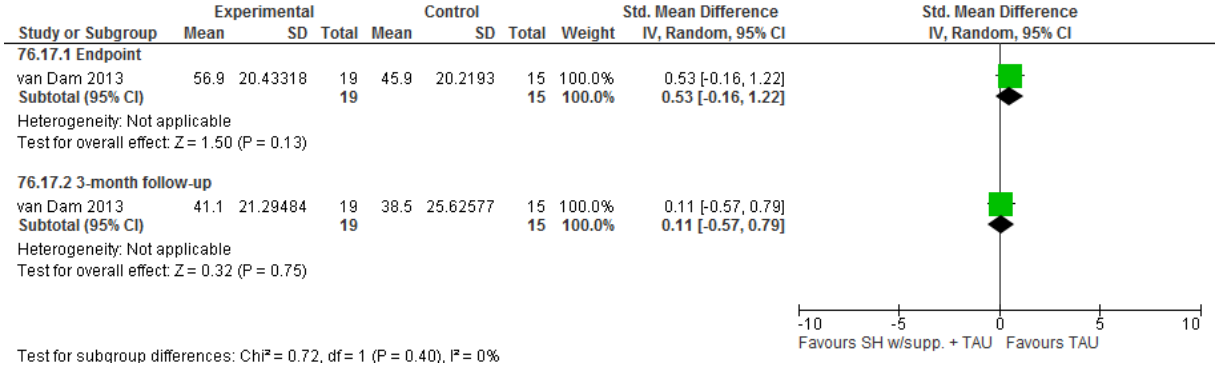


Figure 539: Self-help with support (± TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)

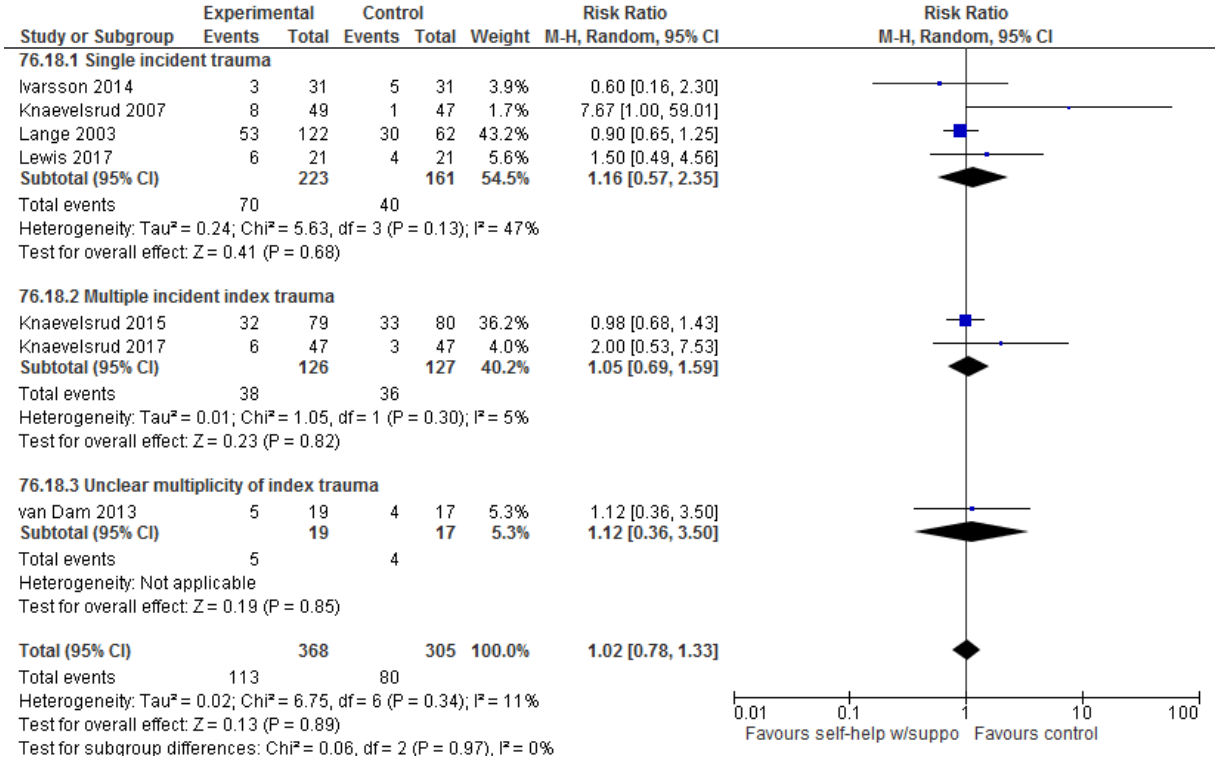
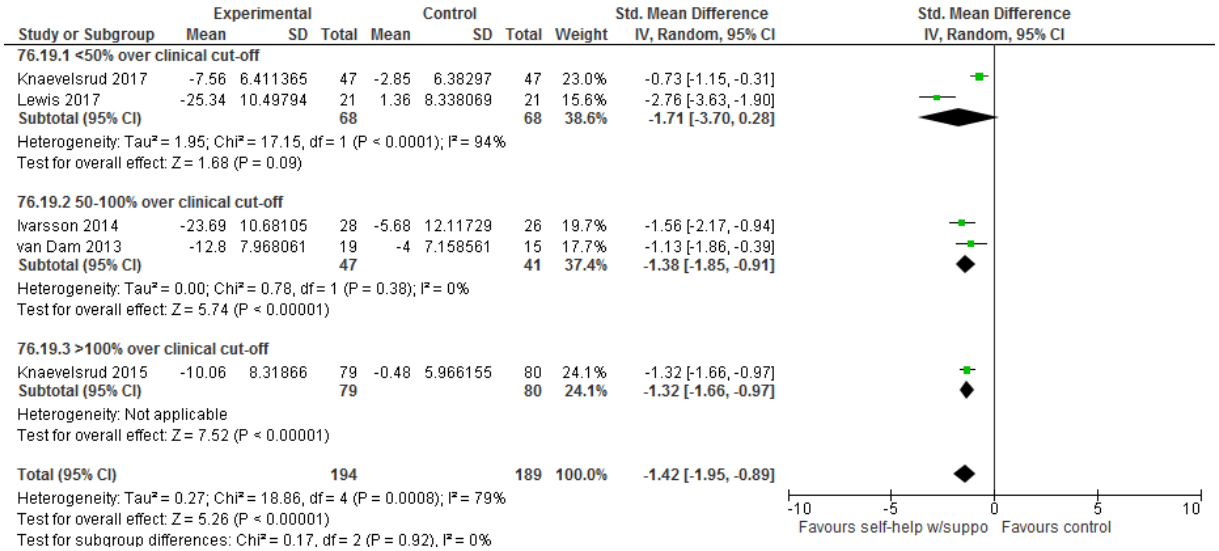


Figure 540: Self-help with support (± TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: Sub-analysis by baseline severity: PTSD symptomatology self-rated at endpoint (IES endpoint/IES-R/PDS/PCL-5 change score)



Sub-analysis by specific intervention: Self-help with support (± TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD

Figure 541: Self-help with support (± TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated at endpoint (IES endpoint/IES-R/PDS/PCL-5 change score)

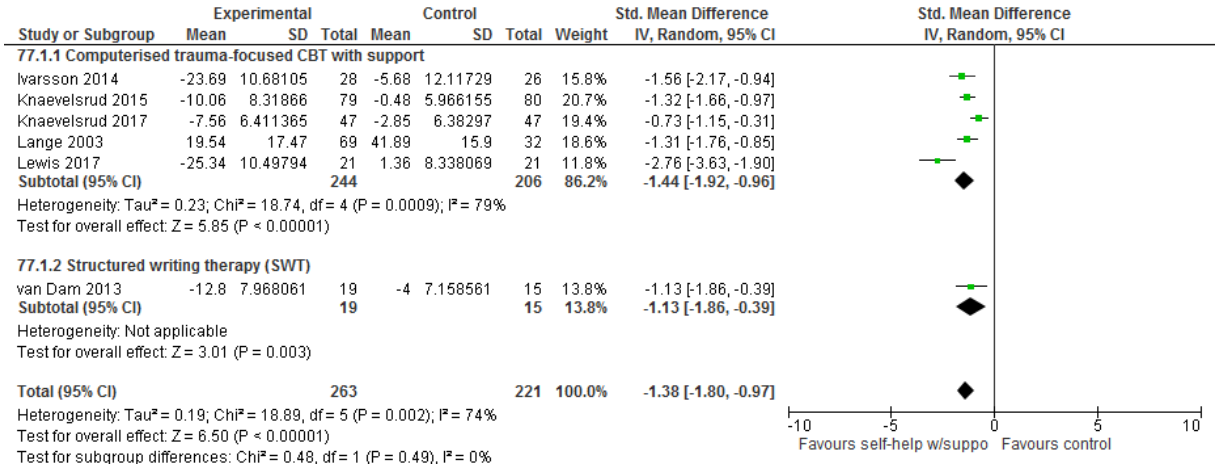


Figure 542: Self-help with support (± TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated (CAPS change score)

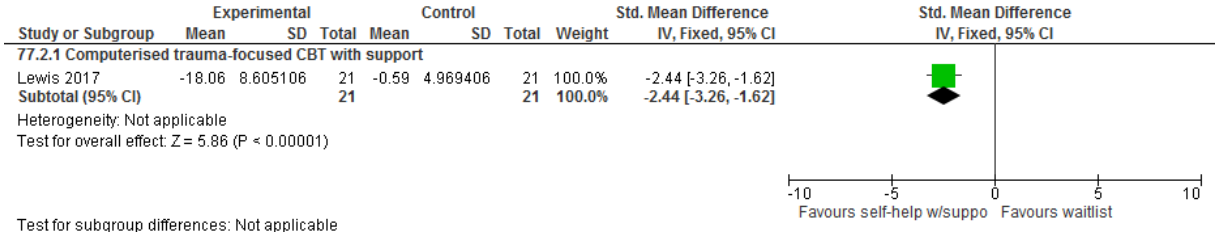
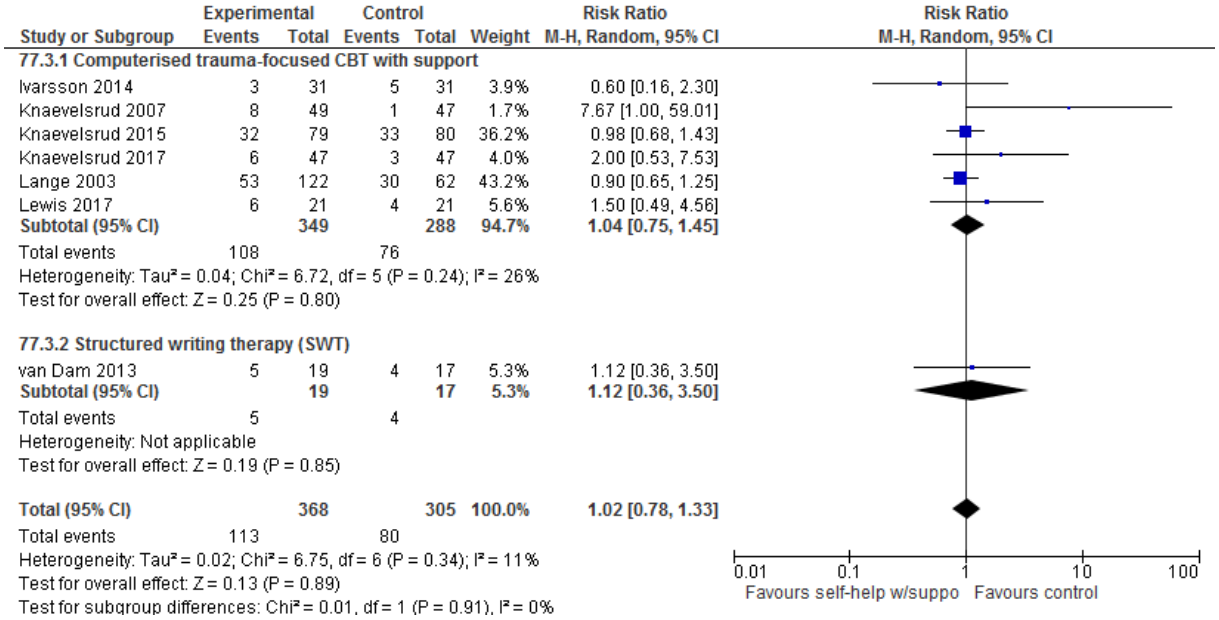


Figure 543: Self-help with support (± TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)



Sub-analysis by diagnostic status at baseline: Self-help with support (± TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD

Figure 544: Self-help with support (± TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated at endpoint (IES endpoint/IES-R/PDS/PCL-5 change score)

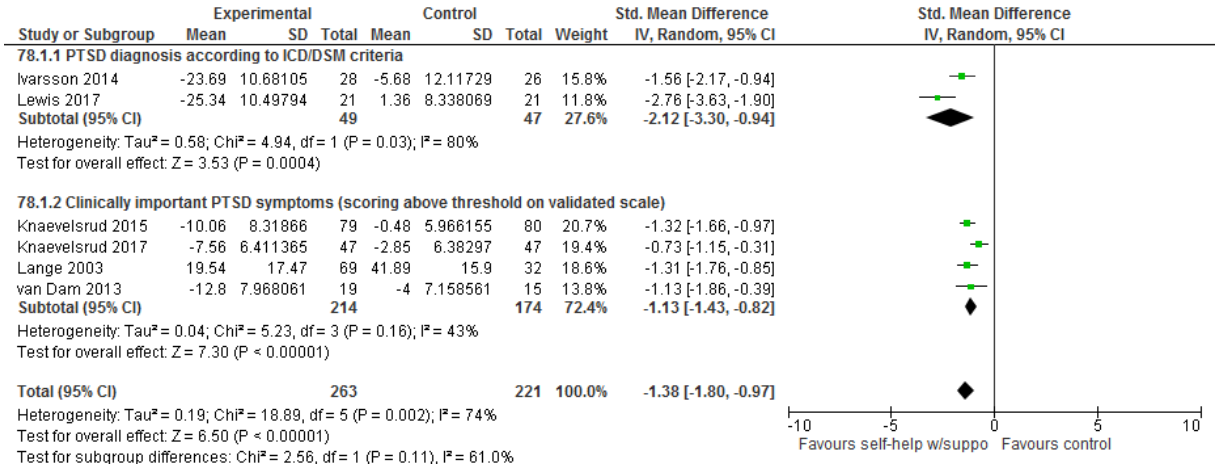


Figure 545: Self-help with support (± TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated (CAPS change score)

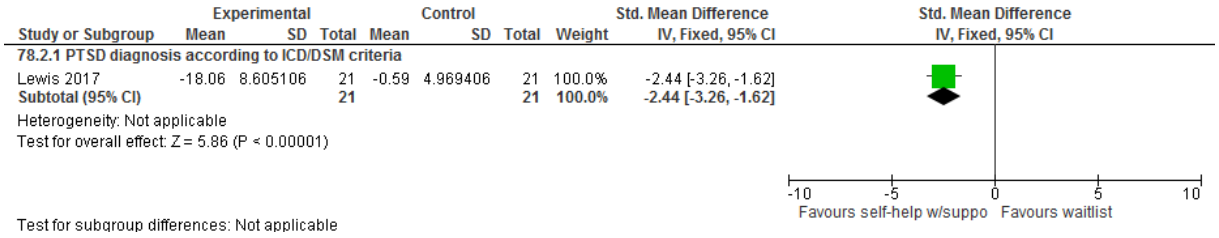
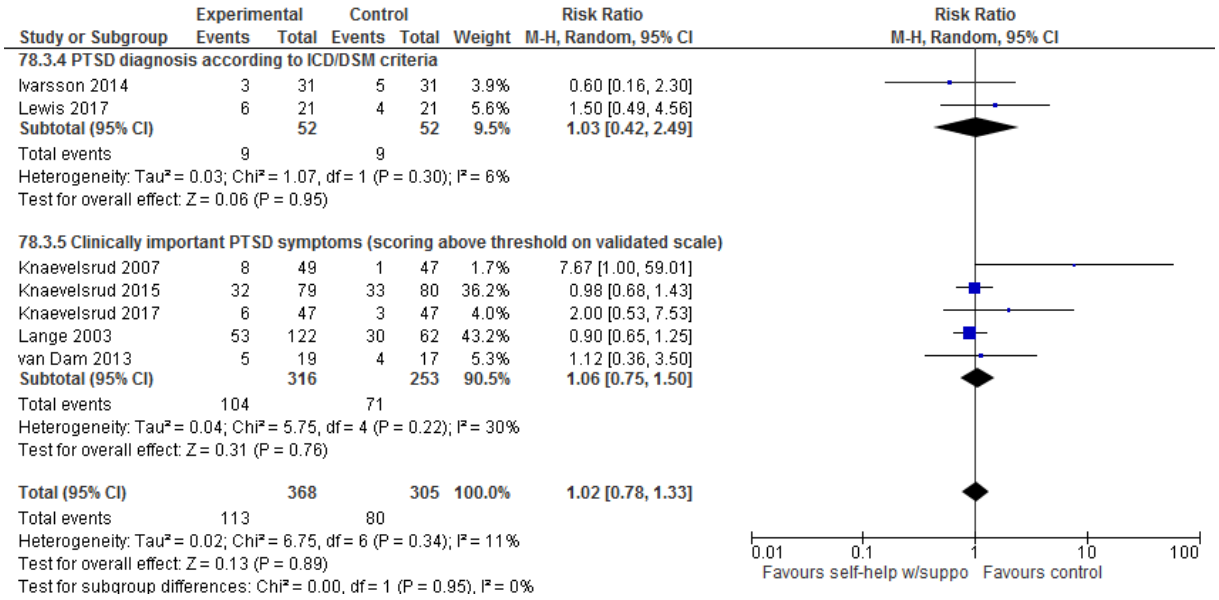


Figure 546: Self-help with support (± TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)



Sub-analysis by trauma type: Self-help with support (± TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD

Figure 547: Self-help with support (± TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated at endpoint (IES endpoint/IES-R/PDS/PCL-5 change score)

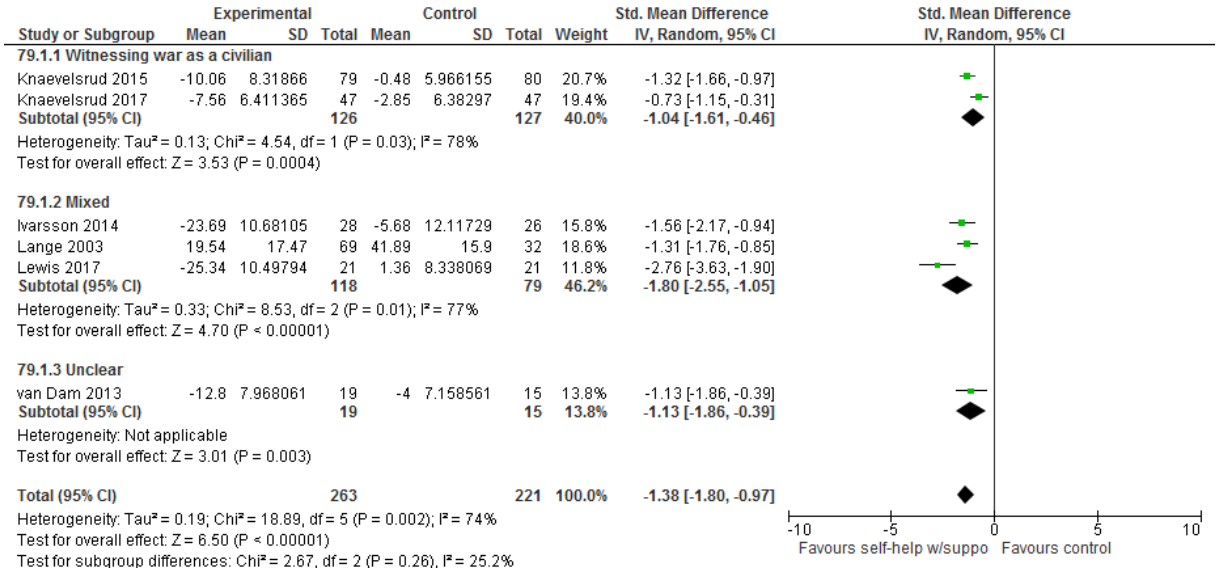


Figure 548: Self-help with support (± TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated (CAPS change score)

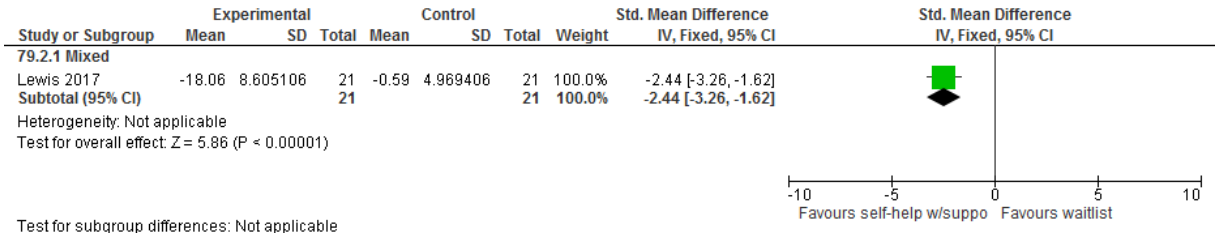


Figure 549: Self-help with support (± TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)

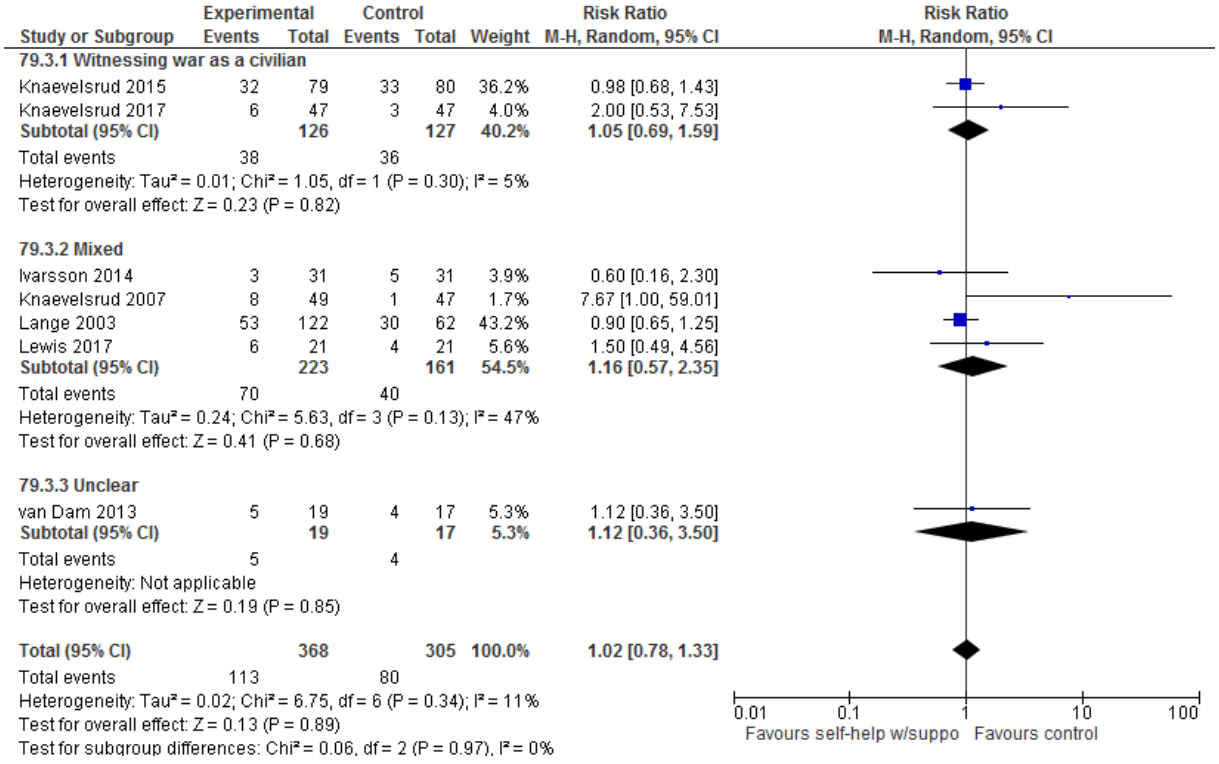


Figure 550: Self-help with support versus self-help without support for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated (PSS-I change score); single incident trauma

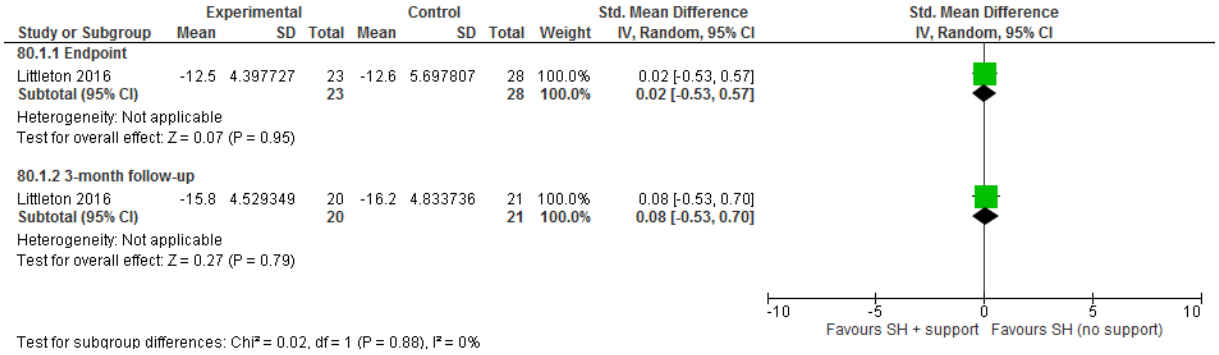


Figure 551: Self-help with support versus self-help without support for delayed treatment (>3 months) of clinically important symptoms/PTSD: Response

(number of people showing clinically significant improvement, based on reliable change indices [RCI], on PSS-I); single incident trauma

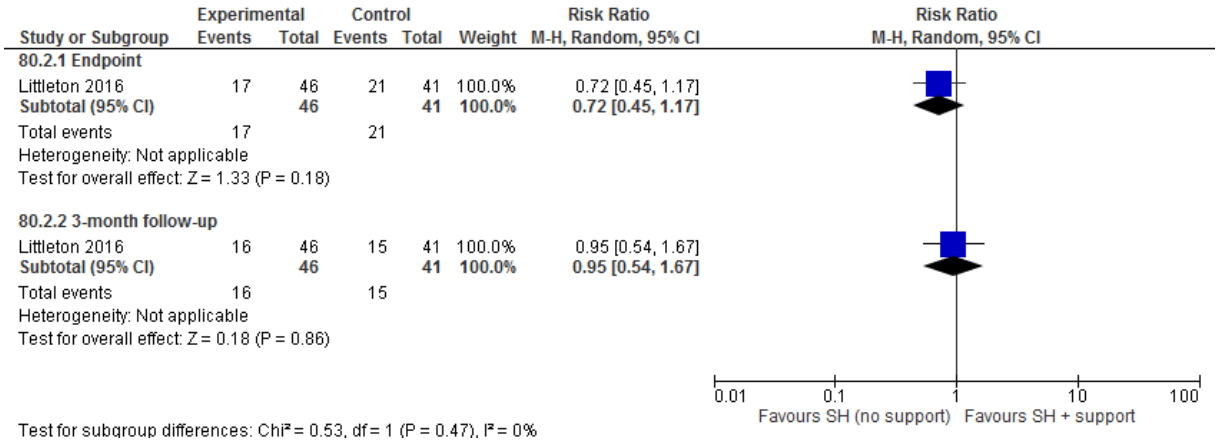


Figure 552: Self-help with support versus self-help without support for delayed treatment (>3 months) of clinically important symptoms/PTSD: Anxiety symptoms (FDAS change score); single incident trauma

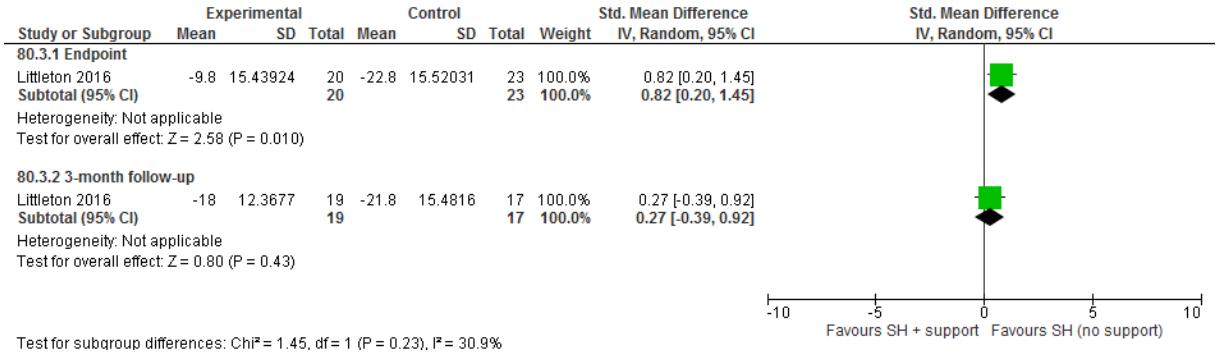


Figure 553: Self-help with support versus self-help without support for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms (CES-D change score); single incident trauma

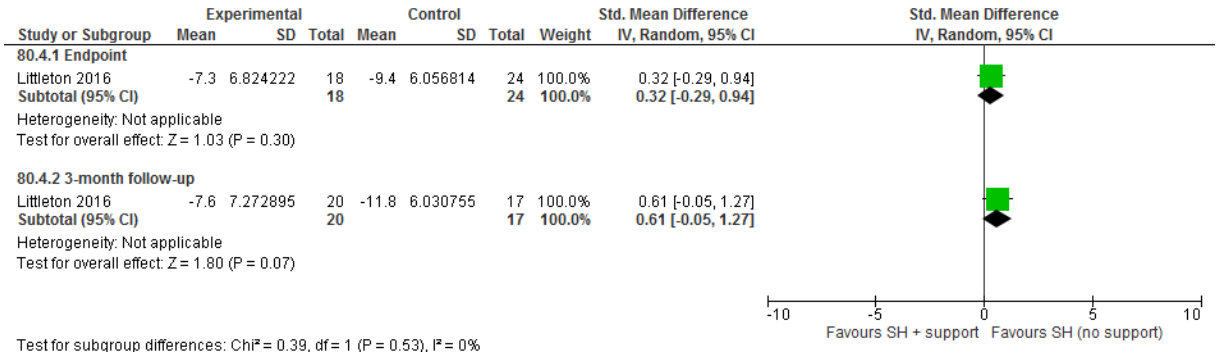
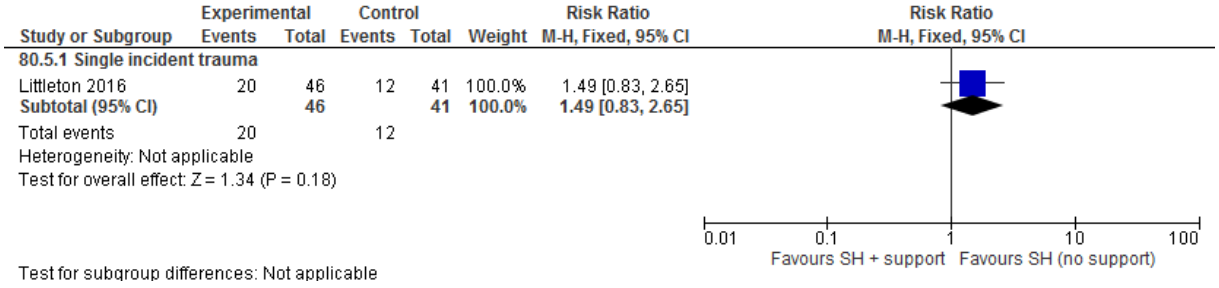


Figure 554: Self-help with support versus self-help without support for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)



Self-help (without support)

Figure 555: Self-help (without support) versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated (IES-R/PCL-C/PDS change scores)

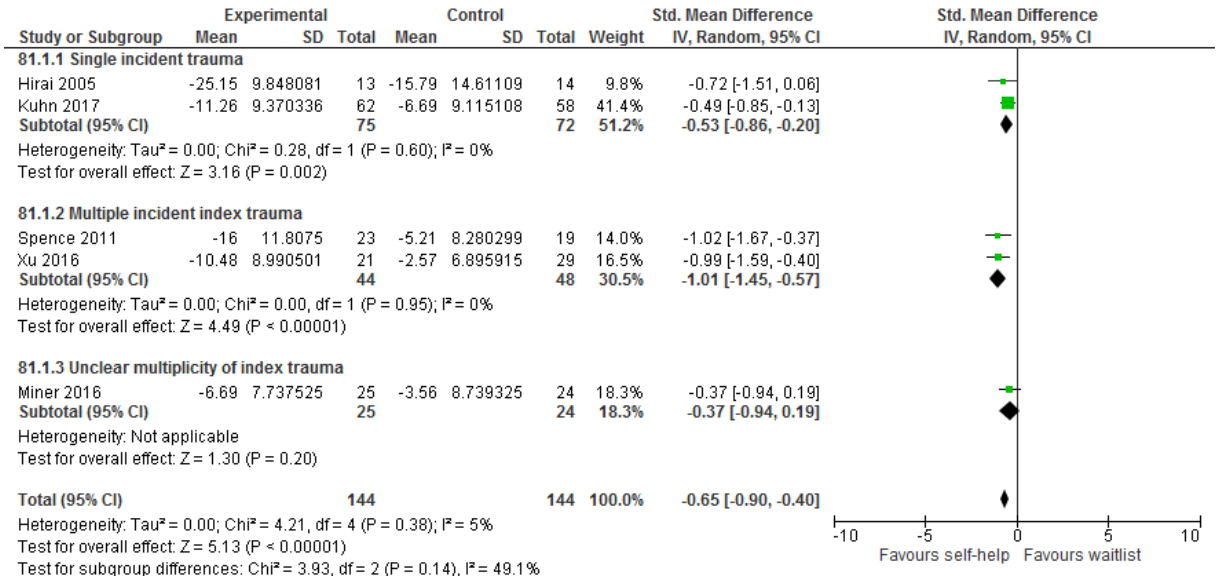


Figure 556: Self-help (without support) versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Remission (number of

people no longer meeting diagnostic criteria for PTSD or no longer above clinical threshold on scale); single incident trauma

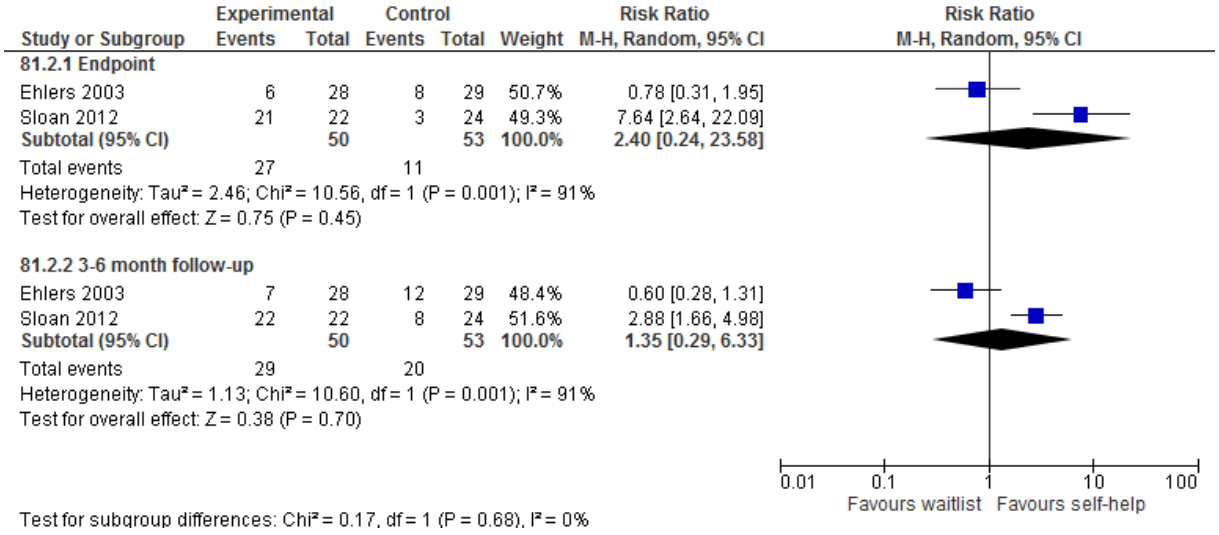


Figure 557: Self-help (without support) versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Response at endpoint (number of people showing improvement of at least 10 points on PCL-C/clinically significant improvement, based on reliable change indices [RCI] on CAPS/≥50% improvement on PDS)

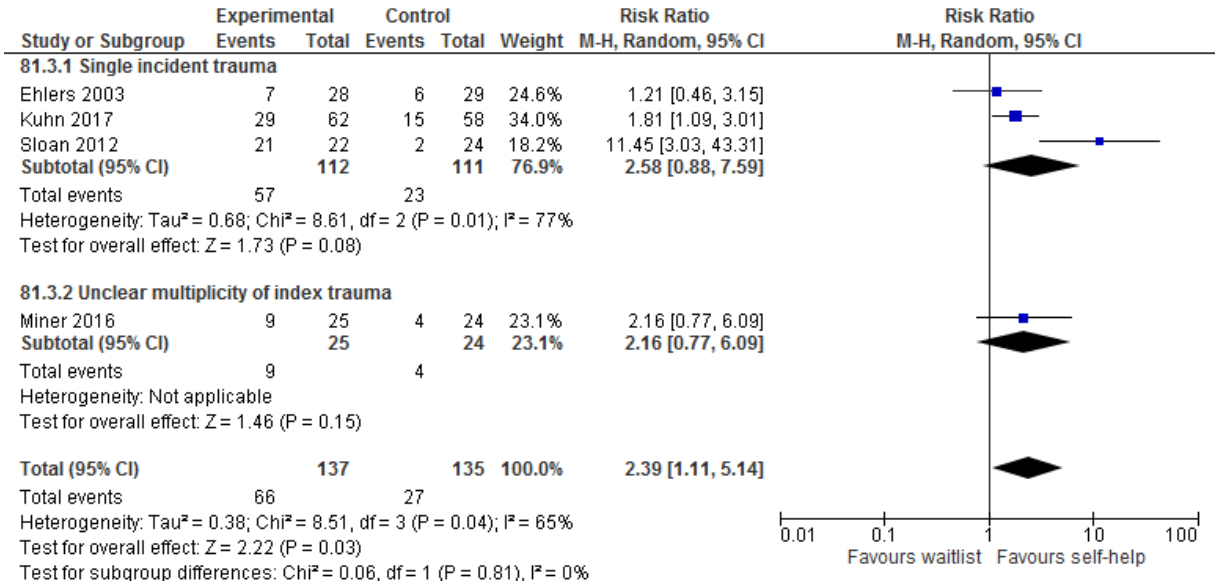


Figure 558: Self-help (without support) versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Response at 3-6 month follow-up (number of people showing clinically significant improvement,

based on reliable change indices [RCI], on CAPS/≥50% improvement on PDS)

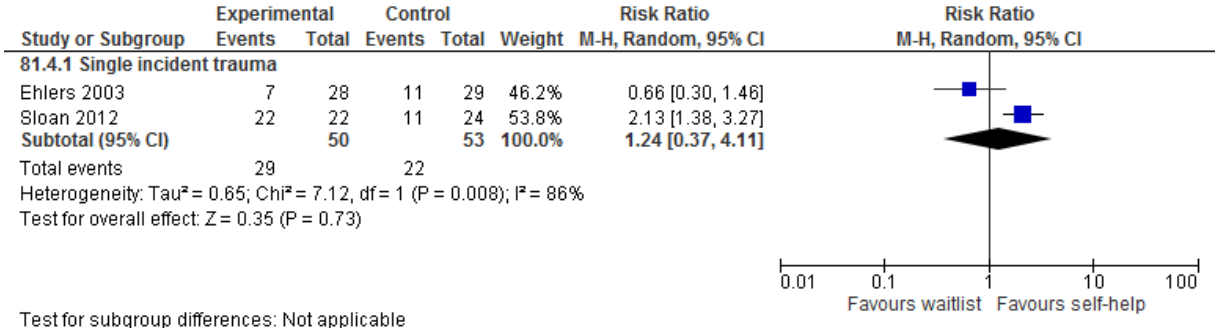


Figure 559: Self-help (without support) versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Functional impairment at endpoint (SDS/B-IPF change score)

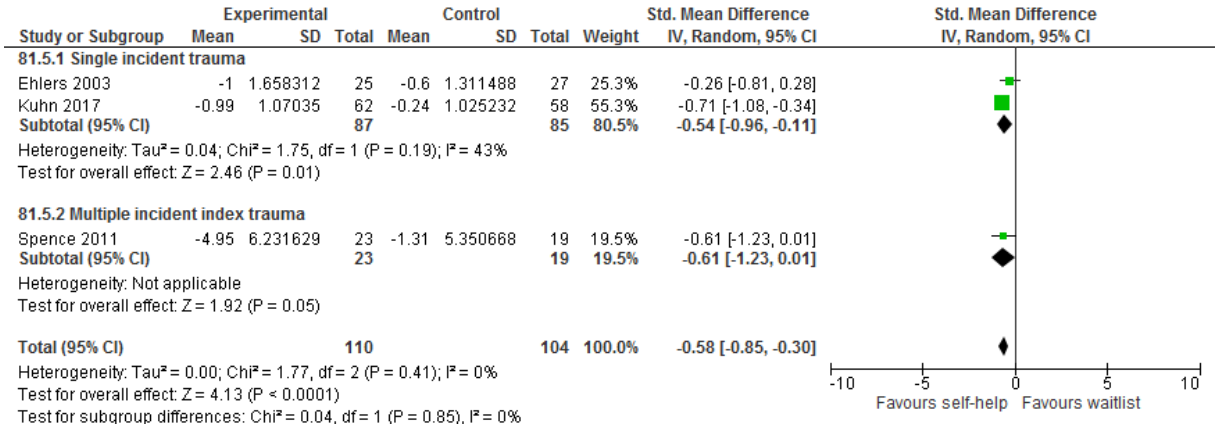


Figure 560: Self-help (without support) versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Functional impairment at 6-month follow-up (SDS change score)

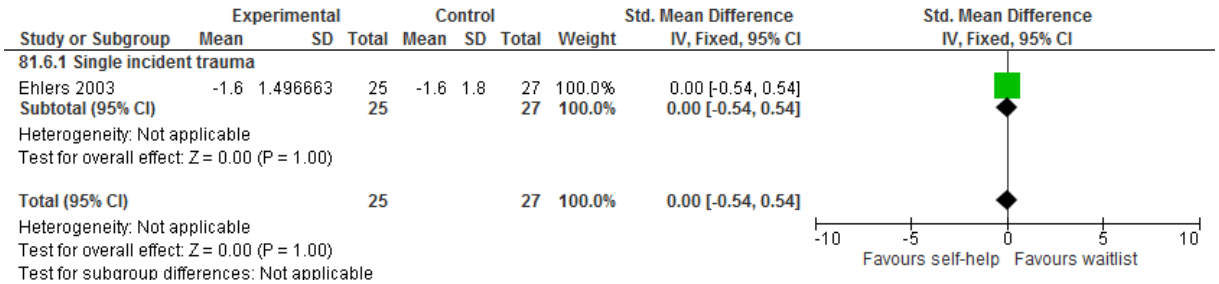


Figure 561: Self-help (without support) versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Anxiety symptoms at endpoint (BAI/STAI State/GAD-7 change score)

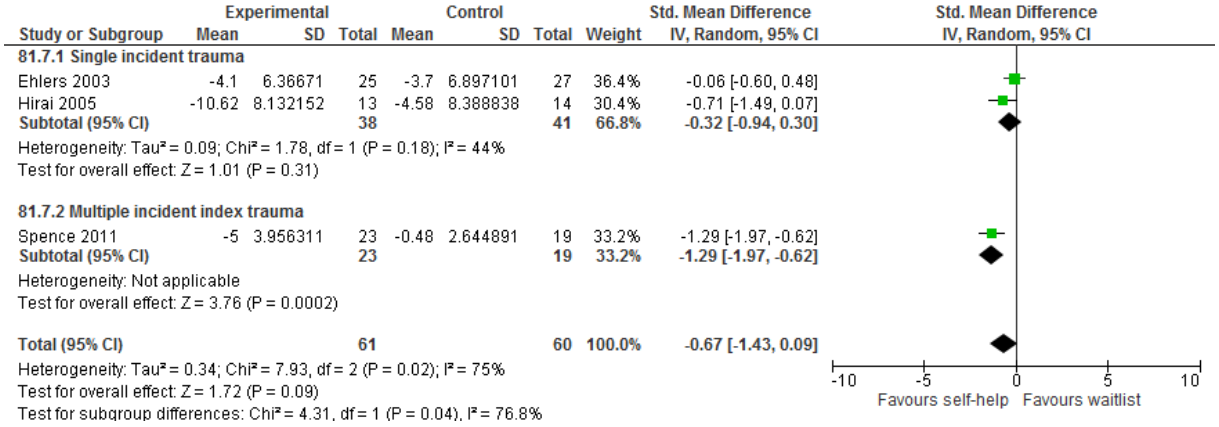


Figure 562: Self-help (without support) versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Anxiety symptoms at 6-month follow-up (BAI change score)

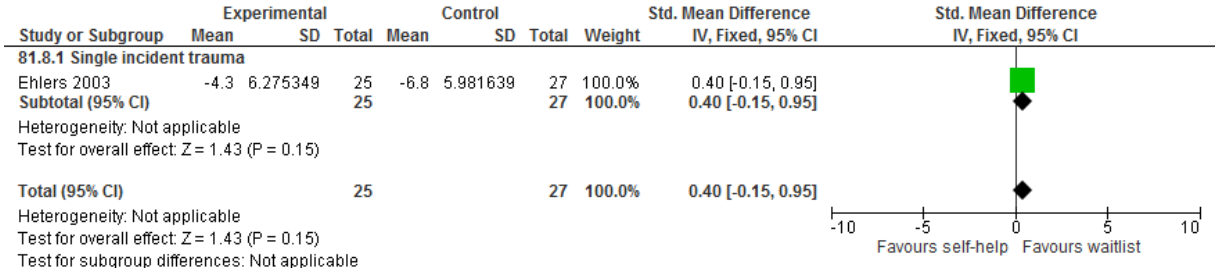


Figure 563: Self-help (without support) versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms at endpoint (BDI-II/PHQ-8/PHQ-9 change score)

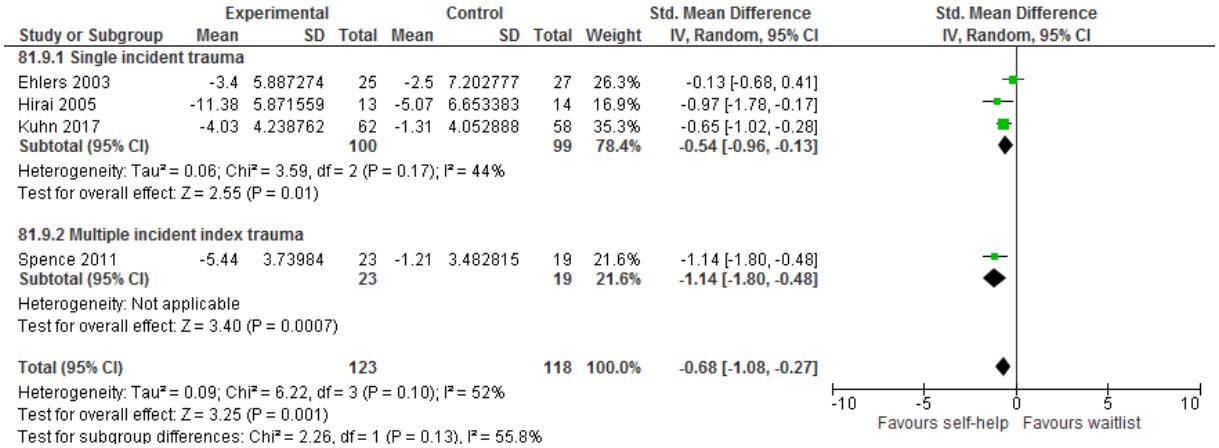


Figure 564: Self-help (without support) versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms at 6-month follow-up (BDI-II change score)

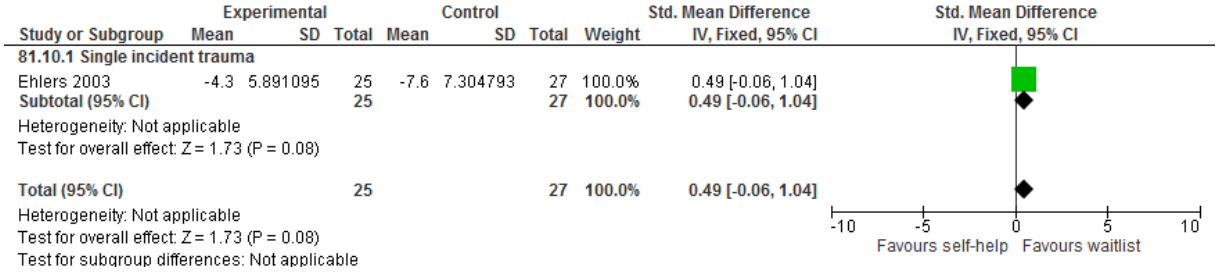


Figure 565: Self-help (without support) versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)

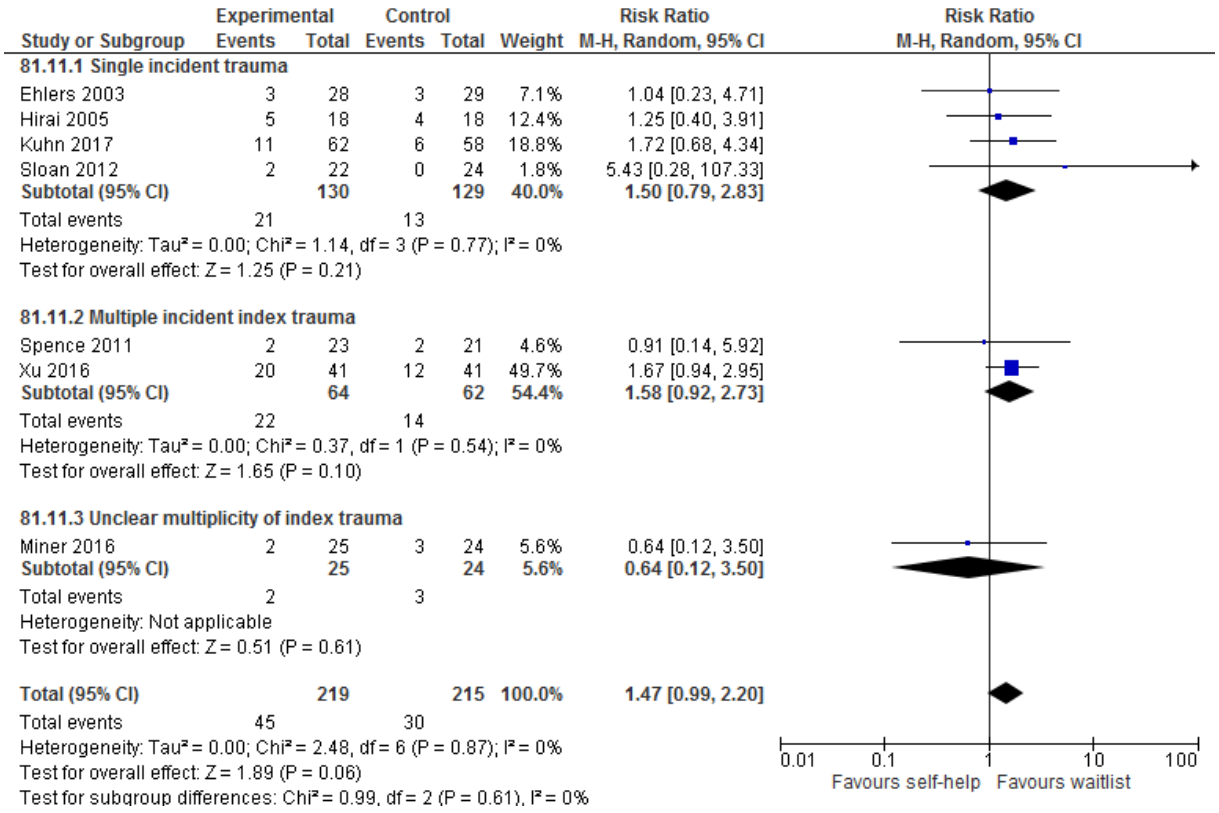
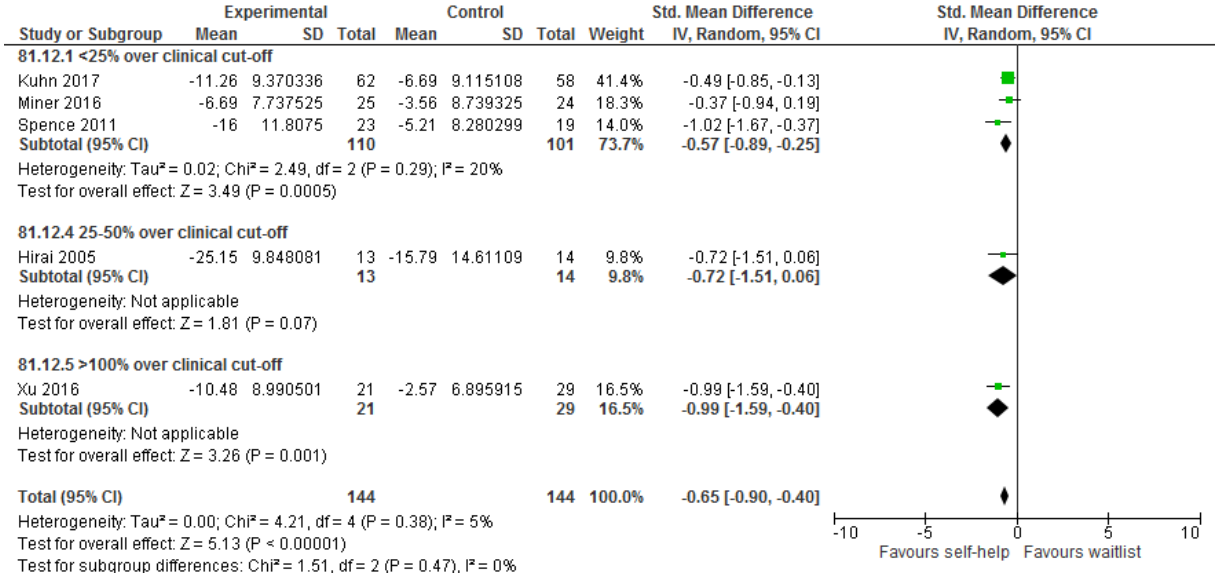


Figure 566: Self-help (without support) versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Sub-analysis by baseline severity: PTSD symptomatology self-rated (IES-R/PCL-C/PDS change scores)



Sub-analysis by specific intervention: Self-help (without support) versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD

Figure 567: Self-help (without support) versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated (IES-R/PCL-C/PDS change scores)

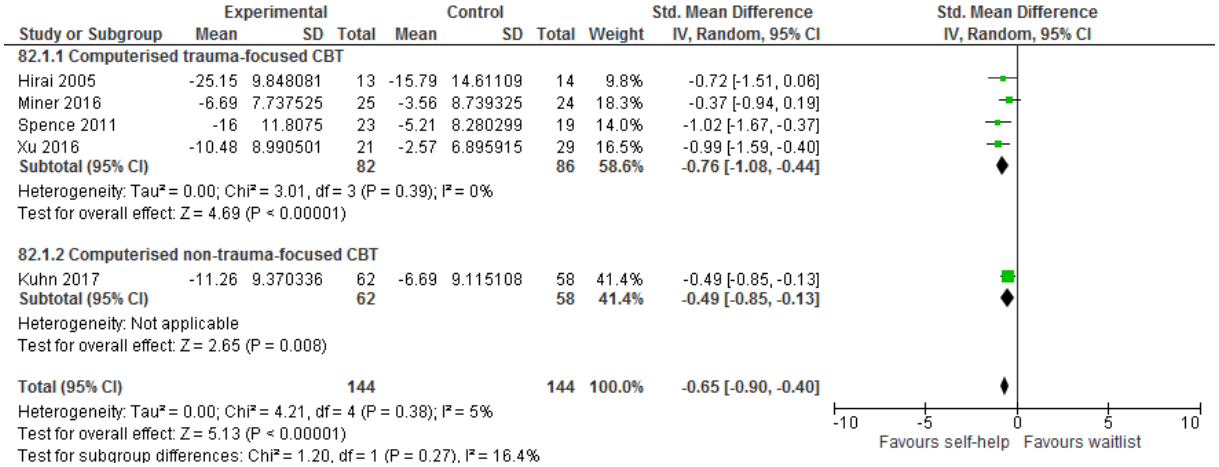
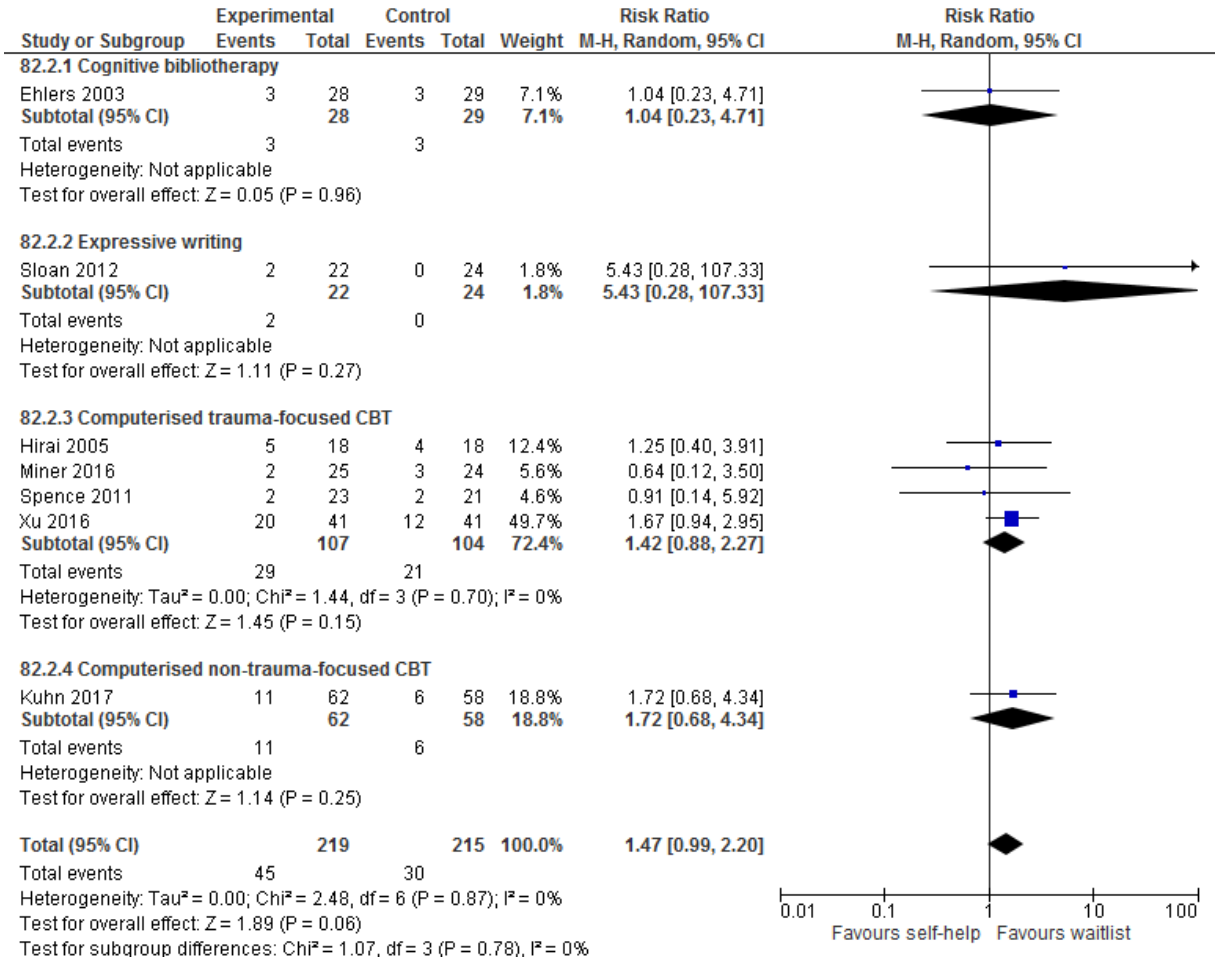


Figure 568: Self-help (without support) versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)



Sub-analysis by diagnostic status at baseline: Self-help (without support) versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD

Figure 569: Self-help (without support) versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated (IES-R/PCL-C/PDS change scores)

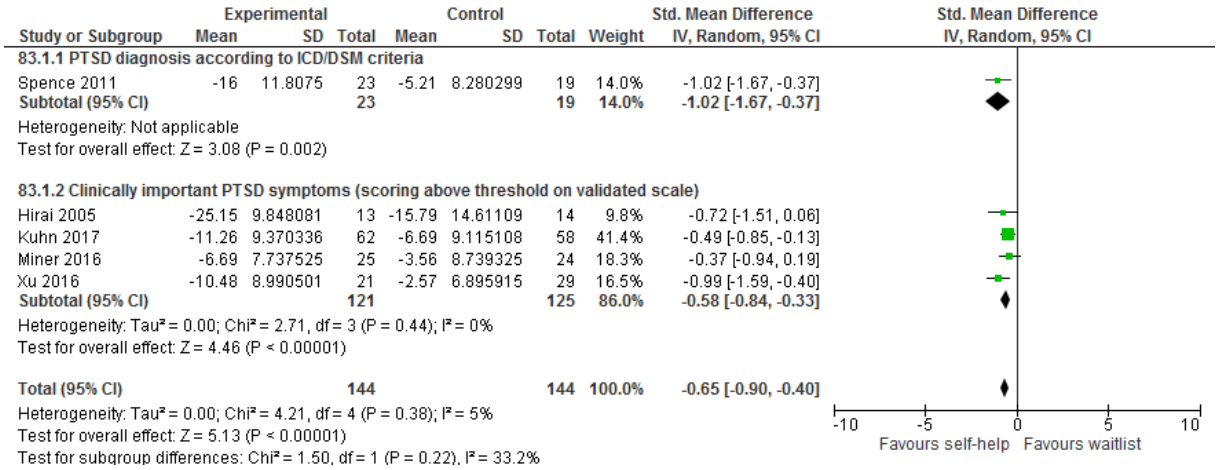
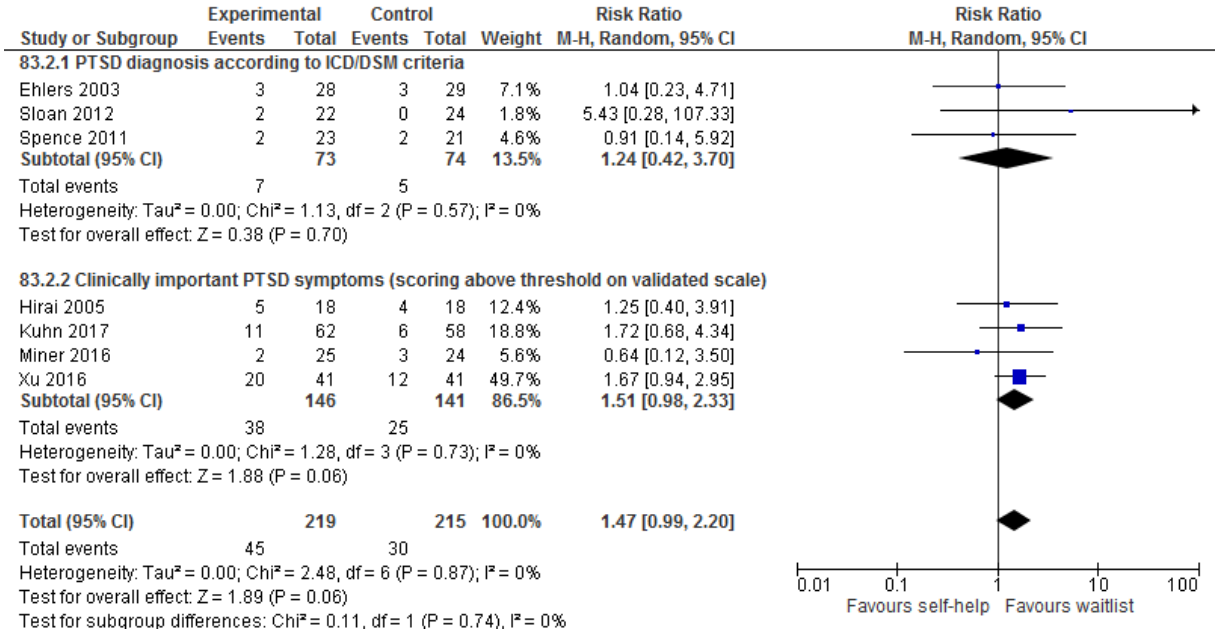


Figure 570: Self-help (without support) versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)



Sub-analysis by trauma type: Self-help (without support) versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD

Figure 571: Self-help (without support) versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated (IES-R/PCL-C/PDS change scores)

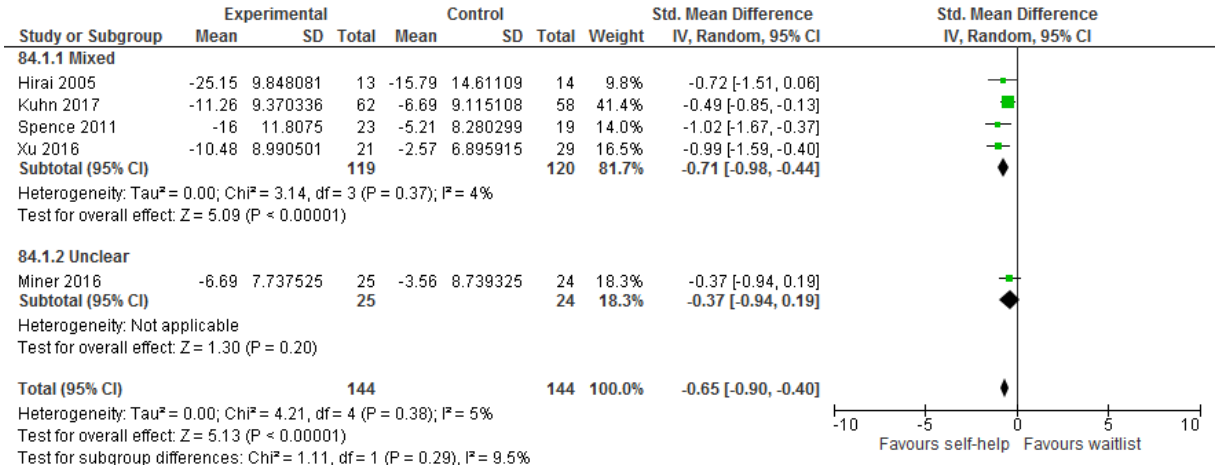


Figure 572: Self-help (without support) versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)

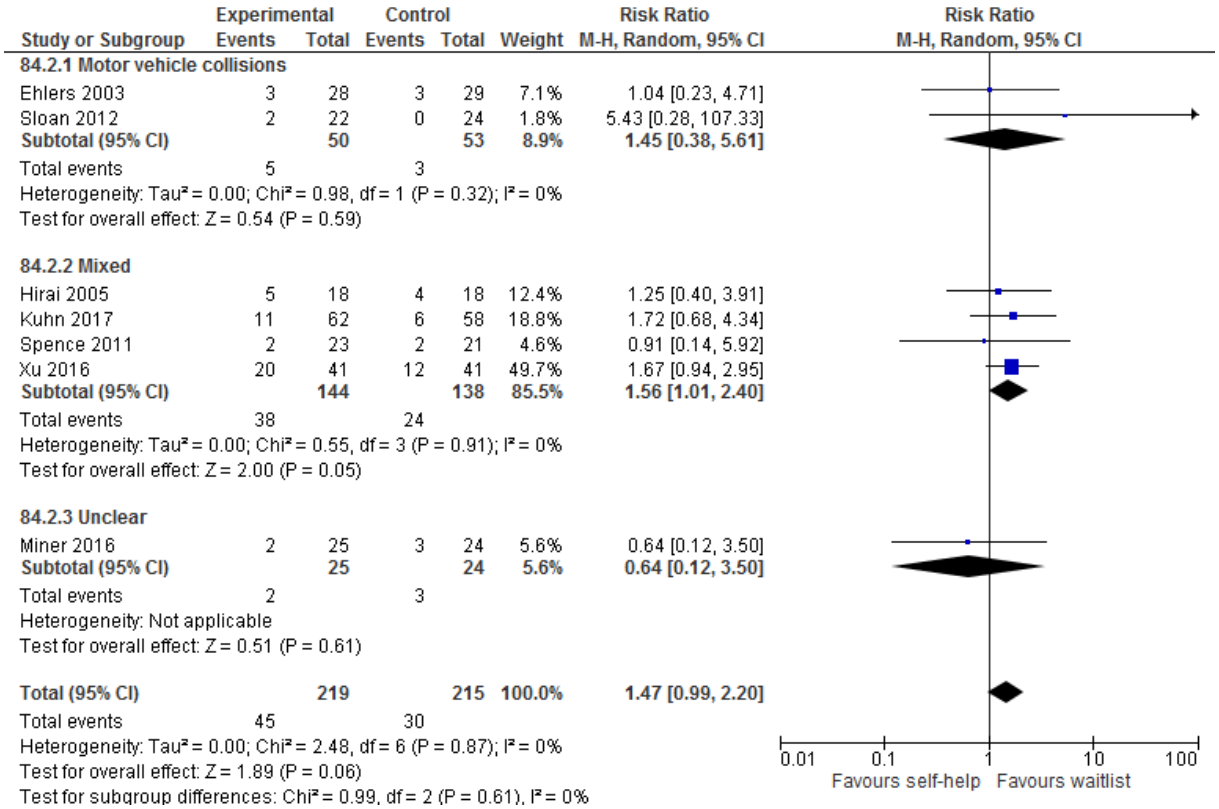


Figure 573: Self-help (without support) versus attention-placebo for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-report at endpoint (PDS/IES change score)

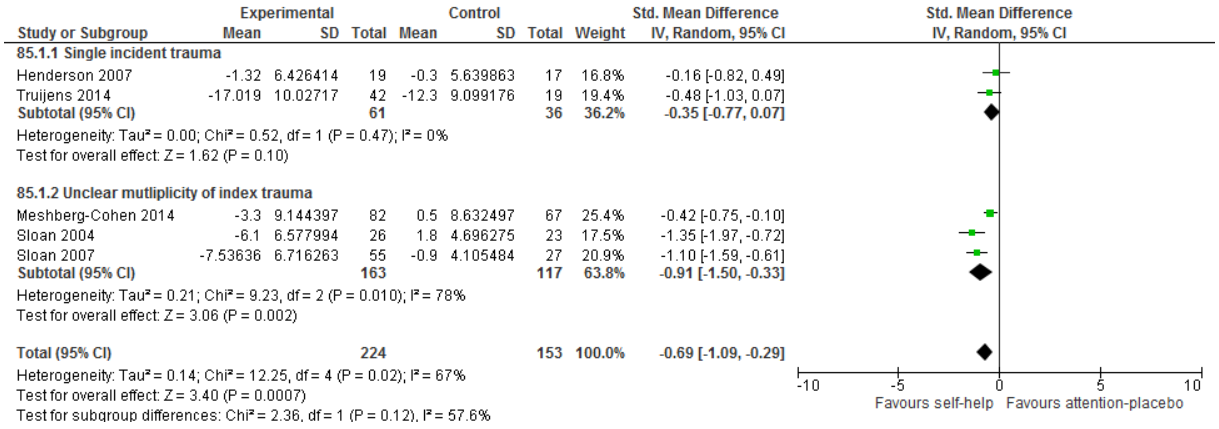


Figure 574: Self-help (without support) versus attention-placebo for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-report at 1-month follow-up (PDS change score)

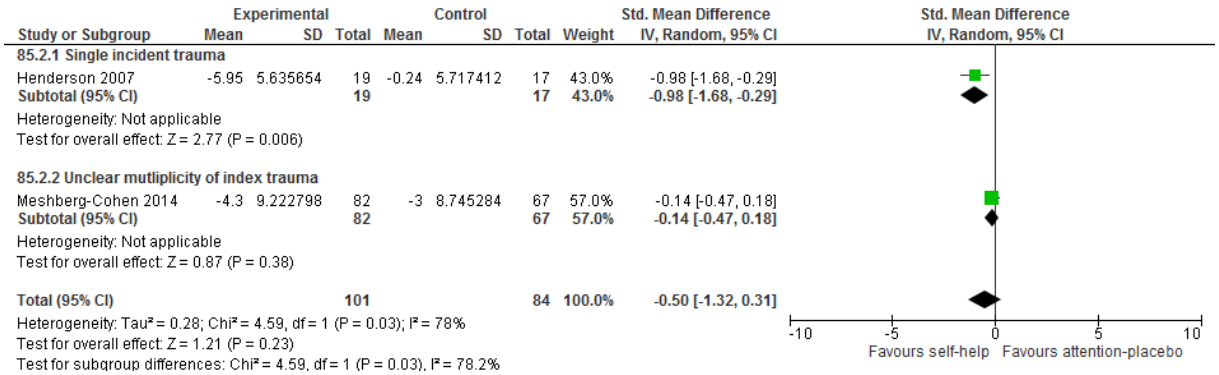


Figure 575: Self-help (without support) versus attention-placebo for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated at endpoint (PSS-I change score)

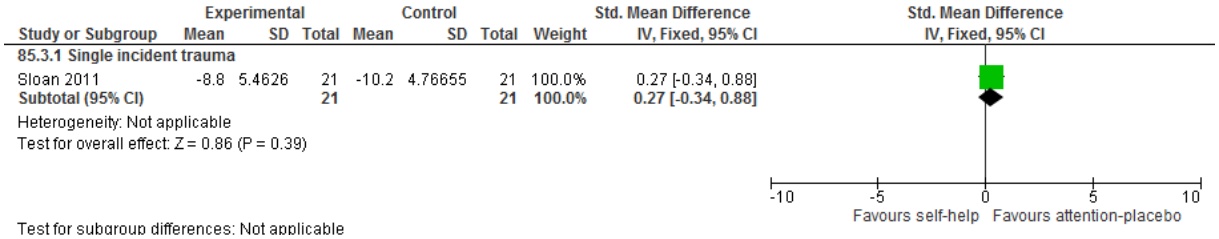


Figure 576: Self-help (without support) versus attention-placebo for delayed treatment (>3 months) of clinically important symptoms/PTSD: Remission (number of people no longer meeting diagnostic criteria for PTSD)

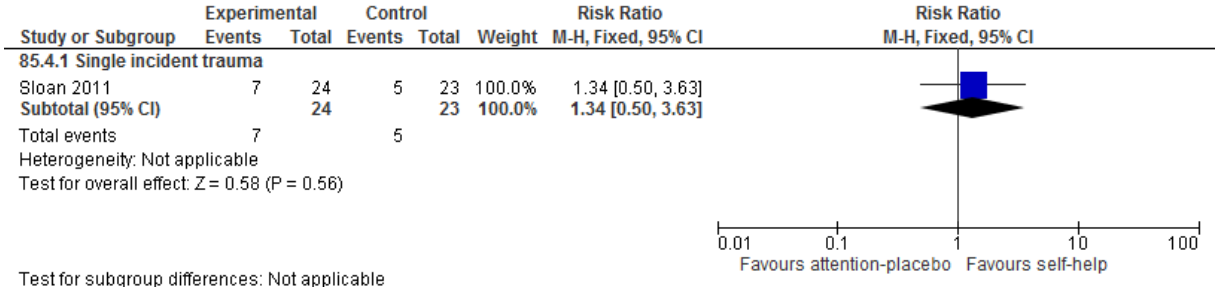


Figure 577: Self-help (without support) versus attention-placebo for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms at endpoint (CES-D/BDI-II change score)

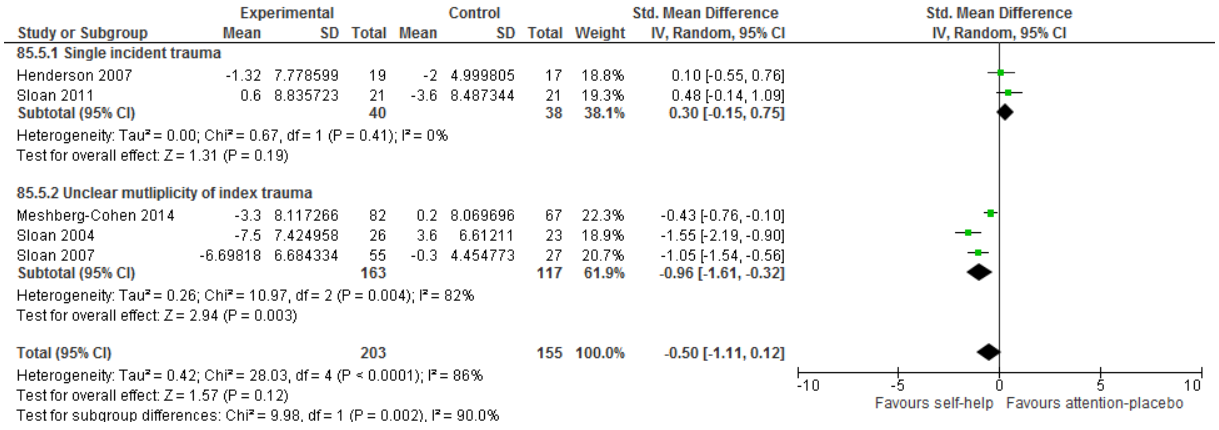


Figure 578: Self-help (without support) versus attention-placebo for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms at 1-month follow-up (CES-D/BDI-II change score)

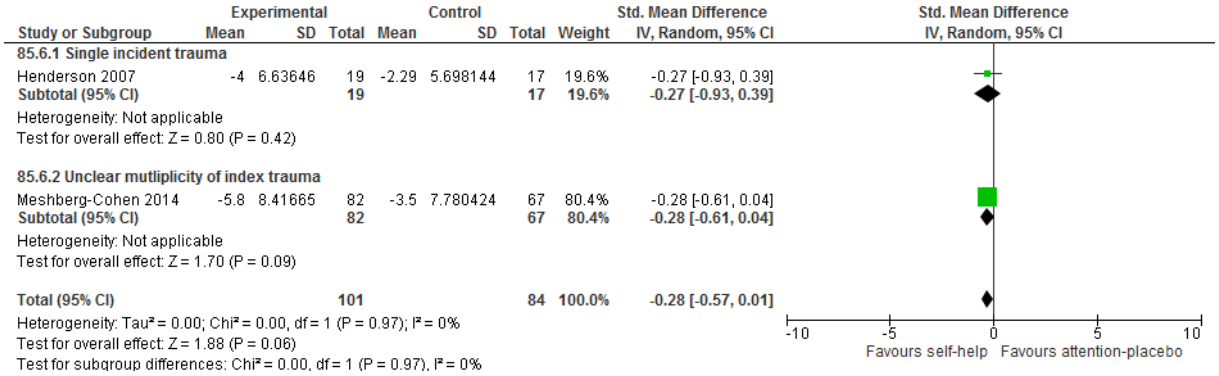


Figure 579: Self-help (without support) versus attention-placebo for delayed treatment (>3 months) of clinically important symptoms/PTSD: Anxiety symptoms at endpoint (STAI State change score)

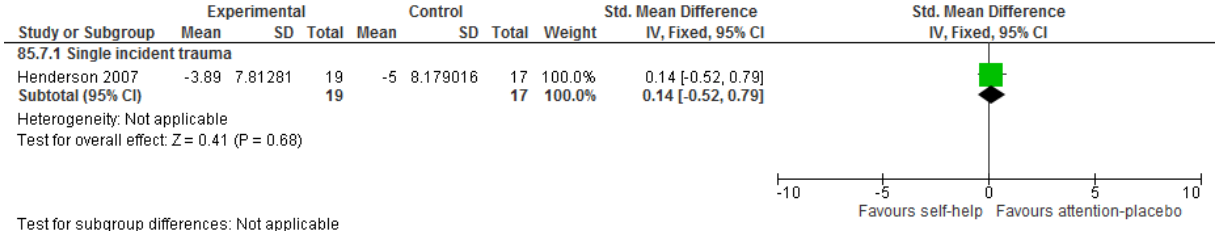


Figure 580: Self-help (without support) versus attention-placebo for delayed treatment (>3 months) of clinically important symptoms/PTSD: Anxiety symptoms at 1-month follow-up (STAI State change score)

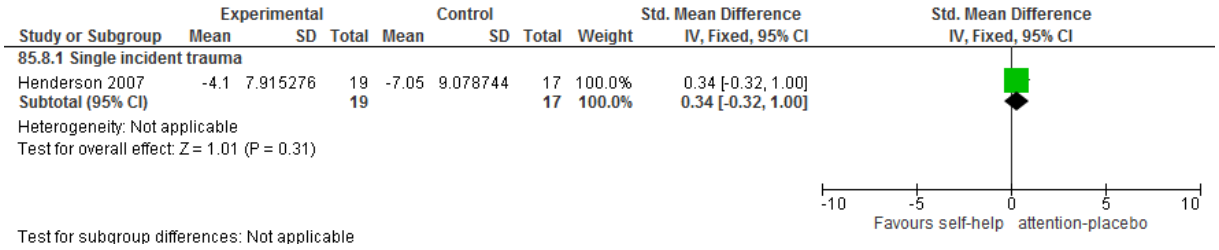
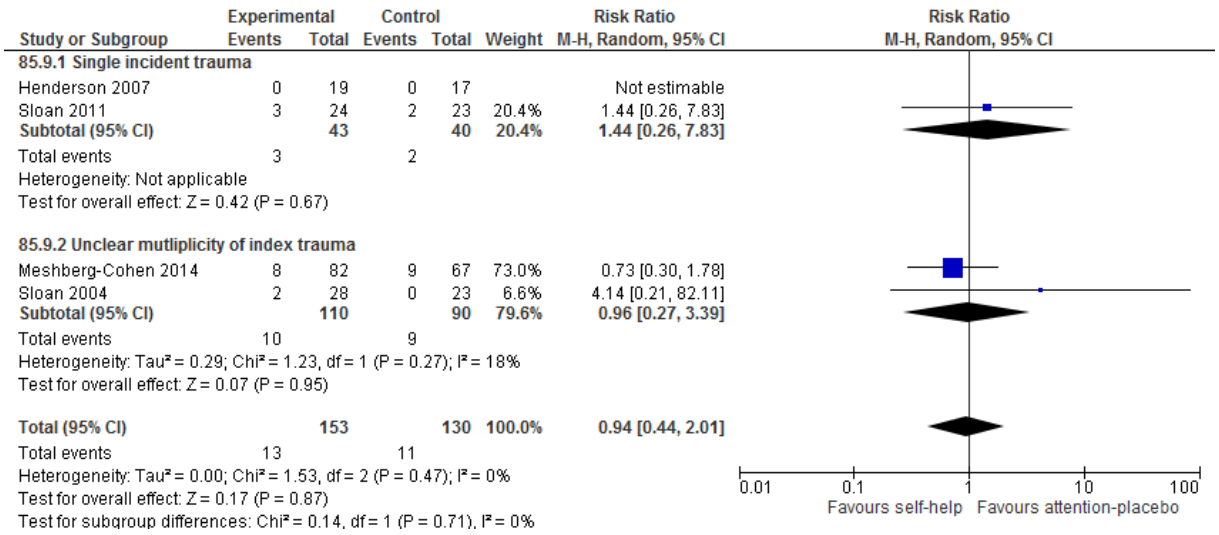


Figure 581: Self-help (without support) versus attention-placebo for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)



Sub-analysis by specific intervention: Self-help (without support) versus attention-placebo for delayed treatment (>3 months) of clinically important symptoms/PTSD

Figure 582: Self-help (without support) versus attention-placebo for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-report at endpoint (PDS/IES change score)

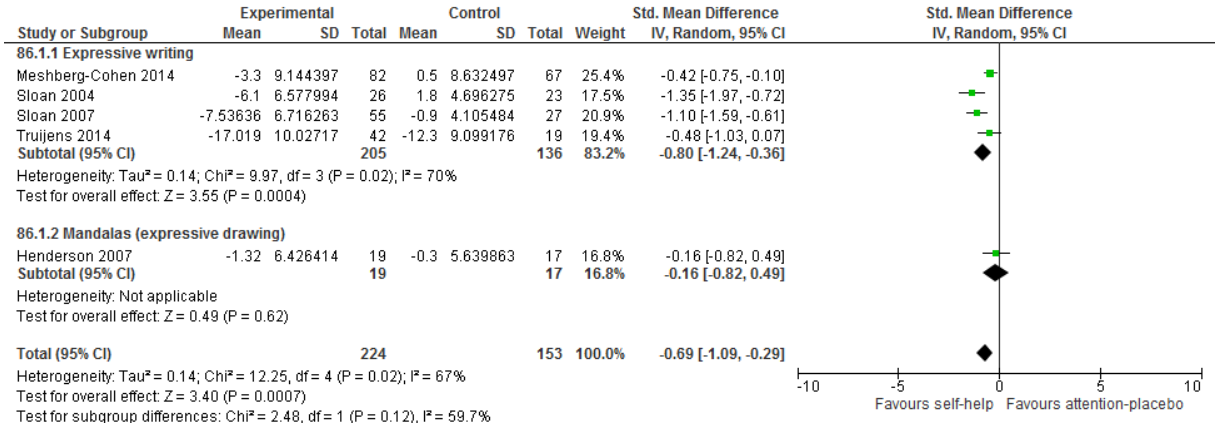


Figure 583: Self-help (without support) versus attention-placebo for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated at endpoint (PSS-I change score)

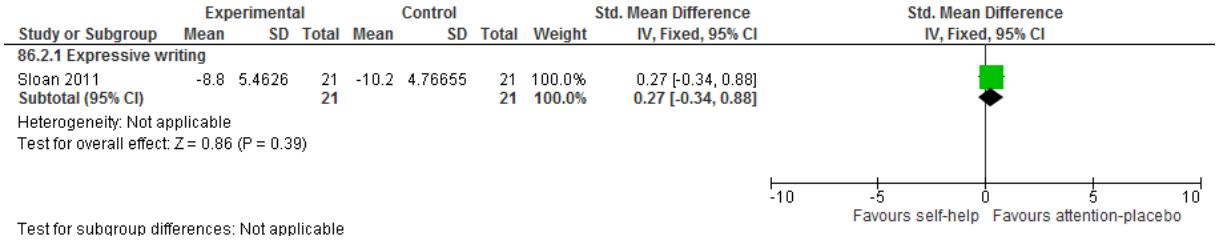
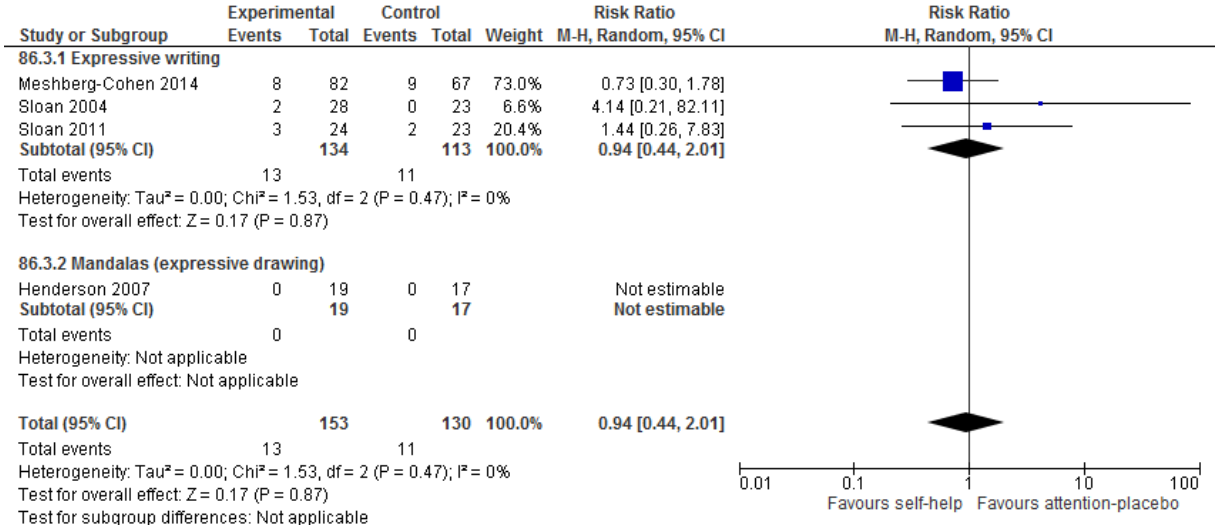


Figure 584: Self-help (without support) versus attention-placebo for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)



Sub-analysis by diagnostic status at baseline: Self-help (without support) versus attention-placebo for delayed treatment (>3 months) of clinically important symptoms/PTSD

Figure 585: Self-help (without support) versus attention-placebo for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-report at endpoint (PDS/IES change score)

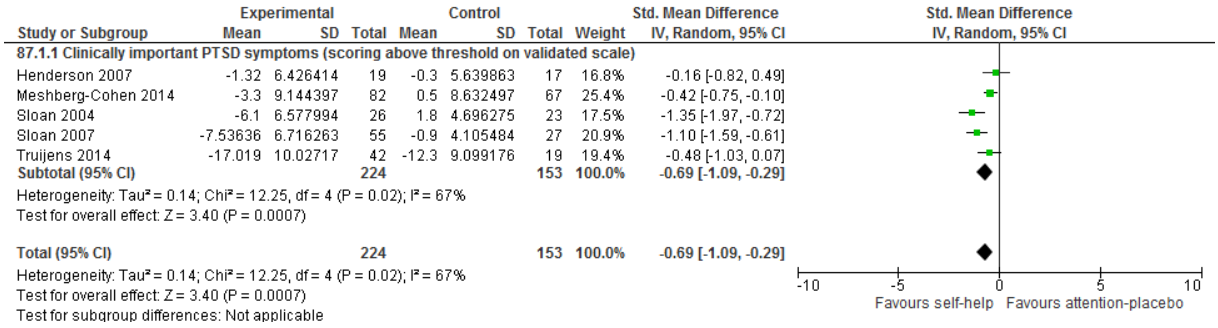


Figure 586: Self-help (without support) versus attention-placebo for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated at endpoint (PSS-I change score)

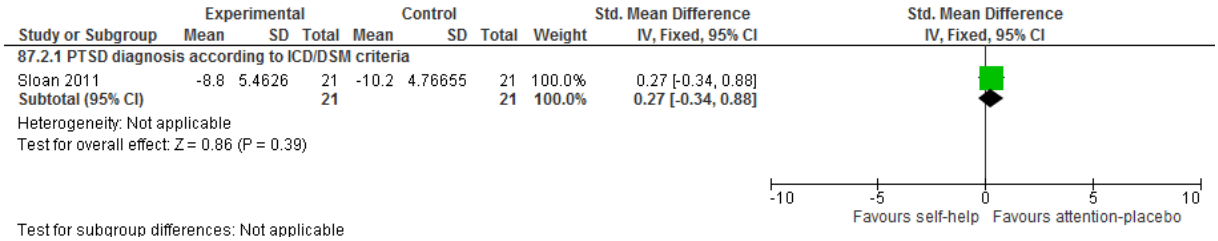
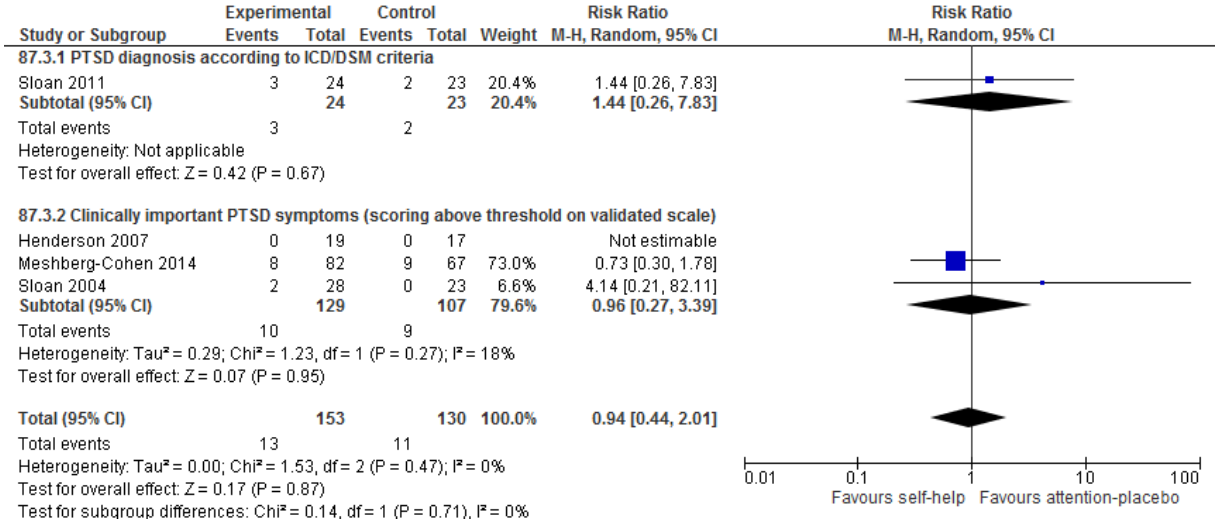


Figure 587: Self-help (without support) versus attention-placebo for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)



Sub-analysis by trauma type: Self-help (without support) versus attention-placebo for delayed treatment (>3 months) of clinically important symptoms/PTSD

Figure 588: Self-help (without support) versus attention-placebo for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-report at endpoint (PDS/IES change score)

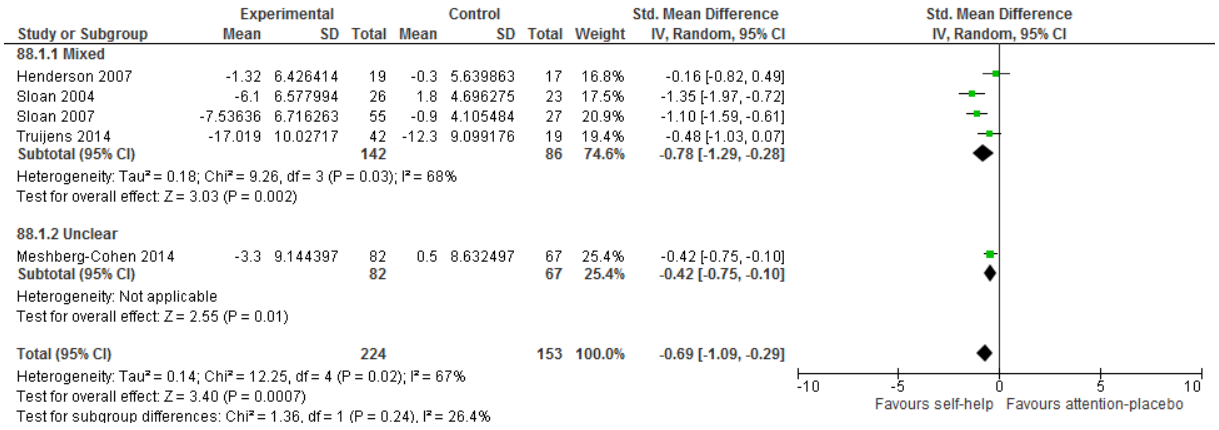


Figure 589: Self-help (without support) versus attention-placebo for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated at endpoint (PSS-I change score)

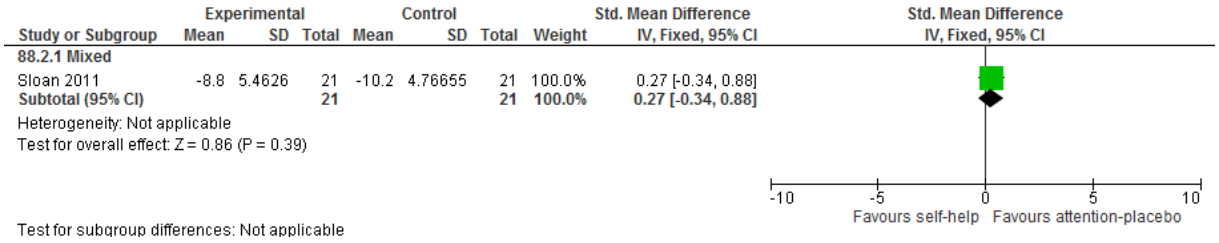
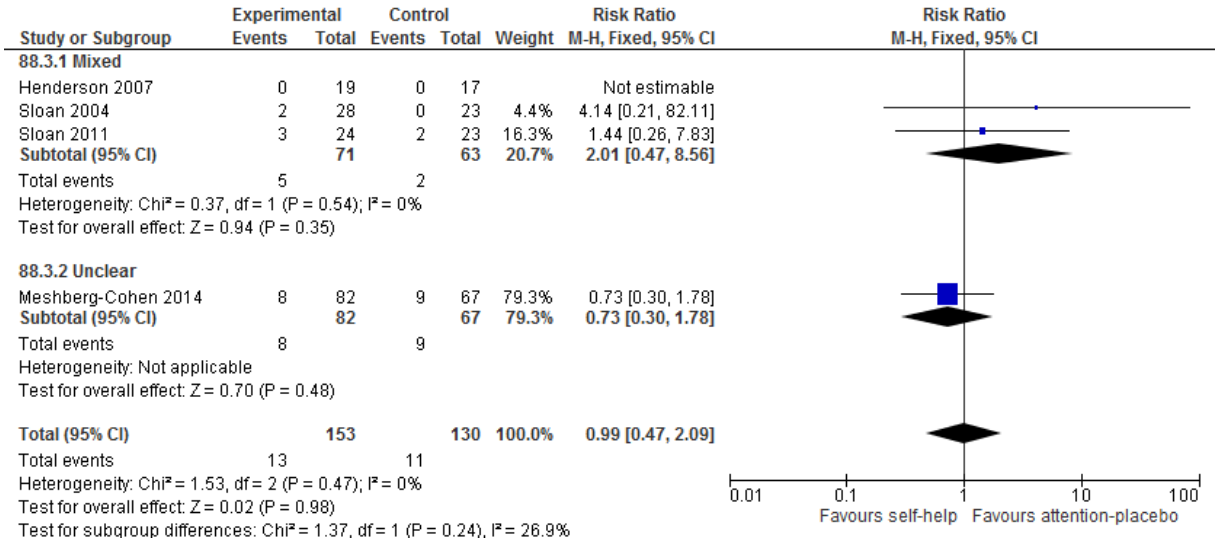


Figure 590: Self-help (without support) versus attention-placebo for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)



Psychosocial interventions for the treatment of PTSD in adults

Meditation/Mindfulness-based stress reduction

Figure 591: Meditation/Mindfulness-based stress reduction (MBSR; ±TAU) versus TAU/attention-placebo/waitlist for delayed treatment (>3 months) of clinically

important symptoms/PTSD: PTSD symptomatology self-report at endpoint (PCL change score)

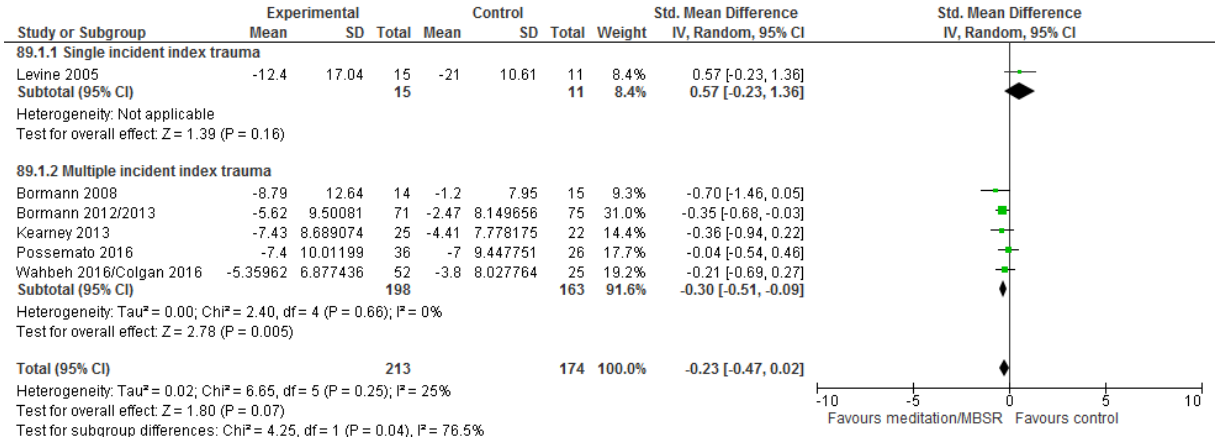


Figure 592: Meditation/Mindfulness-based stress reduction (MBSR; ±TAU) versus TAU/attention-placebo/waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-report at 1-4 month follow-up (PCL change score)

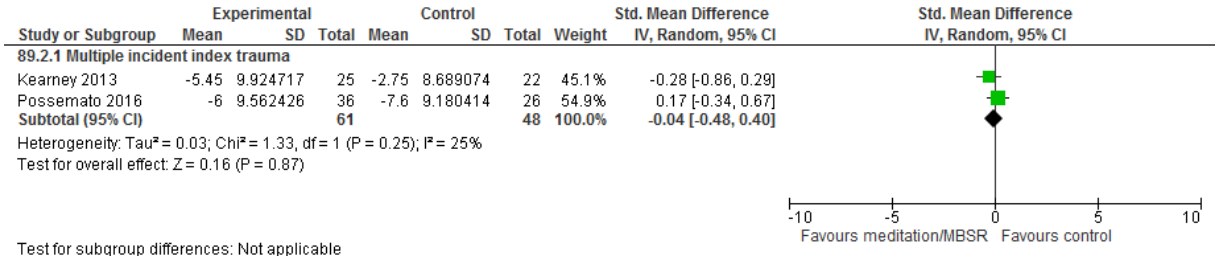


Figure 593: Meditation/Mindfulness-based stress reduction (MBSR; ±TAU) versus TAU/attention-placebo/waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated at endpoint (CAPS/PSS-I change score)

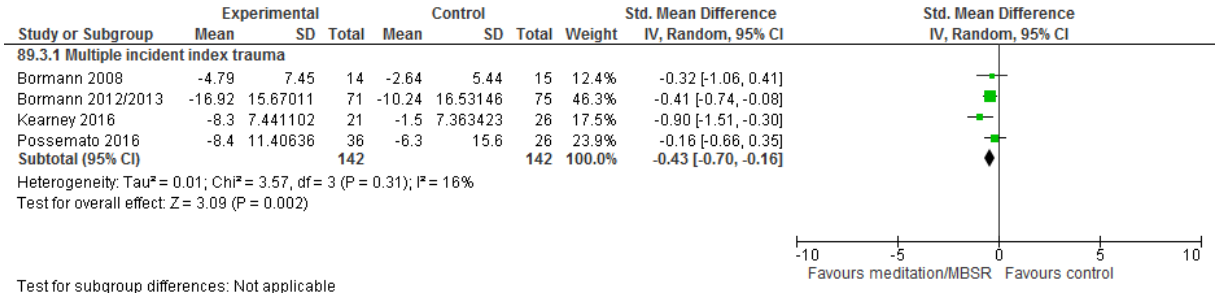


Figure 594: Meditation/Mindfulness-based stress reduction (MBSR; ±TAU) versus TAU/attention-placebo/waitlist for delayed treatment (>3 months) of clinically

important symptoms/PTSD: PTSD symptomatology clinician-rated at 6-month follow-up (PSS-I change score)

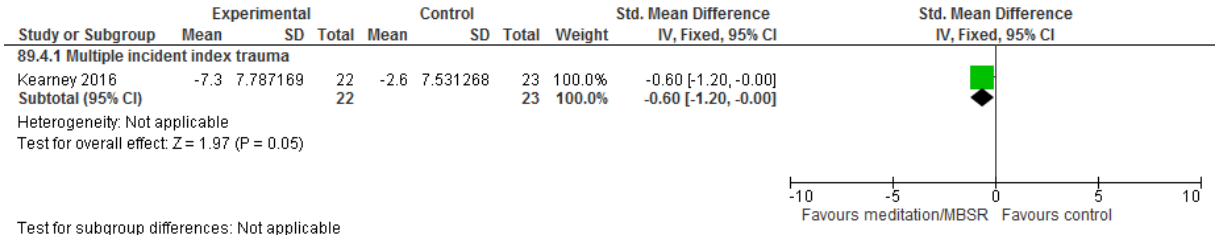


Figure 595: Meditation/Mindfulness-based stress reduction (MBSR; ±TAU) versus TAU/attention-placebo/waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Remission (number of people scoring below clinical threshold on a scale)

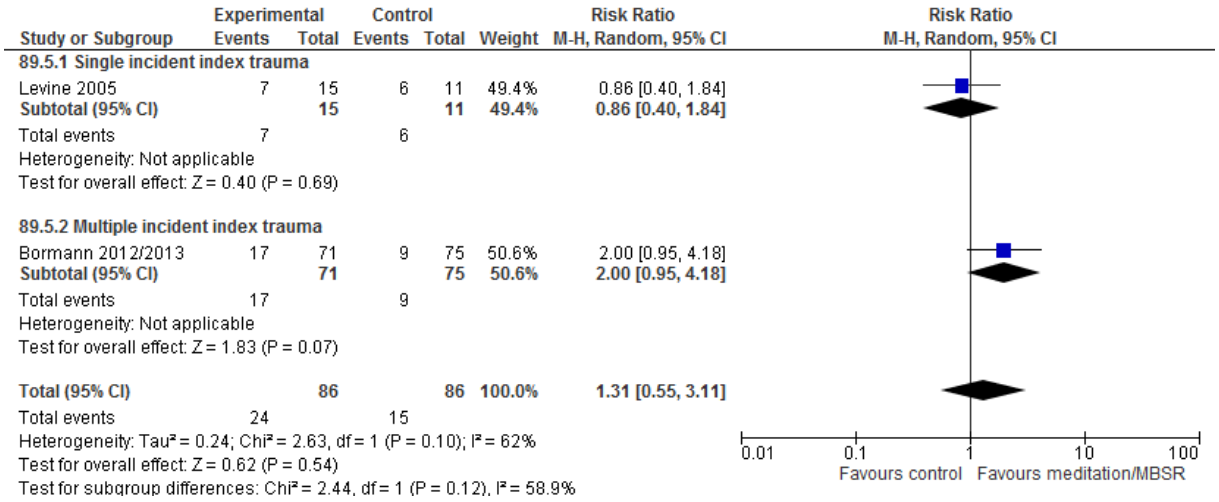


Figure 596: Meditation/Mindfulness-based stress reduction (MBSR; ±TAU) versus TAU/attention-placebo/waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Response at endpoint (number of people showing clinically significant improvement based on RCI [≥10/11 points on PCL-C])

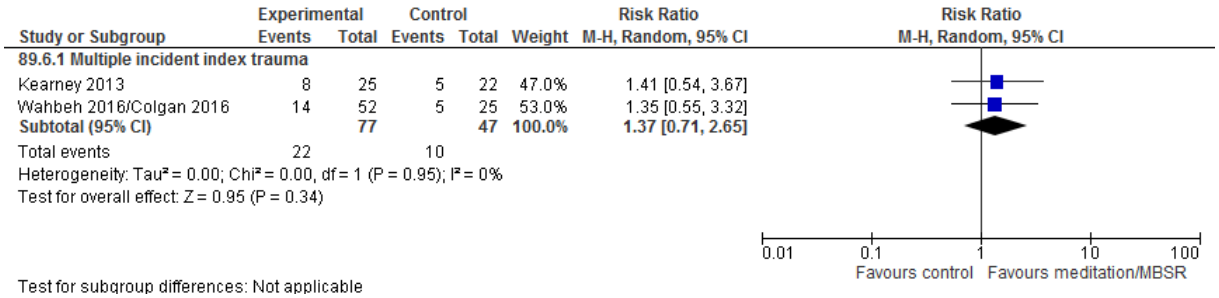


Figure 597: Meditation/Mindfulness-based stress reduction (MBSR; ±TAU) versus TAU/attention-placebo/waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Response at 4-month follow-up (number of

people showing clinically significant improvement based on RCI [≥10 points on PCL-C])

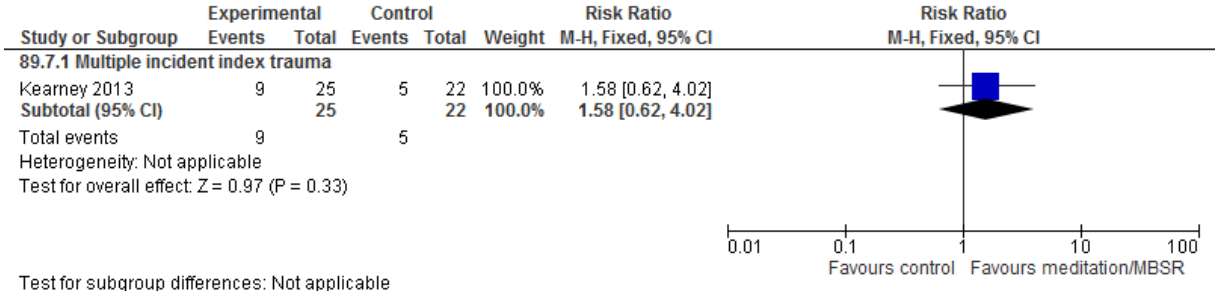


Figure 598: Meditation/Mindfulness-based stress reduction (MBSR; ±TAU) versus TAU/attention-placebo/waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Anxiety symptoms at endpoint (BSI Anxiety/HADS-A change score)

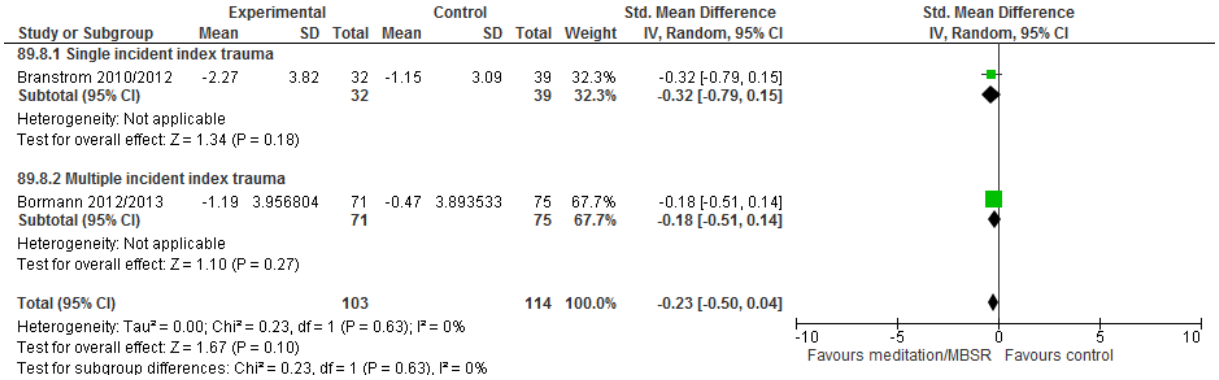


Figure 599: Meditation/Mindfulness-based stress reduction (MBSR; ±TAU) versus TAU/attention-placebo/waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Anxiety symptoms at 3-month follow-up (HADS-A change score)

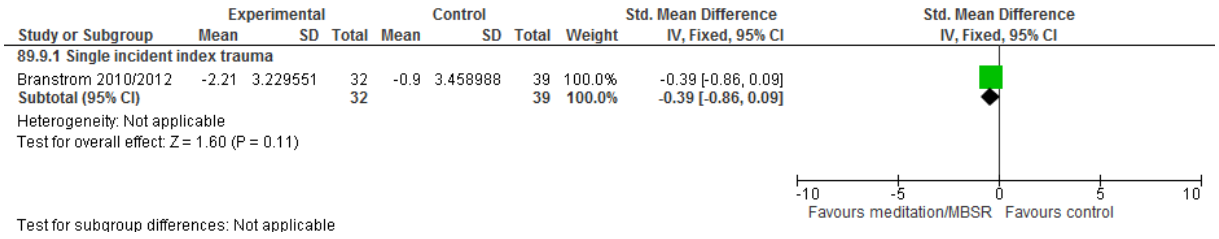


Figure 600: Meditation/Mindfulness-based stress reduction (MBSR; ±TAU) versus TAU/attention-placebo/waitlist for delayed treatment (>3 months) of clinically

important symptoms/PTSD: Depression symptoms at endpoint (BDI/BSI Depression/HADS-D/PHQ-9 change score)

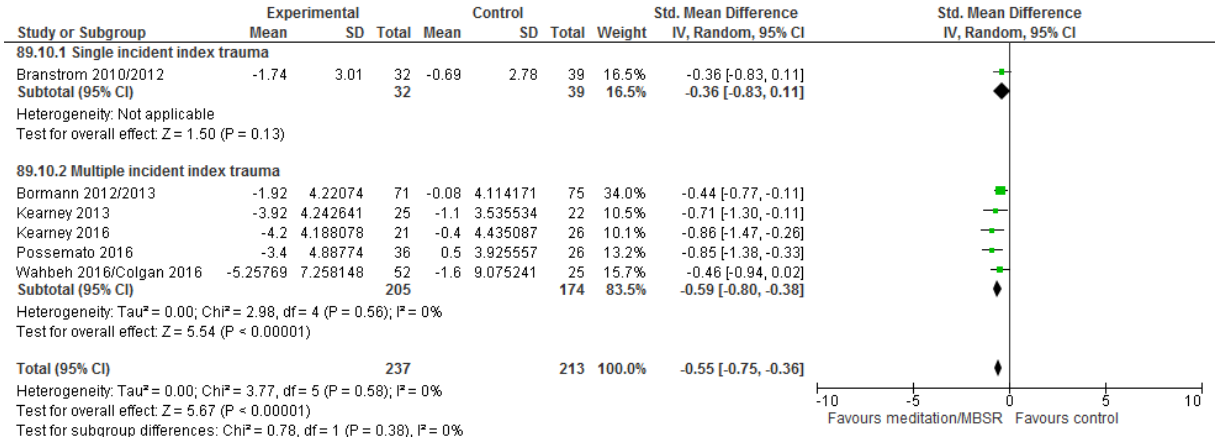


Figure 601: Meditation/Mindfulness-based stress reduction (MBSR; ±TAU) versus TAU/attention-placebo/waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms at 1-6 month follow-up (HADS-D/PHQ-9 change score)

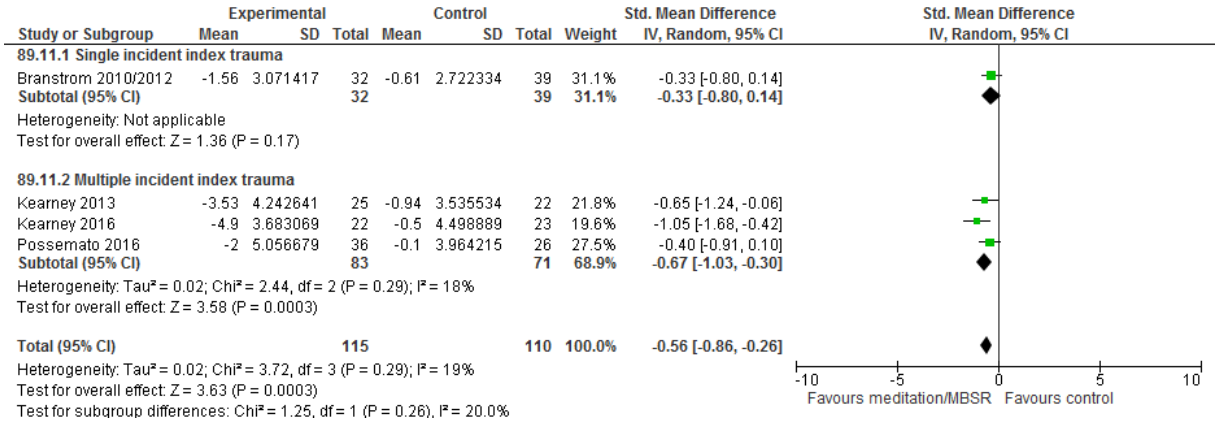


Figure 602: Meditation/Mindfulness-based stress reduction (MBSR; ±TAU) versus TAU/attention-placebo/waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Sleeping difficulties (PSQI change score)

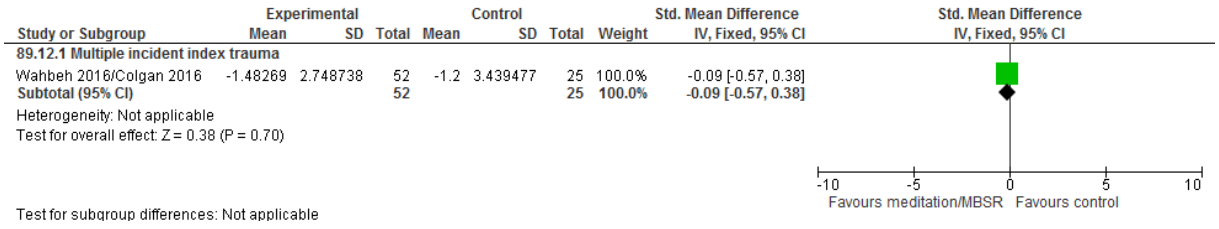


Figure 603: Meditation/Mindfulness-based stress reduction (MBSR; ±TAU) versus TAU/attention-placebo/waitlist for delayed treatment (>3 months) of clinically

important symptoms/PTSD: Emotional and behavioural problems (STAXI-2 change score)

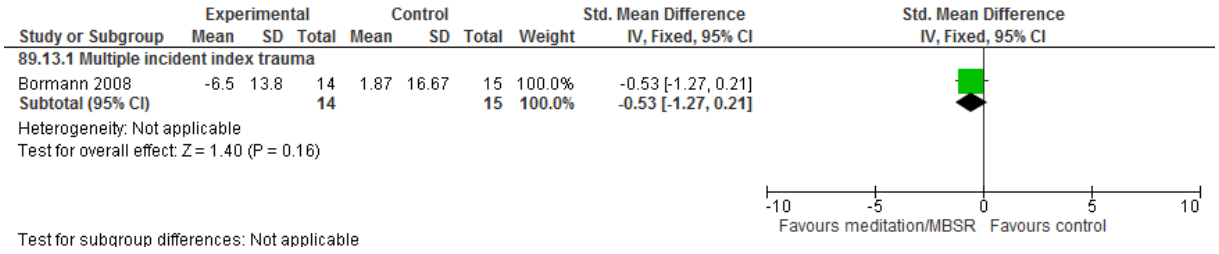


Figure 604: Meditation/Mindfulness-based stress reduction (MBSR; ±TAU) versus TAU/attention-placebo/waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Quality of life at endpoint (Q-LES-Q-SF/SF-8/12 Mental Component summary [MCS] change score)

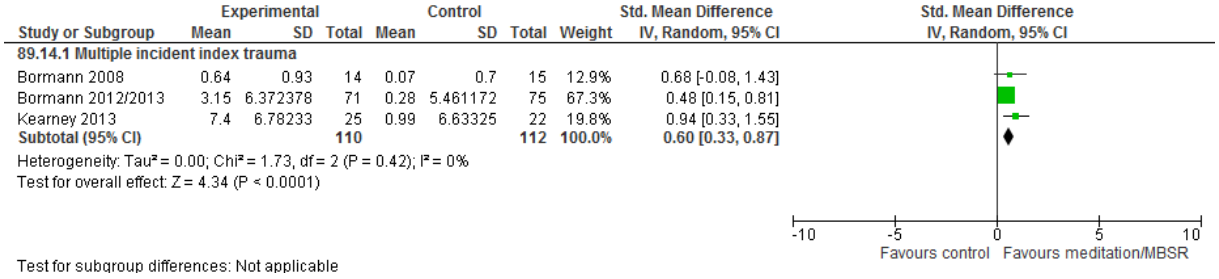


Figure 605: Meditation/Mindfulness-based stress reduction (MBSR; ±TAU) versus TAU/attention-placebo/waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Quality of life at 4-month follow-up (SF-8 Mental Component summary [MCS] change score)

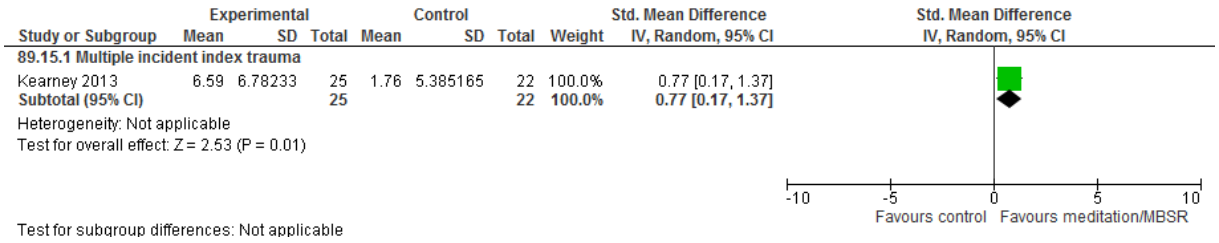
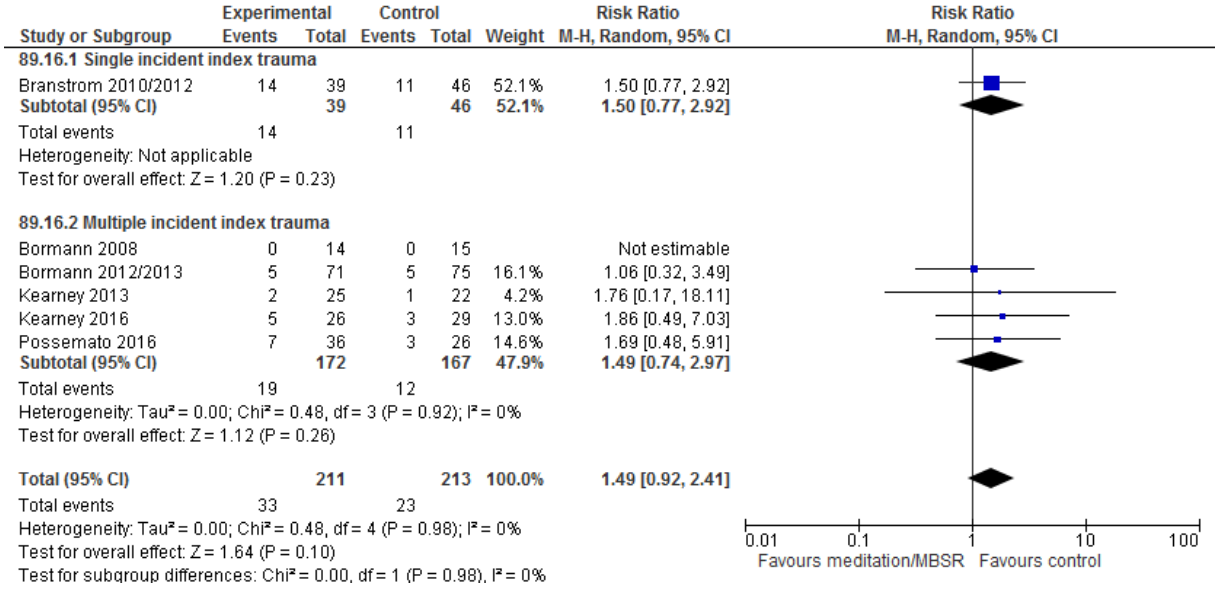


Figure 606: Meditation/Mindfulness-based stress reduction (MBSR; ±TAU) versus TAU/attention-placebo/waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)



Sub-analysis by specific comparison: Meditation/Mindfulness-based stress reduction (MBSR) versus control for delayed treatment (>3 months) of clinically important symptoms/PTSD

Figure 607: Meditation/Mindfulness-based stress reduction (MBSR) versus control for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-report at endpoint (PCL change score)

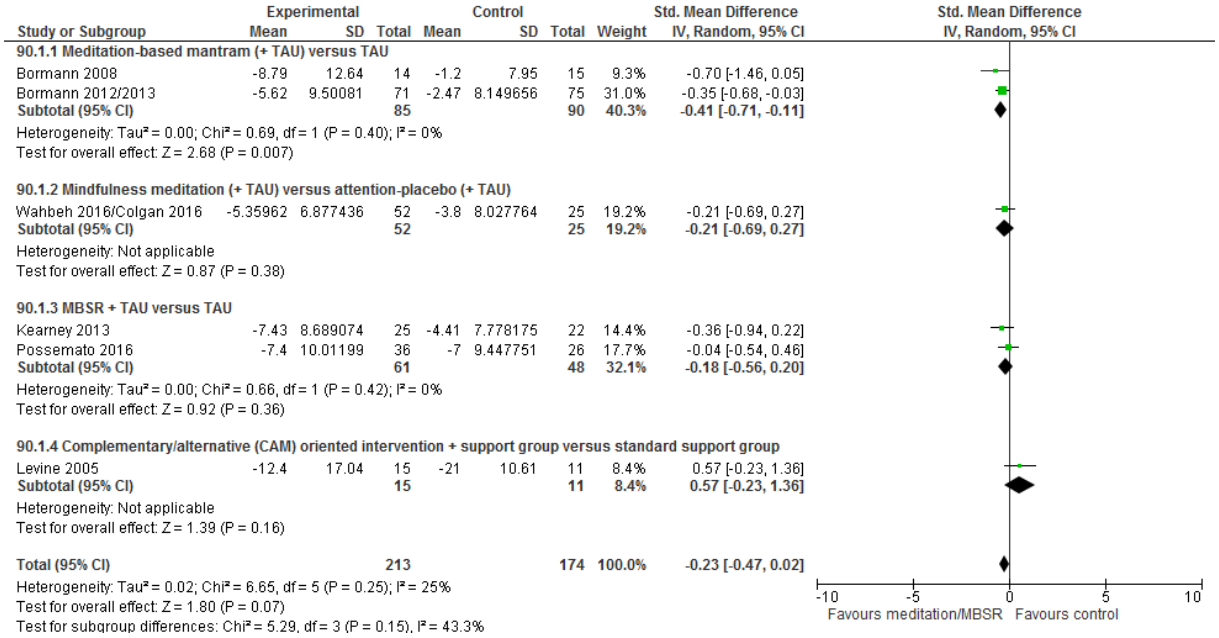


Figure 608: Meditation/Mindfulness-based stress reduction (MBSR) versus control for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated at endpoint (CAPS change score)

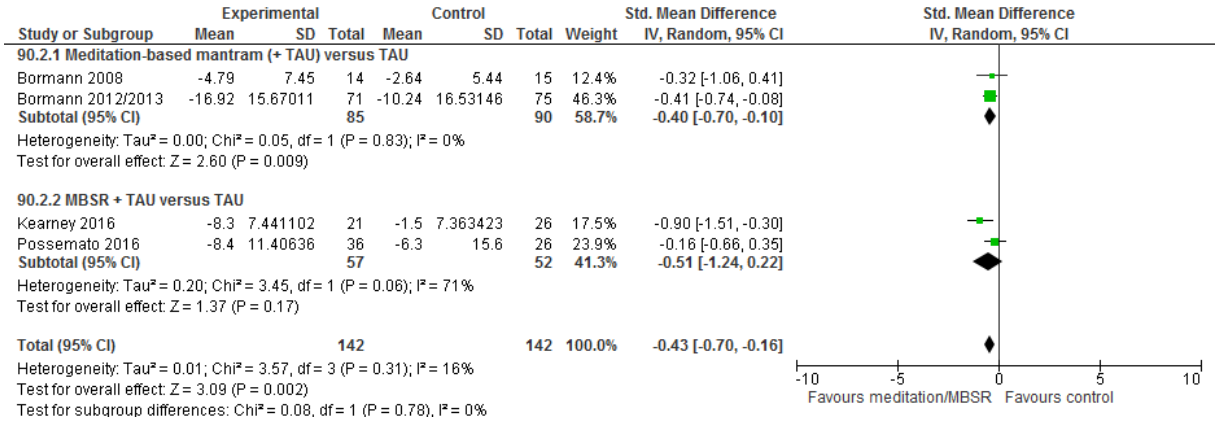
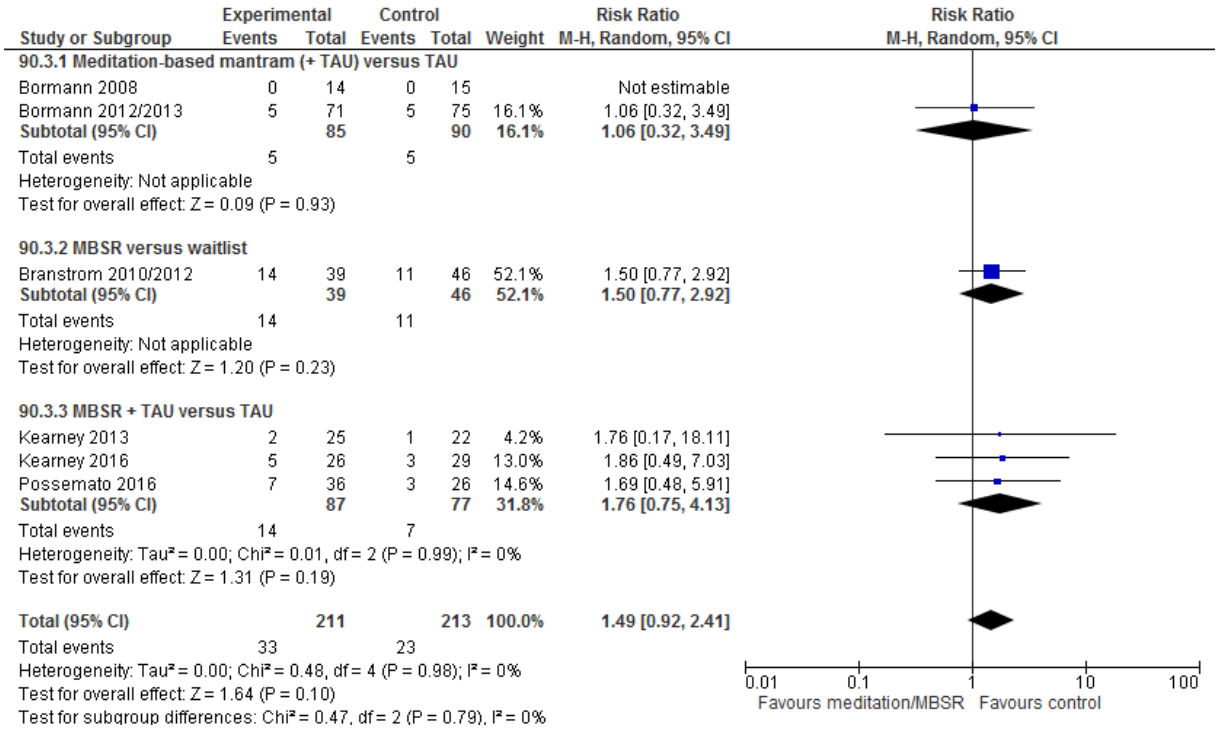


Figure 609: Meditation/Mindfulness-based stress reduction (MBSR) versus control for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)



Sub-analysis by diagnostic status at baseline: Meditation/Mindfulness-based stress reduction (MBSR) versus control for delayed treatment (>3 months) of clinically important symptoms/PTSD

Figure 610: Meditation/Mindfulness-based stress reduction (MBSR) versus control for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-report at endpoint (PCL change score)

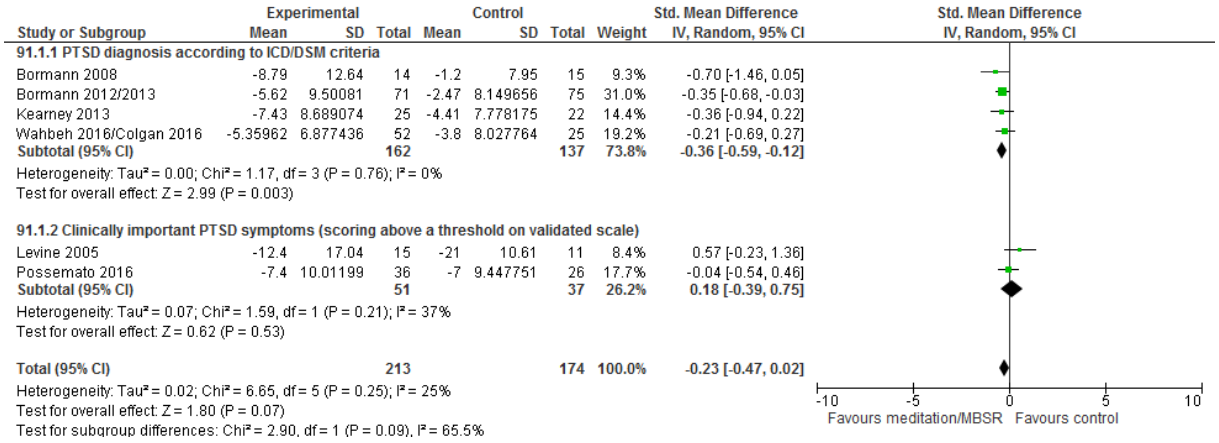


Figure 611: Meditation/Mindfulness-based stress reduction (MBSR) versus control for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated at endpoint (CAPS change score)

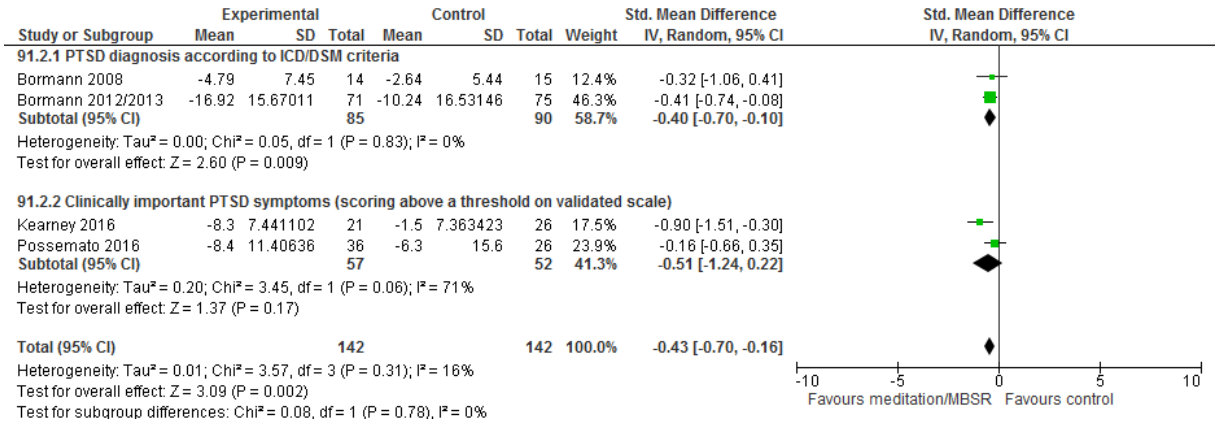
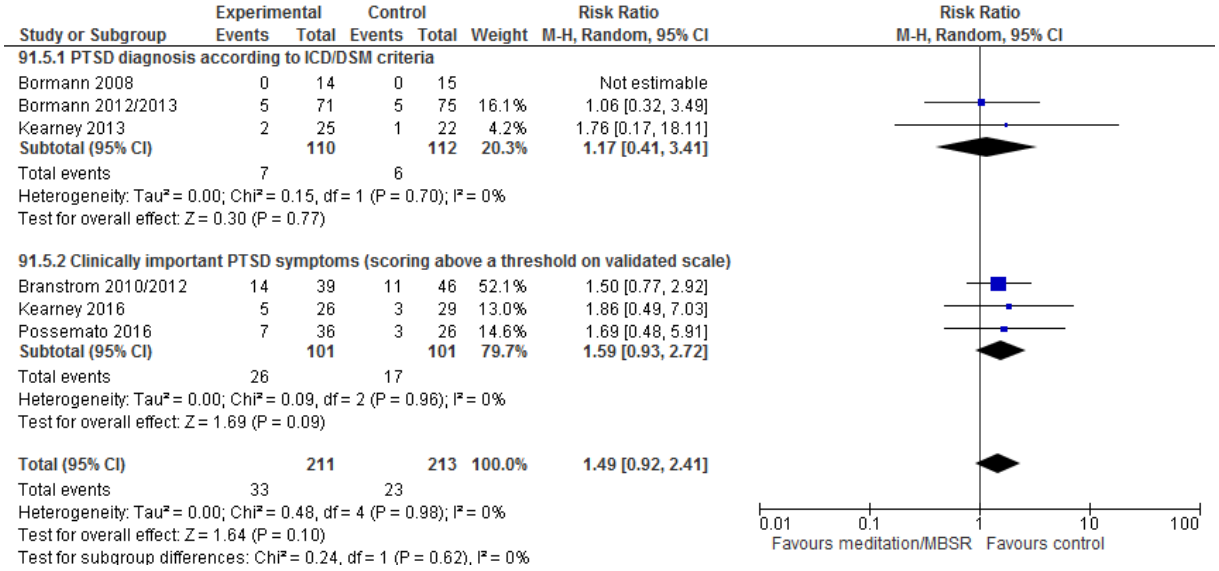


Figure 612: Meditation/Mindfulness-based stress reduction (MBSR) versus control for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)



Sub-analysis by trauma type: Meditation/Mindfulness-based stress reduction (MBSR) versus control for delayed treatment (>3 months) of clinically important symptoms/PTSD

Figure 613: Meditation/Mindfulness-based stress reduction (MBSR) versus control for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-report at endpoint (PCL change score)

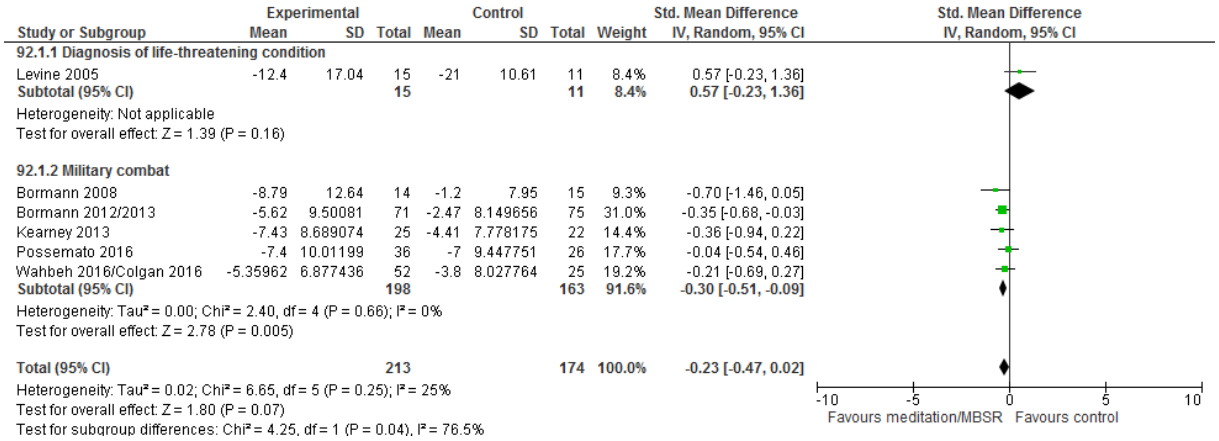


Figure 614: Meditation/Mindfulness-based stress reduction (MBSR) versus control for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated at endpoint (CAPS/PSS-I change score)

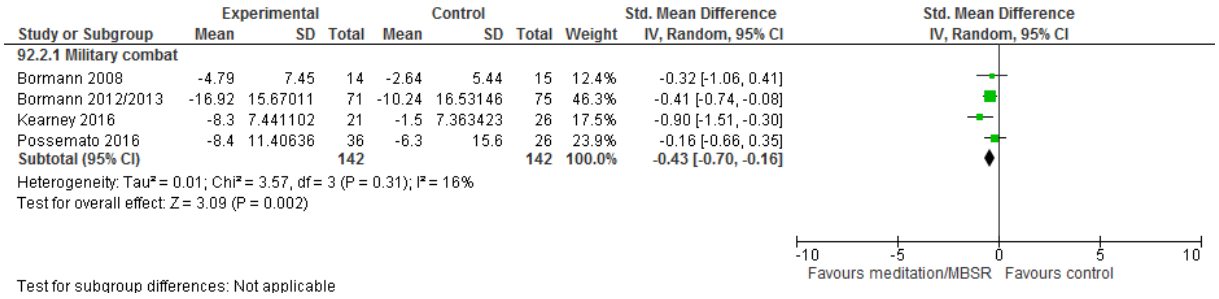
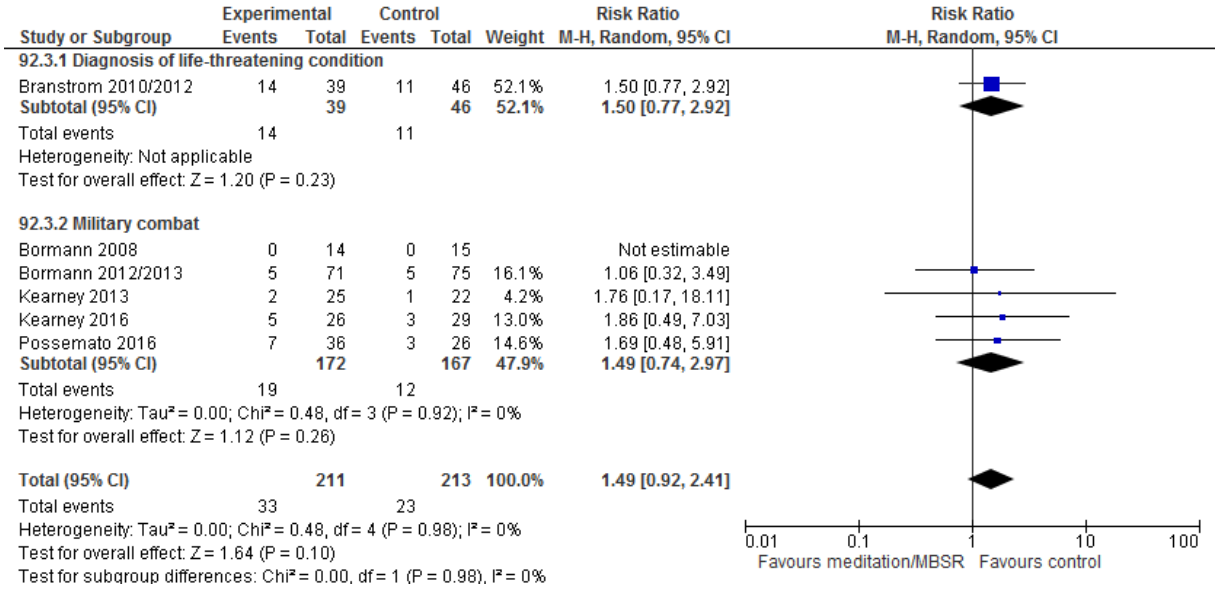


Figure 615: Meditation/Mindfulness-based stress reduction (MBSR) versus control for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)



Meditation

Figure 616: Meditation (+TAU) versus relaxation (+TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-report (PCL change score)

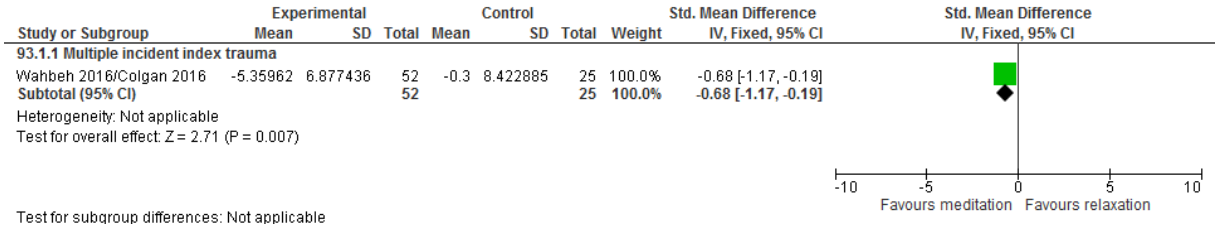


Figure 617: Meditation (+TAU) versus relaxation (+TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Response (number of people showing clinically significant improvement based on RCI [≥11 points on PCL-C])

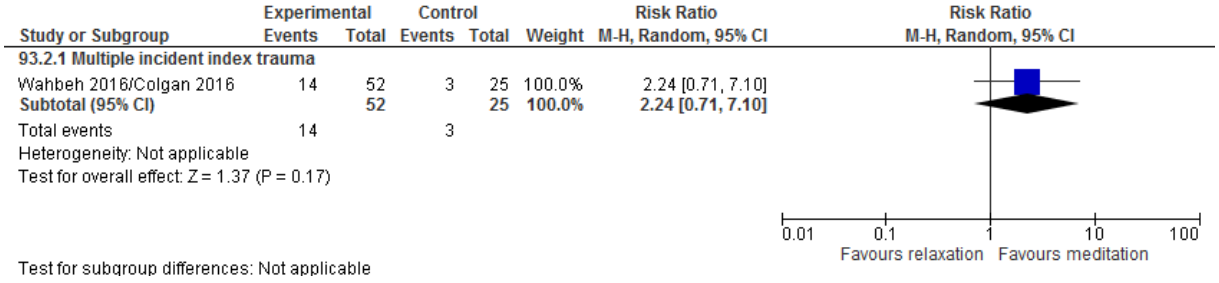


Figure 618: Meditation (+TAU) versus relaxation (+TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms (BDI change score)

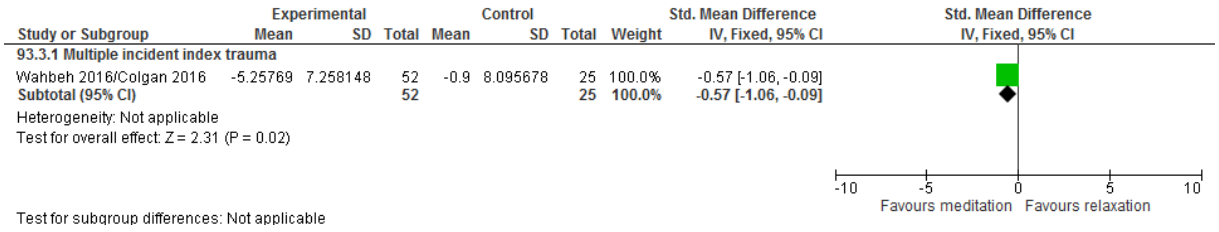
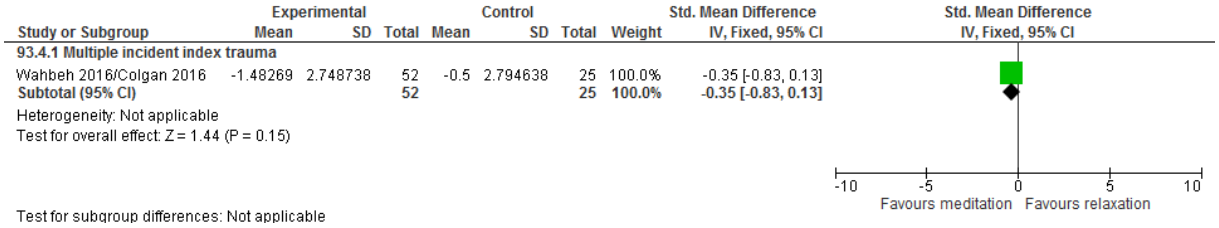


Figure 619: Meditation (+TAU) versus relaxation (+TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Sleeping difficulties (PSQI change score)



Mindfulness-based stress reduction

Figure 620: Mindfulness-based stress reduction (MBSR; +TAU) versus present-centered therapy (+TAU) for delayed treatment (>3 months) of clinically

important symptoms/PTSD: PTSD symptomatology self-rated (PCL change score); Multiple incident index trauma

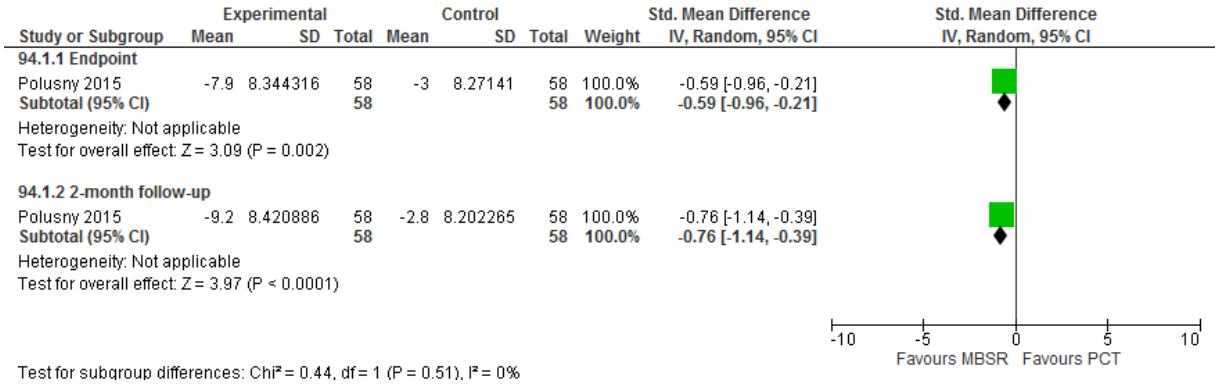


Figure 621: Mindfulness-based stress reduction (MBSR; +TAU) versus present-centered therapy (+TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated (CAPS change score); Multiple incident index trauma

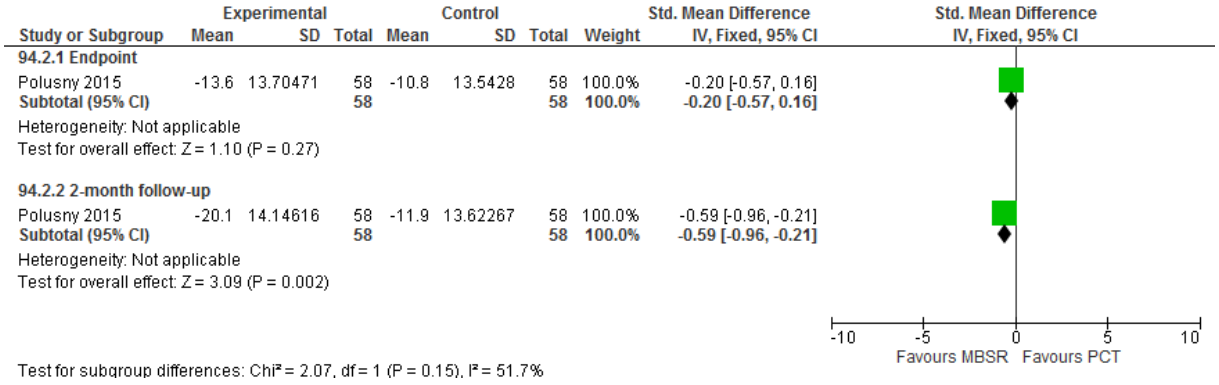


Figure 622: Mindfulness-based stress reduction (MBSR; +TAU) versus present-centered therapy (+TAU) for delayed treatment (>3 months) of clinically

important symptoms/PTSD: Remission (number of people no longer meeting diagnostic criteria for PTSD); Multiple incident index trauma

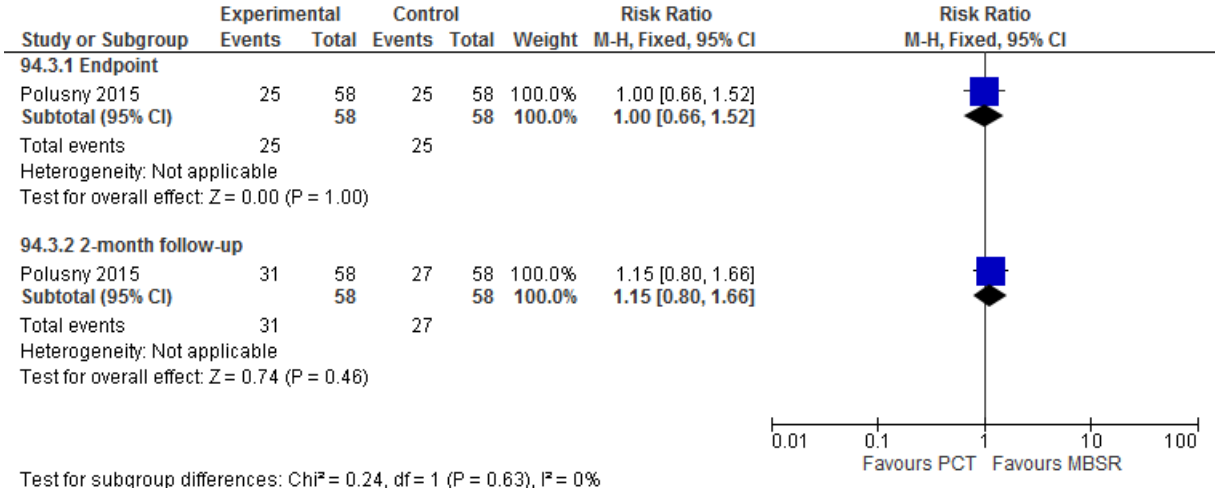


Figure 623: Mindfulness-based stress reduction (MBSR; +TAU) versus present-centered therapy (+TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Response self-rated (number of people showing improvement of at least 10 points on PCL); Multiple incident index trauma

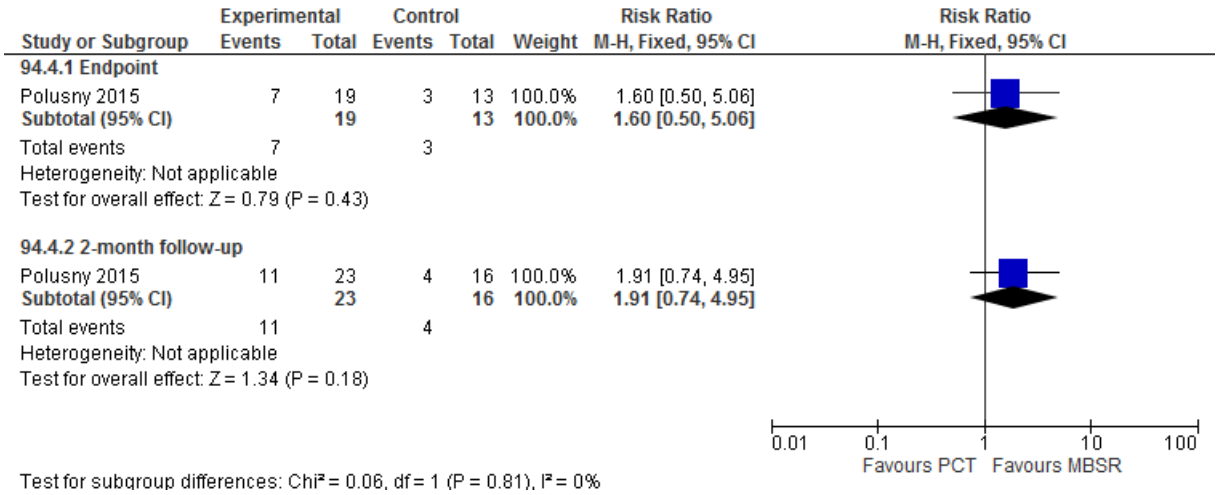


Figure 624: Mindfulness-based stress reduction (MBSR; +TAU) versus present-centered therapy (+TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Response clinician-rated (number of people

showing improvement of at least 10 points on CAPS); Multiple incident index trauma

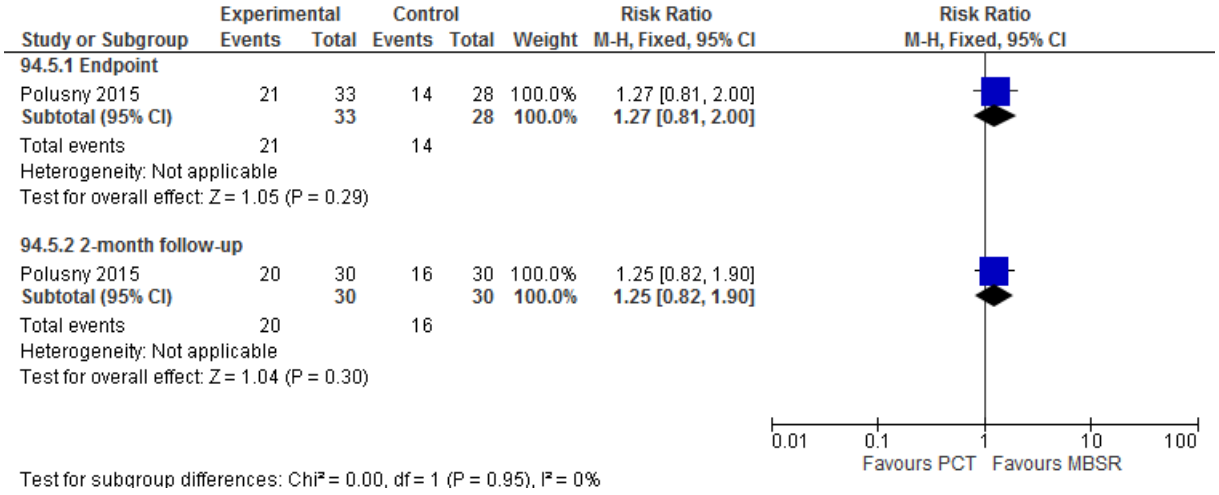


Figure 625: Mindfulness-based stress reduction (MBSR; +TAU) versus present-centered therapy (+TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms (PHQ-9 change score); Multiple incident index trauma

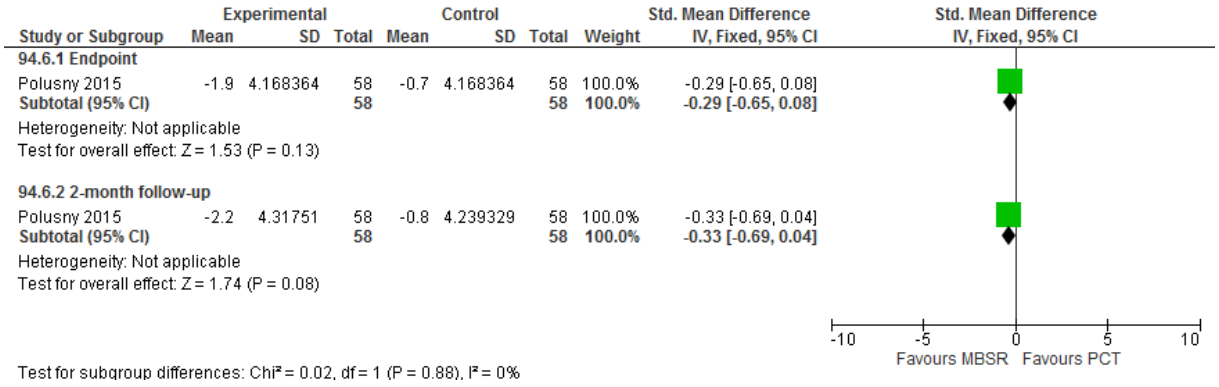


Figure 626: Mindfulness-based stress reduction (MBSR; +TAU) versus present-centered therapy (+TAU) for delayed treatment (>3 months) of clinically

important symptoms/PTSD: Quality of life (WHO-QoL-BREF change score); Multiple incident index trauma

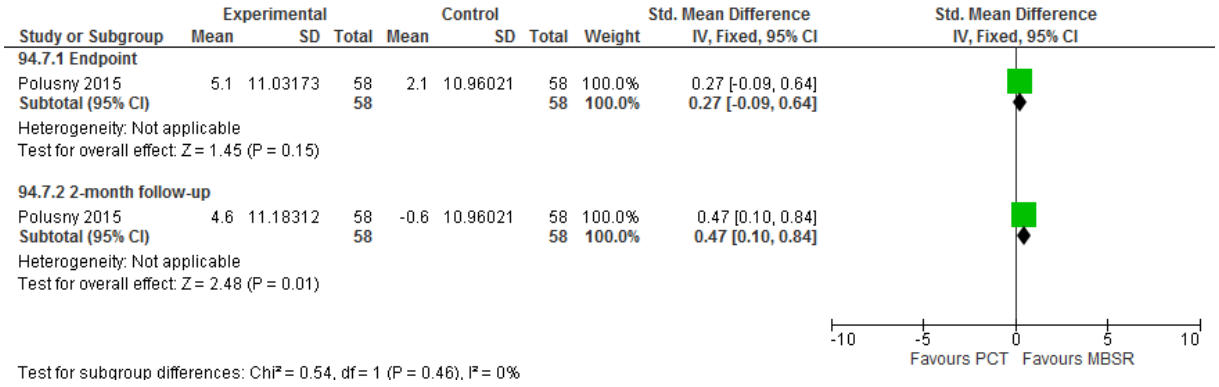
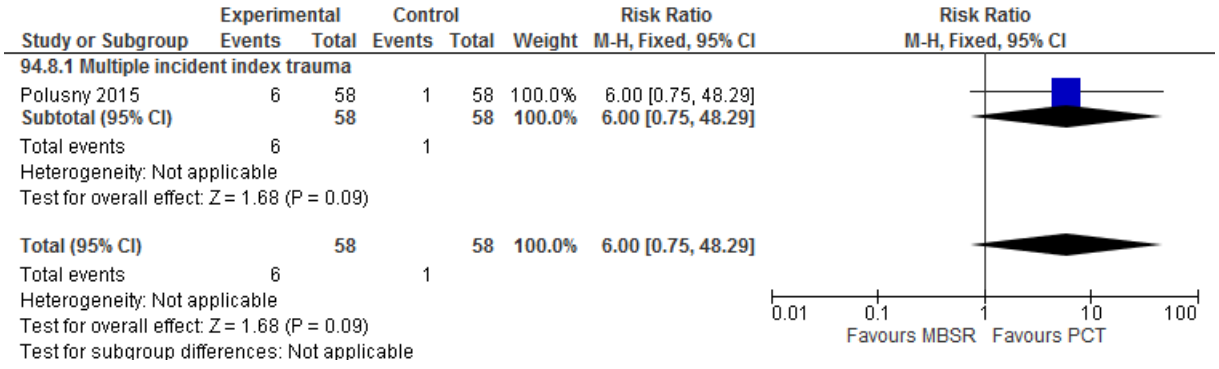


Figure 627: Mindfulness-based stress reduction (MBSR; +TAU) versus present-centered therapy (+TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)



Individual placement and support (IPS) supported employment

Figure 628: Individual placement and support (IPS) supported employment versus standard VA vocational rehabilitation programme (TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated (CAPS change score)

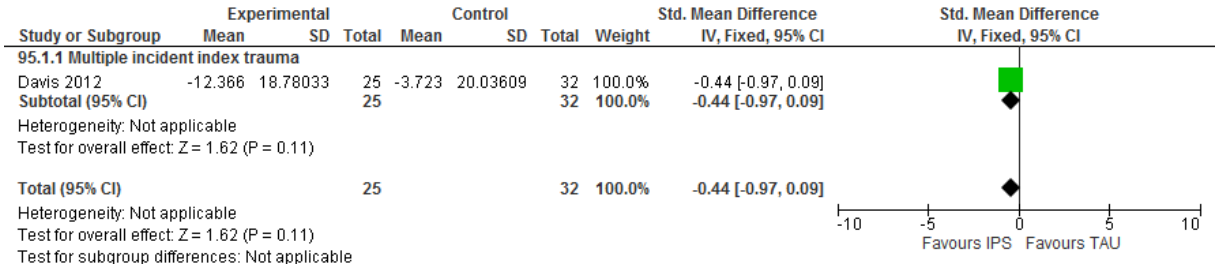


Figure 629: Individual placement and support (IPS) supported employment versus standard VA vocational rehabilitation programme (TAU) for delayed

treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated (DTS change score)

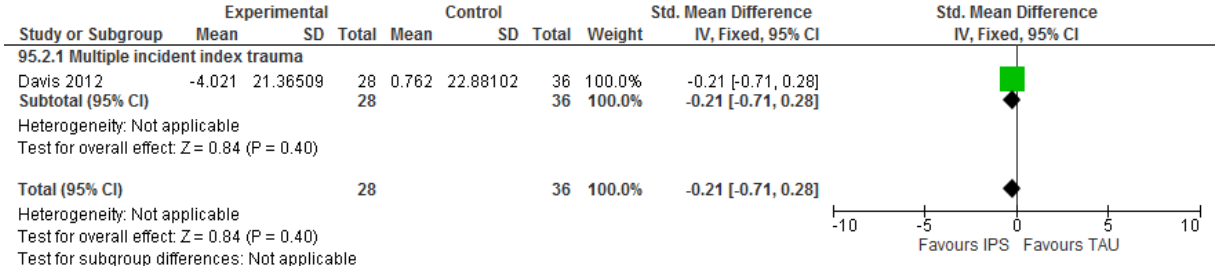


Figure 630: Individual placement and support (IPS) supported employment versus standard VA vocational rehabilitation programme (TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Response (number of people rated as 'much' or 'very much' improved on CGI-I)

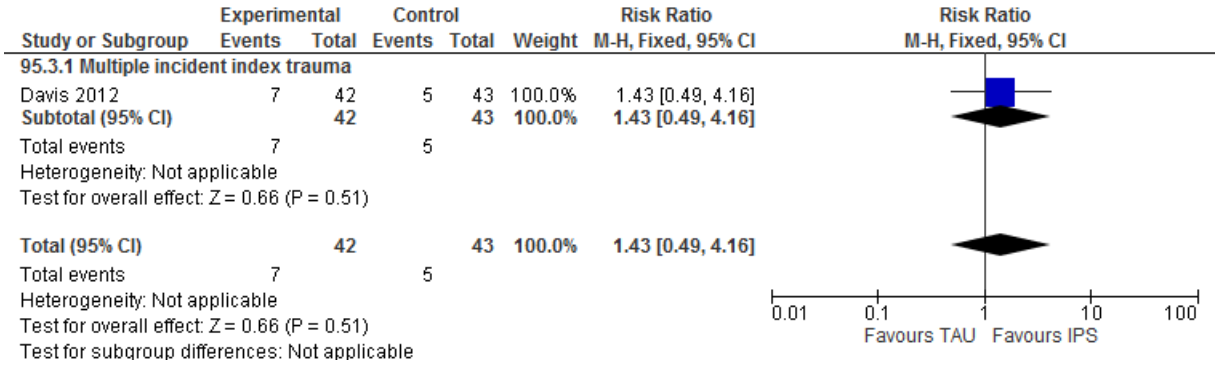


Figure 631: Individual placement and support (IPS) supported employment versus standard VA vocational rehabilitation programme (TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms (QIDS change score)

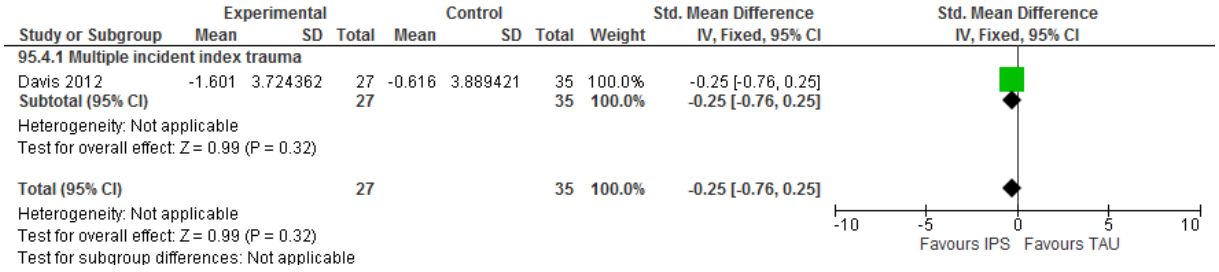


Figure 632: Individual placement and support (IPS) supported employment versus standard VA vocational rehabilitation programme (TAU) for delayed

treatment (>3 months) of clinically important symptoms/PTSD: Competitive employment (number of people who gained competitive employment)

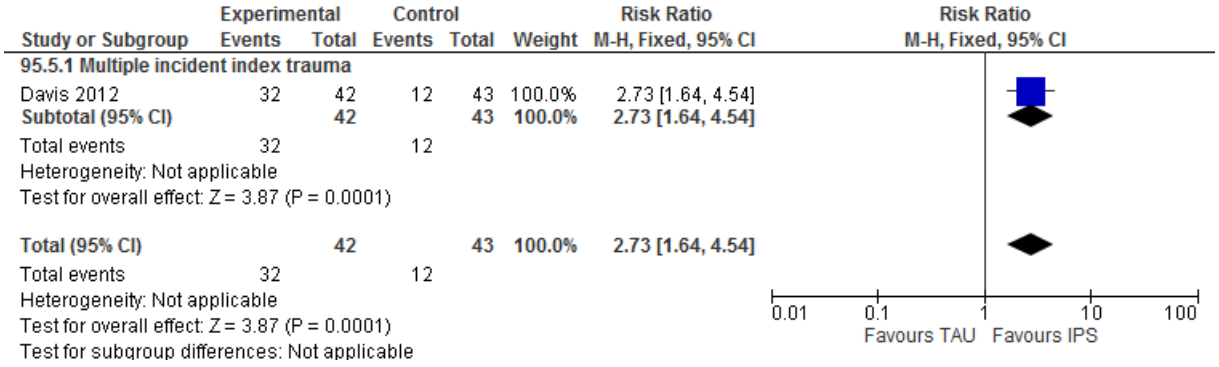


Figure 633: Individual placement and support (IPS) supported employment versus standard VA vocational rehabilitation programme (TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Competitive employment (weeks competitively employed)

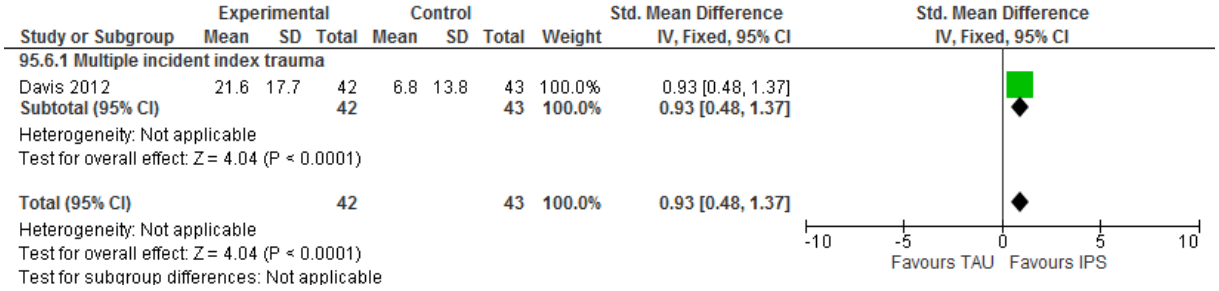
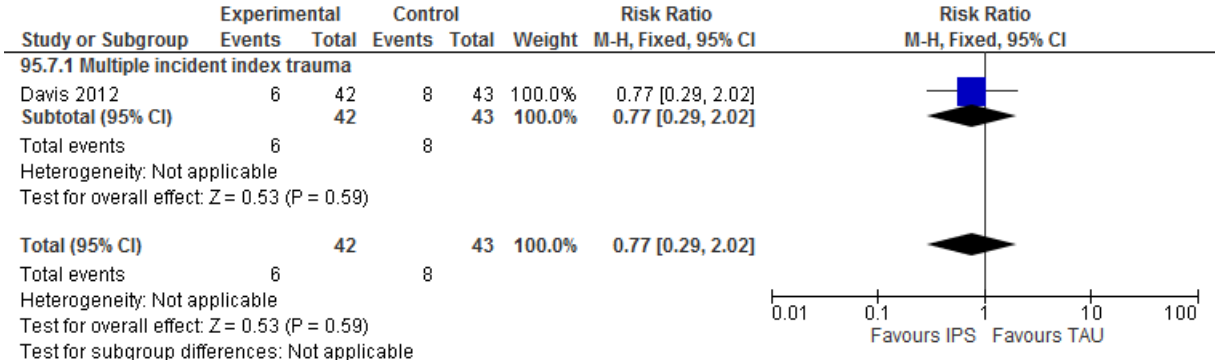


Figure 634: Individual placement and support (IPS) supported employment versus standard VA vocational rehabilitation programme (TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation



Practical support

Figure 635: Practical support versus TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated (PDS change score)

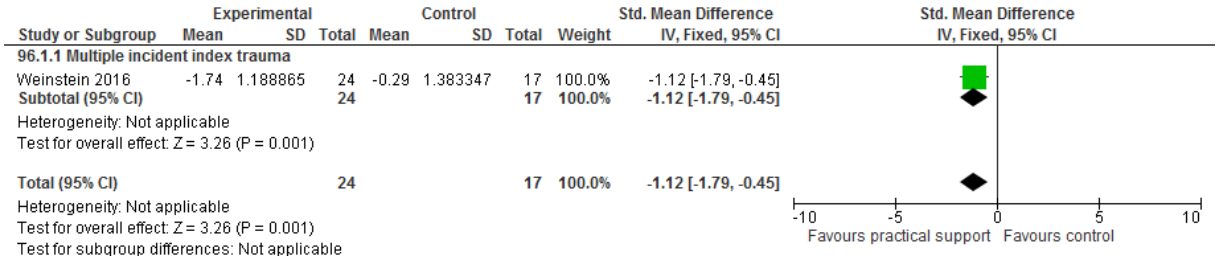
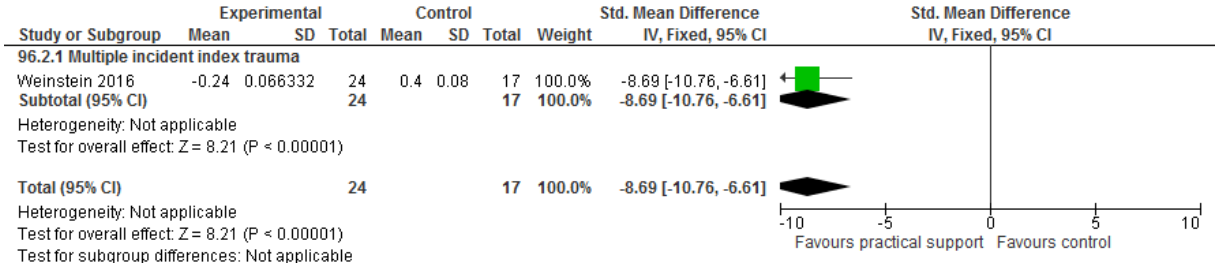


Figure 636: Practical support versus TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms (CES-D change score)



Psychoeducation

Figure 637: Psychoeducation (+TAU) versus TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated at 2-month follow-up (HTQ-IV change score)

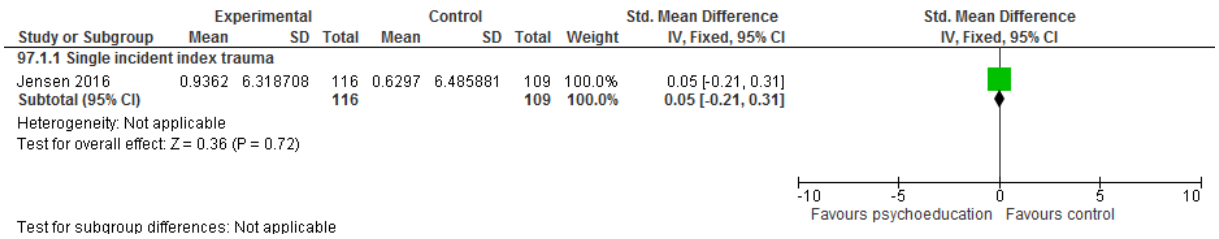


Figure 638: Psychoeducation (+TAU) versus TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: Anxiety symptoms at 2-month follow-up (HADS-A endpoint score)

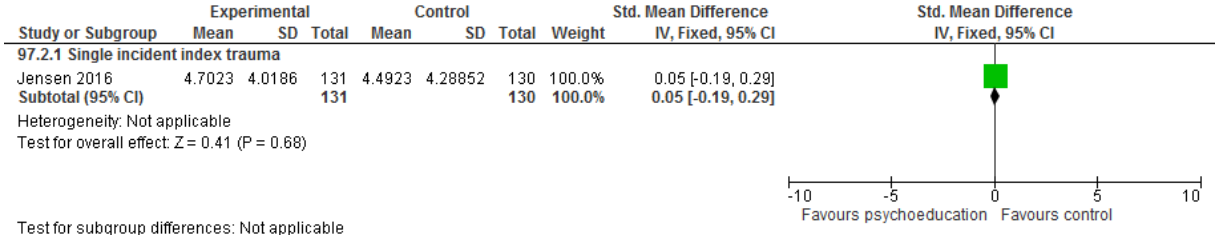


Figure 639: Psychoeducation (+TAU) versus TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms at 2-month follow-up (HADS-D endpoint score)

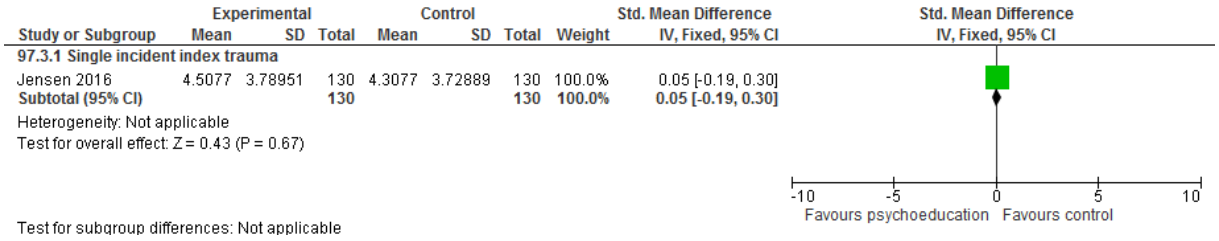


Figure 640: Psychoeducation (+TAU) versus TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: Quality of life at 2-month follow-up (SF-12 MCS)

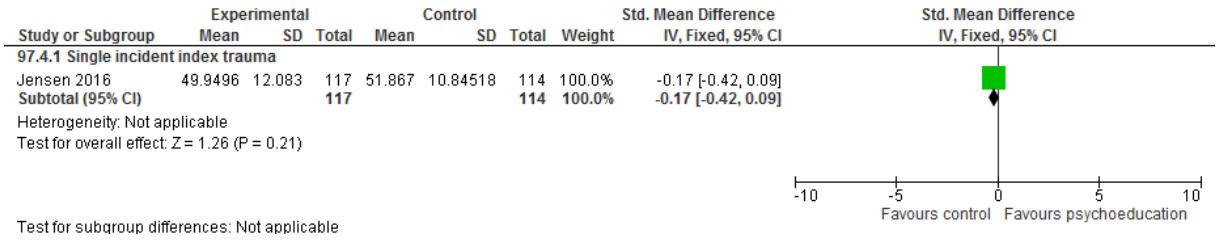


Figure 641: Psychoeducation (+TAU) versus TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)

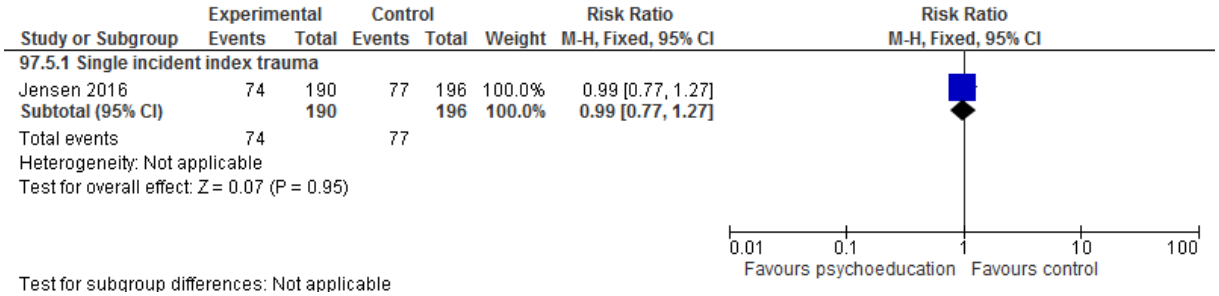


Figure 642: Psychoeducation (±TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated at endpoint (DTS change score)

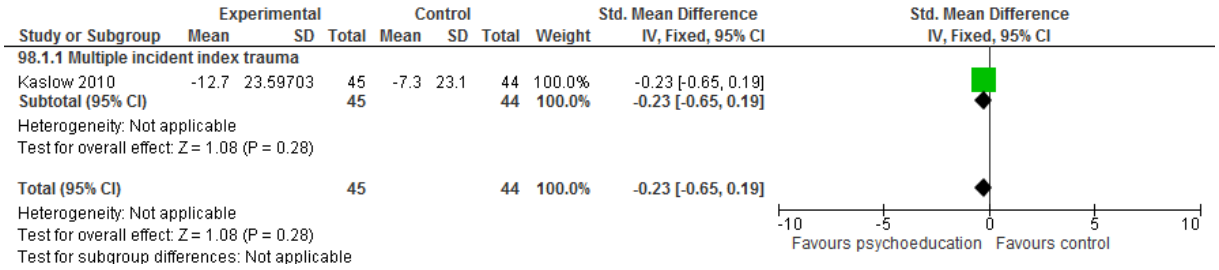


Figure 643: Psychoeducation (±TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated at 1-month follow-up (PCL change score)

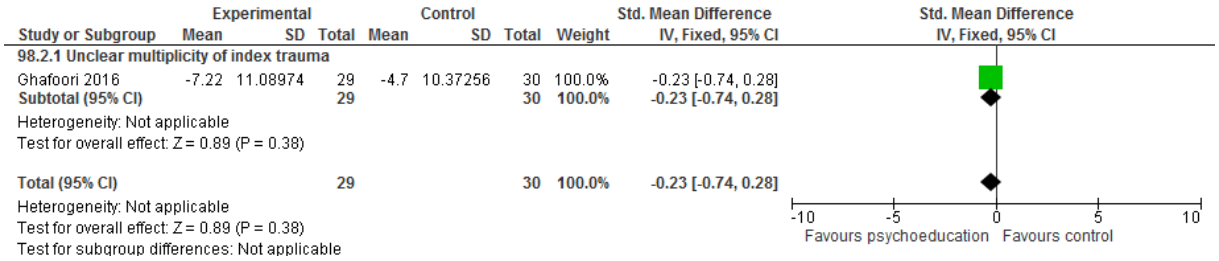


Figure 644: Psychoeducation (±TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated at 6-month follow-up (DTS change score)

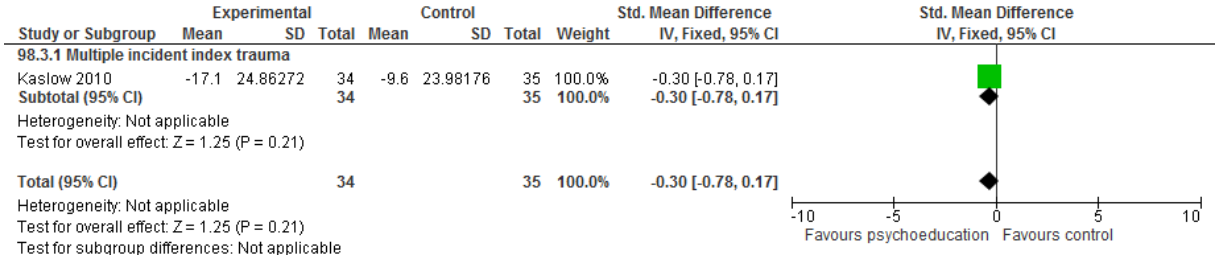


Figure 645: Psychoeducation (±TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated at 12-month follow-up (DTS change score)

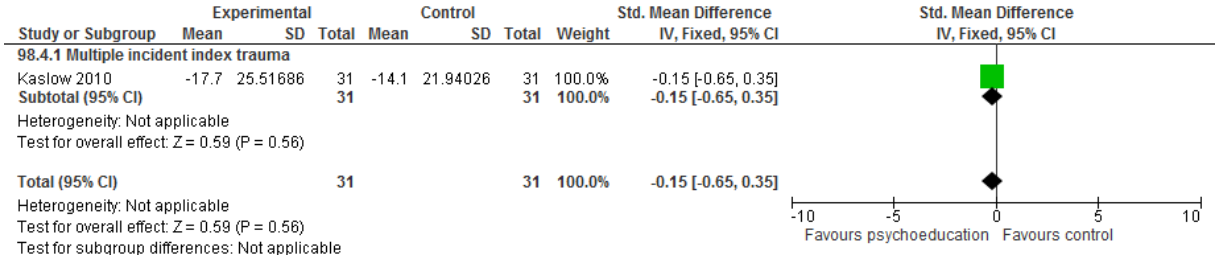


Figure 646: Psychoeducation (±TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: Anxiety symptoms at 1-month follow-up (BSI Anxiety change score)

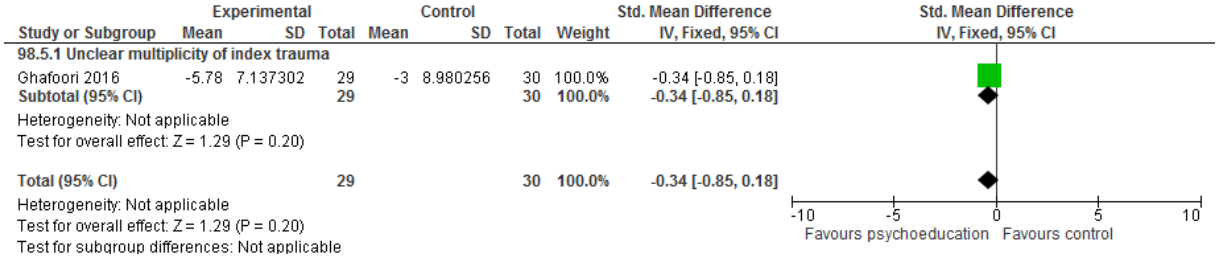


Figure 647: Psychoeducation (±TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms at endpoint (BDI-II change score)

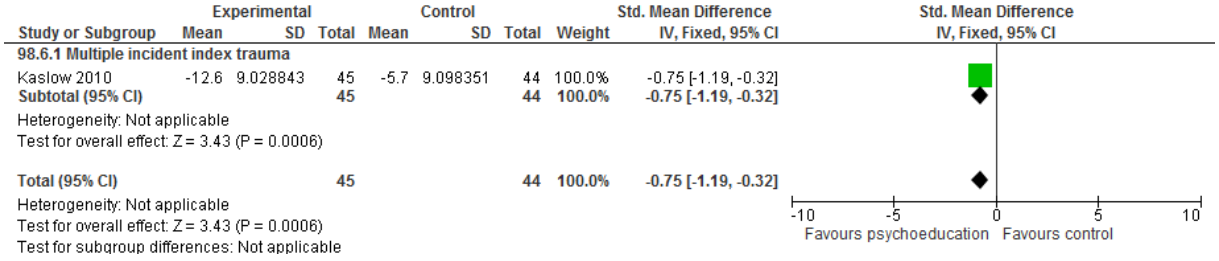


Figure 648: Psychoeducation (±TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms at 1-month follow-up (BSI Depression change score)

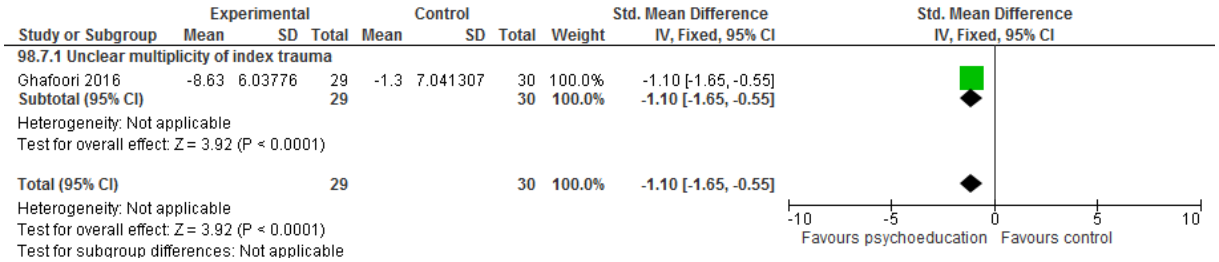


Figure 649: Psychoeducation (±TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms at 6-month follow-up (BDI-II change score)

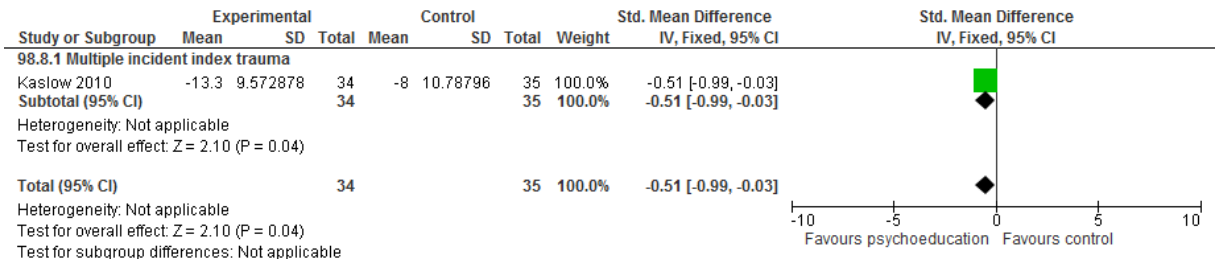


Figure 650: Psychoeducation (±TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms at 12-month follow-up (BDI-II change score)

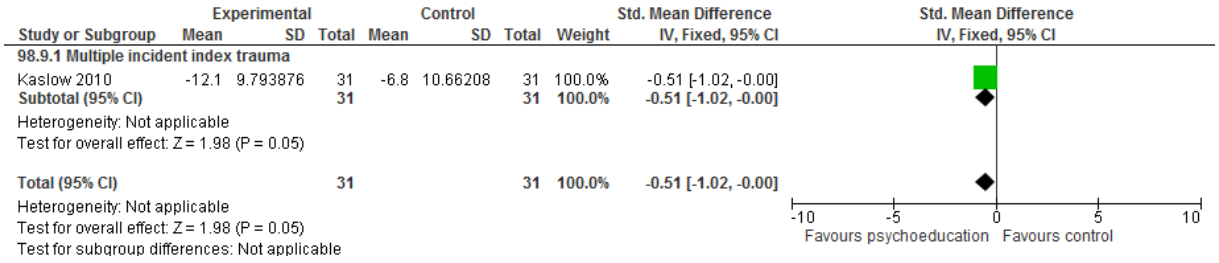


Figure 651: Psychoeducation (±TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: Suicide (BSS change score); Multiple incident index trauma

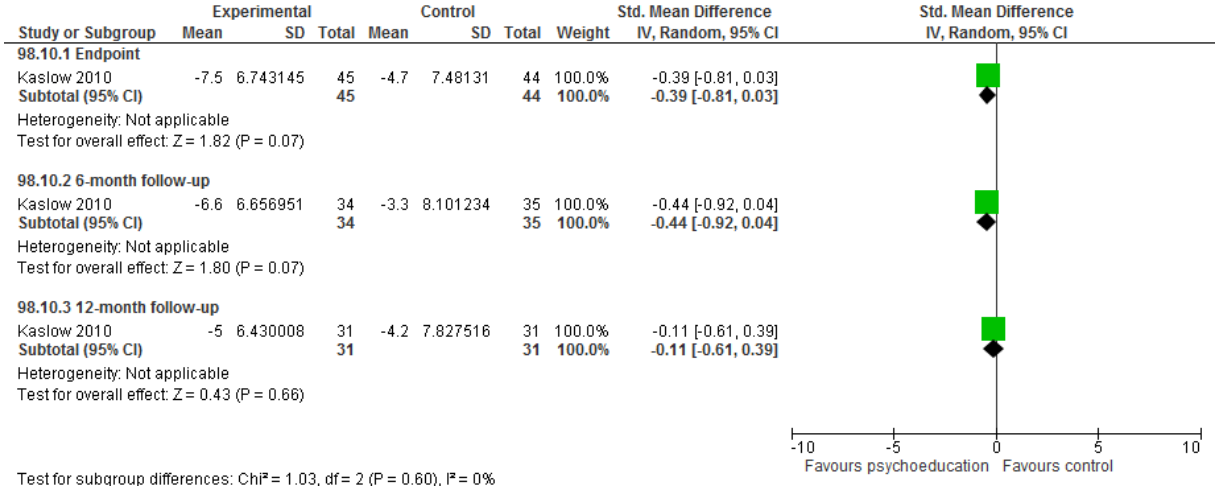
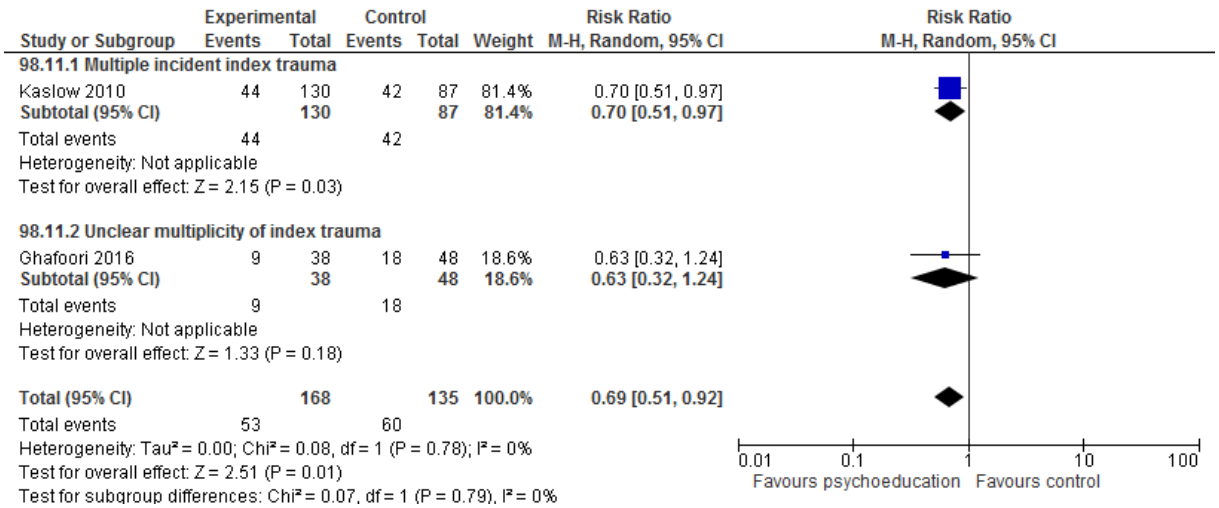


Figure 652: Psychoeducation (±TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)



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

Acupuncture

Figure 653: Acupuncture versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated (PSS-SR change score)

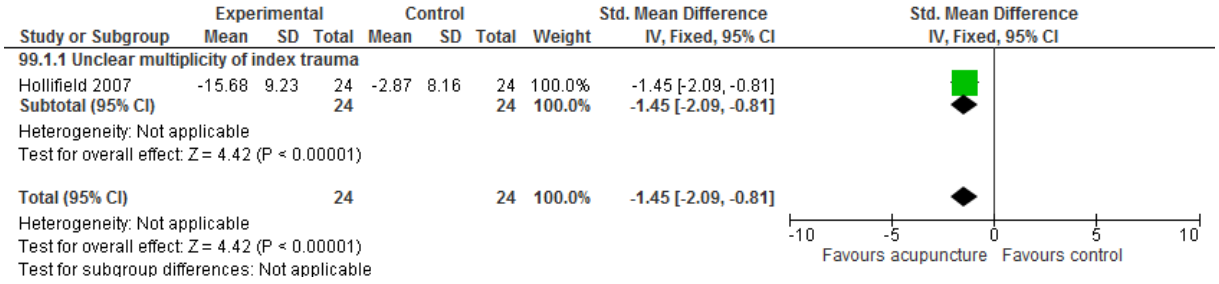


Figure 654: Acupuncture versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Remission (number of people scoring <16 on PSS-SR)

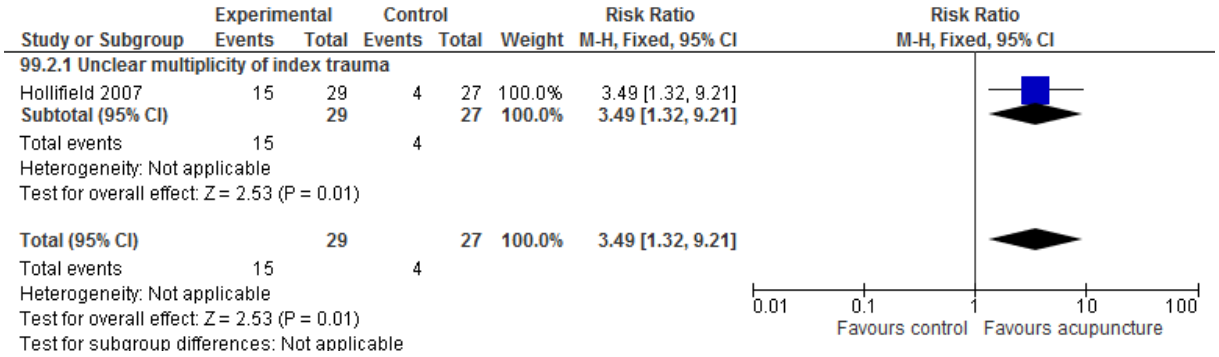


Figure 655: Acupuncture versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms (HSCL-25: Depression, change score)

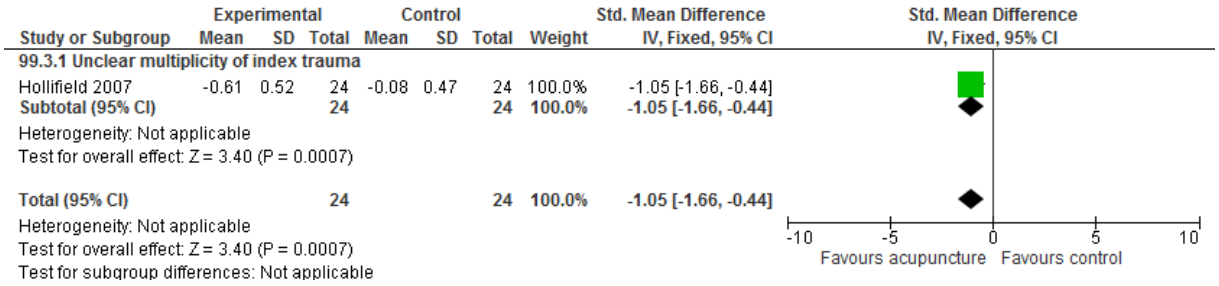


Figure 656: Acupuncture versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Anxiety symptoms (HSCL-25: Anxiety, change score)

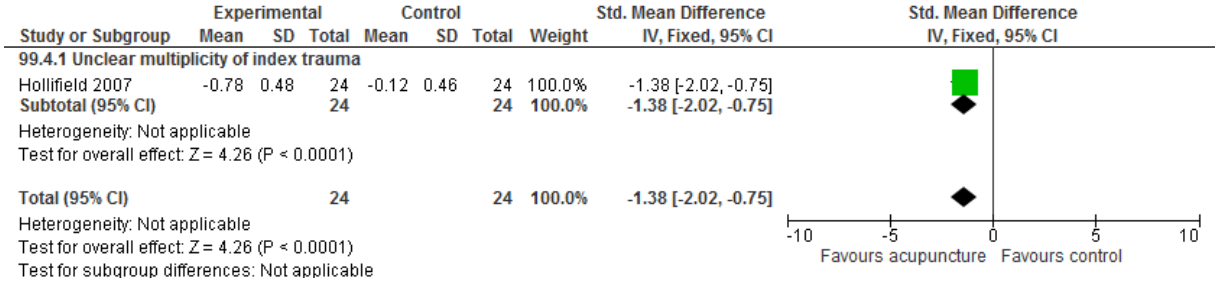


Figure 657: Acupuncture versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Functional impairment (SDS change score)

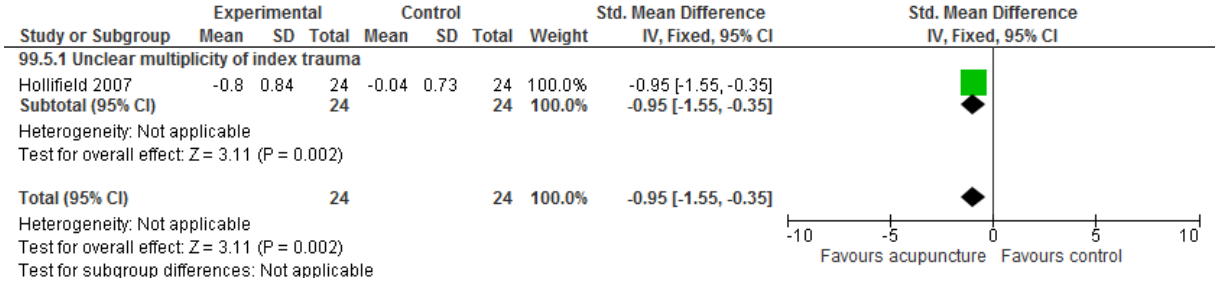


Figure 658: Acupuncture versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)

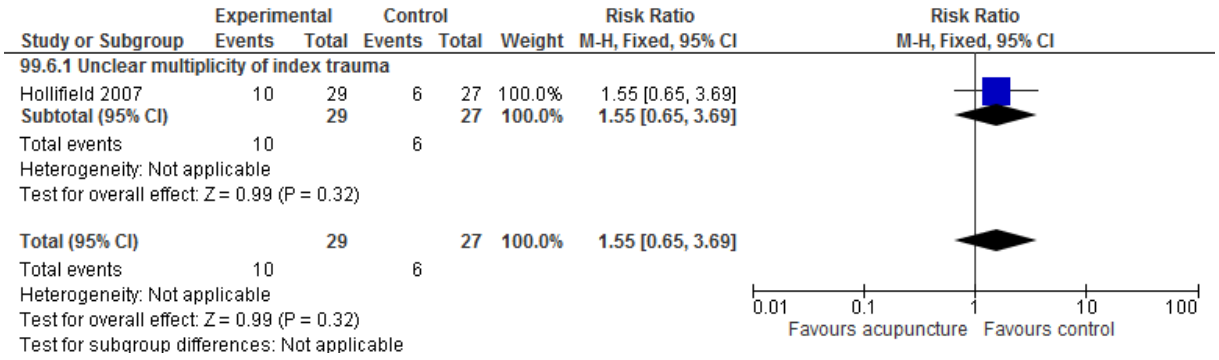


Figure 659: Acupuncture versus paroxetine for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated (CAPS change score); Single incident trauma

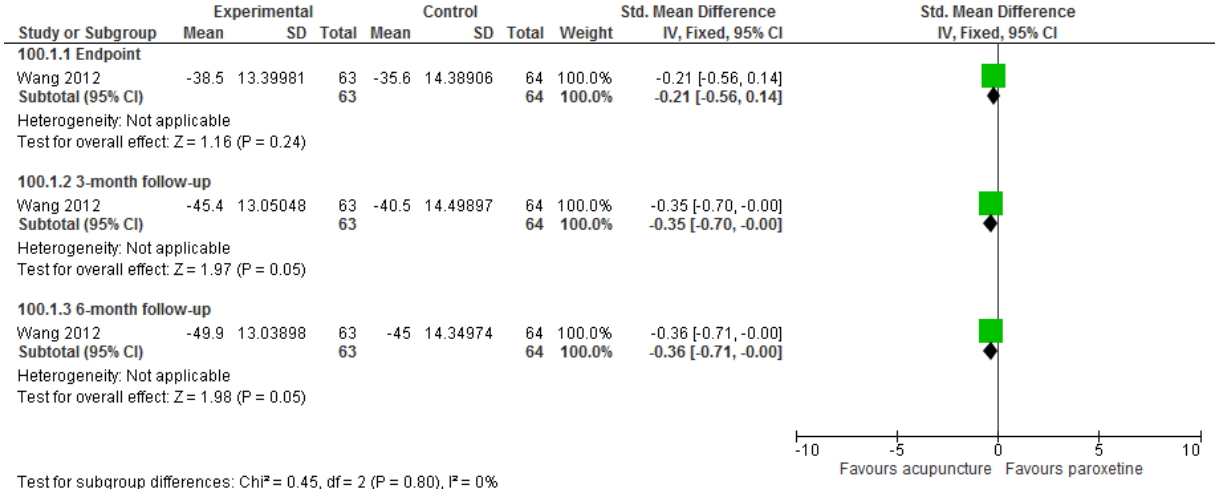


Figure 660: Acupuncture versus paroxetine for delayed treatment (>3 months) of clinically important symptoms/PTSD: Anxiety symptoms (HAM-A change score); Single incident trauma

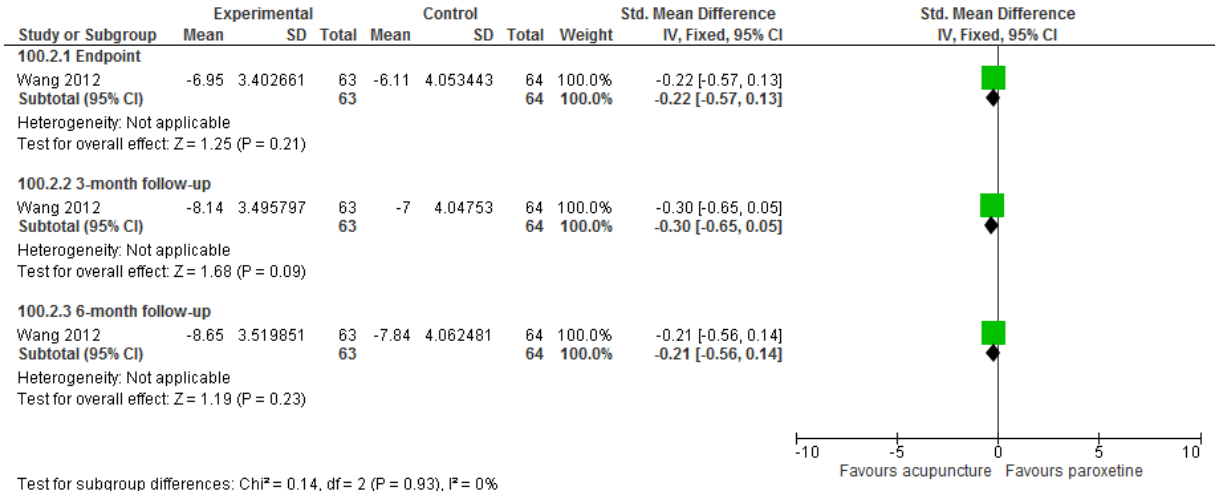


Figure 661: Acupuncture versus paroxetine for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms (HAMD change score); Single incident trauma

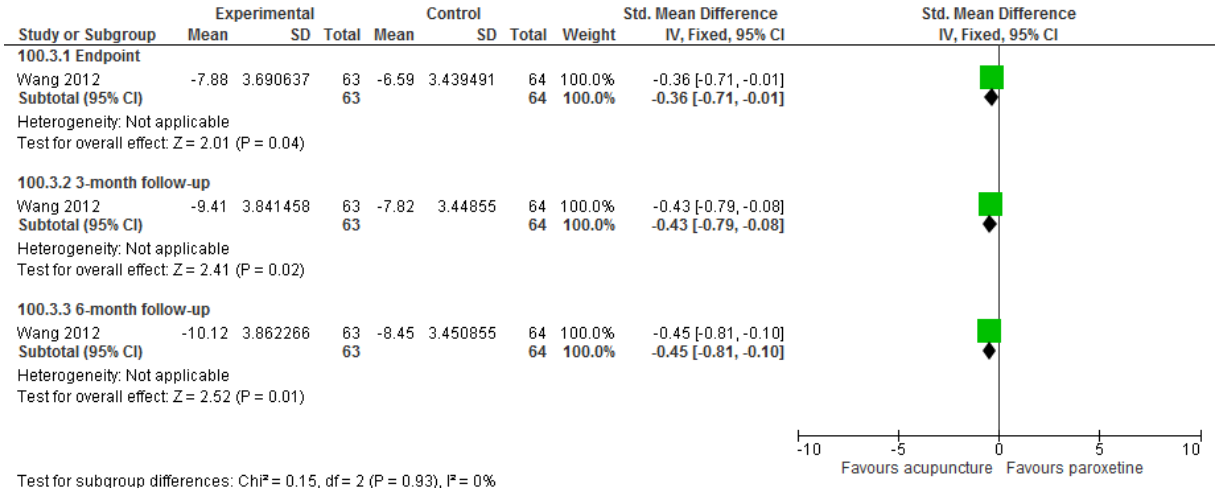
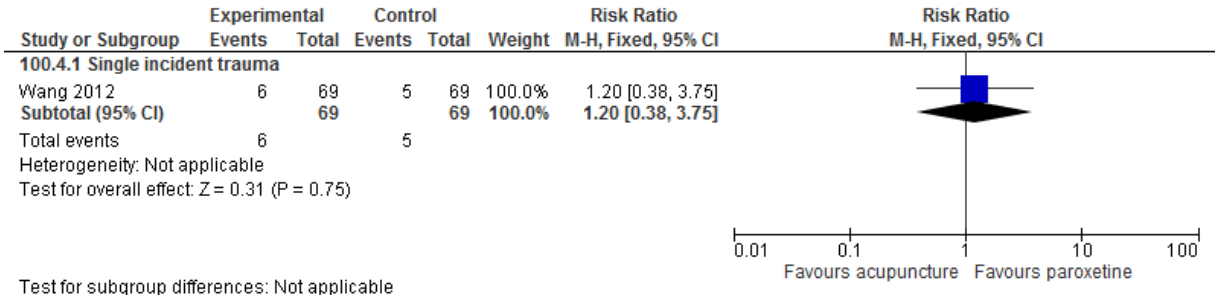


Figure 662: Acupuncture versus paroxetine for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)



Exercise

Figure 663: Exercise (+TAU) versus TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-report (PCL change score)

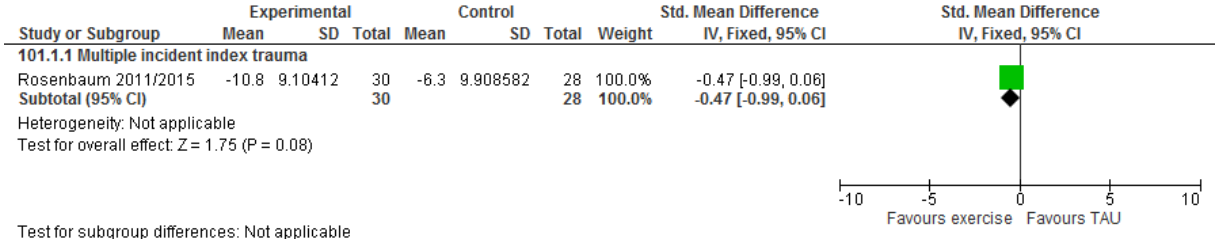


Figure 664: Exercise (+TAU) versus TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated (CAPS change score)

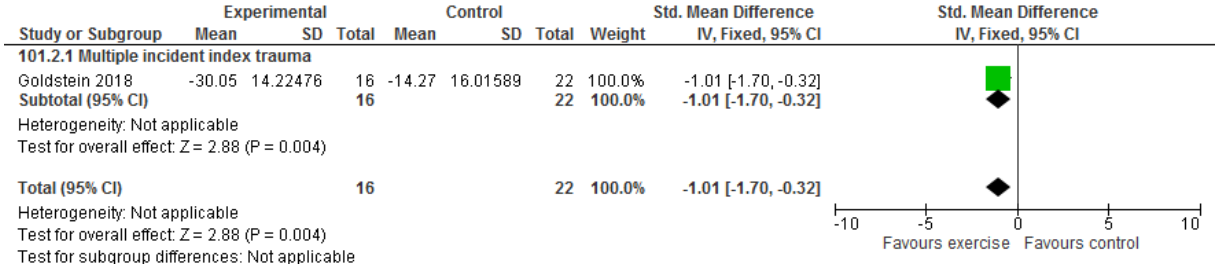


Figure 665: Exercise (+TAU) versus TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: Anxiety symptoms (DASS: Anxiety; change score)

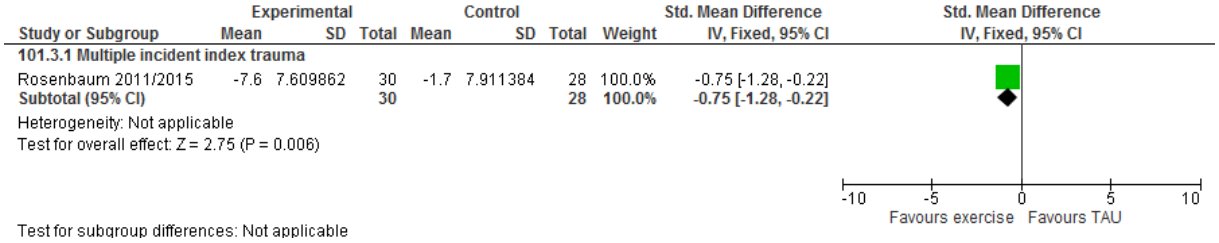


Figure 666: Exercise (+TAU) versus TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms (DASS: Depression; change score)

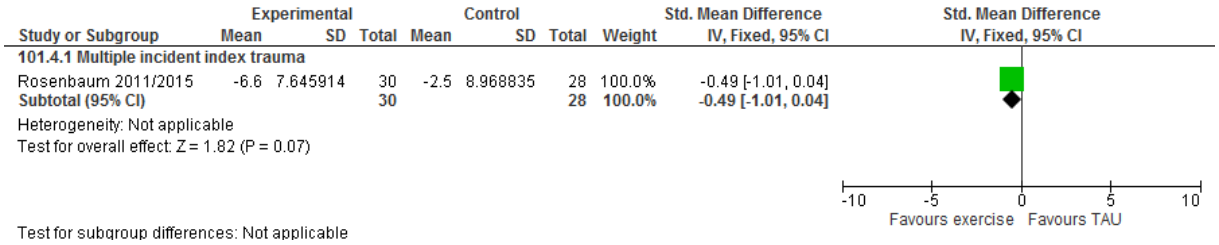


Figure 667: Exercise (+TAU) versus TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: Sleeping difficulties (PSQI change score)

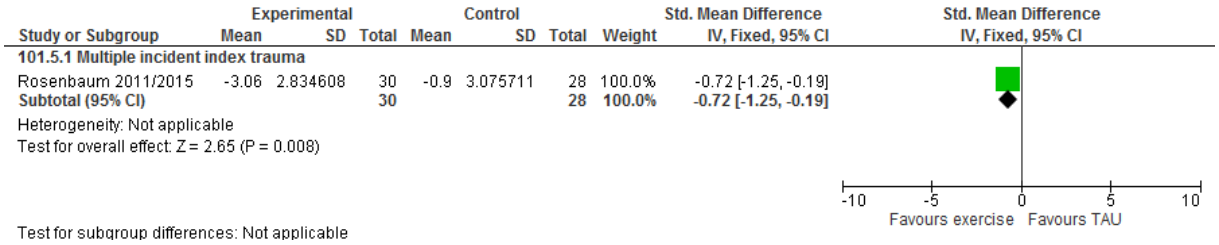
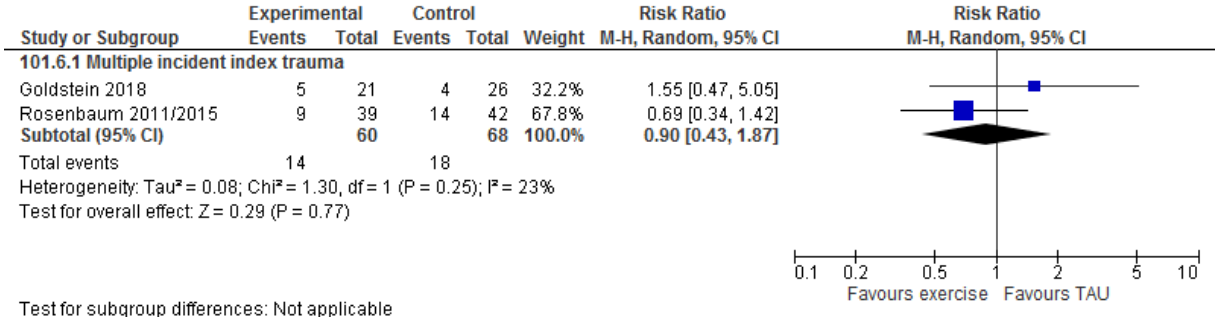


Figure 668: Exercise (+TAU) versus TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)



Repetitive transcranial magnetic stimulation (rTMS)

Figure 669: Repetitive transcranial magnetic stimulation (rTMS) versus sham stimulation for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-report (PCL change score)

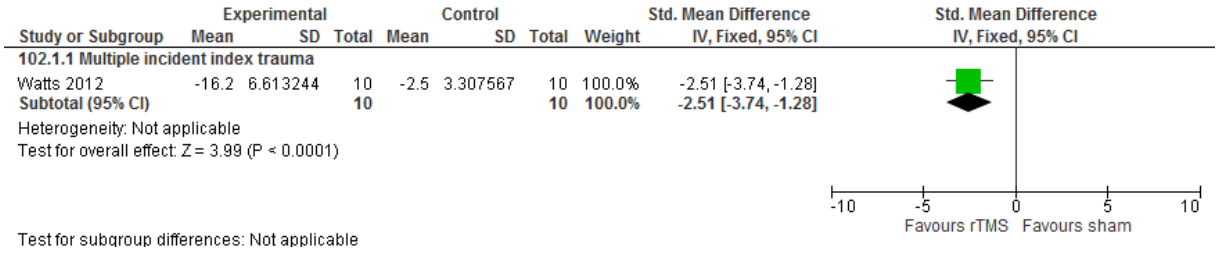


Figure 670: Repetitive transcranial magnetic stimulation (rTMS) versus sham stimulation for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated (CAPS change score)

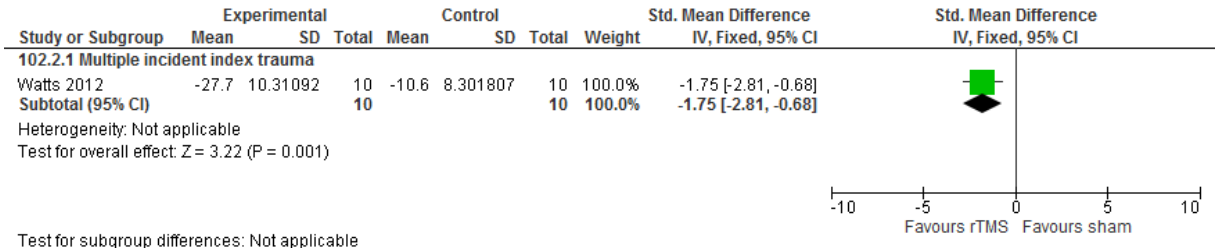
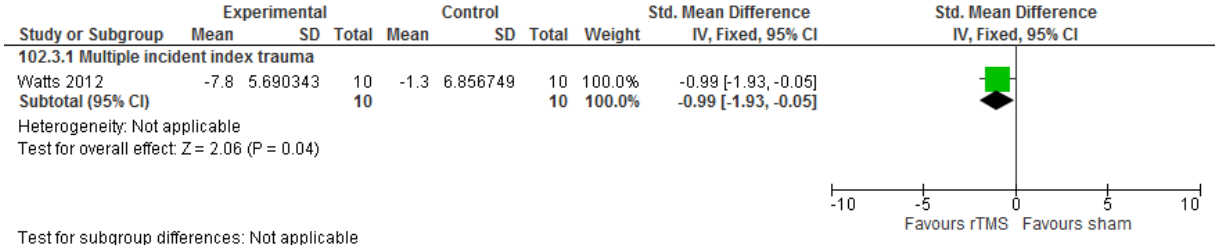


Figure 671: Repetitive transcranial magnetic stimulation (rTMS) versus sham stimulation for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms (BDI change score)



Yoga

Figure 672: Yoga (± TAU) versus TAU/waitlist/attention-placebo for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-report at endpoint (PCL/DTS change score)

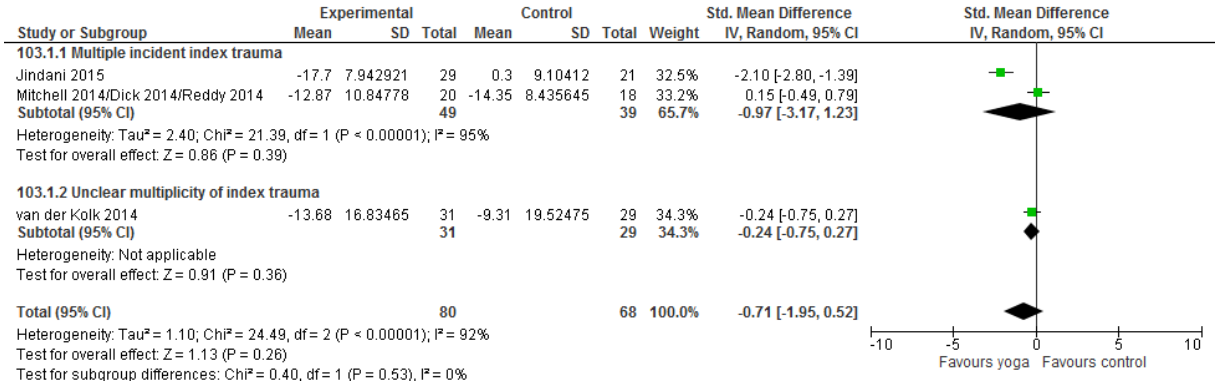


Figure 673: Yoga (± TAU) versus TAU/waitlist/attention-placebo for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-report at 1-month follow-up (PCL change score)

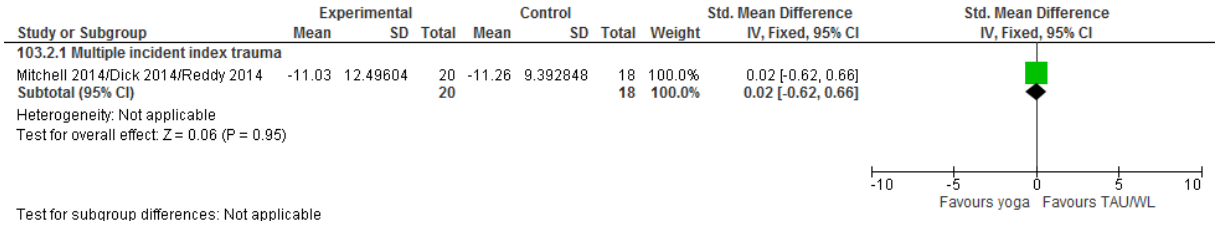


Figure 674: Yoga (± TAU) versus TAU/waitlist/attention-placebo for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated (CAPS change score)

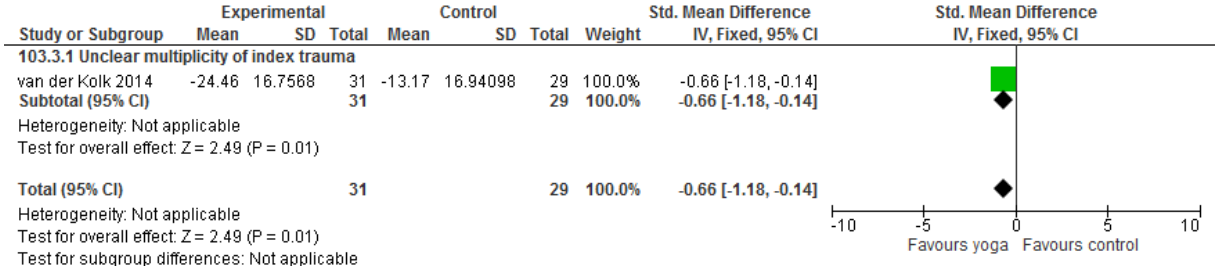


Figure 675: Yoga (± TAU) versus TAU/waitlist/attention-placebo for delayed treatment (>3 months) of clinically important symptoms/PTSD: Remission (number of people no longer meeting diagnostic criteria for PTSD)

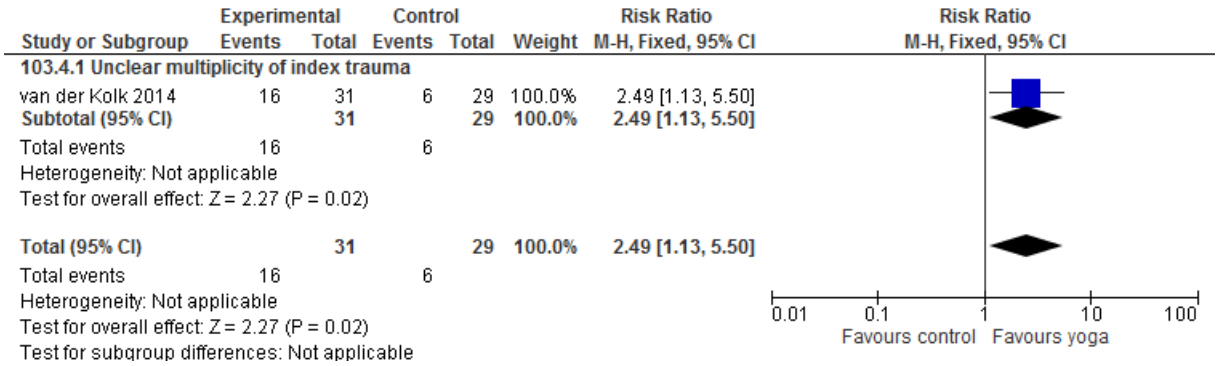


Figure 676: Yoga (± TAU) versus TAU/waitlist/attention-placebo for delayed treatment (>3 months) of clinically important symptoms/PTSD: Dissociative symptoms (DES change score)

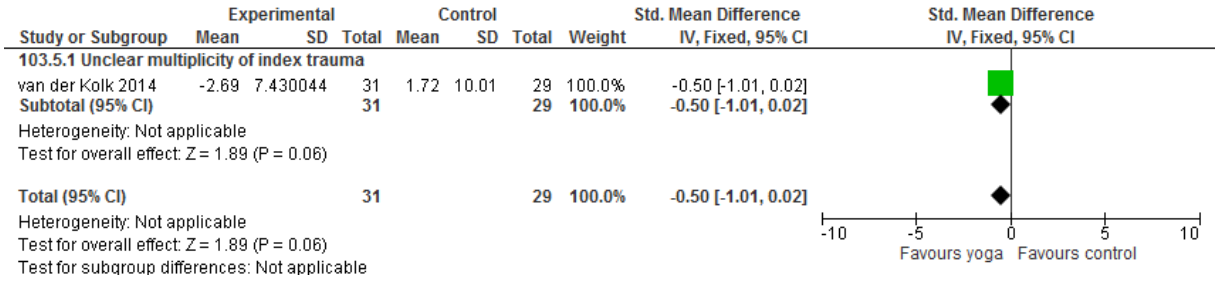


Figure 677: Yoga (± TAU) versus TAU/waitlist/attention-placebo for delayed treatment (>3 months) of clinically important symptoms/PTSD: Anxiety symptoms at endpoint (DASS: Anxiety/STAI: State; change score)

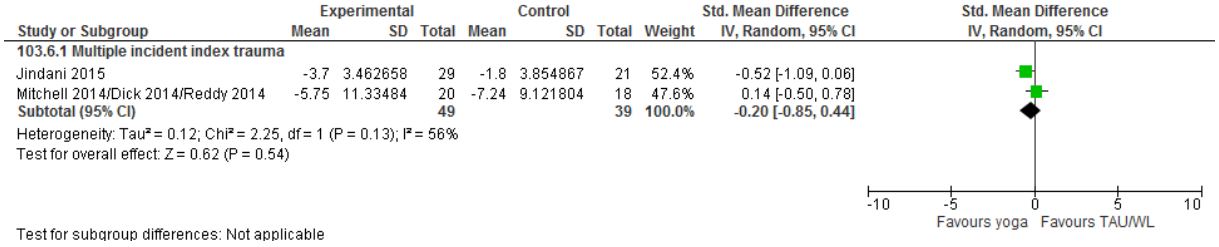


Figure 678: Yoga (± TAU) versus TAU/waitlist/attention-placebo for delayed treatment (>3 months) of clinically important symptoms/PTSD: Anxiety symptoms at 1-month follow-up (STAI: State; change score)

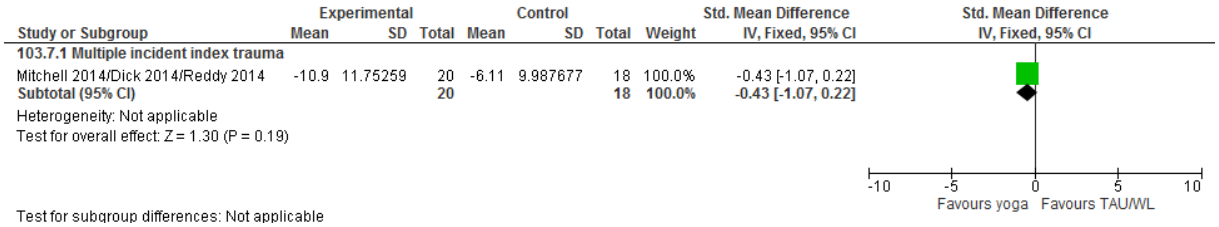


Figure 679: Yoga (± TAU) versus TAU/waitlist/attention-placebo for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms at endpoint (BDI-II/DASS Depression/CES-D change score)

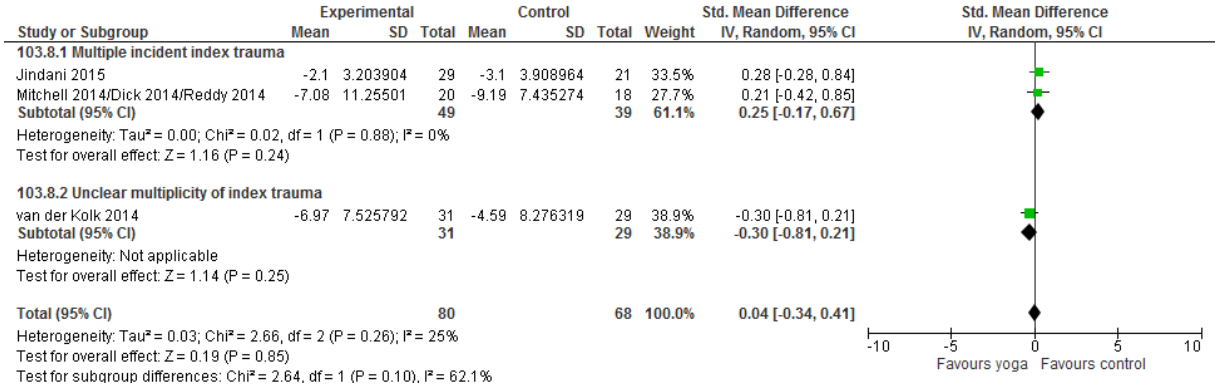


Figure 680: Yoga (± TAU) versus TAU/waitlist/attention-placebo for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms at 1-month follow-up

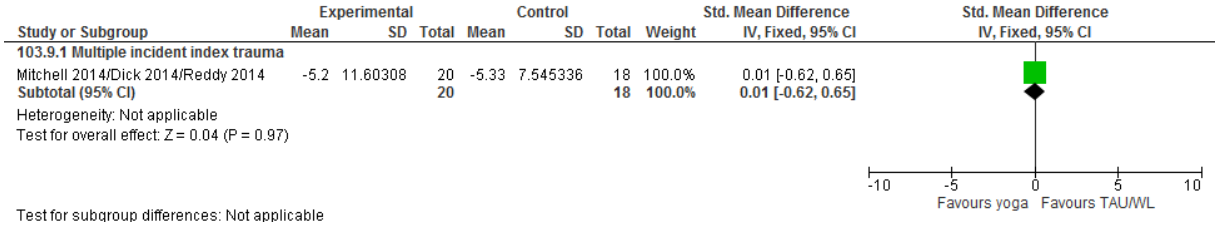


Figure 681: Yoga (± TAU) versus TAU/waitlist/attention-placebo for delayed treatment (>3 months) of clinically important symptoms/PTSD: Symptoms of alcohol use disorder at endpoint (AUDIT change score)

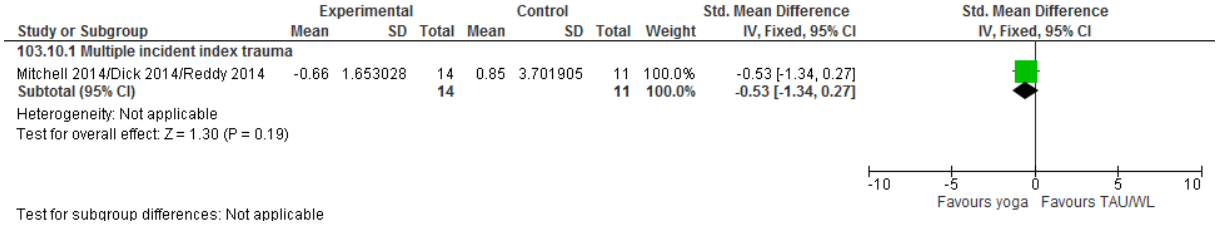


Figure 682: Yoga (± TAU) versus TAU/waitlist/attention-placebo for delayed treatment (>3 months) of clinically important symptoms/PTSD: Symptoms of alcohol use disorder at 1-month follow-up (AUDIT change score)

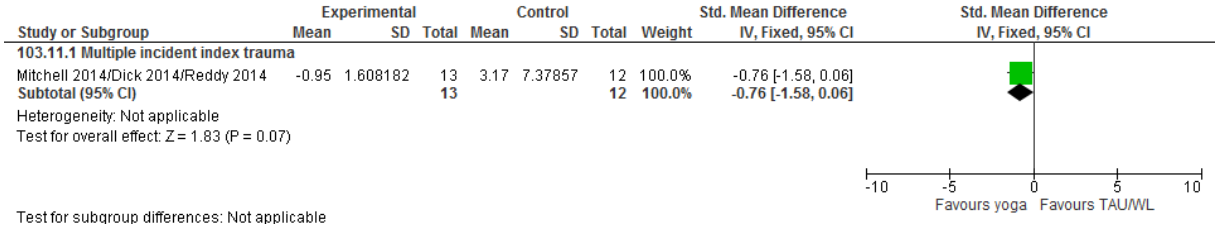


Figure 683: Yoga (± TAU) versus TAU/waitlist/attention-placebo for delayed treatment (>3 months) of clinically important symptoms/PTSD: Symptoms of drug use disorder at endpoint (DUDIT change score)

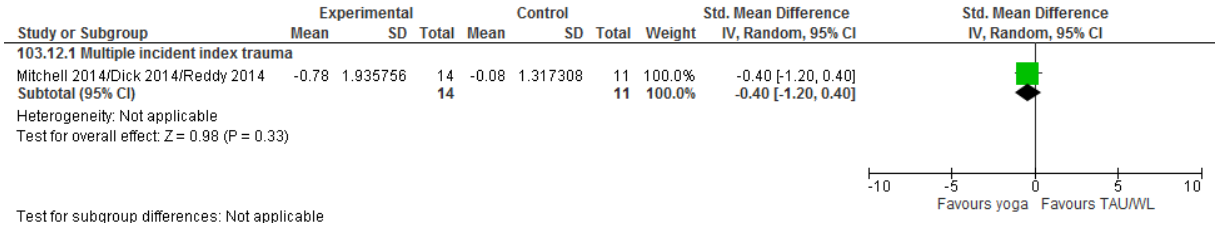


Figure 684: Yoga (± TAU) versus TAU/waitlist/attention-placebo for delayed treatment (>3 months) of clinically important symptoms/PTSD: Symptoms of drug use disorder at 1-month follow-up (DUDIT change score)

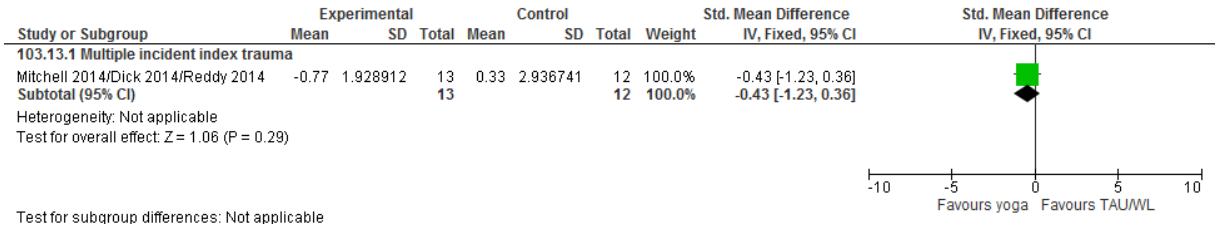


Figure 685: Yoga (± TAU) versus TAU/waitlist/attention-placebo for delayed treatment (>3 months) of clinically important symptoms/PTSD: Sleeping difficutlies (ISI change score)

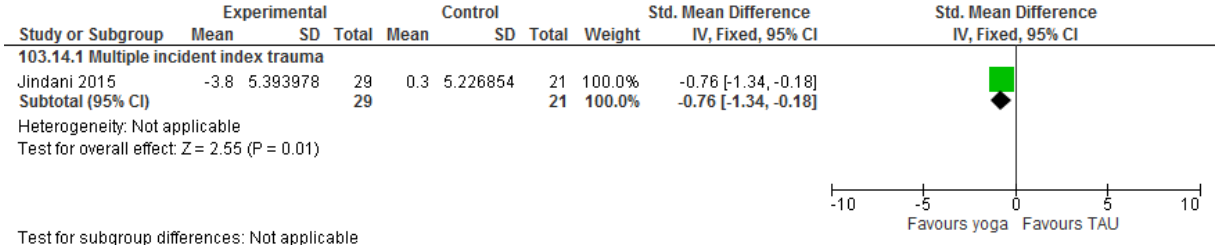
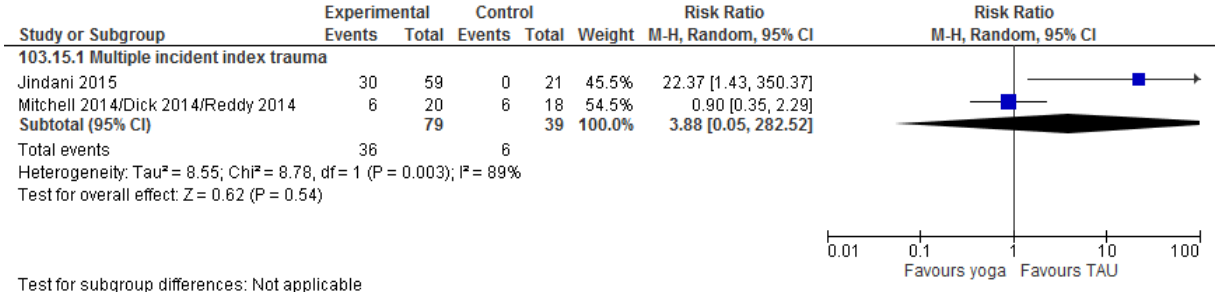


Figure 686: Yoga (± TAU) versus TAU/waitlist/attention-placebo for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)



Bio-/neuro-feedback (±TAU) versus TAU or no treatment

Figure 687: Bio-/neuro-feedback (± TAU) versus TAU or no treatment for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated at endpoint (PCL/DTS/IES-R change score)

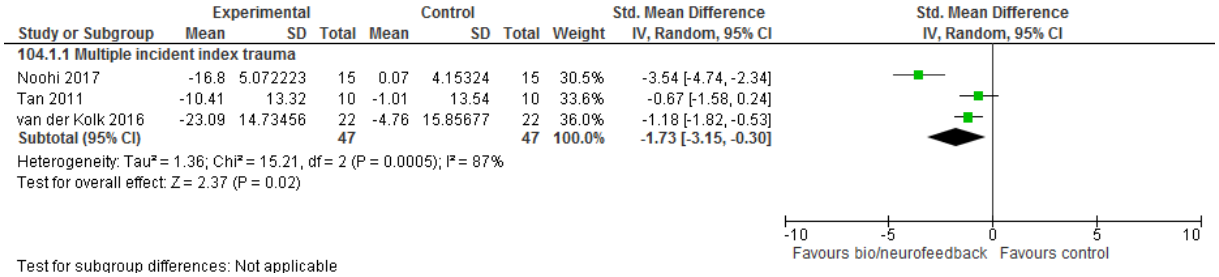


Figure 688: Bio-/neuro-feedback (± TAU) versus TAU or no treatment for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology self-rated at 4-6 week follow-up (DTS/IES-R change score)

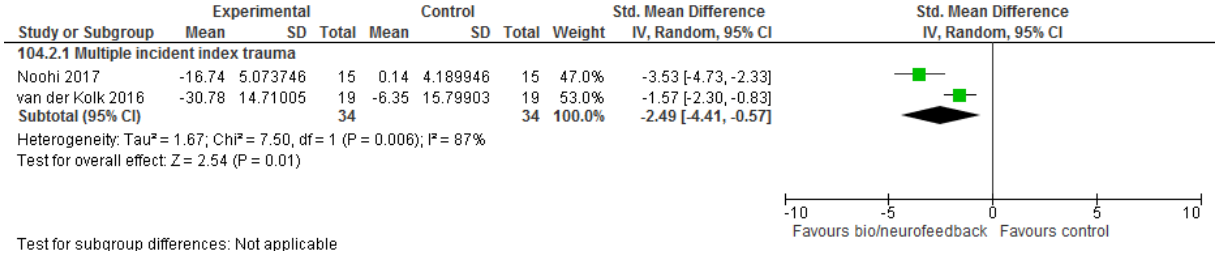


Figure 689: Bio-/neuro-feedback (± TAU) versus TAU or no treatment for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated at endpoint (CAPS change score)

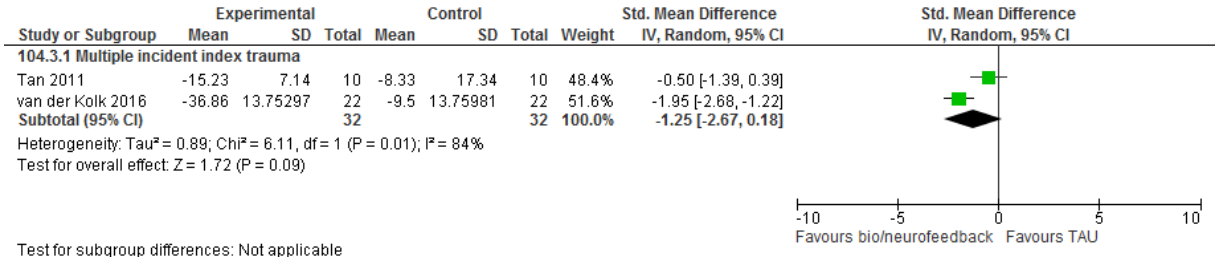


Figure 690: Bio-/neuro-feedback (± TAU) versus TAU or no treatment for delayed treatment (>3 months) of clinically important symptoms/PTSD: PTSD symptomatology clinician-rated at 1-month follow-up (CAPS change score)

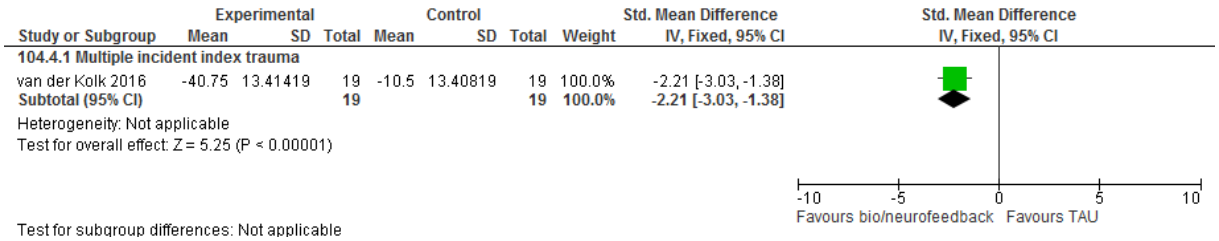


Figure 691: Bio-/neuro-feedback (± TAU) versus TAU or no treatment for delayed treatment (>3 months) of clinically important symptoms/PTSD: Remission at endpoint (number of people no longer meeting diagnostic criteria)

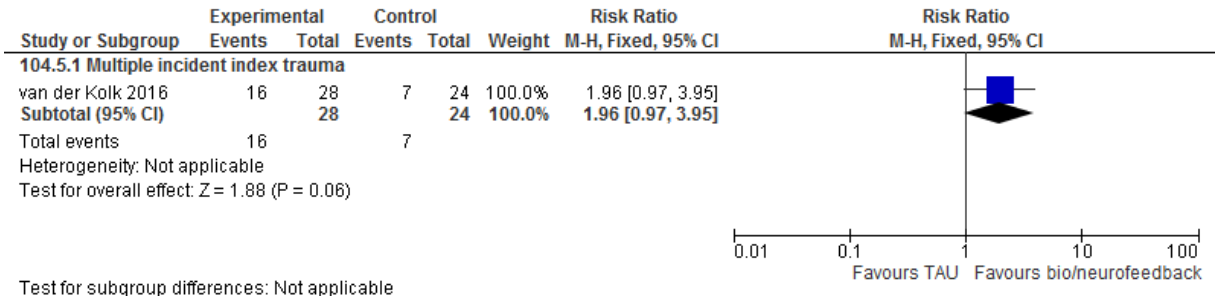


Figure 692: Bio-/neuro-feedback (± TAU) versus TAU or no treatment for delayed treatment (>3 months) of clinically important symptoms/PTSD: Remission at 1-month follow-up (number of people no longer meeting diagnostic criteria)

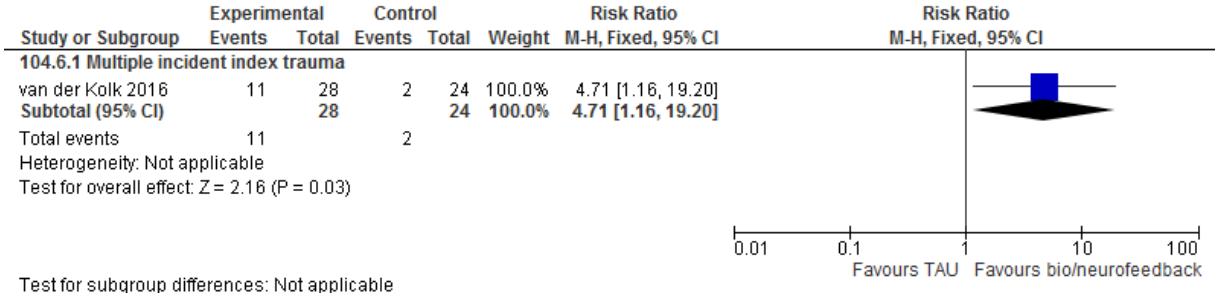


Figure 693: Bio-/neuro-feedback (± TAU) versus TAU or no treatment for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms at endpoint (BDI change score)

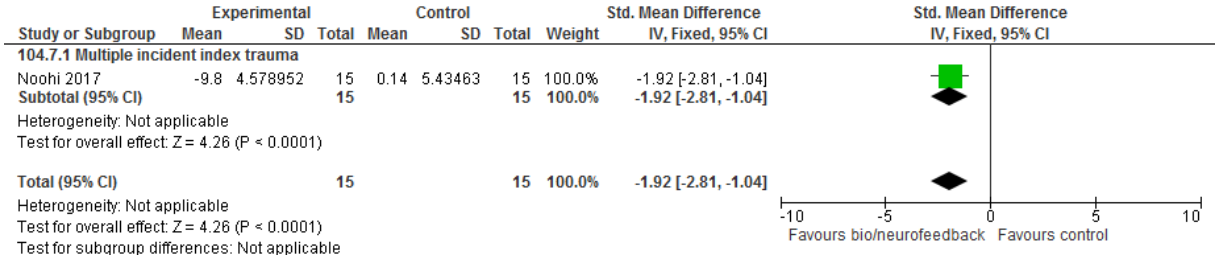


Figure 694: Bio-/neuro-feedback (± TAU) versus TAU or no treatment for delayed treatment (>3 months) of clinically important symptoms/PTSD: Depression symptoms at 6-week follow-up (BDI change score)

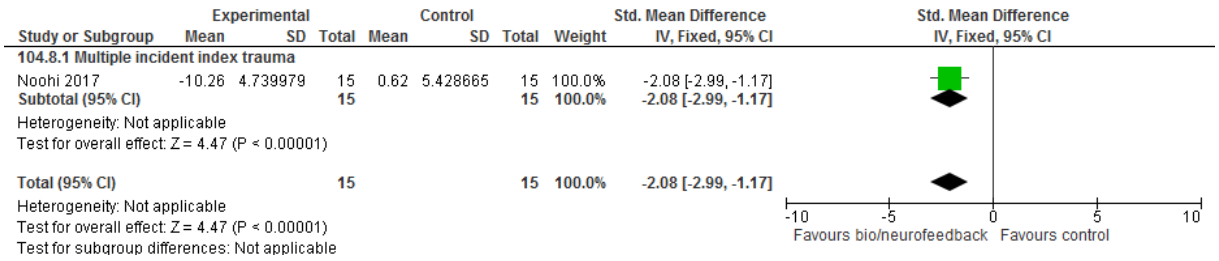
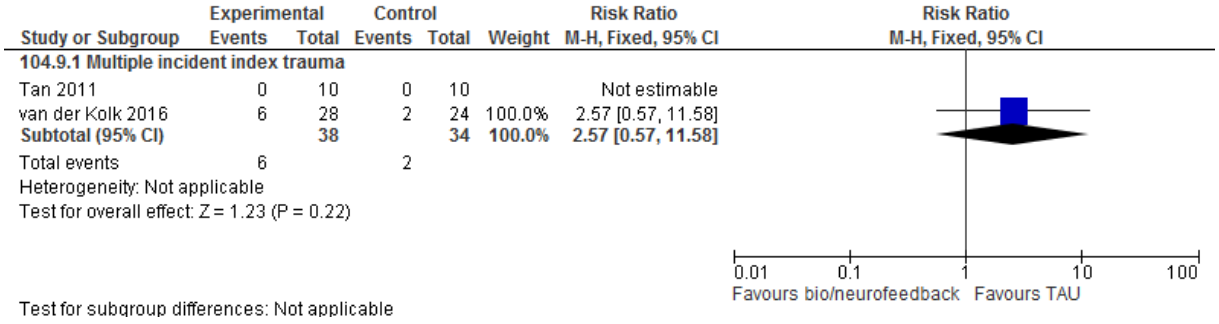


Figure 695: Bio-/neuro-feedback (± TAU) versus TAU or no treatment for delayed treatment (>3 months) of clinically important symptoms/PTSD: Discontinuation (loss to follow-up)



Appendix F – GRADE tables

GRADE tables for "For adults with clinically important post-traumatic stress symptoms, what are the relative benefits and harms of psychological, psychosocial or other non-pharmacological interventions targeted at PTSD symptoms?"

Psychological interventions for the treatment of PTSD in adults

Trauma-focused CBT

Table 112: Clinical evidence profile: Trauma-focused CBT versus waitlist or no treatment for early treatment (1-3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT	Waitlist or no treatment	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology self-rated - Endpoint (follow-up mean 4 weeks; measured with: IES change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	76	76	-	SMD 0.27 lower (0.59 lower to 0.05 higher)	VERY LOW	CRITICAL
PTSD symptomatology self-rated - 10-month follow-up (follow-up mean 43 months; measured with: IES change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[3]	76	76	-	SMD 0.47 lower (0.79 to 0.14 lower)	VERY LOW	CRITICAL
PTSD symptomatology clinician-rated - Endpoint (follow-up mean 4 weeks; measured with: CAPS endpoint/change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT	Waitlist or no treatment	Relative (95% CI)	Absolute		
2	randomised trials	very serious[1]	serious[5]	no serious indirectness	serious[2]	reporting bias[3]	137	128	-	SMD 0.43 lower (0.98 lower to 0.12 higher)	VERY LOW	CRITICAL
PTSD symptomatology clinician-rated - 4-month follow-up (follow-up mean 17 weeks; measured with: CAPS change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	52	46	-	SMD 0.3 lower (0.7 lower to 0.09 higher)	VERY LOW	CRITICAL
PTSD symptomatology clinician-rated - 10-month follow-up (follow-up mean 43 weeks; measured with: CAPS endpoint; Better indicated by lower values)												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[3]	76	76	-	SMD 0.32 lower (0.64 lower to 0 higher)	LOW	CRITICAL
Remission - Endpoint (follow-up mean 4 weeks; assessed with: Number of people no longer meeting diagnostic criteria for PTSD)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	39/79 (49.4%)	21/64 (32.8%)	RR 1.5 (0.99 to 2.28)	164 more per 1000 (from 3 fewer to 420 more)	VERY LOW	CRITICAL
Remission - 4-month follow-up (follow-up mean 17 weeks; assessed with: Number of people no longer meeting diagnostic criteria for PTSD)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	39/79 (49.4%)	27/64 (42.2%)	RR 1.17 (0.81 to 1.68)	72 more per 1000 (from 80 fewer to 287 more)	VERY LOW	CRITICAL

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT	Waitlist or no treatment	Relative (95% CI)	Absolute	Quality	Importance
Response self-rated - Endpoint (follow-up mean 4 weeks; assessed with: Number of participants showing at least 50% improvement from baseline on IES)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[6]	reporting bias[3]	19/76 (25%)	15/76 (19.7%)	RR 1.27 (0.7 to 2.3)	53 more per 1000 (from 59 fewer to 257 more)	VERY LOW	CRITICAL
Response self-rated - 10-month follow-up (follow-up mean 43 months; assessed with: Number of participants showing at least 50% improvement from baseline on IES)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[7]	reporting bias[3]	34/76 (44.7%)	21/76 (27.6%)	RR 1.62 (1.04 to 2.52)	171 more per 1000 (from 11 more to 420 more)	VERY LOW	CRITICAL
Anxiety symptoms - Endpoint (follow-up mean 4 weeks; measured with: HADS-A change score; Better indicated by lower values)												
2	randomised trials	very serious[1]	serious[5]	no serious indirectness	serious[2]	reporting bias[3]	138	128	-	SMD 0.32 lower (0.83 lower to 0.18 higher)	VERY LOW	IMPORTANT
Anxiety symptoms - 4-month follow-up (follow-up mean 17 weeks; measured with: HADS-A change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	54	48	-	SMD 0.34 lower (0.73 lower to 0.05 higher)	VERY LOW	IMPORTANT
Anxiety symptoms - 10-month follow-up (follow-up mean 43 weeks; measured with: HADS-A change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[3]	76	76	-	SMD 0.09 lower (0.41	VERY LOW	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT	Waitlist or no treatment	Relative (95% CI)	Absolute		
										lower to 0.23 higher)		
Depression symptoms - Endpoint (follow-up mean 4 weeks; measured with: HADS-D change score; Better indicated by lower values)												
2	randomised trials	very serious[1]	very serious[8]	no serious indirectness	serious[2]	reporting bias[3]	138	128	-	SMD 0.35 lower (0.96 lower to 0.25 higher)	VERY LOW	IMPORTANT
Depression symptoms - 4-month follow-up (follow-up mean 17 weeks; measured with: HADS-D change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	54	48	-	SMD 0.44 lower (0.83 to 0.04 lower)	VERY LOW	IMPORTANT
Depression symptoms - 10-month follow-up (follow-up mean 43 weeks; measured with: HADS-D change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[3]	76	76	-	SMD 0.09 lower (0.41 lower to 0.23 higher)	VERY LOW	IMPORTANT
Discontinuation (loss to follow-up) (follow-up mean 4 weeks; assessed with: Number of participants lost to follow-up (for any reason))												
2	randomised trials	serious[1]	serious[5]	no serious indirectness	very serious[6]	none	25/155 (16.1%)	25/140 (17.9%)	RR 0.89 (0.42 to 1.9)	20 fewer per 1000 (from 104 fewer to 161 more)	VERY LOW	CRITICAL

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

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

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

[3] Data is not reported/cannot be extracted for all outcomes

[4] *OIS not met (N<400)*
[5] *Substantial heterogeneity (I2=50-80%)*
[6] *95% CI crosses line of no effect and thresholds for both clinically important harm and clinically important benefit*
[7] *OIS not met (events<300)*
[8] *Considerable heterogeneity (I2>80%)*

Table 113: Clinical evidence profile: Trauma-focused CBT versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Trauma-focused CBT**	**Waitlist**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
PTSD symptomatology self-rated at endpoint (follow-up 1-26 weeks; measured with: PCL/SPTSS/HTQ/MPSS/PDS/PSS-SR/IES-R change score; Better indicated by lower values)												
14	randomised trials	very serious[1]	very serious	no serious indirectness	no serious imprecision	none	309	309	-	SMD 1.64 lower (2.29 to 1 lower)	VERY LOW	CRITICAL
PTSD symptomatology self-rated at 6-7 week follow-up (follow-up 6-7 weeks; measured with: IES/HTQ change score; Better indicated by lower values)												
2	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	82	63	-	SMD 0.7 lower (1.12 to 0.28 lower)	VERY LOW	CRITICAL
PTSD symptomatology self-rated at 3-month follow-up (follow-up mean 13 weeks; measured with: HTQ change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[3]	41	22	-	SMD 0.31 lower (0.84 lower to 0.21 higher)	VERY LOW	CRITICAL
PTSD symptomatology self-rated at 8-month follow-up (follow-up mean 35 weeks; measured with: PDS change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	111	55	-	SMD 1 lower (1.34 to 0.66 lower)	VERY LOW	CRITICAL
PTSD symptomatology self-rated at 1-year follow-up (follow-up mean 52 weeks; measured with: IES change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Trauma-focused CBT**	**Waitlist**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	41	41	-	SMD 0.78 lower (1.23 to 0.33 lower)	VERY LOW	CRITICAL
PTSD symptomatology clinician-rated at endpoint (follow-up 2-20 weeks; measured with: CAPS/HTQ/SI–PTSD/PSS-I change score; Better indicated by lower values)												
12	randomised trials	serious[1]	very serious[5]	no serious indirectness	no serious imprecision	reporting bias[3]	347	285	-	SMD 1.35 lower (1.81 to 0.89 lower)	VERY LOW	CRITICAL
PTSD symptomatology clinician-rated at 3-5 month follow-up (follow-up 13-22 weeks; measured with: CAPS/PSS-I/HTQ change score; Better indicated by lower values)												
4	randomised trials	serious[1]	serious[6]	no serious indirectness	no serious imprecision	reporting bias[3]	332	175	-	SMD 0.58 lower (0.9 to 0.25 lower)	VERY LOW	CRITICAL
Remission at endpoint (follow-up 2-20 weeks; assessed with: Number of people no longer meeting diagnostic criteria for PTSD or no longer above clinical threshold on scale)												
14	randomised trials	serious[1]	serious[6]	no serious indirectness	serious[7]	reporting bias[3]	191/321 (59.5%)	56/307 (18.2%)	RR 2.83 (2.2 to 3.64)	334 more per 1000 (from 219 more to 482 more)	VERY LOW	CRITICAL
Remission at 3-6 month follow-up (follow-up 13-26 weeks; assessed with: Number of people no longer meeting diagnostic criteria for PTSD or no longer above clinical threshold on scale)												
3	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[7]	reporting bias3	55/88 (62.5%)	21/87 (24.1%)	RR 2.4 (1.68 to 3.42)	338 more per 1000 (from 164 more to 584 more)	VERY LOW	CRITICAL

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT	Waitlist	Relative (95% CI)	Absolute	Quality	Importance
Remission at 8-month follow-up (follow-up mean 35 weeks; assessed with: Number of people no longer meeting diagnostic criteria for PTSD)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	30/111 (27%)	7/55 (12.7%)	RR 2.12 (1 to 4.53)	143 more per 1000 (from 0 more to 449 more)	VERY LOW	CRITICAL
Response self-rated at endpoint (follow-up 10-13 weeks; assessed with: Number of people showing clinically significant improvement (based on reliable change indices [RCI])/ ≥50% improvement on PDS))												
3	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[7]	reporting bias[3]	38/55 (69.1%)	6/56 (10.7%)	RR 4.75 (2.28 to 9.88)	402 more per 1000 (from 137 more to 951 more)	VERY LOW	CRITICAL
Response self-rated at 6-month follow-up (follow-up mean 26 weeks; assessed with: Number of people showing ≥50% improvement on PDS)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[7]	reporting bias[3]	25/28 (89.3%)	11/29 (37.9%)	RR 2.35 (1.45 to 3.82)	512 more per 1000 (from 171 more to 1000 more)	VERY LOW	CRITICAL
Response clinician-rated (follow-up 2-12 weeks; assessed with: Number of people showing improvement of at least 10 points on CAPS/clinically significant improvement on CAPS based on reliable change indices (RCI))												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Trauma-focused CBT**	**Waitlist**	**Relative (95% CI)**	**Absolute**		
3	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[7]	reporting bias[3]	20/45 (44.4%)	7/44 (15.9%)	RR 2.53 (1.01 to 6.31)	243 more per 1000 (from 2 more to 845 more)	VERY LOW	CRITICAL
Anxiety symptoms at endpoint (follow-up 1-26 weeks; measured with: BAI/HADS-A/STAI State/HSCL-25 Anxiety/DASS Anxiety/HAM-A change score; Better indicated by lower values)												
15	randomised trials	very serious[1]	serious[6]	no serious indirectness	no serious imprecision	reporting bias[3]	410	350	-	SMD 1.33 lower (1.72 to 0.94 lower)	VERY LOW	IMPORTANT
Anxiety symptoms at 2-month follow-up (follow-up 14 weeks; measured with: STAI State change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	41	41	-	SMD 0.65 lower (1.09 to 0.2 lower)	VERY LOW	IMPORTANT
Anxiety symptoms at 5-6 month follow-up (follow-up 22-26 weeks; measured with: BAI/HSCL-25 Anxiety change score; Better indicated by lower values)												
3	randomised trials	serious[1]	very serious[5]	no serious indirectness	no serious imprecision	reporting bias[3]	281	141	-	SMD 0.8 lower (1.43 to 0.17 lower)	VERY LOW	IMPORTANT
Anxiety symptoms at 1-year follow-up (follow-up mean 52 weeks; measured with: STAI State change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	41	41	-	SMD 0.69 lower (1.13 to 0.24 lower)	VERY LOW	IMPORTANT
Depression symptoms at endpoint (follow-up 1-26 weeks; measured with: BDI/BDI-II/CES-D/HADS-D/HSCL-25 Depression/DASS Depression/HAMD change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT	Waitlist	Relative (95% CI)	Absolute	Quality	Importance
19	randomised trials	very serious[1]	serious[6]	no serious indirectness	no serious imprecision	none	520	452	-	SMD 0.94 lower (1.23 to 0.64 lower)	VERY LOW	IMPORTANT
Depression symptoms at 6-7 week follow-up (follow-up 6-7 weeks; measured with: BDI/BDI-II change score; Better indicated by lower values)												
2	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	82	63	-	SMD 0.6 lower (0.94 to 0.26 lower)	VERY LOW	IMPORTANT
Depression symptoms at 3-6 month follow-up (follow-up 13-26 weeks; measured with: BDI-II/CES-D/HSCL-25 Depression change score; Better indicated by lower values)												
5	randomised trials	serious[1]	serious[6]	no serious indirectness	no serious imprecision	reporting bias[3]	363	187	-	SMD 0.53 lower (0.87 to 0.18 lower)	VERY LOW	IMPORTANT
Depression symptoms at 1-year follow-up (follow-up mean 52 weeks; measured with: BDI change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	41	41	-	SMD 0.8 lower (1.25 to 0.35 lower)	VERY LOW	IMPORTANT
Dissociative symptoms at endpoint (follow-up 12-20 weeks; measured with: DES change score; Better indicated by lower values)												
3	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	79	74	-	SMD 1.08 lower (1.42 to 0.73 lower)	LOW	IMPORTANT
Dissociative symptoms at 2-month follow-up (follow-up 8 weeks; measured with: DES change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT	Waitlist	Relative (95% CI)	Absolute	Quality	Importance
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[3]	41	41	-	SMD 0.17 higher (0.26 lower to 0.61 higher)	VERY LOW	IMPORTANT
Dissociative symptoms at 1-year follow-up (follow-up mean 52 weeks; measured with: DES change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[3]	41	41	-	SMD 0.22 higher (0.22 lower to 0.65 higher)	VERY LOW	IMPORTANT
Emotional and behavioural problems: Anger (follow-up mean 18 weeks; measured with: STAXI change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[3]	29	23	-	SMD 0.43 lower (0.98 lower to 0.12 higher)	VERY LOW	IMPORTANT
Substance use (follow-up mean 12 weeks; measured with: Number of days of primary substance use in past 30 days (ASI-Lite change score); Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	20	19	-	SMD 0.2 higher (0.43 lower to 0.83 higher)	VERY LOW	IMPORTANT
Global functioning (follow-up mean 12 weeks; measured with: GAF change score; Better indicated by higher values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[7]	reporting bias[3]	27	24	-	SMD 2.02 higher (1.34 to 2.71 higher)	VERY LOW	IMPORTANT
Functional impairment at endpoint (follow-up 12-26 weeks; measured with: SDS/SAS-SR change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT	Waitlist	Relative (95% CI)	Absolute	Quality	Importance
6	randomised trials	very serious[1]	very serious5	no serious indirectness	serious[2]	none	172	167	-	SMD 1.23 lower (1.89 to 0.58 lower)	VERY LOW	IMPORTANT
Functional impairment at 6-month follow-up (follow-up mean 26 weeks; measured with: SDS change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	28	27	-	SMD 0.95 lower (1.51 to 0.39 lower)	VERY LOW	IMPORTANT
Relationship difficulties (follow-up mean 12 weeks; measured with: IIP change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	22	24	-	SMD 1.72 lower (2.41 to 1.04 lower)	LOW	IMPORTANT
Quality of life at endpoint (follow-up 10-26 weeks; measured with: WHO-5/SF-36 mental health/Q-LES-Q-SF/QOLI change score; Better indicated by higher values)												
4	randomised trials	serious[1]	very serious[5]	no serious indirectness	serious[4]	none	124	112	-	SMD 0.52 higher (0.26 lower to 1.3 higher)	VERY LOW	IMPORTANT
Quality of life at 6-week follow-up (follow-up mean 6 weeks; measured with: WHO-5 change score; Better indicated by higher values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	41	22	-	SMD 0.83 higher (0.29 to 1.37 higher)	VERY LOW	IMPORTANT
Quality of life at 3-month follow-up (follow-up mean 13 weeks; measured with: WHO-5 change score; Better indicated by higher values)												

Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Trauma-focused CBT**	**Waitlist**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	41	22	-	SMD 0.85 higher (0.31 to 1.39 higher)	VERY LOW	IMPORTANT
Discontinuation (loss to follow-up) (follow-up 1-26 weeks; assessed with: Number of participants lost to follow-up (for any reason))												
26	randomised trials	serious[1]	serious[6]	no serious indirectness	no serious imprecision	none	232/1061 (21.9%)	136/773 (17.6%)	RR 1.5 (1.04 to 2.17)	88 more per 1000 (from 7 more to 206 more)	LOW	CRITICAL

ASI=Addition severity index; BAI=Beck Anxiety Index; BDI=Beck Depression Inventory; CAPS=Clinician-administered PTSD symptom scale; CBT=cognitive behavioural therapy; CES-D=Centre of Epidemiological Studies-Depression; CI=confidence interval; DASS=Depression Anxiety Stress Scales; DES=Dissociative Experiences Scales; GAF=Global assessment of functioning; HADS-A/D=Hospital Anxiety and Depression Scale-Anxiety/Depression; HAMD=Hamilton Rating Scale for Depression; HSCL-25=Hopkins Symptom Checklist-25; HTQ=Harvard Trauma Questionnaire; IES-R=Impact of Event Scale-Revised; MPSS=Modified PTSD symptom scale; PCL=PTSD checklist; PDS=Post-traumatic Diagnositic Scale; PSS-I/SR=PTSD symptom scale-interview/self-report; PTSD=post-traumatic stress disorder; RR=risk ratio; SAS-SR=Social Adjustment Scale-Self-Report; SDS=Sheehan Disability Scale; SI-PTSD=Structured interview for PTSD; SMD=standardised mean difference; SPTSS=Screen for post-traumatic stress disorders; STAI=State-Trait Anxiety Inventory; STAXI=State-Trait Anger Experssion Inventory

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

[2] OIS not met (N<400)

[3] Data is not reported/cannot be extracted for all outcomes

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

[5] Considerable heterogeneity (I2>80%)

[6] Substantial heterogeneity (I2=50-80%)

[7] OIS not met (events<300)

Table 114: Clinical evidence profile: Trauma-focused CBT + medication/TAU versus medication/TAU-only (or + attention-placebo) for delayed treatment (>3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT + medication/TAU	Medication/TAU-only (or + attention-placebo)	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology self-rated at endpoint (follow-up 3-26 weeks; measured with: IES/IES-R/PDS/PSS-SR/ HTQ/DTS/PCL/MPSS change score; Better indicated by lower values)												
21	randomised trials	serious[1]	very serious[2]	no serious indirectness	no serious imprecision	none	655	524	-	SMD 1.18 lower (1.55 to 0.82 lower)	VERY LOW	CRITICAL
PTSD symptomatology self-rated at 1-month follow-up (follow-up 4 weeks; measured with: PCL/PDS change score; Better indicated by lower values)												
2	randomised trials	serious[1]	serious[3]	no serious indirectness	serious[4]	reporting bias[5]	66	68	-	SMD 1.56 lower (2.16 to 0.95 lower)	VERY LOW	CRITICAL
PTSD symptomatology self-rated at 3-4 month follow-up (follow-up 13-17 weeks; measured with: PCL/PDS/IES-R change score; Better indicated by lower values)												
4	randomised trials	serious[1]	serious[3]	no serious indirectness	serious[4]	reporting bias[5]	166	120	-	SMD 1.22 lower (1.65 to 0.79 lower)	VERY LOW	CRITICAL
PTSD symptomatology self-rated at 5-6 month follow-up (follow-up 22-26 weeks; measured with: IES-R/PDS change score; Better indicated by lower values)												
3	randomised trials	serious[1]	serious3	no serious indirectness	serious[4]	reporting bias[5]	123	78	-	SMD 0.88 lower (1.45 to 0.31 lower)	VERY LOW	CRITICAL
PTSD symptomatology self-rated at 9-12 month follow-up (follow-up 39-52 weeks; measured with: PDS change score; Better indicated by lower values)												
3	randomised trials	serious[1]	very serious[2]	no serious indirectness	serious[6]	reporting bias[5]	66	55	-	SMD 0.77 lower (1.98	VERY LOW	CRITICAL

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT + medication/TAU	Medication/TAU-only (or + attention-placebo)	Relative (95% CI)	Absolute	Quality	Importance
										lower to 0.44 higher)		
PTSD symptomatology clinician-rated at endpoint (follow-up 2-26 weeks; measured with: CAPS/HTQ/PSS-I/SI-PTSD change score; Better indicated by lower values)												
22	randomised trials	serious[1]	very serious[2]	no serious indirectness	no serious imprecision	none	908	732	-	SMD 1.35 lower (1.69 to 1.02 lower)	VERY LOW	CRITICAL
PTSD symptomatology clinician-rated at 1-month follow-up (follow-up 4 weeks; measured with: CAPS change score; Better indicated by lower values)												
4	randomised trials	serious[1]	very serious[2]	no serious indirectness	serious[4]	reporting bias[5]	124	119	-	SMD 0.81 lower (1.54 to 0.08 lower)	VERY LOW	CRITICAL
PTSD symptomatology clinician-rated at 3-4 month follow-up (follow-up 13-17 weeks; measured with: CAPS change score; Better indicated by lower values)												
5	randomised trials	very serious[1]	very serious[2]	no serious indirectness	serious[4]	reporting bias[5]	138	142	-	SMD 1.01 lower (1.76 to 0.27 lower)	VERY LOW	CRITICAL
PTSD symptomatology clinician-rated at 5-6 month follow-up (follow-up 22-26 weeks; measured with: CAPS/HTQ/PSS-I/PDS change score; Better indicated by lower values)												
7	randomised trials	serious[1]	serious[3]	no serious indirectness	no serious imprecision	reporting bias[5]	316	332	-	SMD 0.78 lower (1.06 to 0.51 lower)	VERY LOW	CRITICAL
PTSD symptomatology clinician-rated at 9-12 month follow-up (follow-up 39-52 weeks; measured with: CAPS/PDS-I/CIDI-PTSD change score; Better indicated by lower values)												
3	randomised trials	serious[1]	very serious[2]	no serious indirectness	serious[6]	reporting bias[5]	51	43	-	SMD 0.6 lower (1.67 lower to 0.47 higher)	VERY LOW	CRITICAL

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT + medication/TAU	Medication/TAU-only (or + attention-placebo)	Relative (95% CI)	Absolute	Quality	Importance
Remission at endpoint (follow-up 6-26 weeks; assessed with: Number of people no longer meeting diagnostic criteria/above threshold on a scale for PTSD)												
12	randomised trials	serious[1]	very serious[2]	no serious indirectness	serious[7]	none	235/505 (46.5%)	59/412 (14.3%)	RR 3.34 (1.95 to 5.73)	335 more per 1000 (from 136 more to 677 more)	VERY LOW	CRITICAL
Remission at 1-3 month follow-up (follow-up 4-13 weeks; assessed with: Number of people no longer meeting diagnostic criteria for PTSD)												
3	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[8]	reporting bias[5]	34/135 (25.2%)	16/114 (14%)	RR 1.67 (0.73 to 3.81)	94 more per 1000 (from 38 fewer to 394 more)	VERY LOW	CRITICAL
Remission at 6-month follow-up (follow-up mean 26 weeks; assessed with: Number of people no longer meeting diagnostic criteria for PTSD)												
4	randomised trials	serious1	no serious inconsistency	no serious indirectness	serious[7]	none	49/176 (27.8%)	17/148 (11.5%)	RR 2.26 (1.39 to 3.66)	145 more per 1000 (from 45 more to 306 more)	LOW	CRITICAL
Remission at 1-year follow-up (follow-up mean 52 weeks; assessed with: Number of people no longer meeting diagnostic criteria for PTSD)												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious[6]	reporting bias[5]	10/17 (58.8%)	2/12 (16.7%)	RR 3.53 (0.94 to 13.29)	422 more per 1000 (from 10 fewer to 1000 more)	LOW	CRITICAL
Response self-rated at endpoint (follow-up 5-20 weeks; assessed with: Number of people showing clinically significant improvement based on reliable change indices [RCI] on IES/IES-R/DTS)												

Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Trauma-focused CBT + medication/TAU**	**Medication/TAU-only (or + attention-placebo)**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
5	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[7]	reporting bias[5]	100/197 (50.8%)	33/131 (25.2%)	RR 1.83 (1.08 to 3.1)	209 more per 1000 (from 20 more to 529 more)	VERY LOW	CRITICAL
Response self-rated at 6-month follow-up (follow-up mean 26 weeks; assessed with: Number of people showing clinically significant improvement (based on reliable change indices [RCI]) on PDS)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[7]	reporting bias[5]	10/16 (62.5%)	3/16 (18.8%)	RR 3.33 (1.12 to 9.9)	437 more per 1000 (from 23 more to 1000 more)	VERY LOW	CRITICAL
Response clinician-rated at endpoint (follow-up 6-14 weeks; assessed with: Number of people showing clinically significant improvement based on reliable change indices [RCI]/improvement of at least 12/30 points on CAPS)												
4	randomised trials	serious[1]	serious[3]	no serious indirectness	serious[7]	reporting bias5	63/129 (48.8%)	19/116 (16.4%)	RR 2.86 (1.44 to 5.69)	305 more per 1000 (from 72 more to 768 more)	VERY LOW	CRITICAL
Response clinician-rated at 1-month follow-up (follow-up mean 4 weeks; assessed with: Number of people showing clinically significant improvement based on reliable change indices [RCI]/improvement of at least 12 points on CAPS)												
2	randomised trials	serious[1]	serious[3]	no serious indirectness	very serious[8]	reporting bias[5]	34/81 (42%)	10/60 (16.7%)	RR 3.65 (0.37 to 36.42)	442 more per 1000 (from 105 fewer to 1000 more)	VERY LOW	CRITICAL
Dissociative symptoms at endpoint (follow-up 6-12 weeks; measured with: DES change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT + medication/TAU	Medication/TAU-only (or + attention-placebo)	Relative (95% CI)	Absolute		
2	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	56	58	-	SMD 0.9 lower (1.29 to 0.52 lower)	LOW	IMPORTANT
Dissociative symptoms at 1-month follow-up (follow-up mean 4 weeks; measured with: DES change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[5]	36	38	-	SMD 0.85 lower (1.33 to 0.37 lower)	VERY LOW	IMPORTANT
Dissociative symptoms at 3-month follow-up (follow-up mean 13 weeks; measured with: DES change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[5]	36	38	-	SMD 0.69 lower (1.16 to 0.22 lower)	VERY LOW	IMPORTANT
Dissociative symptoms at 6-month follow-up (follow-up mean 26 weeks; measured with: DES change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[6]	reporting bias[5]	11	11	-	SMD 0.45 lower (1.3 lower to 0.39 higher)	VERY LOW	IMPORTANT
Dissociative symptoms at 1-year follow-up (follow-up mean 52 weeks; measured with: DES change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[8]	reporting bias[5]	11	11	-	SMD 0.25 lower (1.09 lower to 0.59 higher)	VERY LOW	IMPORTANT
Anxiety symptoms at endpoint (follow-up 5-26 weeks; measured with: BAI/HAM-A/STAI State change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Trauma-focused CBT + medication/TAU**	**Medication/TAU-only (or + attention-placebo)**	**Relative (95% CI)**	**Absolute**		
13	randomised trials	serious[1]	very serious[2]	no serious indirectness	no serious imprecision	none	326	321	-	SMD 0.74 lower (1.12 to 0.35 lower)	VERY LOW	IMPORTANT
Anxiety symptoms at 1-month follow-up (follow-up mean 4 weeks; measured with: STAI State change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[5]	30	30	-	SMD 0.94 lower (1.48 to 0.41 lower)	VERY LOW	IMPORTANT
Anxiety symptoms at 3-month follow-up (follow-up mean 13 weeks; measured with: BAI/STAI State change score; Better indicated by lower values)												
2	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	60	64	-	SMD 0.72 lower (1.09 to 0.35 lower)	LOW	IMPORTANT
Anxiety symptoms at 5-6 month follow-up (follow-up 22-26 weeks; measured with: BAI/STAI State change score; Better indicated by lower values)												
2	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[6]	none	57	41	-	SMD 0.23 lower (0.64 lower to 0.17 higher)	LOW	IMPORTANT
Anxiety symptoms at 9-12 month follow-up (follow-up 39-52 weeks; measured with: STAI State change score; Better indicated by lower values)												
2	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[6]	none	52	44	-	SMD 0.18 higher (0.22 lower to 0.58 higher)	VERY LOW	IMPORTANT
Depression symptoms at endpoint (follow-up 5-26 weeks; measured with: BDI/BDI-II/CES-D/HAMD/MADRS change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Trauma-focused CBT + medication/TAU**	**Medication/TAU-only (or + attention-placebo)**	**Relative (95% CI)**	**Absolute**		
22	randomised trials	serious[1]	very serious[2]	no serious indirectness	no serious imprecision	none	898	638	-	SMD 1.04 lower (1.33 to 0.74 lower)	VERY LOW	IMPORTANT
Depression symptoms at 1-month follow-up (follow-up mean 4 weeks; measured with: BDI/BDI-II/HAMD change score; Better indicated by lower values)												
3	randomised trials	serious[1]	very serious[2]	no serious indirectness	serious[6]	reporting bias[5]	104	90	-	SMD 0.55 lower (1.37 lower to 0.26 higher)	VERY LOW	IMPORTANT
Depression symptoms at 3-4 month follow-up (follow-up 13-17 weeks; measured with: BDI-II/HAMD change score; Better indicated by lower values)												
5	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[5]	198	160	-	SMD 0.72 lower (0.94 to 0.5 lower)	VERY LOW	IMPORTANT
Depression symptoms at 5-6 month follow-up (follow-up 22-26 weeks; measured with: BDI-II/HSCL-25 Depression/HAMD change score; Better indicated by lower values)												
6	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	222	157	-	SMD 0.41 lower (0.62 to 0.2 lower)	LOW	IMPORTANT
Depression symptoms at 9-12 month follow-up (follow-up 39-52 weeks; measured with: HAMD/BDI-II change score; Better indicated by lower values)												
3	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[6]	reporting bias[5]	63	55	-	SMD 0.33 lower (0.7 lower to 0.04 higher)	VERY LOW	IMPORTANT
Personality disorder symptoms - Endpoint (follow-up mean 12 weeks; measured with: BSL change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT + medication/TAU	Medication/TAU-only (or + attention-placebo)	Relative (95% CI)	Absolute		
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[5]	36	38	-	SMD 1.01 lower (1.5 to 0.53 lower)	VERY LOW	IMPORTANT
Personality disorder symptoms - 1-month follow-up (follow-up mean 4 weeks; measured with: BSL change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[5]	36	38	-	SMD 0.63 lower (1.09 to 0.16 lower)	VERY LOW	IMPORTANT
Personality disorder symptoms - 3-month follow-up (follow-up mean 13 weeks; measured with: BSL change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[5]	36	38	-	SMD 0.62 lower (1.09 to 0.15 lower)	VERY LOW	IMPORTANT
Personality disorder symptoms - 6-month follow-up (follow-up mean 26 weeks; measured with: BSL change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[6]	reporting bias[5]	11	11	-	SMD 0.6 higher (0.26 lower to 1.46 higher)	VERY LOW	IMPORTANT
Personality disorder symptoms - 1-year follow-up (follow-up mean 52 weeks; measured with: BSL change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[8]	reporting bias[5]	11	11	-	SMD 0.27 higher (0.57 lower to 1.11 higher)	VERY LOW	IMPORTANT
Alcohol use disorder symptoms at endpoint (follow-up 6-12 weeks; measured with: AUDIT/SADQ change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Trauma-focused CBT + medication/TAU**	**Medication/TAU-only (or + attention-placebo)**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
2	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[6]	reporting bias[5]	54	51	-	SMD 0.07 lower (0.53 lower to 0.38 higher)	VERY LOW	IMPORTANT
Alcohol use disorder symptoms at 3-5 month follow-up (follow-up 13-22 weeks; measured with: AUDIT/SADQ change score; Better indicated by lower values)												
2	randomised trials	very serious[1]	very serious[2]	no serious indirectness	very serious[8]	reporting bias[5]	54	50	-	SMD 0.01 higher (1.07 lower to 1.09 higher)	VERY LOW	IMPORTANT
Alcohol use disorder symptoms at 9 month follow-up (follow-up mean 39 weeks; measured with: SADQ change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[6]	reporting bias[5]	26	21	-	SMD 0.1 higher (0.48 lower to 0.67 higher)	VERY LOW	IMPORTANT
Alcohol use: Percent days abstinent from alcohol (change score) - 3-month follow-up (follow-up mean 13 weeks; measured with: TLFB; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[6]	none	85	41	-	SMD 0.18 higher (0.19 lower to 0.56 higher)	LOW	IMPORTANT
Alcohol use: Percent days abstinent from alcohol (change score) - 6-month follow-up (follow-up mean 26 weeks; measured with: TLFB; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	85	41	-	SMD 0.11 higher (0.26 lower to 0.48 higher)	LOW	IMPORTANT
Alcohol use: Percent drinking days (change score) - Endpoint (follow-up mean 24 weeks; measured with: TLFB; Better indicated by lower values)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Trauma-focused CBT + medication/TAU**	**Medication/TAU-only (or + attention-placebo)**	**Relative (95% CI)**	**Absolute**		
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[6]	reporting bias[5]	40	42	-	SMD 0.2 higher (0.23 lower to 0.64 higher)	VERY LOW	IMPORTANT
Alcohol use: Percent drinking days (change score) - 6-month follow-up (follow-up mean 26 weeks; measured with: TLFB; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[6]	reporting bias[5]	40	42	-	SMD 0.4 lower (0.84 lower to 0.03 higher)	VERY LOW	IMPORTANT
Alcohol use: Drinks per drinking day (change score) - Endpoint (follow-up mean 12 weeks; measured with: TLFB; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[6]	reporting bias[5]	24	22	-	SMD 0.23 higher (0.35 lower to 0.81 higher)	VERY LOW	IMPORTANT
Alcohol use: Drinks per drinking day (change score) - 5-month follow-up (follow-up mean 22 weeks; measured with: TLFB; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[5]	24	21	-	SMD 0.92 higher (0.3 to 1.54 higher)	VERY LOW	IMPORTANT
Alcohol use: Drinks per drinking day (change score) - 9-month follow-up (follow-up mean 39 weeks; measured with: TLFB; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[6]	reporting bias[5]	26	21	-	SMD 0.33 higher (0.25 lower to 0.91 higher)	VERY LOW	IMPORTANT
Drug use: Percent days abstinent from drugs (change score) - 3-month follow-up (follow-up mean 13 weeks; measured with: TLFB; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious	no serious indirectness	serious[4]	none	85	41	-	SMD 0.48 higher (0.11	LOW	IMPORTANT

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT + medication/TAU	Medication/TAU-only (or + attention-placebo)	Relative (95% CI)	Absolute	Quality	Importance
			inconsistency							to 0.86 higher)		
Drug use: Percent days abstinent from drugs (change score) - 6-month follow-up (follow-up mean 26 weeks; measured with: TLFB; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	85	41	-	SMD 0.82 higher (0.43 to 1.21 higher)	LOW	IMPORTANT
Substance use: Number of days of primary substance use in past 30 days - Endpoint (follow-up mean 12 weeks; measured with: ASI-Lite change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	20	24	-	SMD 1.01 higher (0.37 to 1.64 higher)	VERY LOW	IMPORTANT
Substance use: Number of days of primary substance use in past 30 days - 1-month follow-up (follow-up mean 4 weeks; measured with: ASI-Lite change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[7]	none	20	29	-	SMD 0.68 higher (0.1 to 1.27 higher)		IMPORTANT
Substance use: Number of days of primary substance use in past 30 days - 2-month follow-up (follow-up mean 8 weeks; measured with: ASI-Lite change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	22	24	-	SMD 0.87 higher (0.26 to 1.47 higher)	VERY LOW	IMPORTANT
Substance use: Number of days of primary substance use in past 30 days - 3-month follow-up (follow-up mean 13 weeks; measured with: ASI-Lite change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Trauma-focused CBT + medication/TAU**	**Medication/TAU-only (or + attention-placebo)**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	26	24	-	SMD 0.58 higher (0.01 to 1.14 higher)	VERY LOW	IMPORTANT
Substance dependence remission at endpoint (follow-up 12-13 weeks; assessed with: Number of people no longer meeting diagnostic criteria for substance dependence)												
2	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[8]	none	37/88 (42%)	30/77 (39%)	RR 1.04 (0.6 to 1.8)	16 more per 1000 (from 156 fewer to 312 more)	VERY LOW	IMPORTANT
Substance dependence remission at 5-6 month follow-up (follow-up 22-26 weeks; assessed with: Number of people no longer meeting diagnostic criteria for substance dependence)												
2	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[8]	none	44/88 (50%)	35/77 (45.5%)	RR 1.1 (0.79 to 1.53)	45 more per 1000 (from 95 fewer to 241 more)	VERY LOW	IMPORTANT
Substance dependence remission at 9-month follow-up (follow-up mean 39 weeks; assessed with: Number of people no longer meeting diagnostic criteria for substance dependence)												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[6]	reporting bias[5]	12/33 (36.4%)	12/29 (41.4%)	RR 0.88 (0.47 to 1.64)	50 fewer per 1000 (from 219 fewer to 265 more)	VERY LOW	IMPORTANT
Global functioning - Endpoint (follow-up mean 12 weeks; measured with: GAF change score; Better indicated by higher values)												

Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Trauma-focused CBT + medication/TAU**	**Medication/TAU-only (or + attention-placebo)**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[5]	36	38	-	SMD 1.25 higher (0.75 to 1.75 higher)	VERY LOW	IMPORTANT
Global functioning - 1-month follow-up (follow-up mean 4 weeks; measured with: GAF change score; Better indicated by higher values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[5]	36	38	-	SMD 1.77 higher (1.23 to 2.32 higher)	VERY LOW	IMPORTANT
Global functioning - 3-month follow-up (follow-up mean 13 weeks; measured with: GAF change score; Better indicated by higher values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[5]	36	38	-	SMD 1.48 higher (0.96 to 2 higher)	VERY LOW	IMPORTANT
Functional impairment (follow-up 6-26 weeks; measured with: SDS/M2C change score/SAS endpoint; Better indicated by lower values)												
5	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	140	155	-	SMD 0.53 lower (0.87 to 0.18 lower)	LOW	IMPORTANT
Emotional and behavioural problems: Aggression/Anger - Endpoint (follow-up 2-6 weeks; measured with: AAS/DARS-7 change score; Better indicated by lower values)												
2	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious4	reporting bias[5]	45	44	-	SMD 0.42 lower (0.84 lower to 0 higher)	VERY LOW	IMPORTANT
Emotional and behavioural problems: Aggression/Anger - 3-6 month follow-up (follow-up 13-26 weeks; measured with: AAS/DARS-7 change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT + medication/TAU	Medication/TAU-only (or + attention-placebo)	Relative (95% CI)	Absolute	Quality	Importance
2	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[5]	45	44	-	SMD 0.58 lower (1 to 0.15 lower)	VERY LOW	IMPORTANT
Quality of life - Endpoint (follow-up 3-26 weeks; measured with: WHO-5/SF-12 change score; Better indicated by higher values)												
3	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	102	101	-	SMD 0.06 lower (0.34 lower to 0.21 higher)	LOW	IMPORTANT
Quality of life - 3-4 month follow-up (follow-up 13-17 weeks; measured with: WHO-5/SF-12 change score; Better indicated by higher values)												
2	randomised trials	serious[1]	serious[3]	no serious indirectness	very serious[8]	none	45	47	-	SMD 0.16 higher (0.65 lower to 0.97 higher)	VERY LOW	IMPORTANT
Quality of life - 6-month follow-up (follow-up mean 26 weeks; measured with: SF-12 change score; Better indicated by higher values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[5]	33	20	-	SMD 0.67 higher (0.1 to 1.24 higher)	VERY LOW	IMPORTANT
Quality of life - 1-year follow-up (follow-up mean 52 weeks; measured with: SF-12 change score; Better indicated by higher values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[6]	reporting bias[5]	14	11	-	SMD 0.4 higher (0.4 lower to 1.19 higher)	VERY LOW	IMPORTANT
Relationship difficulties - Endpoint (follow-up mean 6 weeks; measured with: ADAS change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT + medication/TAU	Medication/TAU-only (or + attention-placebo)	Relative (95% CI)	Absolute		
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[5]	30	29	-	SMD 0.86 higher (0.33 to 1.4 higher)	VERY LOW	IMPORTANT
Relationship difficulties - 3-month follow-up (follow-up mean 13 weeks; measured with: ADAS change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[6]	reporting bias[5]	30	29	-	SMD 0.15 higher (0.36 lower to 0.66 higher)	VERY LOW	IMPORTANT
Discontinuation (follow-up 2-26 weeks; assessed with: Number of participants lost to follow-up for any reason)												
35	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	459/1506 (30.5%)	320/1258 (25.4%)	RR 1.19 (1.01 to 1.4)	48 more per 1000 (from 3 more to 102 more)	MODERATE	CRITICAL

AAS=Adult attachment scale; ADAS=Alxheimer's Disease Assesment Scale; ASI= Addition severity index; AUDIT=Alcohol use disorders identification test; BAI= Beck Anxiety Index; BSL=Borderline symptom list; CAPS= Clinician-administered PTSD symptom scale; CBT= cognitive behavioural therapy; CI= confidence interval; CES-D= Centre of Epidemiological Studies-Depression; CIDI-PTSD=; DARS=Drug and alcohol recovery service; DES= Dissociative Experiences Scales; DTS=Davidson Trauma Scale; GAF= Global assessment of functioning; HAM-A/D= Hamilton Rating Scale-Anxiety/Depression; HSCL-25= Hopkins Symptom Checklist-25; HTQ= Harvard Trauma Questionnaire; IES-R= Impact of Event Scale-Revised; MADRS=Montgomery-Asberg Depression Rating Scale; MPSS= Modified PTSD symptom scale; PSS-I/SR= PTSD symptom scale-interview/self-report; PCL= PTSD checklist; PDS= Post-traumatic Diagnositic Scale; PTSD= post-traumatic stress disorder; RR= risk ratio; SADQ=Severity of alcohol dependence questionnaire; SAS= Social Adjustment Scale; SF-12=Short form-12; SI-PTSD= Structured interview for PTSD; SMD= standardised mean difference; STAI= State-Trait Anxiety Inventory; TAU=Treatment as usual; TLFB=Alcohol timeline followback;

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

Table 115: Clinical evidence profile: Trauma-focused CBT (+/- TAU) versus eye movement desensitisation and reprocessing (EMDR; +/- TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT (+/- TAU)	Eye movement desensitisation and reprocessing (EMDR; +/- TAU)	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology self-rated at endpoint (follow-up 6-10 weeks; measured with: IES/IES-R/PSS-SR change score; Better indicated by lower values)												
4	randomised trials	serious[1]	very serious[2]	no serious indirectness	serious[3]	none	66	73	-	SMD 0.6 higher (0.27 lower to 1.48 higher)	VERY LOW	CRITICAL
PTSD symptomatology self-rated at 3-month follow-up (follow-up mean 13 weeks; measured with: PSS-SR change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	15	15	-	SMD 0.41 lower (1.13 lower to 0.32 higher)	LOW	CRITICAL
PTSD symptomatology self-rated at 6-month follow-up (follow-up mean 26 weeks; measured with: PSS-SR change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	19	19	-	SMD 0.46 lower (1.11 lower to 0.18 higher)	LOW	CRITICAL
PTSD symptomatology clinician-rated at endpoint (follow-up 6-16 weeks; measured with: CAPS/SI-PTSD change score; Better indicated by lower values)												
5	randomised trials	serious[1]	serious[4]	no serious indirectness	serious[3]	none	97	107	-	SMD 0.2 higher (0.23 lower to 0.63 higher)	VERY LOW	CRITICAL
PTSD symptomatology clinician-rated at 3-month follow-up (follow-up mean 13 weeks; measured with: CAPS change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Trauma-focused CBT (+/- TAU)**	**Eye movement desensitisation and reprocessing (EMDR; +/- TAU)**	**Relative (95% CI)**	**Absolute**		
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	15	15	-	SMD 0.25 lower (0.97 lower to 0.47 higher)	LOW	CRITICAL
PTSD symptomatology clinician-rated at 6-month follow-up (follow-up mean 26 weeks; measured with: CAPS change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[5]	none	19	19	-	SMD 0.07 lower (0.7 lower to 0.57 higher)	VERY LOW	CRITICAL
Remission at endpoint (follow-up 6-8 weeks; assessed with: Number of people no longer meeting diagnostic criteria or no longer above clinical threshold on scale for PTSD)												
4	randomised trials	serious[1]	very serious[2]	no serious indirectness	very serious[5]	none	64/125 (51.2%)	73/105 (69.5%)	RR 0.84 (0.35 to 2.04)	111 fewer per 1000 (from 452 fewer to 723 more)	VERY LOW	CRITICAL
Remission at 3-month follow-up (follow-up mean 13 weeks; assessed with: Number of people no longer above clinical threshold on scale for PTSD)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[5]	none	7/22 (31.8%)	4/19 (21.1%)	RR 1.51 (0.52 to 4.38)	107 more per 1000 (from 101 fewer to 712 more)	VERY LOW	CRITICAL
Remission at 6-month follow-up (follow-up mean 26 weeks; assessed with: Number of people no longer meeting diagnostic criteria for PTSD)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Trauma-focused CBT (+/- TAU)**	**Eye movement desensitisation and reprocessing (EMDR; +/- TAU)**	**Relative (95% CI)**	**Absolute**		
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	19/23 (82.6%)	15/25 (60%)	RR 1.38 (0.95 to 2)	228 more per 1000 (from 30 fewer to 600 more)	LOW	CRITICAL
Response self-rated at endpoint (follow-up mean 10 weeks; assessed with: Number of people showing clinically significant improvement based on reliable change indices (RCI) on IES)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	reporting bias6	9/37 (24.3%)	17/39 (43.6%)	RR 0.56 (0.29 to 1.09)	192 fewer per 1000 (from 309 fewer to 39 more)	VERY LOW	CRITICAL
Response self-rated at 15-month follow-up (follow-up mean 65 weeks; assessed with: Number of people showing clinically significant improvement based on reliable change indices (RCI) on IES)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[5]	reporting bias[6]	6/37 (16.2%)	10/39 (25.6%)	RR 0.63 (0.26 to 1.57)	95 fewer per 1000 (from 190 fewer to 146 more)	VERY LOW	CRITICAL
Dissociative symptoms at endpoint (follow-up mean 6 weeks; measured with: DES/CAPS dissociation cluster change score; Better indicated by lower values)												
2	randomised trials	serious[1]	serious[4]	no serious indirectness	serious[3]	none	35	35	-	SMD 0.41 higher (0.36 lower to 1.18 higher)	VERY LOW	IMPORTANT

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT (+/- TAU)	Eye movement desensitisation and reprocessing (EMDR; +/- TAU)	Relative (95% CI)	Absolute	Quality	Importance
Dissociative symptoms at 3-month follow-up (follow-up mean 13 weeks; measured with: CAPS dissociation cluster change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[5]	none	15	15	-	SMD 0 higher (0.72 lower to 0.72 higher)	VERY LOW	IMPORTANT
Dissociative symptoms at 6-month follow-up (follow-up mean 26 weeks; measured with: DES change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	19	19	-	SMD 0.47 higher (0.17 lower to 1.12 higher)	LOW	IMPORTANT
Anxiety symptoms at endpoint (follow-up 6-16 weeks; measured with: STAI State/HADS-A/HAM-A change score; Better indicated by lower values)												
4	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[7]	reporting bias[6]	93	109	-	SMD 0.62 higher (0.33 to 0.9 higher)	VERY LOW	IMPORTANT
Anxiety symptoms at 6-month follow-up (follow-up mean 26 weeks; measured with: STAI State change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	19	19	-	SMD 0.21 lower (0.85 lower to 0.43 higher)	LOW	IMPORTANT
Depression symptoms at endpoint (follow-up 6-16 weeks; measured with: BDI/BDI-II/HADS-D/MADRS change score; Better indicated by lower values)												
5	randomised trials	serious[1]	serious[4]	no serious indirectness	serious[7]	reporting bias[6]	108	124	-	SMD 0.53 higher (0.19 to	VERY LOW	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Trauma-focused CBT (+/- TAU)**	**Eye movement desensitisation and reprocessing (EMDR; +/- TAU)**	**Relative (95% CI)**	**Absolute**		
										0.86 higher)		
Depression symptoms at 3-month follow-up (follow-up mean 13 weeks; measured with: BDI change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[5]	none	15	15	-	SMD 0.22 higher (0.5 lower to 0.93 higher)	VERY LOW	IMPORTANT
Depression symptoms at 6-month follow-up (follow-up mean 26 weeks; measured with: BDI change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	19	19	-	SMD 0.48 higher (0.17 lower to 1.13 higher)	LOW	IMPORTANT
Functional impairment (follow-up mean 10 weeks; measured with: SDS change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[7]	reporting bias[6]	21	27	-	SMD 0.66 higher (0.07 to 1.25 higher)	VERY LOW	IMPORTANT
Discontinuation (follow-up 6-16 weeks; assessed with: Number of participants lost to follow-up for any reason)												
6	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	54/172 (31.4%)	40/174 (23%)	RR 1.38 (0.98 to 1.94)	87 more per 1000 (from 5 fewer to 216 more)	LOW	CRITICAL

BDI=Beck Depression Inventory; CAPS= Clinician-administered PTSD symptom scale; CBT= cognitive behavioural therapy; CI= confidence interval; DES= Dissociative Experiences Scales; EMDR=Eye movement desensitisation and reprocessing; HADS-A/D=; HAM-A= Hamilton Rating Scale for Anxiety; IES-R=Impact of Event Scale-Revised; MADRS= Montgomery-Asberg Depression Rating Scale; PSS-SR= PTSD symptom scale-self-report; PTSD= post-traumatic stress disorder; RR= risk ratio; SDS=Self-rating Depression Scale; SI-PTSD=; STAI= Structured interview for PTSD; SMD=Standardised mean difference; TAU=Treatment as usual

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

[2] *Considerable heterogeneity (I2>80%)*

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

[4] *Substantial heterogeneity (I2=50-80%)*

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

[6] *Data is not reported/cannot be extracted for all outcomes*

[7] *OIS not met (N<400)*

Table 116: Clinical evidence profile: Trauma-focused CBT (+/-TAU) versus non-trauma-focused CBT (+/- TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT (+/-TAU)	Non-trauma-focused CBT (+/-TAU)	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology self-rated at 1-month follow-up (follow-up mean 4 weeks; measured with: PCL change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	44	55	-	SMD 0.02 higher (0.37 lower to 0.42 higher)	VERY LOW	CRITICAL
PTSD symptomatology self-rated at 3-month follow-up (follow-up mean 13 weeks; measured with: PCL change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[3]	43	55	-	SMD 0.16 higher (0.24 lower to 0.56 higher)	VERY LOW	CRITICAL
PTSD symptomatology self-rated at 6-month follow-up (follow-up mean 26 weeks; measured with: PCL change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Trauma-focused CBT (+/- TAU)**	**Non-trauma-focused CBT (+/- TAU)**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[3]	42	51	-	SMD 0.21 higher (0.2 lower to 0.62 higher)	VERY LOW	CRITICAL
PTSD symptomatology clinician-rated at endpoint (follow-up mean 5 weeks; measured with: PSS-I change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[3]	10	14	-	SMD 0.47 higher (0.35 lower to 1.3 higher)	VERY LOW	CRITICAL
PTSD symptomatology clinician-rated at 1-3 month follow-up (follow-up 4-13 weeks; measured with: CAPS change score; Better indicated by lower values)												
2	randomised trials	serious[1]	serious[5]	no serious indirectness	serious[4]	reporting bias[3]	56	65	-	SMD 0.53 lower (1.35 lower to 0.3 higher)	VERY LOW	CRITICAL
PTSD symptomatology clinician-rated at 6-month follow-up (follow-up mean 26 weeks; measured with: CAPS change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	12	10	-	SMD 1.36 lower (2.31 to 0.41 lower)	VERY LOW	CRITICAL
Remission at endpoint (follow-up mean 5 weeks; assessed with: Number of people no longer meeting diagnostic criteria for PTSD)												

Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Trauma-focused CBT (+/- TAU)**	**Non-trauma-focused CBT (+/- TAU)**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[6]	reporting bias[3]	4/14 (28.6%)	7/17 (41.2%)	RR 0.69 (0.25 to 1.89)	128 fewer per 1000 (from 309 fewer to 366 more)	VERY LOW	CRITICAL
Remission at 1-month follow-up (follow-up mean 4 weeks; assessed with: Number of people no longer meeting diagnostic criteria for PTSD)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[6]	reporting bias[3]	3/15 (20%)	0/13 (0%)	RR 6.12 (0.35 to 108.58)	-	VERY LOW	CRITICAL
Remission at 6-month follow-up (follow-up mean 26 weeks; assessed with: Number of people no longer meeting diagnostic criteria for PTSD)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[6]	reporting bias[3]	2/15 (13.3%)	2/13 (15.4%)	RR 0.87 (0.14 to 5.32)	20 fewer per 1000 (from 132 fewer to 665 more)	VERY LOW	CRITICAL
Remission at 1-year follow-up (follow-up mean 52 weeks; assessed with: Number of people no longer meeting diagnostic criteria for PTSD)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[6]	reporting bias[3]	3/15 (20%)	2/13 (15.4%)	RR 1.3 (0.26 to 6.62)	46 more per 1000 (from 114 fewer to 865 more)	VERY LOW	CRITICAL
Response clinician-rated at endpoint (follow-up mean 5 weeks; assessed with: Number of people showing clinically significant improvement based on reliable change indices (RCI) on PSS-I)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT (+/- TAU)	Non-trauma-focused CBT (+/- TAU)	Relative (95% CI)	Absolute		
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[3]	4/14 (28.6%)	10/17 (58.8%)	RR 0.49 (0.19 to 1.22)	300 fewer per 1000 (from 476 fewer to 129 more)	VERY LOW	CRITICAL
Anxiety symptoms (follow-up mean 5 weeks; measured with: STAI State change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[6]	reporting bias[3]	10	14	-	SMD 0.09 higher (0.72 lower to 0.9 higher)	VERY LOW	IMPORTANT
Depression symptoms at endpoint (follow-up mean 5 weeks; measured with: BDI change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[3]	10	14	-	SMD 0.39 higher (0.43 lower to 1.21 higher)	VERY LOW	IMPORTANT
Depression symptoms at 1-month follow-up (follow-up mean 4 weeks; measured with: BDI/HAMD change score; Better indicated by lower values)												
2	randomised trials	serious[1]	serious[5]	no serious indirectness	serious[4]	reporting bias[3]	54	65	-	SMD 0.48 lower (1.3 lower to 0.33 higher)	VERY LOW	IMPORTANT
Depression symptoms at 3-month follow-up (follow-up mean 13 weeks; measured with: BDI change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT (+/- TAU)	Non-trauma-focused CBT (+/- TAU)	Relative (95% CI)	Absolute	Quality	Importance
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[3]	44	54	-	SMD 0.26 lower (0.66 lower to 0.14 higher)	VERY LOW	IMPORTANT
Depression symptoms at 6-month follow-up (follow-up mean 26 weeks; measured with: BDI/HAMD change score; Better indicated by lower values)												
2	randomised trials	serious[1]	serious[5]	no serious indirectness	serious[4]	reporting bias[3]	53	61	-	SMD 0.7 lower (1.84 lower to 0.45 higher)	VERY LOW	IMPORTANT
Sleeping difficulties - 1-month follow-up (follow-up mean 4 weeks; measured with: PSQI change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[3]	44	53	-	SMD 0.1 lower (0.5 lower to 0.3 higher)	VERY LOW	IMPORTANT
Sleeping difficulties - 3-month follow-up (follow-up mean 13 weeks; measured with: PSQI change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[3]	46	54	-	SMD 0.12 higher (0.27 lower to 0.52 higher)	VERY LOW	IMPORTANT
Sleeping difficulties - 6-month follow-up (follow-up mean 26 weeks; measured with: PSQI change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[3]	46	53	-	SMD 0.17 lower (0.57 lower to	VERY LOW	IMPORTANT

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT (+/- TAU)	Non-trauma-focused CBT (+/- TAU)	Relative (95% CI)	Absolute	Quality	Importance
										0.23 higher)		
Quality of life - 1-month follow-up (follow-up mean 4 weeks; measured with: SF-36 MH change score; Better indicated by higher values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	42	53	-	SMD 0.56 higher (0.15 to 0.97 higher)	VERY LOW	IMPORTANT
Quality of life - 3-month follow-up (follow-up mean 13 weeks; measured with: SF-36 MH change score; Better indicated by higher values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[3]	43	54	-	SMD 0.24 higher (0.16 lower to 0.64 higher)	VERY LOW	IMPORTANT
Quality of life - 6-month follow-up (follow-up mean 26 weeks; measured with: SF-36 MH change score; Better indicated by higher values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[3]	39	52	-	SMD 0.29 higher (0.13 lower to 0.71 higher)	VERY LOW	IMPORTANT
Discontinuation (follow-up 5-13 weeks; assessed with: Number of participants lost to follow-up for any reason)												
3	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[7]	none	24/90 (26.7%)	13/93 (14%)	RR 1.86 (1.01 to 3.43)	120 more per 1000 (from 1 more to 340 more)	LOW	CRITICAL

BDI=Beck Depression Inventory; CAPS=Clinician-administered PTSD scale; CBT=cognitive behavioural therapy; CI=confidence interval; HAMD=Hamilton depression scale; PCL=PTSD checklist; PSS-I=PTSD Symptom Scale-Interview; PSQI=Pittsburgh Sleep Quality Index; PTSD=post-traumatic stress disorder; RR=risk ratio; SF-36=Short form 36; SMD=standardised mean difference; STAI=State-Trait Anxiety Inventory; TAU=treatment as usual

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

[2] *OIS not met (N<400)*

[3] *Data is not reported/cannot be extracted for all outcomes*

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

[5] *Substantial heterogeneity (I2=50-80%)*

[6] *95% CI crosses line of no effect and threshold for both clinically important benefit and clinically important harm*

[7] *OIS not met (events<300)*

Table 117: Clinical evidence profile: Trauma-focused CBT (+/- TAU) versus counselling (+/- TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Trauma-focused CBT (+/- TAU)**	**Counselling (+/- TAU)**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
PTSD symptomatology self-rated at endpoint (follow-up 3-16 weeks; measured with: PCL/PDS/PSS-SR change score; Better indicated by lower values)												
6	randomised trials	serious[1]	serious[2]	no serious indirectness	serious[3]	none	143	134	-	SMD 0.58 lower (1.11 to 0.05 lower)	VERY LOW	CRITICAL
PTSD symptomatology self-rated at 2-4 month follow-up (follow-up 8-17 weeks; measured with: PCL/PDS/PSS-SR change score; Better indicated by lower values)												
5	randomised trials	serious[1]	serious[2]	no serious indirectness	serious[4]	reporting bias[5]	216	218	-	SMD 0.38 lower (0.81 lower to 0.05 higher)	VERY LOW	CRITICAL
PTSD symptomatology self-rated at 6-8 month follow-up (follow-up 26-34 weeks; measured with: PCL/PDS/PSS-SR change score; Better indicated by lower values)												
4	randomised trials	serious[1]	very serious[6]	no serious indirectness	serious[4]	none	199	193	-	SMD 0.3 lower (0.83 lower to 0.24 higher)	VERY LOW	CRITICAL
PTSD symptomatology self-rated at 1-year follow-up (follow-up mean 52 weeks; measured with: PCL/PDS change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Trauma-focused CBT (+/- TAU)**	**Counselling (+/- TAU)**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
2	randomised trials	serious[1]	very serious[6]	no serious indirectness	very serious[7]	reporting bias[5]	42	37	-	SMD 0.91 lower (2.78 lower to 0.95 higher)	VERY LOW	CRITICAL
PTSD symptomatology self-rated at 2-year follow-up (follow-up mean 104 weeks; measured with: PCL change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[5]	22	17	-	SMD 0.54 lower (1.18 lower to 0.11 higher)	VERY LOW	CRITICAL
PTSD symptomatology clinician-rated at endpoint (follow-up 5-16 weeks; measured with: CAPS/PSS-I change score; Better indicated by lower values)												
6	randomised trials	serious[1]	very serious[6]	no serious indirectness	serious[3]	reporting bias[5]	158	163	-	SMD 1.04 lower (1.73 to 0.36 lower)	VERY LOW	CRITICAL
PTSD symptomatology clinician-rated at 3-month follow-up (follow-up mean 13 months; measured with: CAPS change score; Better indicated by lower values)												
3	randomised trials	serious[1]	serious[2]	no serious indirectness	serious[3]	none	90	94	-	SMD 0.89 lower (1.42 to 0.37 lower)	VERY LOW	CRITICAL
PTSD symptomatology clinician-rated at 6-month follow-up (follow-up mean 26 months; measured with: CAPS change score; Better indicated by lower values)												
2	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	64	68	-	SMD 0.85 lower (1.2 to 0.49 lower)	LOW	CRITICAL
PTSD symptomatology clinician-rated at 1-year follow-up (follow-up mean 52 weeks; measured with: CAPS/PSS-I/CIDI-PTSD change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Trauma-focused CBT (+/- TAU)**	**Counselling (+/- TAU)**	**Relative (95% CI)**	**Absolute**		
3	randomised trials	serious[1]	very serious[6]	no serious indirectness	serious[3]	reporting bias[5]	57	52	-	SMD 1.62 lower (2.87 to 0.38 lower)	VERY LOW	CRITICAL
PTSD symptomatology clinician-rated at 2-year follow-up (follow-up mean 104 weeks; measured with: CAPS change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[5]	22	17	-	SMD 0.53 lower (1.17 lower to 0.12 higher)	VERY LOW	CRITICAL
Remission at endpoint (follow-up 5-16 weeks; assessed with: Number of people no longer meeting diagnostic criteria or no longer above threshold on a scale for PTSD)												
6	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[8]	none	89/170 (52.4%)	45/150 (30%)	RR 1.63 (1.25 to 2.13)	189 more per 1000 (from 75 more to 339 more)	LOW	CRITICAL
Remission at 3-month follow-up (follow-up mean 13 weeks; assessed with: Number of people no longer meeting diagnostic criteria or no longer above threshold on a scale for PTSD)												
2	randomised trials	serious[1]	serious[2]	no serious indirectness	serious[8]	reporting bias[5]	37/52 (71.2%)	12/48 (25%)	RR 2.68 (1.29 to 5.59)	420 more per 1000 (from 72 more to 1000 more)	VERY LOW	CRITICAL
Remission at 6-8 month follow-up (follow-up 26-34 weeks; assessed with: Number of people no longer meeting diagnostic criteria or no longer above threshold on a scale for PTSD)												

Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Trauma-focused CBT (+/- TAU)**	**Counselling (+/- TAU)**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
5	randomised trials	serious[1]	serious[2]	no serious indirectness	serious[8]	none	105/246 (42.7%)	63/226 (27.9%)	RR 1.64 (1.1 to 2.44)	178 more per 1000 (from 28 more to 401 more)	VERY LOW	CRITICAL
Remission at 1-year follow-up (follow-up mean 52 weeks; assessed with: Number of people no longer meeting diagnostic criteria for PTSD)												
2	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[8]	reporting bias[5]	28/38 (73.7%)	12/32 (37.5%)	RR 1.86 (1.19 to 2.91)	322 more per 1000 (from 71 more to 716 more)	VERY LOW	CRITICAL
Response clinician-rated (follow-up mean 5 weeks; assessed with: Number of people showing clinically significant improvement on PSS-I based on reliable change indices (RCI))												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[7]	reporting bias[5]	4/14 (28.6%)	2/14 (14.3%)	RR 2 (0.43 to 9.21)	143 more per 1000 (from 81 fewer to 1000 more)	VERY LOW	CRITICAL
Anxiety symptoms at endpoint (follow-up 5-16 weeks; measured with: BAI/STAI State/BSI Anxiety/HAM-A change score; Better indicated by lower values)												
8	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	193	165	-	SMD 0.93 lower (1.2 to 0.67 lower)	LOW	IMPORTANT
Anxiety symptoms at 3-month follow-up (follow-up mean 13 weeks; measured with: BAI/STAI State change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT (+/- TAU)	Counselling (+/- TAU)	Relative (95% CI)	Absolute	Quality	Importance
3	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	90	94	-	SMD 0.7 lower (1 to 0.4 lower)	LOW	IMPORTANT
Anxiety symptoms at 6-8 month follow-up (follow-up 26-34 weeks; measured with: BAI/STAI State/HAM-A change score; Better indicated by lower values)												
4	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	128	100	-	SMD 0.81 lower (1.2 to 0.41 lower)	LOW	IMPORTANT
Anxiety symptoms at 1-year follow-up (follow-up mean 52 weeks; measured with: STAI State change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	reporting bias[5]	28	24	-	SMD 0.88 lower (1.45 to 0.3 lower)	VERY LOW	IMPORTANT
Anxiety symptoms at 2-year follow-up (follow-up mean 104 weeks; measured with: STAI State change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	reporting bias[5]	22	17	-	SMD 0.72 lower (1.38 to 0.07 lower)	VERY LOW	IMPORTANT
Depression symptoms at endpoint (follow-up 5-16 weeks; measured with: BDI/BDI-II/BDI-13/BSI Depression change score; Better indicated by lower values)												
8	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	193	165	-	SMD 0.42 lower (0.68 to 0.17 lower)	LOW	IMPORTANT
Depression symptoms at 3-month follow-up (follow-up mean 13 weeks; measured with: BDI/BDI-II change score; Better indicated by lower values)												
3	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	90	94	-	SMD 0.15 lower (0.44 lower to 0.14 higher)	LOW	IMPORTANT
Depression symptoms at 6-8 month follow-up (follow-up 26-34 weeks; measured with: BDI-II/BDI-13 change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT (+/- TAU)	Counselling (+/- TAU)	Relative (95% CI)	Absolute		
4	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	128	100	-	SMD 0.46 lower (0.73 to 0.19 lower)	LOW	IMPORTANT
Depression symptoms at 1-year follow-up (follow-up mean 52 weeks; measured with: BDI change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[5]	28	24	-	SMD 0.09 lower (0.63 lower to 0.46 higher)	VERY LOW	IMPORTANT
Depression symptoms at 2-year follow-up (follow-up mean 104 weeks; measured with: BDI change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[5]	22	17	-	SMD 0.23 lower (0.87 lower to 0.4 higher)	VERY LOW	IMPORTANT
Functional impairment - Endpoint (follow-up mean 14 weeks; measured with: SDS change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	31	30	-	SMD 0.92 lower (1.45 to 0.39 lower)	LOW	IMPORTANT
Functional impairment - 3-month follow-up (follow-up mean 13 weeks; measured with: SDS change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	31	30	-	SMD 1.01 lower (1.55 to 0.48 lower)	LOW	IMPORTANT
Functional impairment - 6-month follow-up (follow-up mean 26 weeks; measured with: SDS change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	31	30	-	SMD 0.92 lower (1.44	LOW	IMPORTANT

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT (+/- TAU)	Counselling (+/- TAU)	Relative (95% CI)	Absolute	Quality	Importance
										to 0.39 lower)		
Global functioning - Endpoint (follow-up mean 12 weeks; measured with: GAF change score; Better indicated by higher values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	reporting bias[5]	27	27	-	SMD 1.55 higher (0.94 to 2.17 higher)	VERY LOW	IMPORTANT
Global functioning - 3-month follow-up (follow-up mean 13 weeks; measured with: GAF change score; Better indicated by higher values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	reporting bias[5]	26	26	-	SMD 1.1 higher (0.51 to 1.68 higher)	VERY LOW	IMPORTANT
Global functioning - 1-year follow-up (follow-up mean 52 weeks; measured with: GAF change score; Better indicated by higher values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	reporting bias[5]	28	24	-	SMD 0.68 higher (0.12 to 1.25 higher)	VERY LOW	IMPORTANT
Global functioning - 2-year follow-up (follow-up mean 104 weeks; measured with: GAF change score; Better indicated by higher values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[5]	22	17	-	SMD 0.37 higher (0.27 lower to 1.01 higher)	VERY LOW	IMPORTANT
Relationship difficulties - Endpoint (follow-up mean 16 weeks; measured with: IIP change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	33	38	-	SMD 0.12 lower (0.58 lower to 0.35 higher)	LOW	IMPORTANT

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT (+/- TAU)	Counselling (+/- TAU)	Relative (95% CI)	Absolute	Quality	Importance
Relationship difficulties - 3-month follow-up (follow-up mean 13 weeks; measured with: IIP change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	33	38	-	SMD 0.98 lower (1.48 to 0.49 lower)	LOW	IMPORTANT
Relationship difficulties - 6-month follow-up (follow-up mean 26 weeks; measured with: IIP change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	33	38	-	SMD 0.89 lower (1.38 to 0.4 lower)	LOW	IMPORTANT
Quality of life at endpoint (follow-up 3-16 weeks; measured with: QOLI/Q-LES-Q-SF/SF-12 change score; Better indicated by higher values)												
3	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	reporting bias[5]	90	85	-	SMD 0.7 higher (0.39 to 1.01 higher)	VERY LOW	IMPORTANT
Quality of life at 3-4 month follow-up (follow-up 13-17 weeks; measured with: Q-LES-Q-SF/SF-12 change score; Better indicated by higher values)												
2	randomised trials	serious[1]	serious[2]	no serious indirectness	serious[3]	none	46	43	-	SMD 0.89 higher (0.21 to 1.56 higher)	VERY LOW	IMPORTANT
Quality of life at 6-month follow-up (follow-up mean 26 weeks; measured with: Q-LES-Q-SF change score; Better indicated by higher values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	31	30	-	SMD 0.86 higher (0.33 to 1.38 higher)	LOW	IMPORTANT
Quality of life at 1-year follow-up (follow-up mean 52 weeks; measured with: SF-12 change score; Better indicated by higher values)												

Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Trauma-focused CBT (+/- TAU)**	**Counselling (+/- TAU)**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	reporting bias[5]	14	13	-	SMD 1.3 higher (0.45 to 2.14 higher)	VERY LOW	IMPORTANT
Discontinuation (follow-up 3-16 weeks; assessed with: Number of participants lost to follow-up for any reason)												
11	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	101/390 (25.9%)	110/364 (30.2%)	RR 0.89 (0.67 to 1.17)	33 fewer per 1000 (from 100 fewer to 51 more)	LOW	CRITICAL

BAI=Beck Depression Inventory; BDI=Beck Depression Inventory; BSI=Brief Symptom Inventory; CAPS=Clinician-administered PTSD scale; CI=confidence interval; CIDI-PTSD=Composite International Diagnostic Interview-PTSD; GAF=Global Assessment of functioning; HAM-A=Hamilton anxiety rating scale; IIP=Inventory of Interpersonal problems; PCL=PTSD checklist; PDS=PTSD Diagnostic Scale; PSS-I/SR=PTSD symptom scale-interview/self-report; PTSD=post-traumatic stress disorder; RR=risk ratio; SDS=Sheehan Disability Scale; SF-12=Short form-12; SMD=standardised mean difference; STAI=State-Trait Anxiety Inventory; Q-LES-Q-SF=Quality of Life Enjoyment and Statisfaction Questionnaires; QOLI=Quality of life inventory;

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

Table 118: Clinical evidence profile: Trauma-focused CBT (+/- TAU) versus present-centered therapy (+/- TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT (+/- TAU)	Present-centered therapy (+/- TAU)	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology self-rated at endpoint (follow-up 10-30 weeks; measured with: PCL change score; Better indicated by lower values)												
4	randomised trials	serious[1]	very serious[2]	no serious indirectness	serious[3]	none	402	364	-	SMD 1.29 lower (2.59 lower to 0.02 higher)	VERY LOW	CRITICAL
PTSD symptomatology self-rated at 2-3 month follow-up (follow-up 8-13 weeks; measured with: PCL change score; Better indicated by lower values)												
2	randomised trials	serious[1]	very serious[2]	no serious indirectness	very serious[4]	none	193	177	-	SMD 2.83 lower (6.62 lower to 0.97 higher)	VERY LOW	CRITICAL
PTSD symptomatology self-rated at 4-month follow-up (follow-up mean 17 weeks; measured with: PCL change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	52	34	-	SMD 0.26 lower (0.7 lower to 0.17 higher)	VERY LOW	CRITICAL
PTSD symptomatology self-rated at 6-month follow-up (follow-up mean 26 weeks; measured with: PCL change score; Better indicated by lower values)												
2	randomised trials	serious[1]	very serious[2]	no serious indirectness	very serious[4]	none	193	177	-	SMD 2.43 lower (5.8 lower to 0.94 higher)	VERY LOW	CRITICAL
PTSD symptomatology clinician-rated at endpoint (follow-up 10-30 weeks; measured with: CAPS change score; Better indicated by lower values)												
6	randomised trials	serious[1]	very serious[2]	no serious indirectness	no serious imprecision	none	493	477	-	SMD 0.65 lower (1.17	VERY LOW	CRITICAL

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT (+/- TAU)	Present-centered therapy (+/- TAU)	Relative (95% CI)	Absolute	Quality	Importance
										to 0.14 lower)		
PTSD symptomatology clinician-rated at 1-3 month follow-up (follow-up 4-13 weeks; measured with: CAPS change score; Better indicated by lower values)												
4	randomised trials	serious[1]	very serious[2]	no serious indirectness	no serious imprecision	none	308	294	-	SMD 0.91 lower (1.7 to 0.13 lower)	VERY LOW	CRITICAL
PTSD symptomatology clinician-rated at 4-month follow-up (follow-up mean 17 weeks; measured with: CAPS change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[5]	none	52	34	-	SMD 1.6 lower (2.1 to 1.1 lower)	VERY LOW	CRITICAL
PTSD symptomatology clinician-rated at 6-month follow-up (follow-up mean 26 weeks; measured with: CAPS change score; Better indicated by lower values)												
4	randomised trials	serious[1]	very serious[2]	no serious indirectness	no serious imprecision	none	308	294	-	SMD 0.55 lower (1.04 to 0.06 lower)	VERY LOW	CRITICAL
Remission at endpoint (follow-up 10-20 weeks; assessed with: Number of people no longer meeting diagnostic criteria for PTSD)												
3	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	reporting bias[6]	92/268 (34.3%)	59/263 (22.4%)	RR 1.44 (0.97 to 2.13)	99 more per 1000 (from 7 fewer to 253 more)	VERY LOW	CRITICAL
Remission at 1-3 month follow-up (follow-up 4-13 weeks; assessed with: Number of people no longer meeting diagnostic criteria for PTSD)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT (+/- TAU)	Present-centered therapy (+/- TAU)	Relative (95% CI)	Absolute		
3	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[7]	none	103/256 (40.2%)	75/260 (28.8%)	RR 1.42 (1.12 to 1.8)	121 more per 1000 (from 35 more to 231 more)	LOW	CRITICAL
Remission at 6-month follow-up (follow-up mean 26 weeks; assessed with: Number of people no longer meeting diagnostic criteria for PTSD)												
3	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	reporting bias[6]	97/256 (37.9%)	86/260 (33.1%)	RR 1.19 (0.85 to 1.68)	63 more per 1000 (from 50 fewer to 225 more)	VERY LOW	CRITICAL
Response clinician-rated at endpoint (follow-up 10-30 weeks; assessed with: Number of people showing clinically significant improvement based on reliable change indices (RCI) on PSS-I/at least 10-point improvement on CAPS)												
3	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	172/339 (50.7%)	154/341 (45.2%)	RR 1.15 (0.99 to 1.33)	68 more per 1000 (from 5 fewer to 149 more)	LOW	CRITICAL
Response clinician-rated at 3-month follow-up (follow-up mean 13 weeks; assessed with: Number of people showing at least 10-point improvement on CAPS)												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious[3]	none	110/141 (78%)	102/143 (71.3%)	RR 1.09 (0.95 to 1.25)	64 more per 1000 (from 36 fewer to 178 more)	MODERATE	CRITICAL

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT (+/- TAU)	Present-centered therapy (+/- TAU)	Relative (95% CI)	Absolute	Quality	Importance
Response clinician-rated at 6-month follow-up (follow-up mean 26 weeks; assessed with: Number of people showing at least 10-point improvement on CAPS)												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious[7]	none	97/141 (68.8%)	98/143 (68.5%)	RR 1 (0.86 to 1.17)	0 fewer per 1000 (from 96 fewer to 117 more)	MODERATE	CRITICAL
Dissociative symptoms - Endpoint (ITT analysis) (follow-up mean 20 weeks; measured with: DES change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	reporting bias[6]	29	22	-	SMD 0.34 higher (0.22 lower to 0.89 higher)	VERY LOW	IMPORTANT
Dissociative symptoms - 3-month follow-up (completer analysis) (follow-up mean 13 weeks; measured with: DES change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	reporting bias[6]	17	17	-	SMD 0.47 lower (1.15 lower to 0.21 higher)	VERY LOW	IMPORTANT
Dissociative symptoms - 6-month follow-up (completer analysis) (follow-up mean 26 weeks; measured with: DES change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	reporting bias[6]	17	17	-	SMD 0.6 lower (1.29 lower to 0.09 higher)	VERY LOW	IMPORTANT
Anxiety symptoms at endpoint (follow-up 10-20 weeks; measured with: BAI/STAI State/BSI Anxiety change score; Better indicated by lower values)												
4	randomised trials	serious[1]	very serious[2]	no serious indirectness	serious[3]	reporting bias[6]	315	289	-	SMD 0.09 lower (0.6	VERY LOW	IMPORTANT

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT (+/- TAU)	Present-centered therapy (+/- TAU)	Relative (95% CI)	Absolute	Quality	Importance
										lower to 0.42 higher)		
Anxiety symptoms at 3-month follow-up (follow-up mean 13 weeks; measured with: BAI/STAI State change score; Better indicated by lower values)												
3	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	reporting bias[6]	256	260	-	SMD 0.16 lower (0.43 lower to 0.11 higher)	LOW	IMPORTANT
Anxiety symptoms at 6-month follow-up (follow-up mean 26 weeks; measured with: BAI/STAI State change score; Better indicated by lower values)												
3	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	256	260	-	SMD 0.09 lower (0.26 lower to 0.08 higher)	MODERATE	IMPORTANT
Depression symptoms at endpoint (follow-up 10-20 weeks; measured with: BDI/BDI-II/QIDS/BSI Depression change score; Better indicated by lower values)												
5	randomised trials	very serious[1]	very serious[2]	no serious indirectness	serious[3]	reporting bias[6]	367	323	-	SMD 0.44 lower (1.18 lower to 0.29 higher)	VERY LOW	IMPORTANT
Depression symptoms at 2-3 month follow-up (follow-up 8-13 weeks; measured with: BDI/BDI-II/QIDS change score; Better indicated by lower values)												
4	randomised trials	serious[1]	very serious[2]	no serious indirectness	no serious imprecision	none	308	294	-	SMD 0.77 lower (1.34 to 0.19 lower)	VERY LOW	IMPORTANT
Depression symptoms at 4-month follow-up (follow-up mean 17 weeks; measured with: QIDS change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Trauma-focused CBT (+/- TAU)**	**Present-centered therapy (+/- TAU)**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[5]	none	52	34	-	SMD 2.13 lower (2.67 to 1.59 lower)	VERY LOW	IMPORTANT
Depression symptoms at 6-month follow-up (follow-up mean 26 weeks; measured with: BDI/BDI-II/QIDS change score; Better indicated by lower values)												
4	randomised trials	serious[1]	very serious[2]	no serious indirectness	no serious imprecision	reporting bias[6]	308	294	-	SMD 1.23 lower (2.2 to 0.27 lower)	VERY LOW	IMPORTANT
Emotional and behavioural problems: Anger - Endpoint (ITT analysis) (follow-up mean 20 weeks; measured with: STAXI change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	reporting bias[6]	29	22	-	SMD 0.41 lower (0.97 lower to 0.15 higher)	VERY LOW	IMPORTANT
Emotional and behavioural problems: Anger - 3-month follow-up (completer analysis) (follow-up mean 13 weeks; measured with: STAXI change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[4]	reporting bias[6]	17	17	-	SMD 0.02 higher (0.65 lower to 0.7 higher)	VERY LOW	IMPORTANT
Emotional and behavioural problems: Anger - 6-month follow-up (completer analysis) (follow-up mean 26 weeks; measured with: STAXI change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	reporting bias[6]	17	17	-	SMD 0.51 lower (1.2 lower to 0.17 higher)	VERY LOW	IMPORTANT

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT (+/- TAU)	Present-centered therapy (+/- TAU)	Relative (95% CI)	Absolute	Quality	Importance
Quality of life - Endpoint (follow-up 10-30 weeks; measured with: QOLI change score; Better indicated by higher values)												
3	randomised trials	serious[1]	serious[8]	no serious indirectness	serious[3]	none	332	328	-	SMD 0.23 higher (0.05 lower to 0.51 higher)	VERY LOW	IMPORTANT
Quality of life - 3-month follow-up (follow-up mean 13 weeks; measured with: QOLI change score; Better indicated by higher values)												
2	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	158	160	-	SMD 0.27 higher (0.02 lower to 0.55 higher)	LOW	IMPORTANT
Quality of life - 6-month follow-up (follow-up mean 26 weeks; measured with: QOLI change score; Better indicated by higher values)												
2	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[5]	none	158	160	-	SMD 0.19 higher (0.03 lower to 0.41 higher)	LOW	IMPORTANT
Discontinuation (follow-up 10-30 weeks; assessed with: Number of participants lost to follow-up for any reason)												
6	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	119/487 (24.4%)	68/444 (15.3%)	RR 1.34 (0.99 to 1.8)	52 more per 1000 (from 2 fewer to 123 more)	LOW	CRITICAL

BAI=Beck Anxiety Inventory; BDI=Beck Depression inventory; BSI=Brief symptom inventory; CAPS= Clinician administered PTSD scale; CBT=cognitive behavioural therapy; CI=confidence interval; DES=Dissociative Experiences Scale; ITT=intention to treat; PCL=PTSD checklist; RR=risk ratio; SMD=standardised mean difference; STAI=State-Trait Anxiety Inventory; STAXI=State-Trait Anger Expression Inventory; TAU=treatment as usual; QIDS=Quick inventory of depressive symptomology; QOLI=Quality of life inventory

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

[2] Considerable heterogeneity (I2>80%)

[3] *95% CI crosses both line of no effect and threshold for clinically important effect*
[4] *95% CI crosses line of no effect and threshold for both clinically important benefit and clinically important harm*
[5] *OIS not met (N<400)*
[6] *Data is not reported/cannot be extracted for all outcomes*
[7] *OIS not met (events<300)*
[8] *Substantial heterogeneity (I2=50-80%)*

Table 119: Clinical evidence profile: Trauma-focused CBT (+ TAU) versus metacognitive (+ TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT (+ TAU)	Metacognitive (+ TAU)	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology self-rated - Endpoint (follow-up mean 8 weeks; measured with: PDS change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	10	10	-	SMD 1.56 higher (0.53 to 2.59 higher)	VERY LOW	CRITICAL
PTSD symptomatology self-rated - 3-month follow-up (follow-up mean 13 weeks; measured with: PDS change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[3]	10	10	-	SMD 0.67 higher (0.24 lower to 1.58 higher)	VERY LOW	CRITICAL
Remission (follow-up mean 8 weeks; assessed with: Number of people no longer meeting diagnostic criteria for PTSD)												

Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Trauma-focused CBT (+ TAU)**	**Metacognitive (+ TAU)**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[5]	reporting bias[3]	7/11 (63.6%)	9/11 (81.8%)	RR 0.78 (0.46 to 1.32)	180 fewer per 1000 (from 442 fewer to 262 more)	VERY LOW	CRITICAL
Response self-rated (follow-up mean 8 weeks; assessed with: Number of people showing clinically significant improvement based on at least 10-point improvement on IES)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[3]	8/11 (72.7%)	10/11 (90.9%)	RR 0.8 (0.53 to 1.2)	182 fewer per 1000 (from 427 fewer to 182 more)	VERY LOW	CRITICAL
Anxiety symptoms - Endpoint (follow-up mean 8 weeks; measured with: BAI change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[3]	10	10	-	SMD 0.67 higher (0.23 lower to	VERY LOW	IMPORTANT

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT (+ TAU)	Metacognitive (+ TAU)	Relative (95% CI)	Absolute	Quality	Importance
										1.58 higher)		
Anxiety symptoms - 3-month follow-up (follow-up mean 13 weeks; measured with: BAI change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[5]	reporting bias[3]	10	10	-	SMD 0.11 lower (0.98 lower to 0.77 higher)	VERY LOW	IMPORTANT
Depression symptoms - Endpoint (follow-up mean 8 weeks; measured with: BDI-II change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[3]	10	10	-	SMD 0.86 higher (0.07 lower to 1.79 higher)	VERY LOW	IMPORTANT
Depression symptoms - 3-month follow-up (follow-up mean 13 weeks; measured with: BDI-II change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[5]	reporting bias[3]	10	10	-	SMD 0.18 higher (0.69 lower to 1.06 higher)	VERY LOW	IMPORTANT
Discontinuation (follow-up mean 8 weeks; assessed with: Number of participants lost to follow-up for any reason)												

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT (+ TAU)	Metacognitive (+ TAU)	Relative (95% CI)	Absolute	Quality	Importance
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[5]	none	1/11 (9.1%)	1/11 (9.1%)	RR 1 (0.07 to 14.05)	0 fewer per 1000 (from 85 fewer to 1000 more)	VERY LOW	CRITICAL

BAI=Beck Anxiety Inventory; BDI=Beck Depression Inventory; CBT=cognitive behavioural therapy; CI=confidence interval; IES=Impact of event scale; PDS=PTSD diagnostic scale; PTSD=Post-traumatic stress disorder; RR=risk ratio; SMD=standardised mean difference; TAU=treatment as usual;
[1] Risk of bias is high or unclear across multiple domains
[2] OIS not met (N<400)
[3] Data is not reported/cannot be extracted for all outcomes
[4] 95% CI crosses both line of no effect and threshold for clinically important effect
[5] 95% CI crosses line of no effect and threshold for both clinically important benefit and clinically important harm

Table 120: Clinical evidence profile: Trauma-focused CBT versus interpersonal psychotherapy (IPT) for delayed treatment (>3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT	Interpersonal psychotherapy (IPT)	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology clinician-rated (follow-up mean 14 weeks; measured with: CAPS change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	28	36	-	SMD 0.31	LOW	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT	Interpersonal psychotherapy (IPT)	Relative (95% CI)	Absolute		
										lower (0.8 lower to 0.19 higher)		
PTSD symptomatology self-rated (follow-up mean 14 weeks; measured with: PSS-SR change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	17	23	-	SMD 0.62 lower (1.26 lower to 0.02 higher)	LOW	CRITICAL
Remission (follow-up mean 14 weeks; assessed with: Number of people scoring <20 on CAPS)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	7/38 (18.4%)	8/40 (20%)	RR 0.92 (0.37 to 2.29)	16 fewer per 1000 (from 126 fewer to 258 more)	VERY LOW	CRITICAL
Response (follow-up mean 14 weeks; assessed with: Number of people showing ≥30% improvement on CAPS)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT	Interpersonal psychotherapy (IPT)	Relative (95% CI)	Absolute		
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	17/38 (44.7%)	24/40 (60%)	RR 0.75 (0.48 to 1.15)	150 fewer per 1000 (from 312 fewer to 90 more)	LOW	CRITICAL
Depression symptoms (follow-up mean 14 weeks; measured with: HAMD change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	28	35	-	SMD 0.58 lower (1.08 to 0.07 lower)	LOW	IMPORTANT
Functional impairment (follow-up mean 14 weeks; measured with: SAS change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	15	22	-	SMD 0.24 lower (0.9 lower to 0.41 higher)	LOW	IMPORTANT
Quality of life (follow-up mean 14 weeks; measured with: Q-LES-Q-SF change score; Better indicated by higher values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	15	24	-	SMD 0.74 higher (0.07 to	LOW	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT	Interpersonal psychotherapy (IPT)	Relative (95% CI)	Absolute		
										1.4 higher)		
Relationship difficulties (follow-up mean 14 weeks; measured with: IIP change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	16	23	-	SMD 0 higher (0.64 lower to 0.64 higher)	VERY LOW	IMPORTANT
Discontinuation (follow-up mean 14 weeks; assessed with: Number of participants lost to follow-up for any reason)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	11/38 (28.9%)	6/40 (15%)	RR 1.93 (0.79 to 4.7)	139 more per 1000 (from 31 fewer to 555 more)	VERY LOW	CRITICAL

CAPS=Clinician-administered PTSD scale; CBT=cognitive behavioural therapy; CI=confidence interval; HAMD=Hamilton Anxiety Rating Scale; IIP=Inventory of Interpersonal problems; PSS-SR=PTSD symptom scale-self-report; RR=risk ratio; SAS=Social Adjustment Scale; SMD=standardised mean difference; Q-LES-Q-SF=Quality of Life Enjoyment and Satisfaction Questionnaire;

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

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

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

[4] OIS not met (N<400)

Table 121: Clinical evidence profile: Trauma-focused CBT (+ TAU) versus psychodynamic therapy (+ TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Trauma-focused CBT (+ TAU)**	**Psychodynamic therapy (+ TAU)**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
PTSD symptomatology self-rated - Endpoint (follow-up mean 16 weeks; measured with: IES change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	31	29	-	SMD 0.47 lower (0.98 lower to 0.04 higher)	VERY LOW	CRITICAL
PTSD symptomatology self-rated - 3-month follow-up (follow-up mean 13 weeks; measured with: IES change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	31	29	-	SMD 0.24 higher (0.27 lower to 0.75 higher)	VERY LOW	CRITICAL

CBT=cognitive behavioural therapy; CI=confidence interval; IES=Impact of event scale; RR=risk ratio; SMD=standardised mean difference; TAU=treatment as usual

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

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

[3] *Data is not reported/cannot be extracted for all outcomes*

Table 122: Clinical evidence profile: Trauma-focused CBT (+/- TAU) versus self-help (without support; +/- TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT (+/- TAU)	Self-help (without support; +/- TAU)	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology clinician-rated (follow-up mean 12 weeks; measured with: CAPS change score; Better indicated by lower values)												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious[1]	none	63	63	-	SMD 0.83 lower (1.19 to 0.47 lower)	MODERATE	CRITICAL
Remission at endpoint (follow-up mean 12 weeks; assessed with: Number of people no longer meeting diagnostic criteria or scoring below clincal threshold on a scale)												
2	randomised trials	serious[2]	very serious[3]	no serious indirectness	serious[4]	none	50/91 (54.9%)	24/91 (26.4%)	RR 2.32 (0.85 to 6.31)	348 more per 1000 (from 40 fewer to 1000 more)	VERY LOW	CRITICAL
Remission at 6-month follow-up (follow-up mean 26 weeks; assessed with: Number of people scoring <14 on PDS)												
1	randomised trials	serious[2]	no serious inconsistency	no serious indirectness	serious[5]	reporting bias[6]	24/28 (85.7%)	7/28 (25%)	RR 3.43 (1.77 to 6.63)	608 more per 1000 (from 192 more to 1000 more)	VERY LOW	CRITICAL
Response at endpoint (follow-up mean 12 weeks; assessed with: Number of people showing ≥50% improvement on PDS)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT (+/- TAU)	Self-help (without support; +/- TAU)	Relative (95% CI)	Absolute		
1	randomised trials	serious[2]	no serious inconsistency	no serious indirectness	serious[5]	reporting bias[6]	23/28 (82.1%)	7/28 (25%)	RR 3.29 (1.69 to 6.39)	572 more per 1000 (from 173 more to 1000 more)	VERY LOW	CRITICAL
Response at 6-month follow-up (follow-up mean 26 weeks; assessed with: Number of people showing ≥50% improvement on PDS)												
1	randomised trials	serious[2]	no serious inconsistency	no serious indirectness	serious[5]	reporting bias[6]	25/28 (89.3%)	7/28 (25%)	RR 3.57 (1.86 to 6.87)	642 more per 1000 (from 215 more to 1000 more)	VERY LOW	CRITICAL
Depression symptoms at endpoint (follow-up mean 12 weeks; measured with: BDI-II change score; Better indicated by lower values)												
1	randomised trials	serious[2]	no serious inconsistency	no serious indirectness	serious[1]	reporting bias[6]	28	25	-	SMD 1.43 lower (2.04 to 0.82 lower)	VERY LOW	IMPORTANT
Depression symptoms at 6-month follow-up (follow-up mean 12 weeks; measured with: BDI-II change score; Better indicated by lower values)												
1	randomised trials	serious[2]	no serious inconsistency	no serious indirectness	serious[1]	reporting bias[6]	28	25	-	SMD 1.37 lower (1.97 to 0.76 lower)	VERY LOW	IMPORTANT
Anxiety symptoms at endpoint (follow-up mean 12 weeks; measured with: BAI change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT (+/- TAU)	Self-help (without support; +/- TAU)	Relative (95% CI)	Absolute		
1	randomised trials	serious[2]	no serious inconsistency	no serious indirectness	serious[1]	reporting bias[6]	28	25	-	SMD 1.56 lower (2.18 to 0.94 lower)	VERY LOW	IMPORTANT
Anxiety symptoms at 6-month follow-up (follow-up mean 26 weeks; measured with: BAI change score; Better indicated by lower values)												
1	randomised trials	serious[2]	no serious inconsistency	no serious indirectness	serious[1]	reporting bias[6]	28	25	-	SMD 1.56 lower (2.18 to 0.94 lower)	VERY LOW	IMPORTANT
Functional impairment at endpoint (follow-up mean 12 weeks; measured with: SDS change score; Better indicated by lower values)												
1	randomised trials	serious[2]	no serious inconsistency	no serious indirectness	serious[1]	reporting bias[6]	28	25	-	SMD 1 lower (1.57 to 0.42 lower)	VERY LOW	IMPORTANT
Functional impairment at 6-month follow-up (follow-up mean 12 weeks; measured with: SDS change score; Better indicated by lower values)												
1	randomised trials	serious[2]	no serious inconsistency	no serious indirectness	serious[1]	reporting bias[6]	28	25	-	SMD 1.03 lower (1.61 to 0.45 lower)	VERY LOW	IMPORTANT
Discontinuation (follow-up mean 12 weeks; assessed with: Number of participants lost to follow-up for any reason)												
2	randomised trials	no serious risk of bias	very serious[3]	no serious indirectness	very serious[7]	none	11/91 (12.1%)	4/91 (4.4%)	RR 1.43 (0.02 to 100.44)	19 more per 1000 (from 43 fewer to 1000 more)	VERY LOW	CRITICAL

BAI=Beck anxiety inventory; BDI=Beck depression inventory; CAPS=Clinician-administered PTSD scale; CBT=cognitive behavioural therapy; CI=confidence interval; PDS=PTSD diagnostic scale; PTSD=post-traumatic stress disorder; SDS=Sheehan diability scale; RR=risk ratio; SMD=standardised mean difference; TAU=treatment as usual;
[1] OIS not met (N<400)
[2] Risk of bias is high or unclear across multiple domains
[3] Considerable heterogeneity (I2>80%)
[4] 95% CI crosses both line of no effect and threshold for clinically important effect
[5] OIS not met (events<300)
[6] Data is not reported/cannot be extracted for all outcomes
[7] 95% CI crosses line of no effect and threshold for both clinically important benefit and clinically important harm

Table 123: Clinical evidence profile: Trauma-focused CBT versus self-help with support for delayed treatment (>3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Trauma-focused CBT**	**Self-help with support**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
PTSD symptomatology self-rated - 2-month follow-up (follow-up mean 8 weeks; measured with: IES change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	41	44	-	SMD 0.06 lower (0.48 lower to 0.37 higher)	VERY LOW	CRITICAL
PTSD symptomatology self-rated - 1-year follow-up (follow-up mean 52 weeks; measured with: IES change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[3]	41	44	-	SMD 0.09 higher (0.34 lower to 0.52 higher)	VERY LOW	CRITICAL
Dissociative symptoms - 2-month follow-up (follow-up mean 8 weeks; measured with: DES change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT	Self-help with support	Relative (95% CI)	Absolute		
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[3]	41	44	-	SMD 0.35 higher (0.08 lower to 0.78 higher)	VERY LOW	IMPORTANT
Dissociative symptoms - 1-year follow-up (follow-up mean 52 weeks; measured with: DES change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[3]	41	44	-	SMD 0.42 higher (0.01 lower to 0.85 higher)	VERY LOW	IMPORTANT
Anxiety symptoms - 2-month follow-up (follow-up mean 8 weeks; measured with: STAI State change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[3]	41	44	-	SMD 0.22 lower (0.65 lower to 0.21 higher)	VERY LOW	IMPORTANT
Anxiety symptoms - 1-year follow-up (follow-up mean 52 weeks; measured with: STAI State change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[3]	41	44	-	SMD 0.1 lower (0.53 lower to 0.32 higher)	VERY LOW	IMPORTANT
Depression symptoms - 2-month follow-up (follow-up mean 8 weeks; measured with: BDI change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Trauma-focused CBT**	**Self-help with support**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[3]	41	44	-	SMD 0.26 lower (0.68 lower to 0.17 higher)	VERY LOW	IMPORTANT
Depression symptoms - 1-year follow-up (follow-up mean 52 weeks; measured with: BDI change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[3]	41	44	-	SMD 0.23 lower (0.65 lower to 0.2 higher)	VERY LOW	IMPORTANT

BDI=Beck Depression Inventory; CBT=cognitive behavioural therapy; CI=confidence interval; DES=; IES=impact of event scale; PTSD=post-traumatic stress disorder; RR=risk ratio; SMD=standardised mean difference; STAI=State-Trait Anxiety Inventory

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

[2] OIS not met (N<400)

[3] Data is not reported/cannot be extracted for all outcomes

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

Table 124: Clinical evidence profile: Trauma-focused CBT (+ TAU) versus hypnotherapy (+ TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT (+ TAU)	Hypnotherapy (+ TAU)	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology self-rated - Endpoint (follow-up mean 16 weeks; measured with: IES change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	31	29	-	SMD 0.15 lower (0.66 lower to 0.35 higher)	VERY LOW	CRITICAL
PTSD symptomatology self-rated - 3-month follow-up (follow-up mean 13 weeks; measured with: IES change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	31	29	-	SMD 0.2 higher (0.31 lower to 0.71 higher)	VERY LOW	CRITICAL

CBT=cognitive behavioural therapy; CI=confidence interval; IES=impact of event scale; RR=risk ratio; SMD=standardised mean difference; TAU=treatment as usual

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

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

[3] *Data is not reported/cannot be extracted for all outcomes*

Table 125: Clinical evidence profile: Trauma-focused CBT versus psychoeducational session for delayed treatment (>3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT	Psychoeducational session	Relative (95% CI)	Absolute		
PTSD symptomatology self-rated at endpoint (follow-up mean 13 weeks; measured with: IES change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	99	131	-	SMD 0.25 lower (0.51 lower to 0.01 higher)	VERY LOW	CRITICAL
PTSD symptomatology self-rated at 3-month follow-up (follow-up mean 13 weeks; measured with: IES change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[3]	110	134	-	SMD 0.02 higher (0.23 lower to 0.27 higher)	VERY LOW	CRITICAL
PTSD symptomatology self-rated at 6-month follow-up (follow-up mean 26 weeks; measured with: IES change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[3]	104	132	-	SMD 0.06 lower (0.32 lower to 0.2 higher)	VERY LOW	CRITICAL
Discontinuation (follow-up mean 13 weeks; assessed with: Number of participants lost to follow-up for any reason)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[5]	none	68/167 (40.7%)	38/169 (22.5%)	RR 1.81 (1.3 to 2.53)	182 more per 1000 (from 67 more to 344 more)	LOW	CRITICAL

CBT=cognitive behavioural therapy; CI=confidence interval; IES=Impact of event scale; RR=risk ratio; SMD=standardised mean difference

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

[2] *95% CI crosses both line of no effect and threshold for clinically important effect*
[3] *Data is not reported/cannot be extracted for all outcomes*
[4] *OIS not met (N<400)*
[5] *OIS not met (events<300)*

Table 126: Clinical evidence profile: Trauma-focused CBT (+/- TAU) versus relaxation (+/- TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT (+/- TAU)	Relaxation (+/- TAU)	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology self-rated at endpoint (follow-up mean 14 weeks; measured with: PCL/PSS-SR change score; Better indicated by lower values)												
3	randomised trials	serious[1]	serious[2]	no serious indirectness	serious[3]	none	44	40	-	SMD 1.18 lower (2.16 to 0.2 lower)	VERY LOW	CRITICAL
PTSD symptomatology self-rated at 3-month follow-up (follow-up mean 13 weeks; measured with: PCL/PSS-SR change score; Better indicated by lower values)												
2	randomised trials	serious[1]	serious[2]	no serious indirectness	serious[3]	none	27	27	-	SMD 1.47 lower (2.66 to 0.28 lower)	VERY LOW	CRITICAL
PTSD symptomatology clinician-rated at endpoint (follow-up mean 14 weeks; measured with: CAPS change score; Better indicated by lower values)												
2	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	43	39	-	SMD 0.56 lower (1 to 0.12 lower)	LOW	CRITICAL
PTSD symptomatology clinician-rated at 3-month follow-up (follow-up mean 13 weeks; measured with: CAPS change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	15	15	-	SMD 0.78 lower (1.53 to 0.04 lower)	LOW	CRITICAL
Remission at endpoint (follow-up mean 14 weeks; assessed with: Number of people scoring <20 on CAPS)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT (+/- TAU)	Relaxation (+/- TAU)	Relative (95% CI)	Absolute		
2	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[4]	none	15/60 (25%)	8/51 (15.7%)	RR 1.58 (0.73 to 3.46)	91 more per 1000 (from 42 fewer to 386 more)	VERY LOW	CRITICAL
Remission at 3-month follow-up (follow-up mean 13 weeks; assessed with: Number of people scoring <20 on CAPS)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[4]	none	7/22 (31.8%)	4/19 (21.1%)	RR 1.51 (0.52 to 4.38)	107 more per 1000 (from 101 fewer to 712 more)	VERY LOW	CRITICAL
Response (follow-up mean 14 weeks; assessed with: Number of people showing ≥30% improvement on CAPS)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[5]	none	17/38 (44.7%)	9/32 (28.1%)	RR 1.59 (0.82 to 3.07)	166 more per 1000 (from 51 fewer to 582 more)	LOW	CRITICAL
Dissociative symptoms - Endpoint (measured with: CAPS dissociation cluster change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[4]	none	15	15	-	SMD 0.1 higher (0.62 lower to 0.82 higher)	VERY LOW	IMPORTANT
Dissociative symptoms - 3-month follow-up (follow-up mean 13 weeks; measured with: CAPS dissociation cluster change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT (+/- TAU)	Relaxation (+/- TAU)	Relative (95% CI)	Absolute	Quality	Importance
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[5]	none	15	15	-	SMD 0.53 lower (1.26 lower to 0.2 higher)	LOW	IMPORTANT
Anxiety symptoms - Endpoint (follow-up mean 14 weeks; measured with: SCL-90: Anxiety, change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	12	12	-	SMD 1.25 lower (2.13 to 0.36 lower)	LOW	IMPORTANT
Anxiety symptoms - 3-month follow-up (follow-up mean 13 weeks; measured with: SCL-90: Anxiety, change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	12	12	-	SMD 1.23 lower (2.12 to 0.35 lower)	LOW	IMPORTANT
Depression symptoms at endpoint (follow-up mean 14 weeks; measured with: HAMD/BDI change score; Better indicated by lower values)												
2	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[5]	none	43	38	-	SMD 0.39 lower (0.83 lower to 0.05 higher)	LOW	IMPORTANT
Depression symptoms at 3-month follow-up (follow-up mean 13 weeks; measured with: BDI change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[4]	none	15	15	-	SMD 0.13 lower (0.84 lower to 0.59 higher)	VERY LOW	IMPORTANT
Functional impairment (follow-up mean 14 weeks; measured with: SAS change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT (+/- TAU)	Relaxation (+/- TAU)	Relative (95% CI)	Absolute	Quality	Importance
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	15	14	-	SMD 1.21 lower (2.02 to 0.41 lower)	LOW	IMPORTANT
Quality of life (follow-up mean 14 weeks; measured with: Q-LES-Q-SF change score; Better indicated by higher values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	15	14	-	SMD 1.24 higher (0.44 to 2.05 higher)	LOW	IMPORTANT
Relationship difficulties (follow-up mean 14 weeks; measured with: IIP change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	16	14	-	SMD 1.41 lower (2.23 to 0.6 lower)	LOW	IMPORTANT
Discontinuation (follow-up mean 14 weeks; assessed with: Number of participants lost to follow-up for any reason)												
3	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[4]	none	18/72 (25%)	15/63 (23.8%)	RR 1 (0.56 to 1.79)	0 fewer per 1000 (from 105 fewer to 188 more)	VERY LOW	CRITICAL

BDI=Beck Depression Inventory; CAPS=Clinician-administered PTSD scale; CBT=cognitive behavioural therapy; CI=confidence interval; HAMD=Hamilton Rating Scale for Depression; IES=Impact of event scale; PCL=PTSD checklist; PSS-SR=PTSD symptom scale-self-report; SAS=Social Adjustment Scale; SCL-90=Symptom Checklist-90; RR=risk ratio; TAU=treatment as usual; Q-LES-Q-SF=Quality of Life Enjoyment and Satisfaction Questionnaire-Short-form

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

[2] Substantial heterogeneity (I2=50-80%)

[3] OIS not met (N<400)

[4] 95% CI crosses line of no effect and threshold for both clinically important benefit and clinically important harm
[5] 95% CI crosses both line of no effect and threshold for clinically important effect

Table 127: Clinical evidence profile: Trauma-focused CBT versus acupuncture for delayed treatment (>3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT	Acupuncture	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology self-rated - Endpoint (follow-up mean 12 weeks; measured with: PSS-SR change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	25	24	-	SMD 0.38 higher (0.18 lower to 0.95 higher)	VERY LOW	CRITICAL
PTSD symptomatology self-rated - 3-month follow-up (follow-up mean 13 weeks; measured with: PSS-SR change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	25	24	-	SMD 0.01 higher (0.55 lower to 0.57 higher)	VERY LOW	CRITICAL
Remission - Endpoint (follow-up mean 12 weeks; assessed with: Number of people scoring <16 on PSS-SR)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	9/28 (32.1%)	15/29 (51.7%)	RR 0.62 (0.33 to 1.18)	197 fewer per 1000 (from 347 fewer to 93 more)	VERY LOW	CRITICAL
Remission - 3-month follow-up (follow-up mean 13 weeks; assessed with: Number of people scoring <16 on PSS-SR)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT	Acupuncture	Relative (95% CI)	Absolute		
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	13/28 (46.4%)	15/29 (51.7%)	RR 0.9 (0.53 to 1.53)	52 fewer per 1000 (from 243 fewer to 274 more)	VERY LOW	CRITICAL
Depression symptoms - Endpoint (follow-up mean 12 weeks; measured with: HSCL-25: Depression, change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	25	24	-	SMD 0.04 lower (0.6 lower to 0.52 higher)	VERY LOW	IMPORTANT
Depression symptoms - 3-month follow-up (follow-up mean 13 weeks; measured with: HSCL-25: Depression, change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	25	24	-	SMD 0.2 lower (0.76 lower to 0.36 higher)	VERY LOW	IMPORTANT
Anxiety symptoms - Endpoint (follow-up mean 12 weeks; measured with: HSCL-25: Anxiety, change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	25	24	-	SMD 0.37 higher (0.19 lower to 0.94 higher)	VERY LOW	IMPORTANT
Anxiety symptoms - 3-month follow-up (follow-up mean 13 weeks; measured with: HSCL-25: Anxiety, change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	25	24	-	SMD 0.49 higher (0.08 lower	VERY LOW	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT	Acupuncture	Relative (95% CI)	Absolute		
										to 1.05 higher)		
Functional impairment - Endpoint (follow-up mean 12 weeks; measured with: SDS change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	25	24	-	SMD 0.01 higher (0.55 lower to 0.57 higher)	VERY LOW	IMPORTANT
Functional impairment - 3-month follow-up (follow-up mean 13 weeks; measured with: SDS change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	25	24	-	SMD 0.11 lower (0.67 lower to 0.45 higher)	VERY LOW	IMPORTANT
Discontinuation (follow-up mean 12 weeks; assessed with: Number of participants lost to follow-up for any reason)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	7/28 (25%)	10/29 (34.5%)	RR 0.73 (0.32 to 1.64)	93 fewer per 1000 (from 234 fewer to 221 more)	VERY LOW	CRITICAL

CBT= cognitive behavioural therapy; CI=confidence interval; HSCL-25= Hopkins Symptom Checklist-25; RR=risk ratio; PSS-SR=PTSD symptom scale-self-report; SDS= Sheehan Disability Scale; SMD=standardised mean difference;

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

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

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

Table 128: Clinical evidence profile: Trauma-focused CBT versus SSRIs for delayed treatment (>3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT	SSRIs	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology self-rated at endpoint (follow-up 12-26 weeks; measured with: HTQ/PDS change score; Better indicated by lower values)												
2	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	141	85	-	SMD 0.35 higher (0.06 to 0.63 higher)	VERY LOW	CRITICAL
PTSD symptomatology self-rated at 1-year follow-up (follow-up mean 52 weeks; measured with: PDS change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	89	23	-	SMD 0.07 higher (0.38 lower to 0.53 higher)	VERY LOW	CRITICAL
PTSD symptomatology clinician-rated (follow-up 10-12 weeks; measured with: PSS-I/SI–PTSD change score; Better indicated by lower values)												
2	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	118	43	-	SMD 0.76 lower (1.13 to 0.39 lower)	LOW	CRITICAL
Remission (follow-up mean 12 weeks; assessed with: Number of people no longer meeting diagnostic criteria for PTSD)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	72/114 (63.2%)	13/57 (22.8%)	RR 2.77 (1.68 to 4.56)	404 more per 1000 (from 155 more to 812 more)	VERY LOW	CRITICAL
Dissociative symptoms (follow-up mean 10 weeks; measured with: DES change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT	SSRIs	Relative (95% CI)	Absolute		
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[5]	29	20	-	SMD 1.24 lower (1.86 to 0.61 lower)	VERY LOW	IMPORTANT
Anxiety symptoms at endpoint (follow-up 10-26 weeks; measured with: HAM-A/STAI State change score; Better indicated by lower values)												
3	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	170	105	-	SMD 0.43 higher (0.14 to 0.73 higher)	VERY LOW	IMPORTANT
Anxiety symptoms at 1-year follow-up (follow-up mean 12 weeks; measured with: STAI State change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	89	23	-	SMD 0.25 higher (0.21 lower to 0.71 higher)	VERY LOW	IMPORTANT
Depression symptoms at endpoint (follow-up 10-26 weeks; measured with: HAMD/BDI/BDI-II change score; Better indicated by lower values)												
3	randomised trials	very serious[1]	very serious[6]	no serious indirectness	serious[3]	none	170	105	-	SMD 0.26 higher (0.36 lower to 0.87 higher)	VERY LOW	IMPORTANT
Depression symptoms at 1-year follow-up (follow-up mean 12 weeks; measured with: BDI-II change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	89	23	-	SMD 0.27 higher (0.19 lower to 0.73 higher)	VERY LOW	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT	SSRIs	Relative (95% CI)	Absolute		
Functional impairment (follow-up 10-26 weeks; measured with: SDS change score; Better indicated by lower values)												
2	randomised trials	very serious[1]	very serious6	no serious indirectness	very serious[7]	none	81	82	-	SMD 0.06 lower (1.19 lower to 1.07 higher)	VERY LOW	IMPORTANT
Quality of life (follow-up mean 26 weeks; measured with: WHO-5 change score; Better indicated by higher values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	52	62	-	SMD 0.24 lower (0.61 lower to 0.13 higher)	VERY LOW	IMPORTANT
Discontinuation (follow-up 12-26 weeks; assessed with: Number of participants lost to follow-up for any reason)												
2	randomised trials	very serious[1]	very serious[6]	no serious indirectness	very serious[7]	none	52/184 (28.3%)	50/128 (39.1%)	RR 0.79 (0.17 to 3.59)	82 fewer per 1000 (from 324 fewer to 1000 more)	VERY LOW	CRITICAL

BDI= Beck Depression Inventory; CI=confidence interval; CBT= cognitive behavioural therapy; DES= Dissociative Experiences Scales; HAM-A/D= Hamilton Rating Scale for Anxiety/Depression; HTQ= Harvard Trauma Questionnaire; PDS= Post-traumatic Diagnositic Scale; PSS-I= PTSD symptom scale-interview; RR=risk ratio; SDS=; SI-PTSD= Structured interview for PTSD; SMD=standardised mean difference; SSRI=selective serotonin reuptake inhibitors; STAI=State-Trait Anxiety Inventory

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

Table 129: Clinical evidence profile: Trauma-focused CBT + SSRIs versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT + SSRIs	Waitlist	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology self-rated (follow-up mean 26 weeks; measured with: HTQ change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	55	48	-	SMD 0.24 higher (0.15 lower to 0.63 higher)	VERY LOW	CRITICAL
Anxiety symptoms (follow-up mean 26 weeks; measured with: HAM-A change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	55	48	-	SMD 0.64 lower (1.04 to 0.25 lower)	VERY LOW	IMPORTANT
Depression symptoms (follow-up mean 26 weeks; measured with: HAMD change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	55	48	-	SMD 0.75 lower (1.15 to 0.35 lower)	VERY LOW	IMPORTANT
Functional impairment (follow-up mean 26 weeks; measured with: SDS change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	55	48	-	SMD 0.5 lower (0.9 to 0.11 lower)	VERY LOW	IMPORTANT
Quality of life (follow-up mean 26 weeks; measured with: WHO-5 change score; Better indicated by higher values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	55	48	-	SMD 0.04 lower (0.43 lower to	VERY LOW	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Trauma-focused CBT + SSRIs	Waitlist	Relative (95% CI)	Absolute		
										0.35 higher)		
Discontinuation (follow-up mean 26 weeks; assessed with: Number of participants lost to follow-up for any reason)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	26/71 (36.6%)	36/68 (52.9%)	RR 0.69 (0.47 to 1.01)	164 fewer per 1000 (from 281 fewer to 5 more)	LOW	CRITICAL

CBT= cognitive behavioural therapy; CI= confidence interval; HAM-A/D= Hamilton Rating Scale for Anxiety/Depression; HTQ= Harvard Trauma Questionnaire; RR= risk ratio; SDS= Sheehan Disability Scale; SMD= standardised mean difference; SSRI=selective serotonin reuptake inhibitors

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

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

[3] *OIS not met (N<400)*

Non-trauma-focused CBT

Table 130: Clinical evidence profile: Non-trauma-focused CBT (+/- TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Non-trauma-focused CBT (+/- TAU)	Waitlist or TAU	Relative (95% CI)	Absolute		
PTSD symptomatology self-report (follow-up 3-15 weeks; measured with: PCL/DTS/PDS/PSS-SR/MPSS-SR change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Non-trauma-focused CBT (+/- TAU)	Waitlist or TAU	Relative (95% CI)	Absolute		
5	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	120	108	-	SMD 0.93 lower (1.26 to 0.59 lower)	LOW	CRITICAL
PTSD symptomatology clinician-rated at endpoint (follow-up 3-26 weeks; measured with: CAPS change score; Better indicated by lower values)												
4	randomised trials	very serious[1]	serious[3]	no serious indirectness	serious[2]	reporting bias[4]	177	162	-	SMD 0.59 lower (0.81 to 0.37 lower)	VERY LOW	CRITICAL
PTSD symptomatology clinician-rated at 3-month follow-up (follow-up mean 13 weeks; measured with: CAPS change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[5]	none	32	21	-	SMD 0.3 higher (0.25 lower to 0.86 higher)	VERY LOW	CRITICAL
Remission at endpoint (follow-up 12-15 weeks; assessed with: Number of people no longer meeting diagnostic criteria/above threshold on a scale for PTSD)												
3	randomised trials	very serious[1]	very serious[6]	no serious indirectness	very serious[7]	none	51/104 (49%)	23/90 (25.6%)	RR 1.94 (0.65 to 5.83)	240 more per 1000 (from 89 fewer to 1000 more)	VERY LOW	CRITICAL
Remission at 3-month follow-up (follow-up mean 13 weeks; assessed with: Number of people no longer meeting diagnostic criteria)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Non-trauma-focused CBT (+/- TAU)	Waitlist or TAU	Relative (95% CI)	Absolute		
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[5]	none	25/32 (78.1%)	19/21 (90.5%)	RR 0.86 (0.69 to 1.09)	127 fewer per 1000 (from 280 fewer to 81 more)	VERY LOW	CRITICAL
Dissociative symptoms (follow-up mean 15 weeks; measured with: DES change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	16	17	-	SMD 0.77 lower (1.48 to 0.06 lower)	LOW	IMPORTANT
Sleeping difficulties (follow-up 3-8 weeks; measured with: ISI/PSQI change score; Better indicated by lower values)												
5	randomised trials	serious[1]	very serious[6]	no serious indirectness	serious[2]	reporting bias[4]	137	126	-	SMD 1.02 lower (1.29 to 0.75 lower)	VERY LOW	IMPORTANT
Depression symptoms at endpoint (follow-up 3-13 weeks; measured with: BDI/BDI-II change score; Better indicated by lower values)												
4	randomised trials	very serious[1]	serious[3]	no serious indirectness	serious[5]	none	130	104	-	SMD 0.32 lower (0.83 lower to 0.18 higher)	VERY LOW	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Non-trauma-focused CBT (+/- TAU)	Waitlist or TAU	Relative (95% CI)	Absolute		
Depression symptoms at 3-month follow-up (follow-up mean 13 weeks; measured with: BDI change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	32	21	-	SMD 1.03 higher (0.44 to 1.62 higher)	LOW	IMPORTANT
Alcohol use - Endpoint (follow-up 13-26 weeks; measured with: TLFB Number of drinking days; change score; Better indicated by lower values)												
2	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[5]	reporting bias[4]	105	94	-	SMD 0.27 lower (0.56 lower to 0.01 higher)	VERY LOW	IMPORTANT
Alcohol use - 3-month follow-up (follow-up mean 13 weeks; measured with: TLFB Number of drinking days; change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[7]	none	32	21	-	SMD 0.03 higher (0.52 lower to 0.58 higher)	VERY LOW	IMPORTANT
Drug use - Endpoint (follow-up 13-26 weeks; measured with: TLFB Number of drug use days; change score; Better indicated by lower values)												
2	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[5]	reporting bias[4]	105	94	-	SMD 0.14 lower (0.51 lower to	VERY LOW	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Non-trauma-focused CBT (+/- TAU)	Waitlist or TAU	Relative (95% CI)	Absolute		
										0.23 higher)		
Drug use - 3-month follow-up (follow-up mean 13 weeks; measured with: TLFB Number of drug use days; change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	32	21	-	SMD 0.62 lower (1.18 to 0.06 lower)	LOW	IMPORTANT
Discontinuation (follow-up 3-26 weeks; assessed with: Number of participants lost to follow-up for any reason)												
9	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[8]	none	114/358 (31.8%)	106/326 (32.5%)	RR 1.01 (0.81 to 1.24)	3 more per 1000 (from 62 fewer to 78 more)	LOW	CRITICAL

BDI= Beck Depression Inventory; CAPS= Clinician-administered PTSD symptom scale; CBT= cognitive behavioural therapy; CI=confidence interval; DES= Dissociative Experiences Scales; DTS=Davidson Trauma Scale; ISI=Insomnia severity index; MPSS-SR=Modified PTSD Symptom Scale-self-report; PCL= PTSD checklist; PDS= Post-traumatic Diagnositic Scale; PSS-SR= PTSD symptom scale-interview/self-report; PSQI=Pittsburgh Sleep quality index; RR=risk ratio; SMD= standardised mean difference; TAU=treatment as usual; TLFB=alcohol timeline followback

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

Table 131: Clinical evidence profile: Non-trauma-focused CBT (+/- TAU) versus attention-placebo (+/- TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Non-trauma-focused CBT (+/- TAU)	Attention-placebo (+/- TAU)	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology self-report at endpoint (follow-up 3-6 weeks; measured with: PCL/PSS-SR change score; Better indicated by lower values)												
2	randomised trials	serious[1]	serious[2]	no serious indirectness	no serious imprecision	reporting bias[3]	209	204	-	SMD 0.14 lower (0.34 lower to 0.05 higher)	VERY LOW	CRITICAL
PTSD symptomatology self-report at 3-month follow-up (follow-up mean 13 weeks; measured with: PCL change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	33	27	-	SMD 0.56 lower (1.08 to 0.04 lower)	LOW	CRITICAL
PTSD symptomatology clinician-rated (follow-up mean 6 weeks; measured with: CAPS change score; Better indicated by lower values)												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[3]	176	177	-	SMD 0.1 higher (0.11 lower to 0.31 higher)	LOW	CRITICAL
Response (follow-up mean 6 weeks; assessed with: Number of people showing clinically significant improvement, based on reliable change indices (RCI))												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Non-trauma-focused CBT (+/- TAU)	Attention-placebo (+/- TAU)	Relative (95% CI)	Absolute		
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious[5]	reporting bias[3]	84/176 (47.7%)	81/177 (45.8%)	RR 1.04 (0.83 to 1.3)	18 more per 1000 (from 78 fewer to 137 more)	LOW	CRITICAL
Depression symptoms - Endpoint (follow-up mean 3 weeks; measured with: CES-D change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[5]	none	33	27	-	SMD 0.12 lower (0.63 lower to 0.38 higher)	LOW	IMPORTANT
Depression symptoms - 3-month follow-up (follow-up mean 13 weeks; measured with: CES-D change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	33	27	-	SMD 0.89 lower (1.43 to 0.36 lower)	LOW	IMPORTANT
Drug use (follow-up mean 6 weeks; measured with: Substance Use Inventory: Number of days participants used drugs during the past 7 days; change score; Better indicated by lower values)												
1	randomised trials	no serious	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[3]	176	177	-	SMD 0.05 lower	LOW	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Non-trauma-focused CBT (+/- TAU)	Attention-placebo (+/- TAU)	Relative (95% CI)	Absolute		
		risk of bias								(0.26 lower to 0.16 higher)		
Quality of life at endpoint (follow-up mean 3 weeks; measured with: SF-36 change score; Better indicated by higher values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[5]	none	33	27	-	SMD 0.1 higher (0.41 lower to 0.61 higher)	LOW	IMPORTANT
Quality of life at 3-month follow-up (follow-up mean 13 weeks; measured with: SF-36 change score; Better indicated by higher values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[5]	none	33	27	-	SMD 0.25 higher (0.26 lower to 0.76 higher)	LOW	IMPORTANT
Discontinuation (follow-up 3-6 weeks; assessed with: Number of participants lost to follow-up for any reason)												
2	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious[5]	none	72/209 (34.4%)	65/204 (31.9%)	RR 1.11 (0.85 to 1.45)	35 more per 1000 (from 48 fewer to 143 more)	MODERATE	CRITICAL

CAPS= Clinician-administered PTSD scale; CBT= cognitive behavioural therapy; CES-D= Centre of Epidemiological Studies-Depression; CI= confidence interval; PCL= PTSD checklist; PSS-SR= PTSD symptom scale-interview/self-report; RR= risk ratio; SF-36=Short form-36; SMD=standardised mean difference; TAU=treatment as usual

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

[2] *Substantial heterogeneity (I2=50-80%)*

[3] *Data is not reported/cannot be extracted for all outcomes*

[4] *OIS not met (N<400)*

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

Table 132: Clinical evidence profile: Non-trauma-focused CBT (+ TAU) versus psychoeducational group (+ TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Non-trauma-focused CBT (+ TAU)**	**Psychoeducational group (+ TAU)**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
PTSD symptomatology self-report - Endpoint (follow-up mean 14 weeks; measured with: DTS change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	33	44	-	SMD 0.34 lower (0.79 lower to 0.12 higher)	LOW	CRITICAL
PTSD symptomatology self-report - 3-month follow-up (follow-up mean 13 weeks; measured with: DTS change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	32	38	-	SMD 0.31 lower (0.78 lower to 0.17 higher)	LOW	CRITICAL

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Non-trauma-focused CBT (+ TAU)	Psychoeducational group (+ TAU)	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology self-report - 6-month follow-up (follow-up mean 26 weeks; measured with: DTS change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	30	41	-	SMD 0.11 lower (0.58 lower to 0.36 higher)	LOW	CRITICAL
PTSD symptomatology self-report - 1-year follow-up (follow-up mean 52 weeks; measured with: DTS change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	29	37	-	SMD 0.22 lower (0.71 lower to 0.27 higher)	LOW	CRITICAL
PTSD symptomatology clinician-rated - Endpoint (follow-up mean 14 weeks; measured with: CAPS change score; Better indicated by lower values)												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious[2]	none	33	44	-	SMD 0.25 lower (0.71 lower to 0.2 higher)	MODERATE	CRITICAL
PTSD symptomatology clinician-rated - 3-month follow-up (follow-up mean 13 weeks; measured with: CAPS change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Non-trauma-focused CBT (+ TAU)	Psychoeducational group (+ TAU)	Relative (95% CI)	Absolute		
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious[2]	none	32	38	-	SMD 0.2 lower (0.67 lower to 0.27 higher)	MODERATE	CRITICAL
PTSD symptomatology clinician-rated - 6-month follow-up (follow-up mean 26 weeks; measured with: CAPS change score; Better indicated by lower values)												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious[2]	none	30	41	-	SMD 0.18 lower (0.65 lower to 0.29 higher)	MODERATE	CRITICAL
PTSD symptomatology clinician-rated - 1-year follow-up (follow-up mean 52 weeks; measured with: CAPS change score; Better indicated by lower values)												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious[3]	none	29	37	-	SMD 0.53 lower (1.03 to 0.04 lower)	MODERATE	CRITICAL
Depression symptoms - Endpoint (follow-up mean 14 weeks; measured with: HAMD change score; Better indicated by lower values)												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious[3]	none	33	44	-	SMD 1.01 lower (1.49 to	MODERATE	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Non-trauma-focused CBT (+ TAU)	Psychoeducational group (+ TAU)	Relative (95% CI)	Absolute		
										0.53 lower)		
Depression symptoms - 3-month follow-up (follow-up mean 13 weeks; measured with: HAMD change score; Better indicated by lower values)												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious[3]	none	32	38	-	SMD 0.53 lower (1.01 to 0.05 lower)	MODERATE	IMPORTANT
Depression symptoms - 6-month follow-up (follow-up mean 26 weeks; measured with: HAMD change score; Better indicated by lower values)												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious[3]	none	30	41	-	SMD 0.66 lower (1.15 to 0.18 lower)	MODERATE	IMPORTANT
Depression symptoms - 1-year follow-up (follow-up mean 52 weeks; measured with: HAMD change score; Better indicated by lower values)												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious[2]	none	29	37	-	SMD 0.1 lower (0.59 lower to 0.39 higher)	MODERATE	IMPORTANT
Discontinuation (follow-up mean 14 weeks; assessed with: Number of participants lost to follow-up for any reason)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Non-trauma-focused CBT (+ TAU)	Psychoeducational group (+ TAU)	Relative (95% CI)	Absolute		
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious[4]	none	22/55 (40%)	12/56 (21.4%)	RR 1.87 (1.03 to 3.39)	186 more per 1000 (from 6 more to 512 more)	MODERATE	CRITICAL

CAPS= Clinician-administered PTSD scale; CI= confidence interval; DTS=Davidson trauma scale; HAMD= Hamilton Rating Scale for Depression; RR= risk ratio; SMD= standardised mean difference; TAU=treatment as usual
[1] Risk of bias is high or unclear across multiple domains
[2] 95% CI crosses both line of no effect and threshold for clinically important effect
[3] OIS not met (N<400)
[4] OIS not met (events<300)

Table 133: Clinical evidence profile: Non-trauma-focused CBT versus counselling for delayed treatment (>3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Non-trauma-focused CBT	Counselling	Relative (95% CI)	Absolute		
PTSD symptomatology clinician-rated (follow-up mean 5 weeks; measured with: PSS-I change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Non-trauma-focused CBT	Counselling	Relative (95% CI)	Absolute		
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	14	11	-	SMD 1.47 lower (2.38 to 0.57 lower)	VERY LOW	CRITICAL
Remission (follow-up mean 5 weeks; assessed with: Number of people no longer meeting diagnostic criteria for PTSD)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[3]	7/17 (41.2%)	1/14 (7.1%)	RR 5.76 (0.8 to 41.43)	340 more per 1000 (from 14 fewer to 1000 more)	VERY LOW	CRITICAL
Response (follow-up mean 5 weeks; assessed with: Number of people showing clinically significant improvement based on reliable change indices (RCI) on PSS-I)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[5]	reporting bias[3]	10/17 (58.8%)	2/14 (14.3%)	RR 4.12 (1.07 to 15.78)	446 more per 1000 (from 10 more to 1000 more)	VERY LOW	CRITICAL
Anxiety symptoms (follow-up mean 5 weeks; measured with: STAI State change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[3]	14	11	-	SMD 0.65 lower (1.46 lower to 0.17 higher)	VERY LOW	IMPORTANT
Depression symptoms (follow-up mean 5 weeks; measured with: BDI change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Non-trauma-focused CBT	Counselling	Relative (95% CI)	Absolute		
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[3]	14	11	-	SMD 0.81 lower (1.64 lower to 0.02 higher)	VERY LOW	IMPORTANT
Discontinuation (follow-up mean 5 weeks; assessed with: Number of participants lost to follow-up for any reason)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[6]	none	3/17 (17.6%)	3/14 (21.4%)	RR 0.82 (0.2 to 3.46)	39 fewer per 1000 (from 171 fewer to 527 more)	VERY LOW	CRITICAL

BDI= Beck Depression Inventory; CBT= cognitive behavioural therapy; CI= confidence interval; PSS-I= PTSD symptom scale-interview; RR=risk ratio; SMD= standardised mean difference; STAI= State-Trait Anxiety Inventory;

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

[2] OIS not met (N<400)

[3] Data is not reported/cannot be extracted for all outcomes

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

[5] OIS not met (events<300)

[6] 95% CI crosses line of no effect and threshold for both clinically important benefit and clinically important harm

Table 134: Clinical evidence profile: Non-trauma-focused CBT versus present-centered therapy for delayed treatment (>3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Non-trauma-focused CBT	Present-centered therapy	Relative (95% CI)	Absolute		
PTSD symptomatology clinician-rated - Endpoint (follow-up mean 12 weeks; measured with: CAPS change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	48	53	-	SMD 0.09 lower (0.48 lower to 0.3 higher)	VERY LOW	CRITICAL
PTSD symptomatology clinician-rated - 3-month follow-up (follow-up mean 13 weeks; measured with: CAPS change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	48	53	-	SMD 0.04 lower (0.43 lower to 0.35 higher)	VERY LOW	CRITICAL
PTSD symptomatology clinician-rated - 6-month follow-up (follow-up mean 26 weeks; measured with: CAPS change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	48	53	-	SMD 0.23 higher (0.16 lower to 0.62 higher)	VERY LOW	CRITICAL
Remission - Endpoint (follow-up mean 12 weeks; assessed with: Number of people no longer meeting diagnostic criteria for PTSD)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[4]	none	10/48 (20.8%)	8/53 (15.1%)	RR 1.38 (0.59 to 3.21)	57 more per 1000 (from 62 fewer to 334 more)	VERY LOW	CRITICAL
Remission - 3-month follow-up (follow-up mean 13 weeks; assessed with: Number of people no longer meeting diagnostic criteria for PTSD)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Non-trauma-focused CBT	Present-centered therapy	Relative (95% CI)	Absolute		
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[4]	none	14/48 (29.2%)	10/53 (18.9%)	RR 1.55 (0.76 to 3.15)	104 more per 1000 (from 45 fewer to 406 more)	VERY LOW	CRITICAL
Remission - 6-month follow-up (follow-up mean 26 weeks; assessed with: Number of people no longer meeting diagnostic criteria for PTSD)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[4]	none	16/48 (33.3%)	13/53 (24.5%)	RR 1.36 (0.73 to 2.52)	88 more per 1000 (from 66 fewer to 373 more)	VERY LOW	CRITICAL
Depression symptoms - Endpoint (follow-up mean 12 weeks; measured with: BDI change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	48	53	-	SMD 0.2 higher (0.19 lower to 0.59 higher)	VERY LOW	IMPORTANT
Depression symptoms - 3-month follow-up (follow-up mean 13 weeks; measured with: BDI change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	48	53	-	SMD 0.48 higher (0.08 to 0.87 higher)	VERY LOW	IMPORTANT
Depression symptoms - 6-month follow-up (follow-up mean 26 weeks; measured with: BDI change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Non-trauma-focused CBT	Present-centered therapy	Relative (95% CI)	Absolute		
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	48	53	-	SMD 0.06 higher (0.33 lower to 0.45 higher)	VERY LOW	IMPORTANT
Discontinuation (follow-up mean 12 weeks; assessed with: Number of participants lost to follow-up for any reason)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[4]	none	14/48 (29.2%)	18/53 (34%)	RR 0.86 (0.48 to 1.53)	48 fewer per 1000 (from 177 fewer to 180 more)	VERY LOW	CRITICAL

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

Present-centered therapy

Table 135: Clinical evidence profile: Present-centered therapy (+ TAU) versus TAU for early treatment (1-3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Present-centered therapy (+ TAU)	TAU	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology clinician-rated - Endpoint (follow-up 6-23 weeks; measured with: CAPS change score; Better indicated by lower values)												
2	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	60	59	-	SMD 0.52 lower (0.89 to 0.15 lower)	VERY LOW	CRITICAL
PTSD symptomatology clinician-rated - 3-month follow-up (follow-up mean 13 weeks; measured with: CAPS change score; Better indicated by lower values)												
2	randomised trials	very serious[1]	serious[4]	no serious indirectness	serious[5]	reporting bias[3]	60	56	-	SMD 0.44 lower (1.26 lower to 0.37 higher)	VERY LOW	CRITICAL
PTSD symptomatology clinician-rated - 6-month follow-up (follow-up mean 26 weeks; measured with: CAPS change score; Better indicated by lower values)												
2	randomised trials	very serious[1]	serious[4]	no serious indirectness	serious[5]	reporting bias[3]	59	55	-	SMD 0.24 lower (0.91 lower to 0.43 higher)	VERY LOW	CRITICAL

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Present-centered therapy (+ TAU)	TAU	Relative (95% CI)	Absolute	Quality	Importance
Response - Endpoint (follow-up mean 23 weeks; assessed with: Number of people showing improvement of at least 26 points on CAPS)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[5]	none	23/30 (76.7%)	20/30 (66.7%)	RR 1.15 (0.83 to 1.59)	100 more per 1000 (from 113 fewer to 393 more)	LOW	CRITICAL
Response - 3-month follow-up (follow-up mean 13 weeks; assessed with: Number of people showing improvement of at least 26 points on CAPS)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[5]	none	26/30 (86.7%)	20/30 (66.7%)	RR 1.3 (0.97 to 1.74)	200 more per 1000 (from 20 fewer to 493 more)	LOW	CRITICAL
Response - 6-month follow-up (follow-up mean 26 weeks; assessed with: Number of people showing improvement of at least 26 points on CAPS)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[5]	none	24/30 (80%)	23/30 (76.7%)	RR 1.04 (0.8 to 1.36)	31 more per 1000 (from 153 fewer to 276 more)	LOW	CRITICAL
Depression symptoms - Endpoint (follow-up 6-23 weeks; measured with: BDI change score; Better indicated by lower values)												
2	randomised trials	very serious[1]	serious[4]	no serious indirectness	serious[2]	reporting bias[3]	60	59	-	SMD 1.01 lower	VERY LOW	IMPORTANT

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Present-centered therapy (+ TAU)	TAU	Relative (95% CI)	Absolute	Quality	Importance
										(1.69 to 0.32 lower)		
Depression symptoms - 3-month follow-up (follow-up mean 13 weeks; measured with: BDI change score; Better indicated by lower values)												
2	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	60	56	-	SMD 0.77 lower (1.14 to 0.39 lower)	VERY LOW	IMPORTANT
Depression symptoms - 6-month follow-up (follow-up mean 26 weeks; measured with: BDI change score; Better indicated by lower values)												
2	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	59	55	-	SMD 0.79 lower (1.17 to 0.4 lower)	VERY LOW	IMPORTANT
Discontinuation (follow-up 6-23 weeks; assessed with: Number of participants lost to follow-up for any reason)												
2	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[6]	none	5/65 (7.7%)	6/65 (9.2%)	RR 0.83 (0.27 to 2.52)	16 fewer per 1000 (from 67 fewer to 140 more)	VERY LOW	CRITICAL

BDI= Beck Depression Inventory; CAPS= Clinician-administered PTSD scale; CI= confidence interval; RR= risk ratio; SMD= standardised mean difference; TAU=treatment as usual
[1] Risk of bias is high or unclear across multiple domains
[2] OIS not met (N<400)
[3] Data is not reported/cannot be extracted for all outcomes
[4] Substantial heterogeneity (I2=50-80%)

[5] *95% CI crosses both line of no effect and threshold for clinically important effect*
[6] *95% CI crosses line of no effect and threshold for both clinically important benefit and clinically important harm*

Table 136: Clinical evidence profile: Present-centered therapy versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Present-centered therapy	Waitlist	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology clinician-rated (follow-up 12-20 weeks; measured with: CAPS change score; Better indicated by lower values)												
2	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	75	68	-	SMD 1.02 lower (1.37 to 0.67 lower)	VERY LOW	CRITICAL
Remission (follow-up 12-20 weeks; assessed with: Number of people no longer meeting diagnostic criteria for PTSD)												
2	randomised trials	very serious[1]	serious[3]	no serious indirectness	very serious[4]	reporting bias[5]	15/75 (20%)	4/68 (5.9%)	RR 3.65 (0.43 to 31)	156 more per 1000 (from 34 fewer to 1000 more)	VERY LOW	CRITICAL
Dissociative symptoms (follow-up mean 20 weeks; measured with: DES change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[5]	22	23	-	SMD 1.26 lower (1.9 to 0.61 lower)	VERY LOW	IMPORTANT
Anxiety symptoms (follow-up mean 20 weeks; measured with: STAI state change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[5]	22	23	-	SMD 0.66 lower (1.26 to	VERY LOW	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Present-centered therapy	Waitlist	Relative (95% CI)	Absolute		
										0.06 lower)		
Depression symptoms (follow-up 12-20 weeks; measured with: BDI change score; Better indicated by lower values)												
2	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	75	68	-	SMD 0.66 lower (1 to 0.32 lower)	VERY LOW	IMPORTANT
Emotional and behavioural problems: Anger (follow-up mean 20 weeks; measured with: STAXI change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[4]	reporting bias[5]	22	23	-	SMD 0 higher (0.58 lower to 0.58 higher)	VERY LOW	IMPORTANT
Quality of life (follow-up mean 20 weeks; measured with: QOLI change score; Better indicated by higher values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[6]	reporting bias[5]	22	23	-	SMD 0.33 higher (0.26 lower to 0.92 higher)	VERY LOW	IMPORTANT
Discontinuation (follow-up 12-20 weeks; assessed with: Number of participants lost to follow-up for any reason)												
2	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[4]	none	20/75 (26.7%)	13/68 (19.1%)	RR 1.38 (0.74 to 2.55)	73 more per 1000 (from 50 fewer to 296 more)	VERY LOW	CRITICAL

BDI=Beck Depression Inventory; CAPS= Clinician-administered PTSD scale; CI= confidence interval; DES= Dissociative Experiences Scales; RR= risk ratio; SMD= standardised mean difference; STAI= State-Trait Anxiety Inventory; STAXI= State-Trait Anger Experssion Inventory; QOLI=Qualiy of life index
[1] Risk of bias is high or unclear across multiple domains
[2] OIS not met (N<400)
[3] Substantial heterogeneity (I2=50-80%)
[4] 95% CI crosses line of no effect and threshold for both clinically important benefit and clinically important harm
[5] Data is not reported/cannot be extracted for all outcomes
[6] 95% CI crosses both line of no effect and threshold for clinically important effect

Cognitive therapies

Table 137: Clinical evidence profile: Metacognitive therapy (+/- TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Metacognitive therapy (+/- TAU)**	**Waitlist or TAU**	**Relative (95% CI)**	**Absolute**		
PTSD symptomatology self-rated (follow-up mean 8 weeks; measured with: IES/PDS change score; Better indicated by lower values)												
2	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	20	20	-	SMD 3.45 lower (4.51 to 2.39 lower)	VERY LOW	CRITICAL
Response self-rated at endpoint (follow-up mean 8 weeks; assessed with: Number of people showing clinically significant improvement based on at least 10-point improvement on IES)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[3]	10/11 (90.9%)	1/10 (10%)	RR 9.09 (1.4 to 58.91)	809 more per 1000 (from 40 more to 1000 more)	VERY LOW	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Metacognitive therapy (+/- TAU)	Waitlist or TAU	Relative (95% CI)	Absolute		
Anxiety symptoms (follow-up mean 8 weeks; measured with: BAI change score; Better indicated by lower values)												
2	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	20	20	-	SMD 1.97 lower (2.76 to 1.19 lower)	VERY LOW	IMPORTANT
Depression symptoms (follow-up mean 8 weeks; measured with: BDI-II change score; Better indicated by lower values)												
2	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	20	20	-	SMD 2.45 lower (3.32 to 1.57 lower)	VERY LOW	IMPORTANT
Discontinuation (follow-up mean 8 weeks; assessed with: Number of participants lost to follow-up for any reason)												
2	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[5]	none	2/21 (9.5%)	0/20 (0%)	RR 2.87 (0.32 to 25.56)	-	LOW	CRITICAL

BAI= Beck Anxiety Inventory; BDI= Beck Depression Inventory; CI= confidence interval; IES= Impact of Event Scale; PDS= Post-traumatic Diagnostic Scale; RR= risk ratio; SMD= standardised mean difference; TAU=treatment as usual;

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

[2] OIS not met (N<400)

[3] Data is not reported/cannot be extracted for all outcomes

[4] OIS not met (events<300)

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

Behavioural therapies

Table 138: Clinical evidence profile: Single-session behavioural therapy versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Single-session behavioural therapy	Waitlist	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology self-rated at 6-week follow-up (follow-up mean 6 weeks; measured with: TSSC change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	31	28	-	SMD 0.98 lower (1.52 to 0.43 lower)	VERY LOW	CRITICAL
PTSD symptomatology clinician-rated at 6-8 week follow-up (follow-up 6-8 weeks; measured with: CAPS change score; Better indicated by lower values)												
2	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	47	43	-	SMD 1.2 lower (1.65 to 0.75 lower)	VERY LOW	CRITICAL
Response at 6-week follow-up (follow-up mean 6 weeks; assessed with: Number of people rated as 'much' or 'very much' improved on CGI-I)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[3]	17/31 (54.8%)	4/28 (14.3%)	RR 3.84 (1.47 to 10.04)	406 more per 1000 (from 67 more to 1000 more)	VERY LOW	CRITICAL
Functional impairment at 6-8 week follow-up (follow-up 6-8 weeks; measured with: WSA change score; Better indicated by lower values)												
2	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	47	43	-	SMD 0.71 lower (1.14 to 0.28 lower)	VERY LOW	IMPORTANT

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Single-session behavioural therapy	Waitlist	Relative (95% CI)	Absolute	Quality	Importance
Depression symptoms at 6-8 week follow-up (follow-up 6-8 weeks; measured with: BDI change score; Better indicated by lower values)												
2	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	47	43	-	SMD 0.69 lower (1.12 to 0.26 lower)	VERY LOW	IMPORTANT
Discontinuation (follow-up 6-8 weeks; assessed with: Number of participants lost to follow-up for any reason)												
2	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	0/47 (0%)	0/43 (0%)	-	-	LOW	CRITICAL

CAPS= Clinician-administered PTSD scale; CGI-I=Clinical Global impression-improvement; BDI= Beck Depression Inventory; CI=confidence interval; RR=risk ratio; SMD=standardised mean difference; TSSC=total symptom severity complex; WSA=Work and Social Adjustment

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

[2] *OIS not met (N<400)*

[3] *Data is not reported/cannot be extracted for all outcomes*

[4] *OIS not met (events<300)*

Problem solving

Table 139: Clinical evidence profile: Problem solving versus supportive counselling for early treatment (1-3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Problem solving	Supportive counselling	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology self-report - Endpoint (follow-up mean 8 weeks; measured with: IES-R endpoint score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	152	157	-	SMD 0.08 lower (0.3 lower to 0.15 higher)	VERY LOW	CRITICAL
PTSD symptomatology self-report - 3-month follow-up (follow-up mean 13 weeks; measured with: IES-R endpoint score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	152	157	-	SMD 0.17 lower (0.39 lower to 0.05 higher)	VERY LOW	CRITICAL
Discontinuation (follow-up mean 8 weeks; assessed with: Number of participants lost to follow-up for any reason)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	56/152 (36.8%)	49/157 (31.2%)	RR 1.18 (0.86 to 1.61)	56 more per 1000 (from 44 fewer to 190 more)	LOW	CRITICAL

CI=confidence interval; IES-R= Impact of Event Scale-Revised; RR=risk ratio; SMD=standardised mean difference

[1] *Risk of bias is high or unclear across multiple domains*
[2] *OIS not met (N<400)*
[3] *Data is not reported/cannot be extracted for all outcomes*
[4] *OIS not met (events<300)*

Eye movement desensitisation and reprocessing (EMDR)

Table 140: Clinical evidence profile: Eye movement desensitisation and reprocessing (EMDR) versus supportive counselling for early treatment (1-3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Eye movement desensitisation and reprocessing (EMDR)	Supportive counselling	Relative (95% CI)	Absolute		
PTSD symptomatology clinician-rated - Endpoint (follow-up mean 2 weeks; measured with: SPRINT change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	19	20	-	SMD 2.19 lower (3 to 1.38 lower)	VERY LOW	CRITICAL
PTSD symptomatology clinician-rated - 1-month follow-up (follow-up mean 4 weeks; measured with: SPRINT change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	19	20	-	SMD 3 lower (3.94 to 2.06 lower)	VERY LOW	CRITICAL
PTSD symptomatology clinician-rated - 3-month follow-up (follow-up mean 13 weeks; measured with: SPRINT change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	19	20	-	SMD 3.68 lower	VERY LOW	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Eye movement desensitisation and reprocessing (EMDR)	Supportive counselling	Relative (95% CI)	Absolute		
										(4.75 to 2.61 lower)		
Discontinuation (follow-up mean 2 weeks; assessed with: Number of participants lost to follow-up for any reason)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	0/19 (0%)	0/20 (0%)	not pooled	not pooled	LOW	CRITICAL

CI=confidence interval; RR=risk ratio; SMD=standardised mean difference; SPRINT=Short Post-Traumatic Stress Disorder Rating Interview;
[1] Risk of bias is high or unclear across multiple domains
[2] OIS not met (N<400)
[3] OIS not met (events<300)

Table 141: Clinical evidence profile: Eye movement desensitisation and reprocessing (EMDR; +/- TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Eye movement desensitisation and reprocessing (EMDR; +/- TAU)	Waitlist or TAU	Relative (95% CI)	Absolute		
PTSD symptomatology self-report at endpoint (follow-up 2-10 weeks; measured with: IES/IES-R/Trauma Symptoms Inventory/PDS/PSS-SR change scores/M-PTSD endpoint; Better indicated by lower values)												
9	randomised trials	serious[1]	very serious[2]	no serious indirectness	serious[3]	reporting bias[4]	200	193	-	SMD 1.64 lower	VERY LOW	CRITICAL

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Eye movement desensitisation and reprocessing (EMDR; +/- TAU)	Waitlist or TAU	Relative (95% CI)	Absolute	Quality	Importance
										(2.49 to 0.8 lower)		
PTSD symptomatology self-report at 1-month follow-up (follow-up mean 4 weeks; measured with: IES-R change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	49	49	-	SMD 2.21 lower (2.71 to 1.7 lower)	LOW	CRITICAL
PTSD symptomatology clinician-rated (follow-up 2-6 weeks; measured with: SI–PTSD/CAPS change score; Better indicated by lower values)												
2	randomised trials	very serious[1]	very serious[2]	no serious indirectness	serious[3]	reporting bias[4]	33	32	-	SMD 1.42 lower (2 to 0.84 lower)	VERY LOW	CRITICAL
Remission at endpoint (follow-up 6-7 weeks; assessed with: Number of people no longer meeting diagnostic criteria for PTSD)												
2	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious[5]	none	45/74 (60.8%)	5/73 (6.8%)	RR 8.76 (3.69 to 20.82)	532 more per 1000 (from 184 more to 1000 more)	MODERATE	CRITICAL
Remission at 1-month follow-up (follow-up mean 4 weeks; assessed with: Number of people no longer meeting diagnostic criteria for PTSD)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Eye movement desensitisation and reprocessing (EMDR; +/- TAU)	Waitlist or TAU	Relative (95% CI)	Absolute		
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious[5]	none	24/49 (49%)	2/49 (4.1%)	RR 12 (3 to 48.04)	449 more per 1000 (from 82 more to 1000 more)	MODERATE	CRITICAL
Response self-rated (follow-up mean 10 weeks; assessed with: Number of people showing clinically significant improvement, based on reliable change indices (RCI) on IES)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[5]	reporting bias[4]	17/39 (43.6%)	1/29 (3.4%)	RR 12.64 (1.78 to 89.63)	401 more per 1000 (from 27 more to 1000 more)	VERY LOW	CRITICAL
Dissociative symptoms (follow-up mean 6 weeks; measured with: DES change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	20	20	-	SMD 1.32 lower (2.01 to 0.63 lower)	LOW	IMPORTANT
Anxiety symptoms (follow-up 6-10 weeks; measured with: STAI State/HAM-A change score; Better indicated by lower values)												
3	randomised trials	serious[1]	very serious[2]	no serious indirectness	serious[3]	reporting bias[4]	57	56	-	SMD 1.72 lower (2.17 to	VERY LOW	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Eye movement desensitisation and reprocessing (EMDR; +/- TAU)	Waitlist or TAU	Relative (95% CI)	Absolute		
										1.27 lower)		
Depression symptoms at endpoint (follow-up 6-10 weeks; measured with: BDI/BDI-II/MADRS change score; Better indicated by lower values)												
6	randomised trials	serious[1]	serious[6]	no serious indirectness	serious[3]	none	141	138	-	SMD 1.7 lower (2.26 to 1.15 lower)	VERY LOW	IMPORTANT
Depression symptoms at 1-month follow-up (follow-up mean 4 weeks; measured with: BDI-II change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	49	49	-	SMD 1.6 lower (2.06 to 1.14 lower)	LOW	IMPORTANT
Functional impairment (follow-up mean 10 weeks; measured with: SDS change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	reporting bias4	27	24	-	SMD 1.63 lower (2.27 to 0.99 lower)	VERY LOW	IMPORTANT
Discontinuation (follow-up 6-10 weeks; assessed with: Number of participants lost to follow-up for any reason)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Eye movement desensitisation and reprocessing (EMDR; +/- TAU)	Waitlist or TAU	Relative (95% CI)	Absolute		
7	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[5]	none	32/183 (17.5%)	29/173 (16.8%)	RR 0.99 (0.63 to 1.56)	2 fewer per 1000 (from 62 fewer to 94 more)	LOW	CRITICAL

BDI= Beck Depression Inventory; CAPS= Clinician-administered PTSD scale; CI=confidence interval; DES= Dissociative Experiences Scales; HAM-A= Hamilton Rating Scale for Anxiety; IES-R= Impact of Event Scale-Revised; MADRS=Montgomery-Asberg Depression Rating Scale; M-PTSD=Missisippi Scale for Combat-Related PTSD; PDS= Post-traumatic Diagnostic Scale; PSS-SR= PTSD symptom scale-interview/self-report; RR=risk ratio; SDS= Sheehan Disability Scale; SI-PTSD= Structured interview for PTSD; SMD=standardised mean difference; STAI= State-Trait Anxiety Inventory; TAU=Treatment as usual;

[1] Risk of bias is high or unclear across multiple domains
[2] Considerable heterogeneity (I2>80%)
[3] OIS not met (N<400)
[4] Data is not reported/cannot be extracted for all outcomes
[5] OIS not met (events<300)
[6] Substantial heterogeneity (I2=50-80%)

Table 142: Clinical evidence profile: Eye movement desensitisation and reprocessing (EMDR) versus pill placebo for delayed treatment (>3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Eye movement desensitisation and reprocessing (EMDR)	Pill placebo	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology clinician-rated (follow-up mean 8 weeks; measured with: CAPS change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	29	29	-	SMD 0.52 lower (1.04 lower to 0.01 higher)	LOW	CRITICAL
Remission (follow-up mean 8 weeks; assessed with: Number of people scoring <20 on CAPS)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	8/29 (27.6%)	3/26 (11.5%)	RR 2.39 (0.71 to 8.07)	160 more per 1000 (from 33 fewer to 816 more)	VERY LOW	CRITICAL
Depression symptoms (follow-up mean 8 weeks; measured with: BDI II change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	29	29	-	SMD 0.12 lower (0.63 lower to 0.4 higher)	LOW	IMPORTANT
Discontinuation (follow-up mean 8 weeks; assessed with: Number of participants lost to follow-up for any reason)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Eye movement desensitisation and reprocessing (EMDR)	Pill placebo	Relative (95% CI)	Absolute		
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	5/29 (17.2%)	3/26 (11.5%)	RR 1.49 (0.4 to 5.65)	57 more per 1000 (from 69 fewer to 537 more)	VERY LOW	CRITICAL

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

Table 143: Clinical evidence profile: Eye movement desensitisation and reprocessing (EMDR) versus supportive counselling for delayed treatment (>3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Eye movement desensitisation and reprocessing (EMDR)	Supportive counselling	Relative (95% CI)	Absolute		
PTSD symptomatology self-rated (follow-up mean 2 weeks; measured with: IES change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	28	29	-	SMD 1.35 lower (1.93 to	VERY LOW	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Eye movement desensitisation and reprocessing (EMDR)	Supportive counselling	Relative (95% CI)	Absolute		
										0.78 lower)		
Anxiety symptoms (follow-up mean 2 weeks; measured with: STAI State change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	29	30	-	SMD 0.86 lower (1.4 to 0.33 lower)	VERY LOW	IMPORTANT
Depression symptoms (follow-up mean 2 weeks; measured with: BDI change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	30	30	-	SMD 0.74 lower (1.27 to 0.22 lower)	VERY LOW	IMPORTANT
Discontinuation (follow-up mean 2 weeks; assessed with: Number of participants lost to follow-up for any reason)												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[4]	none	4/34 (11.8%)	3/33 (9.1%)	RR 1.29 (0.31 to 5.34)	26 more per 1000 (from 63 fewer to 395 more)	LOW	CRITICAL

BDI= Beck Depression Inventory; CI=confidence interval; IES= Impact of Event Scale; RR=risk ratio; SMD=standardised mean difference; STAI= State-Trait Anxiety Inventory;
[1] Risk of bias is high or unclear across multiple domains
[2] OIS not met (N<400)
[3] Data is not reported/cannot be extracted for all outcomes
[4] 95% CI crosses line of no effect and threshold for both clinically important benefit and clinically important harm

Table 144: Clinical evidence profile: Eye movement desensitisation and reprocessing (EMDR) versus non-trauma-focused CBT for delayed treatment (>3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Eye movement desensitisation and reprocessing (EMDR)**	**Non-trauma-focused CBT**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
PTSD symptomatology clinician-rated - Endpoint (follow-up mean 12 weeks; measured with: CAPS change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	32	29	-	SMD 0.12 higher (0.38 lower to 0.63 higher)	VERY LOW	CRITICAL
PTSD symptomatology clinician-rated - 3-month follow-up (follow-up mean 13 weeks; measured with: CAPS change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	32	31	-	SMD 0.24 higher (0.26 lower to 0.73 higher)	VERY LOW	CRITICAL
PTSD symptomatology self-rated - Endpoint (follow-up mean 12 weeks; measured with: HTQ change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Eye movement desensitisation and reprocessing (EMDR)	Non-trauma-focused CBT	Relative (95% CI)	Absolute	Quality	Importance
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	32	30	-	SMD 0.3 lower (0.8 lower to 0.2 higher)	VERY LOW	CRITICAL
PTSD symptomatology self-rated - 3-month follow-up (follow-up mean 13 weeks; measured with: HTQ change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	31	32	-	SMD 0.02 higher (0.47 lower to 0.52 higher)	VERY LOW	CRITICAL
Response at 3-month follow-up (follow-up mean 13 weeks; assessed with: number of people showing improvement of at least 10 points on CAPS)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	13/37 (35.1%)	13/37 (35.1%)	RR 1 (0.54 to 1.86)	0 fewer per 1000 (from 162 fewer to 302 more)	VERY LOW	CRITICAL
Anxiety symptoms - Endpoint (follow-up mean 12 weeks; measured with: HSCL-25: Anxiety change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	32	30	-	SMD 0.06 lower (0.56 lower to 0.43 higher)	VERY LOW	IMPORTANT
Anxiety symptoms - 3-month follow-up (follow-up mean 13 weeks; measured with: HSCL-25: Anxiety change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Eye movement desensitisation and reprocessing (EMDR)	Non-trauma-focused CBT	Relative (95% CI)	Absolute	Quality	Importance
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	31	32	-	SMD 0.08 higher (0.41 lower to 0.58 higher)	VERY LOW	IMPORTANT
Depression symptoms - Endpoint (follow-up mean 12 weeks; measured with: HSCL-25: Depression change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	32	30	-	SMD 0.05 higher (0.45 lower to 0.54 higher)	VERY LOW	IMPORTANT
Depression symptoms - 3-month follow-up (follow-up mean 13 weeks; measured with: HSCL-25: Depression change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	31	32	-	SMD 0.09 higher (0.4 lower to 0.59 higher)	VERY LOW	IMPORTANT
Discontinuation (follow-up mean 12 weeks; assessed with: Number of participants lost to follow-up for any reason)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	5/37 (13.5%)	5/37 (13.5%)	RR 1 (0.32 to 3.17)	0 fewer per 1000 (from 92 fewer to 293 more)	VERY LOW	CRITICAL

CAPS= Clinician-administered PTSD scale; CBT= cognitive behavioural therapy; CI=confidence interval; HSCL-25= Hopkins Symptom Checklist-25; HTQ= Harvard Trauma Questionnaire; RR=risk ratio; SMD=standardised mean difference

[1] *Risk of bias is high or unclear across multiple domains*
[2] *95% CI crosses both line of no effect and threshold for clinically important effect*
[3] *95% CI crosses line of no effect and threshold for both clinically important benefit and clinically important harm*

Table 145: Clinical evidence profile: Eye movement desensitisation and reprocessing (EMDR) versus 'other active psych intervention' for delayed treatment (>3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Eye movement desensitisation and reprocessing (EMDR)**	**'other active psych intervention'**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
PTSD symptomatology self-rated- Endpoint (follow-up mean 6 weeks; measured with: IES change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	20	20	-	SMD 0.35 lower (0.98 lower to 0.27 higher)	VERY LOW	CRITICAL
PTSD symptomatology self-rated - 3-month follow-up (follow-up mean 13 weeks; measured with: IES change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	19	16	-	SMD 1.06 lower (1.78 to 0.34 lower)	VERY LOW	CRITICAL
PTSD symptomatology self-rated - 18-month follow-up (follow-up mean 78 weeks; measured with: IES change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	14	17	-	SMD 0.75 lower (1.49 to	VERY LOW	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Eye movement desensitisation and reprocessing (EMDR)	'other active psych intervention'	Relative (95% CI)	Absolute		
										0.02 lower)		
Depression symptoms - Endpoint (follow-up mean 6 weeks; measured with: BDI change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	20	20	-	SMD 0.13 lower (0.75 lower to 0.49 higher)	VERY LOW	IMPORTANT
Depression symptoms - 3-month follow-up (follow-up mean 13 weeks; measured with: BDI change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	18	16	-	SMD 1.14 lower (1.87 to 0.41 lower)	VERY LOW	IMPORTANT
Depression symptoms - 18-month follow-up (follow-up mean 78 weeks; measured with: BDI change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	14	17	-	SMD 0.67 lower (1.4 lower to 0.06 higher)	VERY LOW	IMPORTANT
Discontinuation (follow-up mean 6 weeks; assessed with: Number of participants lost to follow-up for any reason)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Eye movement desensitisation and reprocessing (EMDR)	'other active psych intervention'	Relative (95% CI)	Absolute		
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	0/20 (0%)	0/20 (0%)	not pooled	not pooled	LOW	CRITICAL

BDI= Beck Depression Inventory; CI=confidence interval; IES= Impact of Event Scale; RR=risk ratio; SMD=standardised mean difference
[1] Risk of bias is high or unclear across multiple domains
[2] 95% CI crosses both line of no effect and threshold for clinically important effect
[3] OIS not met (N<400)
[4] OIS not met (events<300)

Table 146: Clinical evidence profile: Eye movement desensitisation and reprocessing (EMDR; +/- TAU) versus relaxation (+/- TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Eye movement desensitisation and reprocessing (EMDR; +/- TAU)	Relaxation (+/- TAU)	Relative (95% CI)	Absolute		
PTSD symptomatology self-rated at endpoint (follow-up mean 6 weeks; measured with: IES/PSS-SR change score; Better indicated by lower values)												
2	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	25	27	-	SMD 0.26 lower (0.82 lower to 0.3 higher)	LOW	CRITICAL

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Eye movement desensitisation and reprocessing (EMDR; +/- TAU)	Relaxation (+/- TAU)	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology self-rated at 3-month follow-up (follow-up mean 13 weeks; measured with: PSS-SR change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	15	15	-	SMD 0.54 lower (1.27 lower to 0.19 higher)	LOW	CRITICAL
PTSD symptomatology self-rated at 6-month follow-up (follow-up mean 26 weeks; measured with: IES-R change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	20	22	-	SMD 0.16 lower (0.77 lower to 0.45 higher)	VERY LOW	CRITICAL
PTSD symptomatology clinician-rated at endpoint (measured with: CAPS change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	15	15	-	SMD 0.24 lower (0.96 lower to 0.48 higher)	LOW	CRITICAL
PTSD symptomatology clinician-rated at 3-month follow-up (follow-up mean 13 weeks; measured with: CAPS change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	15	15	-	SMD 0.45 lower (1.18 lower to 0.27 higher)	LOW	CRITICAL
PTSD symptomatology clinician-rated at 6-month follow-up (follow-up mean 26 weeks; measured with: CAPS change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Eye movement desensitisation and reprocessing (EMDR; +/- TAU)	Relaxation (+/- TAU)	Relative (95% CI)	Absolute		
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	20	22	-	SMD 0.3 lower (0.91 lower to 0.3 higher)	VERY LOW	CRITICAL
Remission at endpoint (assessed with: Number of people no longer meeting diagnostic criteria or no longer above clinical threshold on a scale for PTSD)												
2	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[4]	reporting bias[3]	18/44 (40.9%)	19/44 (43.2%)	RR 0.93 (0.43 to 2.01)	30 fewer per 1000 (from 246 fewer to 436 more)	VERY LOW	CRITICAL
Remission at 3-month follow-up (follow-up mean 13 weeks; assessed with: Number of people no longer above clinical threshold on a scale for PTSD)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[4]	none	4/19 (21.1%)	4/19 (21.1%)	RR 1 (0.29 to 3.43)	0 fewer per 1000 (from 149 fewer to 512 more)	VERY LOW	CRITICAL
Remission at 6-month follow-up (follow-up mean 26 weeks; assessed with: Number of people no longer meeting diagnostic criteria for PTSD)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	20/25 (80%)	17/25 (68%)	RR 1.18 (0.84 to 1.64)	122 more per 1000 (from 109 fewer to 435 more)	VERY LOW	CRITICAL

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Eye movement desensitisation and reprocessing (EMDR; +/- TAU)	Relaxation (+/- TAU)	Relative (95% CI)	Absolute	Quality	Importance
Dissociative symptoms - Endpoint (measured with: CAPS dissociation cluster change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[4]	none	15	15	-	SMD 0.09 higher (0.63 lower to 0.8 higher)	VERY LOW	IMPORTANT
Dissociative symptoms - 3-month follow-up (follow-up mean 13 weeks; measured with: CAPS dissociation cluster change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	15	15	-	SMD 0.45 lower (1.18 lower to 0.27 higher)	LOW	IMPORTANT
Anxiety symptoms at endpoint/follow-up (follow-up 6-41 weeks; measured with: HADS-A/STAI state change score ; Better indicated by lower values)												
2	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	30	34	-	SMD 0.22 lower (0.72 lower to 0.27 higher)	VERY LOW	IMPORTANT
Depression symptoms ar endpoint (follow-up mean 6 weeks; measured with: BDI change score; Better indicated by lower values)												
2	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[5]	none	25	27	-	SMD 0.64 lower (1.2 to 0.08 lower)	LOW	IMPORTANT
Depression symptoms at 3-6 month follow-up (follow-up 13-26 weeks; measured with: BDI/HADS-D change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Eye movement desensitisation and reprocessing (EMDR; +/- TAU)	Relaxation (+/- TAU)	Relative (95% CI)	Absolute		
2	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	35	37	-	SMD 0.19 lower (0.65 lower to 0.27 higher)	VERY LOW	IMPORTANT
Quality of life (follow-up mean 15 weeks; measured with: Functional Assessment of Quality of Life in MS change score; Better indicated by higher values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[4]	reporting bias[3]	20	22	-	SMD 0.03 higher (0.57 lower to 0.64 higher)	VERY LOW	IMPORTANT
Discontinuation (follow-up 6-15 weeks; assessed with: Number of participants lost to follow-up for any reason)												
3	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[4]	none	9/54 (16.7%)	8/57 (14%)	RR 1.16 (0.49 to 2.77)	22 more per 1000 (from 72 fewer to 248 more)	VERY LOW	CRITICAL

BDI= Beck Depression Inventory; CAPS= Clinician-administered PTSD symptom scale; CI=confidence interval; HADS-A= Hospital Anxiety and Depression Scale-Anxiety; IES= Impact of Event Scale; PSS-SR= PTSD symptom scale- self-report; RR=risk ratio; SMD=standardised mean difference; STAI= State-Trait Anxiety Inventory; TAU=treatment as usual

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

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

[3] Data is not reported/cannot be extracted for all outcomes

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

[5] OIS not met (N<400)

Table 147: Clinical evidence profile: Eye movement desensitisation and reprocessing (EMDR) versus combined somatic and cognitive therapies for delayed treatment (>3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Eye movement desensitisation and reprocessing (EMDR)	Combined somatic and cognitive therapies	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology self-report - Endpoint (follow-up mean 8 weeks; measured with: PCL-C change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	23	23	-	SMD 0.14 lower (0.72 lower to 0.44 higher)	LOW	CRITICAL
PTSD symptomatology self-report - 3-month follow-up (follow-up mean 13 weeks; measured with: PCL-C change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	23	23	-	SMD 0.04 higher (0.54 lower to 0.62 higher)	VERY LOW	CRITICAL
PTSD symptomatology clinician-rated - Endpoint (follow-up mean 8 weeks; measured with: CAPS change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	23	23	-	SMD 0.15 lower (0.73 lower to 0.43 higher)	LOW	CRITICAL

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Eye movement desensitisation and reprocessing (EMDR)	Combined somatic and cognitive therapies	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology clinician-rated - 3-month follow-up (follow-up mean 13 weeks; measured with: CAPS change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	23	23	-	SMD 0.01 lower (0.59 lower to 0.57 higher)	VERY LOW	CRITICAL
Response self-rated - Endpoint (follow-up mean 8 weeks; assessed with: Number of people showing clinically significant improvement, based on reliable change indices (RCI) on PCL-C)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	8/23 (34.8%)	2/23 (8.7%)	RR 4 (0.95 to 16.84)	261 more per 1000 (from 4 fewer to 1000 more)	LOW	CRITICAL
Response self-rated - 3-month follow-up (follow-up mean 13 weeks; assessed with: Number of people showing clinically significant improvement, based on reliable change indices (RCI) on PCL-C)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	6/23 (26.1%)	4/23 (17.4%)	RR 1.5 (0.49 to 4.62)	87 more per 1000 (from 89 fewer to 630 more)	VERY LOW	CRITICAL

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Eye movement desensitisation and reprocessing (EMDR)	Combined somatic and cognitive therapies	Relative (95% CI)	Absolute	Quality	Importance
Response clinician-rated - Endpoint (follow-up mean 8 weeks; assessed with: Number of people showing clinically significant improvement, based on RCI on CAPS)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	10/23 (43.5%)	9/23 (39.1%)	RR 1.11 (0.56 to 2.22)	43 more per 1000 (from 172 fewer to 477 more)	VERY LOW	CRITICAL
Response clinician-rated - 3-month follow-up (follow-up mean 13 weeks; assessed with: Number of people showing clinically significant improvement, based on RCI on CAPS)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	8/23 (34.8%)	9/23 (39.1%)	RR 0.89 (0.42 to 1.89)	43 fewer per 1000 (from 227 fewer to 348 more)	VERY LOW	CRITICAL
Anxiety symptoms - Endpoint (follow-up mean 8 weeks; measured with: HADS-A change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	23	23	-	SMD 0.04 higher (0.53 lower to 0.62 higher)	VERY LOW	IMPORTANT
Anxiety symptoms - 3-month follow-up (follow-up mean 13 weeks; measured with: HADS-A change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Eye movement desensitisation and reprocessing (EMDR)	Combined somatic and cognitive therapies	Relative (95% CI)	Absolute		
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	23	23	-	SMD 0.09 lower (0.67 lower to 0.49 higher)	LOW	IMPORTANT
Depression symptoms - Endpoint (follow-up mean 8 weeks; measured with: HADS-D change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	23	23	-	SMD 0.24 lower (0.82 lower to 0.34 higher)	LOW	IMPORTANT
Depression symptoms - 3-month follow-up (follow-up mean 13 weeks; measured with: HADS-D change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	23	23	-	SMD 0.19 lower (0.77 lower to 0.39 higher)	LOW	IMPORTANT
Quality of life - Endpoint (follow-up mean 8 weeks; measured with: Satisfaction with Life Scale; change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	23	23	-	SMD 0.11 higher	LOW	IMPORTANT

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Eye movement desensitisation and reprocessing (EMDR)	Combined somatic and cognitive therapies	Relative (95% CI)	Absolute	Quality	Importance
										(0.47 lower to 0.68 higher)		
Quality of life - 3-month follow-up (follow-up mean 13 weeks; measured with: Satisfaction with Life Scale change score; Better indicated by higher values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	23	23	-	SMD 0.51 higher (0.08 lower to 1.09 higher)	LOW	IMPORTANT
Discontinuation (follow-up mean 8 weeks; assessed with: Number of participants lost to follow-up for any reason)												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[3]	none	10/23 (43.5%)	9/23 (39.1%)	RR 1.11 (0.56 to 2.22)	43 more per 1000 (from 172 fewer to 477 more)	LOW	CRITICAL

CAPS= Clinician-administered PTSD scale; CI=confidence interval; HADS-A/D= Hospital Anxiety and Depression Scale-Anxiety/Depression; PCL-C= PTSD checklist-Civilian; RR=risk ratio; SMD=standardised mean difference

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

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

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

Table 148: Clinical evidence profile: Eye movement desensitisation and reprocessing (EMDR) versus fluoxetine for delayed treatment (>3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Eye movement desensitisation and reprocessing (EMDR)	Fluoxetine	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology clinician-rated - Endpoint (follow-up mean 8 weeks; measured with: CAPS change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	29	30	-	SMD 0.38 lower (0.9 lower to 0.13 higher)	LOW	CRITICAL
PTSD symptomatology clinician-rated - 6-month follow-up (follow-up mean 26 weeks; measured with: CAPS change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	24	26	-	SMD 0.91 lower (1.5 to 0.33 lower)	LOW	CRITICAL
Remission - Endpoint (follow-up mean 8 weeks; assessed with: Number of people scoring <20 on CAPS)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[4]	none	8/29 (27.6%)	4/30 (13.3%)	RR 2.07 (0.7 to 6.13)	143 more per 1000 (from 40 fewer to 684 more)	VERY LOW	CRITICAL
Remission - 6-month follow-up (follow-up mean 26 weeks; assessed with: Number of people scoring <20 on CAPS)												

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Eye movement desensitisation and reprocessing (EMDR)	Fluoxetine	Relative (95% CI)	Absolute	Quality	Importance
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[5]	none	14/24 (58.3%)	0/26 (0%)	RR 31.32 (1.97 to 497.93)	-	LOW	CRITICAL
Depression symptoms - Endpoint (follow-up mean 8 weeks; measured with: BDI-II change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	29	30	-	SMD 0.29 lower (0.81 lower to 0.22 higher)	LOW	IMPORTANT
Depression symptoms - 6-month follow-up (follow-up mean 26 weeks; measured with: BDI-II change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	24	26	-	SMD 1.05 lower (1.64 to 0.45 lower)	LOW	IMPORTANT
Discontinuation (follow-up mean 8 weeks; assessed with: Number of participants lost to follow-up for any reason)												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[4]	none	5/29 (17.2%)	4/30 (13.3%)	RR 1.29 (0.38 to 4.34)	39 more per 1000 (from 83 fewer to 445 more)	LOW	CRITICAL

BDI=Beck Depression Inventory CAPS= Clinician-administered PTSD scale; CI=confidence interval; RR=risk ratio; SMD=standardised mean difference
[1] Risk of bias is high or unclear across multiple domains
[2] 95% CI crosses both line of no effect and threshold for clinically important effect
[3] OIS not met (N<400)
[4] 95% CI crosses line of no effect and threshold for both clinically important benefit and clinically important harm
[5] OIS not met (events<300)

Hypnotherapy

Table 149: Clinical evidence profile: Hypnotherapy + TAU versus TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Hypnotherapy + TAU**	**TAU**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
PTSD symptomatology self-rated (follow-up mean 16 weeks; measured with: IES change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	29	23	-	SMD 0.89 lower (1.46 to 0.31 lower)	VERY LOW	CRITICAL

CI=confidence interval; IES=Impact of event scale; RR=risk ratio; SMD=standardised mean difference; TAU=treatment as usual
[1] Risk of bias is high or unclear across multiple domains
[2] OIS not met (N<400)
[3] Data is not reported/cannot be extracted for all outcomes

Table 150: Clinical evidence profile: Hypnotherapy followed by trauma-focused CBT versus symptom monitoring followed by trauma-focused CBT for delayed treatment (>3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Hypnotherapy followed by trauma-focused CBT	Symptom monitoring followed by trauma-focused CBT	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology clinician-rated - Endpoint (follow-up mean 15 weeks; measured with: CAPS change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	29	25	-	SMD 0.29 lower (0.83 lower to 0.24 higher)	VERY LOW	CRITICAL
PTSD symptomatology clinician-rated - 3-month follow-up (follow-up mean 13 weeks; measured with: CAPS change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	30	35	-	SMD 0.16 lower (0.65 lower to 0.33 higher)	VERY LOW	CRITICAL
Depression symptoms - Endpoint (follow-up mean 15 weeks; measured with: BDI-II change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	29	25	-	SMD 0.62 lower (1.17 to	VERY LOW	IMPORTANT

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Hypnotherapy followed by trauma-focused CBT	Symptom monitoring followed by trauma-focused CBT	Relative (95% CI)	Absolute	Quality	Importance
										0.07 lower)		
Depression symptoms - 3-month follow-up (follow-up mean 13 weeks; measured with: BDI-II change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	30	35	-	SMD 0.25 lower (0.74 lower to 0.24 higher)	VERY LOW	IMPORTANT
Sleeping difficulties - Endpoint (follow-up mean 15 weeks; measured with: PSQI change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	29	25	-	SMD 0.41 lower (0.95 lower to 0.13 higher)	VERY LOW	IMPORTANT
Sleeping difficulties - 3-month follow-up (follow-up mean 13 weeks; measured with: PSQI change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	30	35	-	SMD 0.31 lower (0.8 lower to 0.18 higher)	VERY LOW	IMPORTANT

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Hypnotherapy followed by trauma-focused CBT	Symptom monitoring followed by trauma-focused CBT	Relative (95% CI)	Absolute	Quality	Importance
Discontinuation (follow-up mean 15 weeks; assessed with: Number of participants lost to follow-up for any reason)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	23/52 (44.2%)	31/56 (55.4%)	RR 0.8 (0.54 to 1.17)	111 fewer per 1000 (from 255 fewer to 94 more)	LOW	CRITICAL

BDI= Beck Depression Inventory; CAPS= Clinician-administered PTSD scale; CBT= cognitive behavioural therapy; CI=confidence interval; PSQI=Pittsburgh Sleep Quality Index; RR=risk ratio; SMD=standardised mean difference

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

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

[3] OIS not met (N<400)

Table 151: Clinical evidence profile: Hypnotherapy (+ TAU) versus zolpidem (+ TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Hypnotherapy (+ TAU)	Zolpidem (+ TAU)	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology self-report - Endpoint (follow-up mean 2 weeks; measured with: IES change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	17	15	-	SMD 0.91	LOW	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Hypnotherapy (+ TAU)	Zolpidem (+ TAU)	Relative (95% CI)	Absolute		
										lower (1.64 to 0.17 lower)		
PTSD symptomatology self-report - 1-month follow-up (follow-up mean 4 weeks; measured with: IES change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	17	15	-	SMD 1.16 lower (1.91 to 0.4 lower)	LOW	CRITICAL
Depression symptoms - Endpoint (follow-up mean 2 weeks; measured with: BDI change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	17	15	-	SMD 0.78 lower (1.51 to 0.06 lower)	LOW	IMPORTANT
Depression symptoms - 1-month follow-up (follow-up mean 4 weeks; measured with: BDI change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	17	15	-	SMD 0.87 lower (1.6 to 0.14 lower)	LOW	IMPORTANT
Discontinuation (follow-up mean 2 weeks; assessed with: Number of participants lost to follow-up for any reason)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Hypnotherapy (+ TAU)	Zolpidem (+ TAU)	Relative (95% CI)	Absolute		
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	0/17 (0%)	1/16 (6.3%)	RR 0.31 (0.01 to 7.21)	43 fewer per 1000 (from 62 fewer to 388 more)	VERY LOW	CRITICAL
Discontinuation due to adverse events (follow-up mean 2 weeks; assessed with: Number of participants who dropped out due to adverse events)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	0/17 (0%)	1/16 (6.3%)	RR 0.31 (0.01 to 7.21)	43 fewer per 1000 (from 62 fewer to 388 more)	VERY LOW	CRITICAL

BDI= Beck Depression Inventory; CI=confidence interval; IES= Impact of Event Scale; RR=risk ratio; SMD=standardised mean difference; TAU=treatment as usual
[1] Risk of bias is high or unclear across multiple domains
[2] OIS not met (N<400)
[3] 95% CI crosses line of no effect and threshold for both clinically important benefit and clinically important harm

Interpersonal psychotherapy (IPT)

Table 152: Clinical evidence profile: Interpersonal psychotherapy (IPT) versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Interpersonal psychotherapy (IPT)	Waitlist	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology clinician-rated - Endpoint (follow-up mean 17 weeks; measured with: CAPS change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	32	16	-	SMD 1.19 lower (1.84 to 0.54 lower)	VERY LOW	CRITICAL
PTSD symptomatology clinician-rated - 4-month follow-up (follow-up mean 17 weeks; measured with: CAPS change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[3]	32	16	-	SMD 0.38 lower (0.99 lower to 0.22 higher)	VERY LOW	CRITICAL
Remission (follow-up mean 17 weeks; assessed with: Number of people no longer meeting diagnostic criteria for PTSD)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[5]	reporting bias[3]	16/32 (50%)	2/16 (12.5%)	RR 4 (1.05 to 15.31)	375 more per 1000 (from 6 more to 1000 more)	VERY LOW	CRITICAL
Depression symptoms - Endpoint (follow-up mean 17 weeks; measured with: HAMD change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	32	16	-	SMD 0.96 lower (1.59	VERY LOW	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Interpersonal psychotherapy (IPT)	Waitlist	Relative (95% CI)	Absolute		
										to 0.33 lower)		
Depression symptoms - 4-month follow-up (follow-up mean 17 weeks; measured with: HAMD change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[3]	32	16	-	SMD 0.39 lower (0.99 lower to 0.22 higher)	VERY LOW	IMPORTANT
Discontinuation (follow-up mean 17 weeks; assessed with: Number of participants lost to follow-up for any reason)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	12/32 (37.5%)	9/16 (56.3%)	RR 0.67 (0.36 to 1.24)	186 fewer per 1000 (from 360 fewer to 135 more)	LOW	CRITICAL

CAPS= Clinician-administered PTSD scale; CI=confidence interval; HAMD= Hamilton Rating Scale for Depression; IPT=interpersonal psychotherapy; RR=risk ratio; SMD=standardised mean difference

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

[2] OIS not met (N<400)

[3] Data is not reported/cannot be extracted for all outcomes

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

[5] OIS not met (events<300)

Psychodynamic therapies

Table 153: Clinical evidence profile: Psychodynamic therapy (+/- TAU) versus waitlist (+/- TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Psychodynamic therapy (+/- TAU)	Waitlist (+/- TAU)	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology self-rated (follow-up mean 16 weeks; measured with: IES change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	29	23	-	SMD 0.83 lower (1.4 to 0.25 lower)	VERY LOW	CRITICAL
Remission (follow-up mean 5 weeks; assessed with: Number of people no longer met criteria for PTSD based on HTQ DSM-IV PTSD algorithm)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[3]	47/49 (95.9%)	7/29 (24.1%)	RR 3.97 (2.08 to 7.6)	717 more per 1000 (from 261 more to 1000 more)	VERY LOW	CRITICAL
Anxiety symptoms (follow-up mean 5 weeks; measured with: HSCL-25: Anxiety change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	52	32	-	SMD 2.73 lower (3.35 to 2.12 lower)	VERY LOW	IMPORTANT

Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Psychodynamic therapy (+/- TAU)**	**Waitlist (+/- TAU)**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
Depression symptoms (follow-up mean 5 weeks; measured with: HSCL-25: Depression change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	52	32	-	SMD 3.03 lower (3.67 to 2.39 lower)	VERY LOW	IMPORTANT
Discontinuation (follow-up mean 5 weeks; assessed with: Number of participants lost to follow-up for any reason)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[5]	none	1/53 (1.9%)	1/33 (3%)	RR 0.62 (0.04 to 9.62)	12 fewer per 1000 (from 29 fewer to 261 more)	VERY LOW	CRITICAL

CI=confidence interval; HSCL-25= Hopkins Symptom Checklist-25; HTQ DSM-IV PTSD=Harvard Trauma Questionnaire for PTSD; IES= Impact of Event Scale; RR=risk ratio; SMD=standardised mean difference; TAU=treatment as usual

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

[2] OIS not met (N<400)

[3] Data is not reported/cannot be extracted for all outcomes

[4] OIS not met (events<300)

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

Table 154: Clinical evidence profile: Interpersonal psychotherapy (IPT) versus relaxation for delayed treatment (>3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Interpersonal psychotherapy (IPT)	Relaxation	Relative (95% CI)	Absolute		
PTSD symptomatology clinician-rated (follow-up mean 14 weeks; measured with: CAPS change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	36	24	-	SMD 0.36 lower (0.88 lower to 0.16 higher)	LOW	CRITICAL
PTSD symptomatology self-rated (follow-up mean 14 weeks; measured with: PSS-SR change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	23	13	-	SMD 0.77 lower (1.48 to 0.07 lower)	LOW	CRITICAL
Remission (follow-up mean 14 weeks; assessed with: Number of people scoring <20 on CAPS)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[4]	none	8/40 (20%)	5/32 (15.6%)	RR 1.28 (0.46 to 3.54)	44 more per 1000 (from 84 fewer to 397 more)	VERY LOW	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Interpersonal psychotherapy (IPT)	Relaxation	Relative (95% CI)	Absolute		
Response (follow-up mean 14 weeks; assessed with: Number of people showing ≥30% improvement on CAPS)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[5]	none	24/40 (60%)	9/32 (28.1%)	RR 2.13 (1.16 to 3.92)	318 more per 1000 (from 45 more to 821 more)	LOW	CRITICAL
Depression symptoms (follow-up mean 14 weeks; measured with: HAMD change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	35	23	-	SMD 0.28 higher (0.24 lower to 0.81 higher)	LOW	IMPORTANT
Funtional impairment (follow-up mean 14 weeks; measured with: SAS change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	22	14	-	SMD 0.98 lower (1.69 to 0.27 lower)	LOW	IMPORTANT
Quality of life (follow-up mean 14 weeks; measured with: Q-LES-Q-SF change score; Better indicated by higher values)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Interpersonal psychotherapy (IPT)	Relaxation	Relative (95% CI)	Absolute		
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	24	14	-	SMD 0.59 higher (0.09 lower to 1.26 higher)	LOW	IMPORTANT
Relationship difficulties (follow-up mean 14 weeks; measured with: IIP change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	23	14	-	SMD 1.32 lower (2.06 to 0.58 lower)	LOW	IMPORTANT
Discontinuation (follow-up mean 14 weeks; assessed with: Number of participants lost to follow-up for any reason)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	6/40 (15%)	11/32 (34.4%)	RR 0.44 (0.18 to 1.05)	192 fewer per 1000 (from 282 fewer to 17 more)	LOW	CRITICAL

CAPS= Clinician-administered PTSD scale; CI=confidence interval; HAMD= Hamilton Rating Scale for Depression; IIP=Inventory of interpersonal problems; PSS-SR= PTSD symptom scale-self-report; RR=risk ratio; SAS= Social Adjustment Scale; SMD=standardised mean difference; Q-LES-Q-SF=Quality of Life Enjoyment and Satisfaction Questionnaire;

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

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

[3] *OIS not met (N<400)*

[4] *95% CI crosses line of no effect and threshold for both clinically important benefit and clinically important harm*
[5] *OIS not met (events<300)*

Counselling

Table 155: Clinical evidence profile: Counselling (+/- TAU) versus TAU or waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Counselling (+/- TAU)	TAU or waitlist	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology self-rated at endpoint (follow-up 3-14 weeks; measured with: PCL/PDS/HTQ change score; Better indicated by lower values)												
4	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	145	104	-	SMD 0.97 lower (1.24 to 0.69 lower)	VERY LOW	CRITICAL
PTSD symptomatology self-rated at 1-4 month follow-up (follow-up 4-17 weeks; measured with: HTQ/PDS change score; Better indicated by lower values)												
2	randomised trials	serious[1]	serious[4]	no serious indirectness	serious[5]	none	172	62	-	SMD 0.63 lower (1.51 lower to 0.25 higher)	VERY LOW	CRITICAL
PTSD symptomatology self-rated at 8-12 month follow-up (follow-up 32-52 weeks; measured with: PDS change score; Better indicated by lower values)												
2	randomised trials	very serious[1]	serious[4]	no serious indirectness	serious[2]	reporting bias[3]	124	66	-	SMD 1.03 lower (1.68 to 0.38 lower)	VERY LOW	CRITICAL
PTSD symptomatology clinician-rated at endpoint (follow-up 12-14 weeks; measured with: CAPS change score; Better indicated by lower values)												
2	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	57	54	-	SMD 0.94 lower (1.39 to 0.49 lower)	LOW	CRITICAL

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Counselling (+/- TAU)	TAU or waitlist	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology clinician-rated at 1-year follow-up (follow-up mean 52 weeks; measured with: CIDI-PTSD change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[6]	reporting bias[3]	13	11	-	SMD 0.22 lower (1.03 lower to 0.58 higher)	VERY LOW	CRITICAL
Remission at endpoint (follow-up 12-14 weeks; assessed with: Number of people no longer meeting diagnostic criteria or no longer above clinical threshold on a scale for PTSD)												
2	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[7]	reporting bias[3]	16/51 (31.4%)	6/51 (11.8%)	RR 2.38 (1.05 to 5.38)	162 more per 1000 (from 6 more to 515 more)	VERY LOW	CRITICAL
Remission at 8-12 month follow-up (follow-up 32-52 weeks; assessed with: Number of people no longer meeting diagnostic criteria for PTSD)												
2	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[5]	reporting bias[3]	33/125 (26.4%)	9/67 (13.4%)	RR 1.94 (0.98 to 3.85)	126 more per 1000 (from 3 fewer to 383 more)	VERY LOW	CRITICAL
Anxiety symptoms at endpoint (follow-up 12-14 weeks; measured with: BAI/STAI State change score; Better indicated by lower values)												
2	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	57	54	-	SMD 0.77 lower (1.16 to 0.39 lower)	LOW	IMPORTANT
Anxiety symptoms at 1-month follow-up (follow-up mean 4 weeks; measured with: HSCL Anxiety change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Counselling (+/- TAU)	TAU or waitlist	Relative (95% CI)	Absolute		
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[5]	none	159	50	-	SMD 0.3 lower (0.61 lower to 0.02 higher)	LOW	IMPORTANT
Depression symptoms at endpoint (follow-up 12-14 weeks; measured with: BDI change score; Better indicated by lower values)												
2	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	57	54	-	SMD 0.73 lower (1.12 to 0.35 lower)	LOW	IMPORTANT
Depression symptoms at 1-month follow-up (follow-up mean 4 weeks; measured with: HSCL Depression change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	159	50	-	SMD 0.36 lower (0.68 to 0.04 lower)	LOW	IMPORTANT
Functional impairment (follow-up mean 14 weeks; measured with: SDS change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	30	30	-	SMD 0.93 lower (1.47 to 0.4 lower)	LOW	IMPORTANT
Global functioning (follow-up mean 12 weeks; measured with: GAF change score; Better indicated by higher values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[5]	reporting bias[3]	27	24	-	SMD 0.44 higher (0.12 lower to 0.99 higher)	VERY LOW	IMPORTANT
Quality of life at endpoint (follow-up 3-14 weeks; measured with: Q-LES-Q-SF/SF-12 change score; Better indicated by higher values)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Counselling (+/- TAU)	TAU or waitlist	Relative (95% CI)	Absolute		
2	randomised trials	serious[1]	very serious[8]	no serious indirectness	very serious[6]	none	43	42	-	SMD 0.05 lower (1.4 lower to 1.3 higher)	VERY LOW	IMPORTANT
Quality of life at 4-month follow-up (follow-up mean 17 weeks; measured with: SF-12 change score; Better indicated by higher values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	13	12	-	SMD 1.48 lower (2.39 to 0.58 lower)	VERY LOW	IMPORTANT
Quality of life at 1-year follow-up (follow-up mean 52 weeks; measured with: SF-12 change score; Better indicated by higher values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	13	11	-	SMD 0.93 lower (1.79 to 0.08 lower)	VERY LOW	IMPORTANT
Discontinuation (follow-up 3-26 weeks; assessed with: Number of participants lost to follow-up for any reason)												
6	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[6]	none	95/432 (22%)	48/214 (22.4%)	RR 1.07 (0.59 to 1.96)	16 more per 1000 (from 92 fewer to 215 more)	VERY LOW	CRITICAL

BAI= Beck Anxiety Inventory; BDI= Beck Depression Inventory; CAPS= Clinician-administered PTSD symptom scale; CI=confidence interval; CIDI-PTSD=Composite International Diagnostic Interview-PTSD; GAF=Global Assessment of Functioning; HSCL= Hopkins Symptom Checklist-; HTQ= Harvard Trauma Questionnaire; PCL= PTSD checklist; PDS= Post-traumatic Diagnositic Scale; RR=risk ratio; SDS= Sheehan Disability Scale; SF-12=Short-form-12; SMD=standardised mean difference; STAI= State-Trait Anxiety Inventory; TAU=treatment as usual; Q-LES-W-SF= Quality of Life Enjoyment and Satisfaction Questionnaire;

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

[2] *OIS not met (N<400)*

[3] *Data is not reported/cannot be extracted for all outcomes*

[4] *Substantial heterogeneity (I2=50-80%)*

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

[6] *95% CI crosses line of no effect and threshold for both clinically important benefit and clinically important harm*
[7] *OIS not met (events<300)*
[8] *Considerable heterogeneity (I2>80%)*

Combined somatic and cognitive therapies

Table 156: Clinical evidence profile: Combined somatic and cognitive therapies (+/- TAU) versus waitlist (+/- TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Combined somatic and cognitive therapies (+/- TAU)**	**Waitlist (+/- TAU)**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
PTSD symptomatology self-rated (follow-up 0.1-15 weeks; measured with: PCL/PDS/MPSS change score; Better indicated by lower values)												
5	randomised trials	serious[1]	very serious[2]	no serious indirectness	no serious imprecision	reporting bias[3]	273	271	-	SMD 1.97 lower (3.03 to 0.9 lower)	VERY LOW	CRITICAL
PTSD symptomatology clinician-rated (follow-up mean 15 weeks; measured with: CAPS change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[3]	32	28	-	SMD 1.15 lower (1.7 to 0.6 lower)	VERY LOW	CRITICAL
Remission (follow-up mean 6 weeks; assessed with: Number of people scoring <50 on PCL)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Combined somatic and cognitive therapies (+/- TAU)	Waitlist (+/- TAU)	Relative (95% CI)	Absolute		
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[5]	none	26/32 (81.3%)	2/26 (7.7%)	RR 10.56 (2.76 to 40.42)	735 more per 1000 (from 135 more to 1000 more)	LOW	CRITICAL
Anxiety symptoms (follow-up mean 4 weeks; measured with: SA-45 Anxiety T-score change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[3]	29	25	-	SMD 1.81 lower (2.45 to 1.17 lower)	VERY LOW	IMPORTANT
Depression symptoms (follow-up 4-15 weeks; measured with: CES-D/SA-45 Depression T-score change score; Better indicated by lower values)												
2	randomised trials	very serious[1]	serious[6]	no serious indirectness	serious[4]	reporting bias[3]	61	53	-	SMD 1.47 lower (1.89 to 1.04 lower)	VERY LOW	IMPORTANT
Sleeping difficulties (follow-up mean 6 weeks; measured with: ISI change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	27	22	-	SMD 1.71 lower (2.37 to	LOW	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Combined somatic and cognitive therapies (+/- TAU)**	**Waitlist (+/- TAU)**	**Relative (95% CI)**	**Absolute**		
										1.04 lower)		
Discontinuation (follow-up 0.1-15 weeks; assessed with: Number of participants lost to follow-up for any reason)												
5	random ised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[7]	none	38/307 (12.4%)	27/300 (9%)	RR 1.29 (0.64 to 2.62)	26 more per 1000 (from 32 fewer to 146 more)	VERY LOW	CRITICAL

CAPS= Clinician-administered PTSD scale; CES-D= Clinician-administered PTSD symptom scale; CI=confidence interval; ISI=Insomnia severity index; MPSS=Modified PTSD symptom scale; PCL= PTSD checklist; PDS= Post-traumatic Diagnositic Scale; RR=risk ratio; SA-45=Symptom assessment-45; SMD=standardised mean difference; TAU=treatment as usual

[1] *Risk of bias is high or unclear across multiple domains*
[2] *Considerable heterogeneity (I2>80%)*
[3] *Data is not reported/cannot be extracted for all outcomes*
[4] *OIS not met (N<400)*
[5] *OIS not met (events<300)*
[6] *Substantial heterogeneity (I2=50-80%)*
[7] *95% CI crosses line of no effect and threshold for both clinically important benefit and clinically important harm*

Resilience-oriented treatment

Table 157: Clinical evidence profile: Resilience-oriented treatment versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Resilience-oriented treatment	Waitlist	Relative (95% CI)	Absolute		
PTSD symptomatology self-report (follow-up mean 12 weeks; measured with: PDS change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	20	19	-	SMD 1.6 lower (2.33 to 0.87 lower)	LOW	CRITICAL
Anxiety symptoms (follow-up mean 12 weeks; measured with: STAI state change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	20	19	-	SMD 1.33 lower (2.03 to 0.63 lower)	LOW	IMPORTANT
Depression symptoms (follow-up mean 12 weeks; measured with: BDI-II change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	20	19	-	SMD 1.19 lower (1.88 to 0.51 lower)	LOW	IMPORTANT
Discontinuation (follow-up mean 12 weeks; assessed with: Number of participants lost to follow-up for any reason)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	1/20 (5%)	2/19 (10.5%)	RR 0.47 (0.05 to 4.82)	56 fewer per 1000 (from 100 fewer to 402 more)	VERY LOW	CRITICAL

BDI= Beck Depression Inventory; CI=confidence interval; PDS=; RR=risk ratio; SMD=standardised mean difference; STAI= State-Trait Anxiety Inventory;

[1] *Risk of bias is high or unclear across multiple domains*
[2] *OIS not met (N<400)*
[3] *95% CI crosses line of no effect and threshold for both clinically important benefit and clinically important harm*

Attention bias modification

Table 158: Clinical evidence profile: Attention bias modification versus attention-placebo for delayed treatment (>3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Attention bias modification**	**Attention-placebo**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
PTSD symptomatology self-report (follow-up 3-4 weeks; measured with: PCL/SRIP change score; Better indicated by lower values)												
3	randomised trials	serious[1]	very serious[2]	no serious indirectness	serious[3]	reporting bias[4]	83	87	-	SMD 2.48 higher (0.32 lower to 5.28 higher)	VERY LOW	CRITICAL
PTSD symptomatology clinician-rated - Endpoint (follow-up 3-4 weeks; measured with: CAPS change score; Better indicated by lower values)												
2	randomised trials	serious[1]	very serious[2]	no serious indirectness	very serious[5]	reporting bias[4]	56	62	-	SMD 1.62 higher (2.31 lower to 5.55 higher)	VERY LOW	CRITICAL
Anxiety symptoms - Endpoint (follow-up mean 3 weeks; measured with: HADS-A change score; Better indicated by lower values)												
1	randomised trials	no serious	no serious inconsistency	no serious indirectness	serious[3]	reporting bias[4]	34	38	-	SMD 0.04 lower	LOW	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Attention bias modification	Attention-placebo	Relative (95% CI)	Absolute		
		risk of bias								(0.5 lower to 0.43 higher)		
Anxiety symptoms - 3-week follow-up (follow-up mean 3 weeks; measured with: HADS-A change score; Better indicated by lower values)												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious[3]	reporting bias[4]	34	38	-	SMD 0.22 lower (0.68 lower to 0.25 higher)	LOW	IMPORTANT
Depression symptoms - Endpoint (follow-up 3-4 weeks; measured with: PHQ-9/HADS-D change score; Better indicated by lower values)												
3	randomised trials	serious[1]	very serious[2]	no serious indirectness	serious[3]	reporting bias[4]	83	87	-	SMD 1.82 higher (0.4 lower to 4.05 higher)	VERY LOW	IMPORTANT
Depression symptoms - 3-week follow-up (follow-up mean 3 weeks; measured with: HADS-D change score; Better indicated by lower values)												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious[3]	reporting bias[4]	34	38	-	SMD 0.26 lower (0.72 lower to 0.21 higher)	LOW	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Attention bias modification	Attention-placebo	Relative (95% CI)	Absolute		
Discontinuation (follow-up 3-4 weeks; assessed with: Number of participants lost to follow-up for any reason)												
3	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[5]	none	28/97 (28.9%)	35/103 (34%)	RR 0.87 (0.57 to 1.31)	44 fewer per 1000 (from 146 fewer to 105 more)	VERY LOW	CRITICAL

CAPS=; CI=confidence interval; HADS-A/D= Hospital Anxiety and Depression Scale-Anxiety/Depression; PCL= PTSD checklist; PHQ-9=patient health questionnaire-9; RR=risk ratio; SMD=standardised mean difference; SRIP= Self-Rating Inventory for PTSD

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

[2] *Considerable heterogeneity (I2>80%)*

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

[4] Data is not reported/cannot be extracted for all outcomes

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

Couple interventions

Table 159: Clinical evidence profile: Couple intervention versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Couple intervention	Waitlist	Relative (95% CI)	Absolute		
Response (follow-up mean 12 weeks; assessed with: Number of people showing improvement of at least 10 points on CAPS)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Couple intervention**	**Waitlist**	**Relative (95% CI)**	**Absolute**		
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	reporting bias[3]	13/20 (65%)	12/20 (60%)	RR 1.08 (0.67 to 1.75)	48 more per 1000 (from 198 fewer to 450 more)	VERY LOW	CRITICAL
Remission (follow-up mean 12 weeks; assessed with: Number of people who no longer met DSM-IV-TR diagnostic criteria and CAPS score<45)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[3]	13/20 (65%)	4/20 (20%)	RR 3.25 (1.28 to 8.27)	450 more per 1000 (from 56 more to 1000 more)	VERY LOW	CRITICAL
Response for relationship difficulties (follow-up mean 12 weeks; assessed with: Number of participants showing improvement of at least 10 points on DAS)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	reporting bias[3]	8/20 (40%)	5/20 (25%)	RR 1.6 (0.63 to 4.05)	150 more per 1000 (from 93 fewer to 763 more)	VERY LOW	CRITICAL
Remission for relationship difficulties (follow-up mean 12 weeks; assessed with: Number of participants scoring ≥98 on DAS)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Couple intervention	Waitlist	Relative (95% CI)	Absolute		
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	reporting bias[3]	13/20 (65%)	13/20 (65%)	RR 1 (0.63 to 1.58)	0 fewer per 1000 (from 240 fewer to 377 more)	VERY LOW	CRITICAL
Discontinuation (follow-up mean 12 weeks; assessed with: Number of participants lost to follow-up for any reason)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	4/20 (20%)	1/20 (5%)	RR 4 (0.49 to 32.72)	150 more per 1000 (from 25 fewer to 1000 more)	VERY LOW	CRITICAL

CAPS= Clinician-administered PTSD scale; CI=confidence interval; DAS=Dyadic Adjustment Scale; DSM-IV-TR=Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition (Text Revision); RR=risk ratio; SMD=standardised mean difference

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

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

[3] Data is not reported/cannot be extracted for all outcomes

[4] OIS not met (events<300)

Table 160: Clinical evidence profile: Couple intervention versus psychoeducation sessions for delayed treatment (>3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Couple intervention	Psychoeducation sessions	Relative (95% CI)	Absolute		
PTSD symptomatology self-rated - Endpoint (follow-up mean 12 weeks; measured with: PCL-M change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	22	21	-	SMD 1.44 lower (2.12 to 0.76 lower)	VERY LOW	CRITICAL
PTSD symptomatology self-rated - 3-month follow-up (follow-up mean 13 weeks; measured with: PCL-M change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	21	20	-	SMD 1.49 lower (2.19 to 0.79 lower)	VERY LOW	CRITICAL
PTSD symptomatology clinician-rated - Endpoint (follow-up mean 12 weeks; measured with: CAPS change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	22	21	-	SMD 2.15 lower (2.91 to 1.38 lower)	VERY LOW	CRITICAL
PTSD symptomatology clinician-rated - 3-month follow-up (follow-up mean 13 weeks; measured with: CAPS change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	21	20	-	SMD 2.39 lower (3.21 to	VERY LOW	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Couple intervention	Psychoeducation sessions	Relative (95% CI)	Absolute		
										1.57 lower)		
Remission (follow-up mean 12 weeks; assessed with: Number of people scoring <45 on CAPS at endpoint)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	15/29 (51.7%)	2/28 (7.1%)	RR 7.24 (1.82 to 28.81)	446 more per 1000 (from 59 more to 1000 more)	VERY LOW	CRITICAL
Anxiety symptoms - Endpoint (follow-up mean 12 weeks; measured with: STAI State change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	22	21	-	SMD 0.83 lower (1.46 to 0.2 lower)	VERY LOW	IMPORTANT
Anxiety symptoms - 3-month follow-up (follow-up mean 13 weeks; measured with: STAI State change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	21	20	-	SMD 1.09 lower (1.75 to 0.43 lower)	VERY LOW	IMPORTANT
Depression symptoms - Endpoint (follow-up mean 12 weeks; measured with: CES-D change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	22	21	-	SMD 0.56 lower (1.17	VERY LOW	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Couple intervention	Psychoeducation sessions	Relative (95% CI)	Absolute		
										lower to 0.05 higher)		
Depression symptoms - 3-month follow-up (follow-up mean 13 weeks; measured with: CES-D change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	21	20	-	SMD 0.85 lower (1.49 to 0.2 lower)	VERY LOW	IMPORTANT
Relationship difficulties - Endpoint (follow-up mean 12 weeks; measured with: DAS change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	22	21	-	SMD 0.89 higher (0.26 to 1.52 higher)	VERY LOW	IMPORTANT
Relationship difficulties - 3-month follow-up (follow-up mean 13 weeks; measured with: DAS change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	21	20	-	SMD 1 higher (0.35 to 1.66 higher)	VERY LOW	IMPORTANT
Discontinuation (follow-up mean 12 weeks; assessed with: Number of participants lost to follow-up for any reason)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Couple intervention	Psychoeducation sessions	Relative (95% CI)	Absolute		
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[5]	none	7/29 (24.1%)	7/28 (25%)	RR 0.97 (0.39 to 2.4)	7 fewer per 1000 (from 153 fewer to 350 more)	VERY LOW	CRITICAL

CAPS= Clinician-administered PTSD scale; CES-D= Centre of Epidemiological Studies-Depression; DAS=Dyadic Adjustment Scale; CI=confidence interval; PCL-M= PTSD checklist-Military; RR=risk ratio; SMD=standardised mean difference; STAI= State-Trait Anxiety Inventory;
[1] Risk of bias is high or unclear across multiple domains
[2] OIS not met (N<400)
[3] OIS not met (events<300)
[4] 95% CI crosses both line of no effect and threshold for clinically important effect
[5] 95% CI crosses line of no effect and threshold for both clinically important benefit and clinically important harm

Parent training/family interventions

Table 161: Clinical evidence profile: Family therapy versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Family therapy	Waitlist	Relative (95% CI)	Absolute		
PTSD symptomatology self-report at 4-month follow-up (follow-up mean 17 weeks; measured with: UCLA PTSD-RI change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	72	70	-	SMD 0.15 higher (0.18	VERY LOW	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Family therapy	Waitlist	Relative (95% CI)	Absolute		
										lower to 0.48 higher)		
Anxiety symptoms at 4-month follow-up (follow-up mean 17 weeks; measured with: STAI State change score; Better indicated by lower values)												
1	random ised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	72	70	-	SMD 0.12 higher (0.21 lower to 0.45 higher)	VERY LOW	IMPORTANT

CI=confidence interval; RR=risk ratio; SMD=standardised mean difference; STAI= State-Trait Anxiety Inventory; UCLA PTSD-RI=UCLA PTSD-Reaction Index;
[1] Risk of bias is high or unclear across multiple domains
[2] OIS not met (N<400)
[3] Data is not reported/cannot be extracted for all outcomes

Table 162: Clinical evidence profile: Child-parent psychotherapy (using play) versus case management and individual treatment (for parent-only) for delayed treatment (>3 months) of clinically important symptoms/PTSD (in parent)

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Child-parent psychotherapy (using play)	Case management and individual treatment (for parent-only)	Relative (95% CI)	Absolute		
PTSD symptomatology clinician-rated (follow-up mean 50 weeks; measured with: CAPS change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Child-parent psychotherapy (using play)**	**Case management and individual treatment (for parent-only)**	**Relative (95% CI)**	**Absolute**		
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	36	29	-	SMD 0.67 lower (1.17 to 0.17 lower)	VERY LOW	CRITICAL
Remission (follow-up mean 50 weeks; assessed with: Number of people no longer meeting diagnostic criteria for PTSD)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[3]	12/16 (75%)	5/12 (41.7%)	RR 1.8 (0.87 to 3.72)	333 more per 1000 (from 54 fewer to 1000 more)	VERY LOW	CRITICAL
Discontinuation (follow-up mean 50 weeks; assessed with: Number of participants lost to follow-up for any reason)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[5]	none	6/42 (14.3%)	4/33 (12.1%)	RR 1.18 (0.36 to 3.84)	22 more per 1000 (from 78 fewer to 344 more)	VERY LOW	CRITICAL

CAPS= Clinician-administered PTSD scale; CI=confidence interval; RR=risk ratio; SMD=standardised mean difference
[1] Risk of bias is high or unclear across multiple domains
[2] OIS not met (N<400)
[3] Data is not reported/cannot be extracted for all outcomes
[4] 95% CI crosses both line of no effect and threshold for clinically important effect
[5] 95% CI crosses line of no effect and threshold for both clinically important benefit and clinically important harm

Self-help with support

Table 163: Clinical evidence profile: Self-help with support (+/- TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Self-help with support (+/- TAU)	Waitlist or TAU	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology self-rated at endpoint (follow-up 5-10 weeks; measured with: IES endpoint/IES-R/PDS/PCL-5 change score; Better indicated by lower values)												
6	randomised trials	serious[1]	serious[2]	no serious indirectness	no serious imprecision	none	263	221	-	SMD 1.38 lower (1.8 to 0.97 lower)	LOW	CRITICAL
PTSD symptomatology self-rated at 1-3 month follow-up (follow-up 4-13 weeks; measured with: IES/PCL-5/PDS change score; Better indicated by lower values)												
3	randomised trials	serious[1]	very serious[3]	no serious indirectness	serious[4]	reporting bias[5]	84	77	-	SMD 0.85 lower (1.18 to 0.52 lower)	VERY LOW	CRITICAL
PTSD symptomatology self-rated at 1-year follow-up (follow-up mean 52 weeks; measured with: IES change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[5]	44	41	-	SMD 0.83 lower (1.27 to 0.38 lower)	VERY LOW	CRITICAL
PTSD symptomatology clinician-rated - Endpoint (follow-up mean 10 weeks; measured with: CAPS change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	21	21	-	SMD 2.44 lower (3.26 to 1.62 lower)	LOW	CRITICAL
PTSD symptomatology clinician-rated - 1-month follow-up (follow-up mean 4 weeks; measured with: CAPS change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Self-help with support (+/- TAU)**	**Waitlist or TAU**	**Relative (95% CI)**	**Absolute**		
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	21	21	-	SMD 2.02 lower (2.78 to 1.27 lower)	LOW	CRITICAL
Response (follow-up 5-8 weeks; assessed with: Number of people showing clinically significant improvement, based on reliable change indices (RCI) on IES-R/PDS)												
2	randomised trials	serious[1]	serious[2]	no serious indirectness	serious[6]	none	57/110 (51.8%)	10/111 (9%)	RR 5.69 (1.4 to 23.05)	423 more per 1000 (from 36 more to 1000 more)	VERY LOW	CRITICAL
Remission (follow-up 5-8 weeks; assessed with: Number of people no longer above threshold on CAPS/<20 on PDS)												
2	randomised trials	serious[1]	very serious[3]	no serious indirectness	very serious[7]	none	53/105 (50.5%)	19/106 (17.9%)	RR 3.01 (0.65 to 14)	360 more per 1000 (from 63 fewer to 1000 more)	VERY LOW	CRITICAL
Functional impairment - Endpoint (follow-up mean 10 weeks; measured with: SDS change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	21	21	-	SMD 1.69 lower (2.41 to 0.98 lower)	LOW	IMPORTANT
Functional impairment - 1-month follow-up (follow-up mean 4 weeks; measured with: SDS change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Self-help with support (+/- TAU)**	**Waitlist or TAU**	**Relative (95% CI)**	**Absolute**		
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	21	21	-	SMD 0.96 lower (1.6 to 0.32 lower)	LOW	IMPORTANT
Quality of life (follow-up 5-8 weeks; measured with: QOLI/EUROHIS-QOL change score; Better indicated by higher values)												
3	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	154	153	-	SMD 0.95 higher (0.64 to 1.26 higher)	VERY LOW	IMPORTANT
Sleeping difficulties (follow-up mean 5 weeks; measured with: SCL-90 Sleeping problems change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[5]	69	32	-	SMD 0.83 lower (1.27 to 0.4 lower)	VERY LOW	IMPORTANT
Anxiety symptoms at endpoint (follow-up 5-10 weeks; measured with: BAI/BSI Anxiety/HSCL-25 Anxiety/SCL-90 Anxiety change score; Better indicated by lower values)												
6	randomised trials	serious[1]	serious[2]	no serious indirectness	no serious imprecision	reporting bias[5]	293	252	-	SMD 0.94 lower (1.24 to 0.63 lower)	VERY LOW	IMPORTANT
Anxiety symptoms at 1-2 month follow-up (follow-up 4-8 weeks; measured with: BAI/STAI State change score; Better indicated by lower values)												
2	randomised trials	very serious[1]	serious[2]	no serious indirectness	serious[4]	reporting bias[5]	65	62	-	SMD 0.64 lower (1 to 0.28 lower)	VERY LOW	IMPORTANT
Anxiety symptoms at 1-year follow-up (follow-up mean 52 weeks; measured with: STAI State change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Self-help with support (+/- TAU)**	**Waitlist or TAU**	**Relative (95% CI)**	**Absolute**		
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[5]	44	41	-	SMD 0.58 lower (1.01 to 0.14 lower)	VERY LOW	IMPORTANT
Depression symptoms at endpoint (follow-up 5-10 weeks; measured with: BDI/BDI-II/BSI Depression/HSCL-25 Depression/SCL-90 Depression change score); Better indicated by lower values)												
6	randomised trials	serious[1]	serious[2]	no serious indirectness	no serious imprecision	reporting bias[5]	293	252	-	SMD 1.1 lower (1.51 to 0.7 lower)	VERY LOW	IMPORTANT
Depression symptoms at 1-2 month follow-up (follow-up 4-8 weeks; measured with: BDI change score; Better indicated by lower values)												
2	randomised trials	very serious[1]	serious[2]	no serious indirectness	serious[4]	reporting bias[5]	65	62	-	SMD 0.53 lower (0.89 to 0.17 lower)	VERY LOW	IMPORTANT
Depression symptoms at 1-year follow-up (follow-up mean 52 weeks; measured with: BDI change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[5]	44	41	-	SMD 0.46 lower (0.89 to 0.03 lower)	VERY LOW	IMPORTANT
Alcohol use disorder symptoms - Endpoint (follow-up mean 10 weeks; measured with: AUDIT change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[8]	none	21	21	-	SMD 0.17 lower (0.77 lower to 0.44 higher)	LOW	IMPORTANT
Alcohol use disorder symptoms - 1-month follow-up (follow-up mean 4 weeks; measured with: AUDIT change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Self-help with support (+/- TAU)**	**Waitlist or TAU**	**Relative (95% CI)**	**Absolute**		
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[7]	none	21	21	-	SMD 0.02 higher (0.59 lower to 0.62 higher)	VERY LOW	IMPORTANT
Substance use disorder symptoms - Endpoint (follow-up mean 10 weeks; measured with: TLFB: Number of days abstinent from alcohol in the last 90 days; change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[8]	none	19	15	-	SMD 0.53 higher (0.16 lower to 1.22 higher)	LOW	IMPORTANT
Substance use disorder symptoms - 3-month follow-up (follow-up mean 13 weeks; measured with: TLFB: Number of days abstinent from alcohol in the last 90 days; change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[7]	none	19	15	-	SMD 0.11 higher (0.57 lower to 0.79 higher)	VERY LOW	IMPORTANT
Discontinuation (follow-up 5-10 weeks; assessed with: Number of participants lost to follow-up for any reason)												
7	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[7]	none	113/368 (30.7%)	80/305 (26.2%)	RR 1.02 (0.78 to 1.33)	5 more per 1000 (from 58 fewer to 87 more)	VERY LOW	CRITICAL

AUDIT=Alcohol use disorders identification test; BAI= Beck Anxiety Inventory ; BDI= Beck Depression Inventory; BSI=Brief Symptom Inventory; CAPS= Clinician-administered PTSD scale; CI=confidence interval; EUROHIS-QOL=an instrument to meaure quality of life derived from WHOQOL project; HSCL-25= Hopkins Symptom Checklist-25; IES-R= Impact of Event Scale-Revised; PCL= PTSD checklist; PDS= Post-traumatic Diagnostic Scale; RR=risk ratio; SCL-90=Symptom Checklist-90; SDS= Sheehan Disability Scale; SMD=standardised mean difference; STAI= State-Trait Anxiety Inventory; TAU=treatment as usual; QOLI=Quality of life inventory; TLFB=alcohol timeline feedback;

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

Table 164: Clinical evidence profile: Self-help with support versus self-help without support for delayed treatment (>3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Self-help with support**	**Self-help without support**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
PTSD symptomatology clinician-rated - Endpoint (follow-up mean 14 weeks; measured with: PSS-I change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	23	28	-	SMD 0.02 higher (0.53 lower to 0.57 higher)	VERY LOW	CRITICAL
PTSD symptomatology clinician-rated - 3-month follow-up (follow-up mean 13 weeks; measured with: PSS-I change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	20	21	-	SMD 0.08 higher (0.53 lower to 0.7 higher)	VERY LOW	CRITICAL
Response - Endpoint (follow-up mean 14 weeks; assessed with: Number of people showing clinically significant improvement, based on reliable change indices (RCI) on PSS-I)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	17/46 (37%)	21/41 (51.2%)	RR 0.72 (0.45 to 1.17)	143 fewer per 1000 (from 282 fewer to 87 more)	VERY LOW	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Self-help with support	Self-help without support	Relative (95% CI)	Absolute		
Response - 3-month follow-up (follow-up mean 13 weeks; assessed with: Number of people showing clinically significant improvement, based on reliable change indices (RCI) on PSS-I)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[2]	none	16/46 (34.8%)	15/41 (36.6%)	RR 0.95 (0.54 to 1.67)	18 fewer per 1000 (from 168 fewer to 245 more)	VERY LOW	CRITICAL
Anxiety symptoms - Endpoint (follow-up mean 14 weeks; measured with: FDAS change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	20	23	-	SMD 0.82 higher (0.2 to 1.45 higher)	VERY LOW	IMPORTANT
Anxiety symptoms - 3-month follow-up (follow-up mean 13 weeks; measured with: FDAS change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	19	17	-	SMD 0.27 higher (0.39 lower to 0.92 higher)	VERY LOW	IMPORTANT
Depression symptoms - Endpoint (follow-up mean 14 weeks; measured with: CES-D change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	18	24	-	SMD 0.32 higher (0.29 lower to 0.94 higher)	VERY LOW	IMPORTANT
Depression symptoms - 3-month follow-up (follow-up mean 13 weeks; measured with: CES-D change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Self-help with support**	**Self-help without support**	**Relative (95% CI)**	**Absolute**		
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	20	17	-	SMD 0.61 higher (0.05 lower to 1.27 higher)	VERY LOW	IMPORTANT
Discontinuation (follow-up mean 14 weeks; assessed with: Number of participants lost to follow-up for any reason)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	20/46 (43.5%)	12/41 (29.3%)	RR 1.49 (0.83 to 2.65)	143 more per 1000 (from 50 fewer to 483 more)	LOW	CRITICAL

CES-D= Centre of Epidemiological Studies-Depression; CI=confidence interval; FDAS=Four Dimensional Anxiety Scale; PSS-I= PTSD symptom scale-interview; RR=risk ratio; SMD=standardised mean difference

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

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

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

[4] OIS not met (N<400)

Self-help (without support)

Table 165: Clinical evidence profile: Self-help (without support) versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Self-help (without support)	Waitlist	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology self-rated (follow-up 4-13 weeks; measured with: IES-R/PCL-C/PDS change scores; Better indicated by lower values)												
5	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	144	144	-	SMD 0.65 lower (0.9 to 0.4 lower)	LOW	CRITICAL
Remission - Endpoint (follow-up 6-12 weeks; assessed with: Number of people no longer meeting diagnostic criteria for PTSD or no longer above clinical threshold on scale)												
2	randomised trials	serious[1]	very serious[3]	no serious indirectness	serious[4]	reporting bias[5]	27/50 (54%)	11/53 (20.8%)	RR 2.61 (1.42 to 4.81)	334 more per 1000 (from 87 more to 791 more)	VERY LOW	CRITICAL
Remission - 3-6 month follow-up (follow-up 13-26 weeks; assessed with: Number of people no longer meeting diagnostic criteria for PTSD or no longer above clinical threshold on scale)												
2	randomised trials	serious[1]	very serious[3]	no serious indirectness	serious[4]	reporting bias[5]	29/50 (58%)	20/53 (37.7%)	RR 1.53 (1.01 to 2.34)	200 more per 1000 (from 4 more to 506 more)	VERY LOW	CRITICAL
Response at endpoint (follow-up 4-13 weeks; assessed with: Number of people showing improvement of at least 10 points on PCL-C/clinically significant improvement, based on reliable change indices (RCI) on CAPS/≥50% improvement on PDS)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Self-help (without support)	Waitlist	Relative (95% CI)	Absolute		
4	randomised trials	serious[1]	serious[6]	no serious indirectness	serious[4]	none	66/137 (48.2%)	27/135 (20%)	RR 2.39 (1.11 to 5.14)	278 more per 1000 (from 22 more to 828 more)	VERY LOW	CRITICAL
Response at 3-6 month follow-up (follow-up 13-26 weeks; assessed with: Number of people showing clinically significant improvement, based on reliable change indices (RCI) on CAPS/≥50% improvement on PDS)												
2	randomised trials	serious[1]	very serious[3]	no serious indirectness	serious[7]	reporting bias[5]	29/50 (58%)	22/53 (41.5%) 41.9%	RR 1.4 (0.96 to 2.05)	166 more per 1000 (from 17 fewer to 436 more)	VERY LOW	CRITICAL
Functional impairment at endpoint (follow-up 8-13 weeks; measured with: SDS/B-IPF change score; Better indicated by lower values)												
3	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	110	104	-	SMD 0.58 lower (0.85 to 0.3 lower)	LOW	IMPORTANT
Functional impairment at 6-month follow-up (follow-up mean 26 weeks; measured with: SDS change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[8]	reporting bias[5]	25	27	-	SMD 0 higher (0.54 lower to 0.54 higher)	VERY LOW	IMPORTANT
Anxiety symptoms at endpoint (follow-up 8-12 weeks; measured with: BAI/STAI State/GAD-7 change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Self-help (without support)	Waitlist	Relative (95% CI)	Absolute		
3	randomised trials	serious[1]	serious[6]	no serious indirectness	serious[7]	reporting bias[5]	61	60	-	SMD 0.67 lower (1.43 lower to 0.09 higher)	VERY LOW	IMPORTANT
Anxiety symptoms at 6-month follow-up (follow-up mean 26 weeks; measured with: BAI change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[7]	reporting bias[5]	25	27	-	SMD 0.4 higher (0.15 lower to 0.95 higher)	VERY LOW	IMPORTANT
Depression symptoms at endpoint (follow-up 8-13 weeks; measured with: BDI-II/PHQ-8/PHQ-9 change score; Better indicated by lower values)												
4	randomised trials	serious[1]	serious[6]	no serious indirectness	serious[2]	reporting bias[5]	123	118	-	SMD 0.68 lower (1.08 to 0.27 lower)	VERY LOW	IMPORTANT
Depression symptoms at 6-month follow-up (follow-up mean 26 weeks; measured with: BDI-II change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[7]	reporting bias[5]	25	27	-	SMD 0.49 higher (0.06 lower to 1.04 higher)	VERY LOW	IMPORTANT
Discontinuation (follow-up 4-13 weeks; assessed with: Number of participants lost to follow-up for any reason)												
7	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[7]	none	45/219 (20.5%)	30/215 (14%)	RR 1.47 (0.99 to 2.2)	66 more per 1000 (from 1 fewer to 167 more)	LOW	CRITICAL

B-IPF=Brief Inventory Psycosocial Functioning; CAPS= Clinician-administered PTSD scale; CI=confidence interval; GAD-7=Generalised Anxiety Disorder; IES-R= Impact of Event Scale-Revised; PCL-C= PTSD checklist-Civilian; PDS= Post-traumatic Diagnostic Scale; PHQ-8/9=Patient health questionnaire for depression; RR=risk ratio; SDS= Sheehan Disability Scale; SMD=standardised mean difference; STAI= State-Trait Anxiety Inventory;

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

Table 166: Clinical evidence profile: Self-help (without support) versus attention-placebo for delayed treatment (>3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Self-help (without support)	Attention-placebo	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology self-report at endpoint (follow-up 0.1-0.6 weeks; measured with: PDS/IES change score; Better indicated by lower values)												
5	randomised trials	serious[1]	serious[2]	no serious indirectness	serious[3]	none	224	153	-	SMD 0.69 lower (1.09 to 0.29 lower)	VERY LOW	CRITICAL
PTSD symptomatology self-report at 1-month follow-up (follow-up mean 4 weeks; measured with: PDS change score; Better indicated by lower values)												
2	randomised trials	very serious[1]	serious[2]	no serious indirectness	serious[4]	none	101	84	-	SMD 0.5 lower (1.32 lower to 0.31 higher)	VERY LOW	CRITICAL
PTSD symptomatology clinician-rated at endpoint (follow-up mean 0.4 weeks; measured with: PSS-I change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Self-help (without support)	Attention-placebo	Relative (95% CI)	Absolute		
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	serious[4]	none	21	21	-	SMD 0.27 higher (0.34 lower to 0.88 higher)	MODERATE	CRITICAL
Remission (follow-up mean 0.4 weeks; assessed with: Number of people no longer meeting diagnostic criteria for PTSD)												
1	randomised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[5]	none	7/24 (29.2%)	5/23 (21.7%)	RR 1.34 (0.5 to 3.63)	74 more per 1000 (from 109 fewer to 572 more)	LOW	CRITICAL
Depression symptoms at endpoint (follow-up 0.4-0.6 weeks; measured with: CES-D/BDI-II change score; Better indicated by lower values)												
5	randomised trials	serious[1]	very serious[6]	no serious indirectness	serious[4]	none	203	155	-	SMD 0.5 lower (1.11 lower to 0.12 higher)	VERY LOW	IMPORTANT
Depression symptoms at 1-month follow-up (follow-up mean 4 weeks; measured with: CES-D/BDI-II change score; Better indicated by lower values)												
2	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	101	84	-	SMD 0.28 lower (0.57 lower to	VERY LOW	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Self-help (without support)	Attention-placebo	Relative (95% CI)	Absolute		
										0.01 higher)		
Anxiety symptoms at endpoint (follow-up mean 0.4 weeks; measured with: STAI State change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[5]	none	19	17	-	SMD 0.14 higher (0.52 lower to 0.79 higher)	VERY LOW	IMPORTANT
Anxiety symptoms at 1-month follow-up (follow-up mean 4 weeks; measured with: STAI State change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	19	17	-	SMD 0.34 higher (0.32 lower to 1 higher)	VERY LOW	IMPORTANT
Discontinuation (follow-up 0.4-0.6 weeks; assessed with: Number of participants lost to follow-up for any reason)												
4	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[5]	none	13/153 (8.5%)	11/130 (8.5%)	RR 0.99 (0.47 to 2.09)	1 fewer per 1000 (from 45 fewer to 92 more)	VERY LOW	CRITICAL

BDI= Beck Depression Inventory; CES-D= Centre of Epidemiological Studies-Depression; CI=confidence interval; IES= Impact of Event Scale; PDS= Post-traumatic Diagnositic Scale; PSS-I= PTSD symptom scale-interview; RR=risk ratio; SMD=standardised mean difference; STAI= State-Trait Anxiety Inventory

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

[2] *Substantial heterogeneity (I2=50-80%)*

[3] *OIS not met (N<400)*

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

[5] *95% CI crosses line of no effect and threshold for both clinically important benefit and clinically important harm*
[6] *Considerable heterogeneity (I2>80%)*

Psychosocial interventions for the treatment of PTSD in adults

Meditation/Mindfulness-based stress reduction (MBSR)

Table 167: Clinical evidence profile: Meditation/Mindfulness-based stress reduction (MBSR; +/- TAU) versus TAU/attention-placebo/waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Meditation /Mindfulness-based stress reduction (MBSR; +/- TAU)	TAU/attention-placebo/ waitlist	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology self-report at endpoint (follow-up 4-12 weeks; measured with: PCL change score; Better indicated by lower values)												
6	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	213	174	-	SMD 0.23 lower (0.47 lower to 0.02 higher)	LOW	CRITICAL
PTSD symptomatology self-report at 1-4 month follow-up (follow-up 4-17 weeks; measured with: PCL change score; Better indicated by lower values)												
2	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	61	48	-	SMD 0.04 lower (0.48 lower to	VERY LOW	CRITICAL

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Meditation /Mindfulness-based stress reduction (MBSR; +/- TAU)	TAU/attention-placebo/ waitlist	Relative (95% CI)	Absolute	Quality	Importance
										0.4 higher)		
PTSD symptomatology clinician-rated at endpoint (follow-up 4-8 weeks; measured with: CAPS/PSS-I change score; Better indicated by lower values)												
4	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	142	142	-	SMD 0.43 lower (0.7 to 0.16 lower)	LOW	CRITICAL
PTSD symptomatology clinician-rated at 6-month follow-up (follow-up mean 26 weeks; measured with: PSS-I change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	22	23	-	SMD 0.6 lower (1.2 lower to 0 higher)	VERY LOW	CRITICAL
Remission (follow-up 6-12 weeks; assessed with: Number of people scoring below clinical threshold on a scale)												
2	randomised trials	serious[1]	serious[4]	no serious indirectness	very serious[5]	none	24/86 (27.9%)	15/86 (17.4%)	RR 1.31 (0.55 to 3.11)	54 more per 1000 (from 78 fewer to 368 more)	VERY LOW	CRITICAL
Response at endpoint (follow-up 6-8 weeks; assessed with: Number of people showing clinically significant improvement based on RCI ≥10/11 points on PCL-C)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Meditation /Mindfulness-based stress reduction (MBSR; +/- TAU)	TAU/attention-placebo/ waitlist	Relative (95% CI)	Absolute		
2	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[5]	reporting bias[3]	22/77 (28.6%)	10/47 (21.3%)	RR 1.37 (0.71 to 2.65)	79 more per 1000 (from 62 fewer to 351 more)	VERY LOW	CRITICAL
Response at 4-month follow-up (follow-up mean 17 weeks; assessed with: Number of people showing clinically significant improvement based on RCI ≥10 points on PCL-C)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[5]	none	9/25 (36%)	5/22 (22.7%)	RR 1.58 (0.62 to 4.02)	132 more per 1000 (from 86 fewer to 686 more)	VERY LOW	CRITICAL
Anxiety symptoms at endpoint (follow-up 6-8 weeks; measured with: BSI Anxiety/HADS-A change score; Better indicated by lower values)												
2	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[6]	reporting bias[3]	103	114	-	SMD 0.23 lower (0.5 lower to 0.04 higher)	VERY LOW	IMPORTANT
Anxiety symptoms at 3-month follow-up (follow-up mean 13 weeks; measured with: HADS-A change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Meditation /Mindfulness-based stress reduction (MBSR; +/- TAU)**	**TAU/attention-placebo/ waitlist**	**Relative (95% CI)**	**Absolute**		
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[6]	reporting bias[3]	32	39	-	SMD 0.39 lower (0.86 lower to 0.09 higher)	VERY LOW	IMPORTANT
Depression symptoms at endpoint (follow-up 4-8 weeks; measured with: BDI/BSI Depression/HADS-D/PHQ-9 change score; Better indicated by lower values)												
6	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	no serious imprecision	none	237	213	-	SMD 0.55 lower (0.75 to 0.36 lower)	MODERATE	IMPORTANT
Depression symptoms at 1-6 month follow-up (follow-up 4-26 weeks; measured with: HADS-D/PHQ-9 change score; Better indicated by lower values)												
4	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	115	110	-	SMD 0.56 lower (0.86 to 0.26 lower)	VERY LOW	IMPORTANT
Sleeping difficulties (follow-up mean 6 weeks; measured with: PSQI change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[6]	reporting bias[3]	52	25	-	SMD 0.09 lower (0.57	VERY LOW	IMPORTANT

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Meditation /Mindfulness-based stress reduction (MBSR; +/- TAU)	TAU/attention-placebo/ waitlist	Relative (95% CI)	Absolute	Quality	Importance
										lower to 0.38 higher)		
Emotional and behavioural problems (follow-up mean 6 weeks; measured with: STAXI-2 change score; Better indicated by lower values)												
1	random ised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[6]	none	14	15	-	SMD 0.53 lower (1.27 lower to 0.21 higher)	VERY LOW	IMPORTANT
Quality of life at endpoint (follow-up 6-8 weeks; measured with: Q-LES-Q-SF/SF-8/12 Mental Component summary (MCS) change score; Better indicated by higher values)												
3	random ised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	110	112	-	SMD 0.6 higher (0.33 to 0.87 higher)	LOW	IMPORTANT
Quality of life at 4-month follow-up (follow-up mean 17 weeks; measured with: SF-8 Mental Component summary (MCS) change score; Better indicated by higher values)												
1	random ised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	25	22	-	SMD 0.77 higher (0.17 to 1.37 higher)	VERY LOW	IMPORTANT
Discontinuation (follow-up 4-8 weeks; assessed with: Number of participants lost to follow-up for any reason)												

Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Meditation /Mindfulness-based stress reduction (MBSR; +/- TAU)**	**TAU/attention-placebo/ waitlist**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
6	random ised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[6]	none	33/211 (15.6%)	23/213 (10.8%)	RR 1.49 (0.92 to 2.41)	53 more per 1000 (from 9 fewer to 152 more)	LOW	CRITICAL

BDI= Beck Depression Inventory; BSI=Brief Symptom Inventory; CAPS= Clinician-administered PTSD scale; CI=confidence interval; HADS-A/D= Hospital Anxiety and Depression Scale-Anxiety/Depression; PCL-C= PTSD checklist-Civilian; PHQ-9=patient heatlth questionnaire for depression; PSS-I= PTSD symptom scale-interview; PSQI=Pittsburgh Sleep Quality Index; RR=risk ratio; SF-8/12=Short-form 8/12; SMD=standardised mean difference; STAXI= State-Trait Anger Experssion Inventory; TAU=Treatment as usual; Q-LES-Q-SF= Quality of Life Enjoyment and Satisfaction Questionnaire

[1] *Risk of bias is high or unclear across multiple domains*
[2] *OIS not met (N<400)*
[3] *Data is not reported/cannot be extracted for all outcomes*
[4] *Substantial heterogeneity (I2=50-80%)*
[5] *95% CI crosses line of no effect and threshold for both clinically important benefit and clinically important harm*
[6] *95% CI crosses both line of no effect and threshold for clinically important effect*

Table 168: Clinical evidence profile: Meditation (+ TAU) versus relaxation (+ TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Meditation (+ TAU)	Relaxation (+ TAU)	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology self-report (follow-up mean 6 weeks; measured with: PCL change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	52	25	-	SMD 0.68 lower (1.17 to 0.19 lower)	VERY LOW	CRITICAL
Response (follow-up mean 6 weeks; assessed with: Number of people showing clinically significant improvement based on RCI ≥11 points on PCL-C)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[4]	reporting bias[3]	14/52 (26.9%)	3/25 (12%)	RR 2.24 (0.71 to 7.1)	149 more per 1000 (from 35 fewer to 732 more)	VERY LOW	CRITICAL
Depression symptoms (follow-up mean 6 weeks; measured with: BDI change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	52	25	-	SMD 0.57 lower (1.06 to 0.09 lower)	VERY LOW	IMPORTANT
Sleeping difficulties (follow-up mean 6 weeks; measured with: PSQI change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Meditation (+ TAU)	Relaxation (+ TAU)	Relative (95% CI)	Absolute		
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[5]	reporting bias[3]	52	25	-	SMD 0.35 lower (0.83 lower to 0.13 higher)	VERY LOW	IMPORTANT

BDI= Beck Depression Inventory; CI=confidence interval; PCL-C= PTSD checklist-Civilian; PSQI=Pittsburgh Sleep Quality Index; RR=risk ratio; SMD=standardised mean difference; TAU=treatment as usual;
[1] Risk of bias is high or unclear across multiple domains
[2] OIS not met (N<400)
[3] Data is not reported/cannot be extracted for all outcomes
[4] 95% CI crosses line of no effect and threshold for both clinically important benefit and clinically important harm
[5] 95% CI crosses both line of no effect and threshold for clinically important effect

Table 169: Clinical evidence profile: Mindfulness-based stress reduction (MBSR; + TAU) versus present-centered therapy (+ TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Mindfulness-based stress reduction (MBSR; + TAU)	Present-centered therapy (+ TAU)	Relative (95% CI)	Absolute		
PTSD symptomatology self-rated - Endpoint (follow-up mean 9 weeks; measured with: PCL change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	58	58	-	SMD 0.59 lower	VERY LOW	CRITICAL

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Mindfulness-based stress reduction (MBSR; + TAU)	Present-centered therapy (+ TAU)	Relative (95% CI)	Absolute	Quality	Importance
										(0.96 to 0.21 lower)		
PTSD symptomatology self-rated - 2-month follow-up (follow-up mean 8 weeks; measured with: PCL change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	58	58	-	SMD 0.76 lower (1.14 to 0.39 lower)	VERY LOW	CRITICAL
PTSD symptomatology clinician-rated - Endpoint (follow-up mean 9 weeks; measured with: CAPS change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	58	58	-	SMD 0.2 lower (0.57 lower to 0.16 higher)	VERY LOW	CRITICAL
PTSD symptomatology clinician-rated - 2-month follow-up (follow-up mean 8 weeks; measured with: CAPS change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	58	58	-	SMD 0.59 lower (0.96 to 0.21 lower)	VERY LOW	CRITICAL
Remission - Endpoint (follow-up mean 9 weeks; assessed with: Number of people no longer meeting diagnostic criteria for PTSD)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Mindfulness-based stress reduction (MBSR; + TAU)**	**Present-centered therapy (+ TAU)**	**Relative (95% CI)**	**Absolute**		
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[4]	none	25/58 (43.1%)	25/58 (43.1%)	RR 1 (0.66 to 1.52)	0 fewer per 1000 (from 147 fewer to 224 more)	VERY LOW	CRITICAL
Remission - 2-month follow-up (follow-up mean 8 weeks; assessed with: Number of people no longer meeting diagnostic criteria for PTSD)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	31/58 (53.4%)	27/58 (46.6%)	RR 1.15 (0.8 to 1.66)	70 more per 1000 (from 93 fewer to 307 more)	VERY LOW	CRITICAL
Response self-rated - Endpoint (follow-up mean 9 weeks; assessed with: Number of people showing improvement of at least 10 points on PCL)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[4]	none	7/19 (36.8%)	3/13 (23.1%)	RR 1.6 (0.5 to 5.06)	138 more per 1000 (from 115 fewer to 937 more)	VERY LOW	CRITICAL
Response self-rated - 2-month follow-up (follow-up mean 8 weeks; assessed with: Number of people showing improvement of at least 10 points on PCL)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Mindfulness-based stress reduction (MBSR; + TAU)**	**Present-centered therapy (+ TAU)**	**Relative (95% CI)**	**Absolute**		
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	very serious[4]	none	11/23 (47.8%)	4/16 (25%)	RR 1.91 (0.74 to 4.95)	227 more per 1000 (from 65 fewer to 987 more)	VERY LOW	CRITICAL
Response clinician-rated - Endpoint (follow-up mean 9 weeks; assessed with: Number of people showing improvement of at least 10 points on CAPS)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	21/33 (63.6%)	14/28 (50%)	RR 1.27 (0.81 to 2)	135 more per 1000 (from 95 fewer to 500 more)	VERY LOW	CRITICAL
Response clinician-rated - 2-month follow-up (follow-up mean 8 weeks; assessed with: Number of people showing improvement of at least 10 points on CAPS)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	20/30 (66.7%)	16/30 (53.3%)	RR 1.25 (0.82 to 1.9)	133 more per 1000 (from 96 fewer to 480 more)	VERY LOW	CRITICAL
Depression symptoms - Endpoint (follow-up mean 9 weeks; measured with: PHQ-9 change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Mindfulness-based stress reduction (MBSR; + TAU)	Present-centered therapy (+ TAU)	Relative (95% CI)	Absolute		
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	58	58	-	SMD 0.29 lower (0.65 lower to 0.08 higher)	VERY LOW	IMPORTANT
Depression symptoms - 2-month follow-up (follow-up mean 8 weeks; measured with: PHQ-9 change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	58	58	-	SMD 0.33 lower (0.69 lower to 0.04 higher)	VERY LOW	IMPORTANT
Quality of life - Endpoint (follow-up mean 9 weeks; measured with: WHO-QoL-BREF change score; Better indicated by higher values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	58	58	-	SMD 0.27 higher (0.09 lower to 0.64 higher)	VERY LOW	IMPORTANT
Quality of life - 2-month follow-up (follow-up mean 8 weeks; measured with: WHO-QoL-BREF change score; Better indicated by higher values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	58	58	-	SMD 0.47 higher	VERY LOW	IMPORTANT

Quality assessment							No of patients		Effect			
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Mindfulness-based stress reduction (MBSR; + TAU)**	**Present-centered therapy (+ TAU)**	**Relative (95% CI)**	**Absolute**	**Quality**	**Importance**
										(0.1 to 0.84 higher)		
Discontinuation (follow-up mean 9 weeks; assessed with: Number of participants lost to follow-up for any reason)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[4]	none	6/58 (10.3%)	1/58 (1.7%)	RR 6 (0.75 to 48.29)	86 more per 1000 (from 4 fewer to 815 more)	VERY LOW	CRITICAL

CAPS= Clinician-administered PTSD scale; CI=confidence interval; PCL= PTSD checklist; PHQ-9= Patient health questionnaire-9 item; RR=risk ratio; SMD=standardised mean difference; TAU=treatment as usual; WHO-QoL-BREF=an instrument World Health Organisation Quality of Life Measure, brief version;

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

[2] OIS not met (N<400)

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

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

Supported employment

Table 170: Clinical evidence profile: Individual placement and support (IPS) supported employment versus standard VA vocational rehabilitation programme (TAU) for delayed treatment (>3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Individual placement and support (IPS) supported employment	Standard VA vocational rehabilitation programme (TAU)	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology clinician-rated (follow-up mean 52 weeks; measured with: CAPS change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	25	32	-	SMD 0.44 lower (0.97 lower to 0.09 higher)	LOW	CRITICAL
PTSD symptomatology self-rated (follow-up mean 52 weeks; measured with: DTS change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	28	36	-	SMD 0.21 lower (0.71 lower to 0.28 higher)	LOW	CRITICAL
Response (follow-up mean 52 weeks; assessed with: Number of people rated as 'much' or 'very much' improved on CGI-I)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	7/42 (16.7%)	5/43 (11.6%)	RR 1.43 (0.49 to 4.16)	50 more per 1000 (from 59 fewer to 367 more)	VERY LOW	CRITICAL
Depression symptoms (follow-up mean 52 weeks; measured with: QIDS change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	27	35	-	SMD 0.25 lower (0.76	LOW	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Individual placement and support (IPS) supported employment	Standard VA vocational rehabilitation programme (TAU)	Relative (95% CI)	Absolute		
										lower to 0.25 higher)		
Competitive employment (follow-up mean 52 weeks; assessed with: Number of people who gained competitive employment)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	32/42 (76.2%)	12/43 (27.9%)	RR 2.73 (1.64 to 4.54)	483 more per 1000 (from 179 more to 988 more)	LOW	IMPORTANT
Competitive employment (follow-up mean 52 weeks; measured with: Weeks competitively employed; Better indicated by higher values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[5]	none	42	43	-	SMD 0.93 higher (0.48 to 1.37 higher)	LOW	IMPORTANT
Discontinuation (follow-up mean 52 weeks; assessed with: Number of participants lost to follow-up for any reason)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	6/42 (14.3%)	8/43 (18.6%)	RR 0.77 (0.29 to 2.02)	43 fewer per 1000 (from 132 fewer to 190 more)	VERY LOW	CRITICAL

CAPS= Clinician-administered PTSD scale; CI=confidence interval; DTS=Davidson Trauma Scale; QIDS= Quick Inventory of Depressive Symptomatology; RR=risk ratio; SMD=standardised mean difference; TAU=treatment as usual

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

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

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

[4] OIS not met (events<300)
[5] OIS not met (N<400)

Practical support

Table 171: Clinical evidence profile: Practical support versus TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Practical support	TAU	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology self-rated (follow-up mean 1 weeks; measured with: PDS change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	24	17	-	SMD 1.12 lower (1.79 to 0.45 lower)	VERY LOW	CRITICAL
Depression symptoms (follow-up mean 1 weeks; measured with: CES-D change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	24	17	-	SMD 8.69 lower (10.76 to 6.61 lower)	VERY LOW	IMPORTANT

CES-D= Centre of Epidemiological Studies-Depression; CI=confidence interval; PDS= Post-traumatic Diagnositic Scale; RR=risk ratio; SMD=standardised mean difference; TAU=treatment as usual
[1] *Risk of bias is high or unclear across multiple domains*
[2] *OIS not met (N<400)*
[3] *Data is not reported/cannot be extracted for all outcomes*

Psychoeducation

Table 172: Clinical evidence profile: Psychoeducation (+ TAU) versus TAU for early treatment (1-3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Psychoeducation (+ TAU)	TAU	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology self-rated at 2-month follow-up (follow-up mean 8 weeks; measured with: HTQ-IV change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	116	109	-	SMD 0.05 higher (0.21 lower to 0.31 higher)	LOW	CRITICAL
Anxiety symptoms at 2-month follow-up (follow-up mean 8 weeks; measured with: HADS-A endpoint score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	131	130	-	SMD 0.05 higher (0.19 lower to 0.29 higher)	LOW	IMPORTANT
Depression symptoms at 2-month follow-up (follow-up mean 8 weeks; measured with: HADS-D endpoint score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	130	130	-	SMD 0.05 higher (0.19 lower to 0.3 higher)	LOW	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Psychoeducation (+ TAU)**	**TAU**	**Relative (95% CI)**	**Absolute**		
Quality of life at 2-month follow-up (follow-up mean 8 weeks; measured with: SF-12 MCS; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	117	114	-	SMD 0.17 lower (0.42 lower to 0.09 higher)	LOW	IMPORTANT
Discontinuation (follow-up mean 8 weeks; assessed with: Number of participants lost to follow-up for any reason)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	74/190 (38.9%)	77/196 (39.3%)	RR 0.99 (0.77 to 1.27)	4 fewer per 1000 (from 90 fewer to 106 more)	VERY LOW	CRITICAL

CI=confidence interval; HADS-A/D= Hospital Anxiety and Depression Scale-Anxiety/Depression; HTQ-IV= Harvard Trauma Questionnaire-IV; RR=risk ratio; SF-12 MCS= Short Form-12; Mental Component Summary; SMD=standardised mean difference; TAU=treatment as usual

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

[2] OIS not met (N<400)

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

Table 173: Clinical evidence profile: Psychoeducation (+/- TAU) versus waitlist or TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Psychoeducation (+/- TAU)	Waitlist or TAU	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology self-rated at endpoint (measured with: DTS change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	45	44	-	SMD 0.23 lower (0.65 lower to 0.19 higher)	LOW	CRITICAL
PTSD symptomatology self-rated at 1-month follow-up (follow-up mean 4 weeks; measured with: PCL change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	29	30	-	SMD 0.23 lower (0.74 lower to 0.28 higher)	VERY LOW	CRITICAL
PTSD symptomatology self-rated at 6-month follow-up (follow-up mean 26 weeks; measured with: DTS change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	34	35	-	SMD 0.3 lower (0.78 lower to 0.17 higher)	LOW	CRITICAL
PTSD symptomatology self-rated at 12-month follow-up (follow-up mean 52 weeks; measured with: DTS change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	31	31	-	SMD 0.15 lower	LOW	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Psychoeducation (+/- TAU)	Waitlist or TAU	Relative (95% CI)	Absolute		
										(0.65 lower to 0.35 higher)		
Anxiety symptoms at 1-month follow-up (follow-up mean 4 weeks; measured with: BSI Anxiety change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	29	30	-	SMD 0.34 lower (0.85 lower to 0.18 higher)	VERY LOW	IMPORTANT
Depression symptoms at endpoint (measured with: BDI-II change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	45	44	-	SMD 0.75 lower (1.19 to 0.32 lower)	LOW	IMPORTANT
Depression symptoms at 1-month follow-up (follow-up mean 4 weeks; measured with: BSI Depression change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[3]	29	30	-	SMD 1.1 lower (1.65 to 0.55 lower)	VERY LOW	IMPORTANT
Depression symptoms at 6-month follow-up (follow-up mean 26 weeks; measured with: BDI-II change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	34	35	-	SMD 0.51 lower	LOW	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Psychoeducation (+/- TAU)	Waitlist or TAU	Relative (95% CI)	Absolute		
										(0.99 to 0.03 lower)		
Depression symptoms at 12-month follow-up (follow-up mean 52 weeks; measured with: BDI-II change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	31	31	-	SMD 0.51 lower (1.02 lower to 0 higher)	LOW	IMPORTANT
Suicide - Endpoint (measured with: BSS change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	45	44	-	SMD 0.39 lower (0.81 lower to 0.03 higher)	LOW	IMPORTANT
Suicide - 6-month follow-up (follow-up mean 26 weeks; measured with: BSS change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	34	35	-	SMD 0.44 lower (0.92 lower to 0.04 higher)	LOW	IMPORTANT
Suicide - 12-month follow-up (follow-up mean 52 weeks; measured with: BSS change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Psychoeducation (+/- TAU)**	**Waitlist or TAU**	**Relative (95% CI)**	**Absolute**		
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	31	31	-	SMD 0.11 lower (0.61 lower to 0.39 higher)	LOW	IMPORTANT
Discontinuation (assessed with: Number of participants lost to follow-up for any reason)												
2	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[5]	none	53/168 (31.5%)	60/135 (44.4%)	RR 0.69 (0.51 to 0.92)	138 fewer per 1000 (from 36 fewer to 218 fewer)	LOW	CRITICAL

BDI= Beck Depression Inventory; BSI=Brief Symptom Inventory; BSS=Beck Scale for Suicidal Ideation; CI=confidence interval; DTS=; PCL= PTSD checklist; RR=risk ratio; SMD=standardised mean difference; TAU=treatment as usual

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

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

[3] *Data is not reported/cannot be extracted for all outcomes*

[4] *OIS not met (N<400)*

[5] *OIS not met (events<300)*

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

Acupuncture

Table 174: Clinical evidence profile: Acupuncture versus waitlist for delayed treatment (>3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Acupuncture	Waitlist	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology self-rated (follow-up mean 12 weeks; measured with: PSS-SR change score; Better indicated by lower values)												
1	random ised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	24	24	-	SMD 1.45 lower (2.09 to 0.81 lower)	VERY LOW	CRITICAL
Remission (follow-up mean 12 weeks; assessed with: Number of people scoring <16 on PSS-SR)												
1	random ised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	15/29 (51.7%)	4/27 (14.8%)	RR 3.49 (1.32 to 9.21)	369 more per 1000 (from 47 more to 1000 more)	VERY LOW	CRITICAL
Depression symptoms (follow-up mean 12 weeks; measured with: HSCL-25 Depression change score; Better indicated by lower values)												
1	random ised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	24	24	-	SMD 1.05 lower (1.66 to 0.44 lower)	VERY LOW	IMPORTANT

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Acupuncture	Waitlist	Relative (95% CI)	Absolute	Quality	Importance
Anxiety symptoms (follow-up mean 12 weeks; measured with: HSCL-25 Anxiety change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	24	24	-	SMD 1.38 lower (2.02 to 0.75 lower)	VERY LOW	IMPORTANT
Functional impairment (follow-up mean 12 weeks; measured with: SDS change score; Better indicated by lower values)												
1	randomised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	24	24	-	SMD 0.95 lower (1.55 to 0.35 lower)	VERY LOW	IMPORTANT
Discontinuation (follow-up mean 12 weeks; assessed with: Number of participants lost to follow-up for any reason)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[4]	none	10/29 (34.5%)	6/27 (22.2%)	RR 1.55 (0.65 to 3.69)	122 more per 1000 (from 78 fewer to 598 more)	VERY LOW	CRITICAL

CI=confidence interval; HSCL-25= Hopkins Symptom Checklist-25; PSS-SR PTSD symptom scale-self-report =; RR=risk ratio; SDS= Sheehan Disability Scale; SMD=standardised mean difference

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

[2] OIS not met (N<400)

[3] OIS not met (events<300)

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

Table 175: Clinical evidence profile: Acupuncture versus paroxetine for delayed treatment (>3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Acupuncture	Paroxetine	Relative (95% CI)	Absolute		
PTSD symptomatology clinician-rated - Endpoint (follow-up mean 12 weeks; measured with: CAPS change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	63	64	-	SMD 0.21 lower (0.56 lower to 0.14 higher)	LOW	CRITICAL
PTSD symptomatology clinician-rated - 3-month follow-up (follow-up mean 13 weeks; measured with: CAPS change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	63	64	-	SMD 0.35 lower (0.7 lower to 0 higher)	LOW	CRITICAL
PTSD symptomatology clinician-rated - 6-month follow-up (follow-up mean 26 weeks; measured with: CAPS change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	63	64	-	SMD 0.36 lower (0.71 lower to 0 higher)	LOW	CRITICAL
Anxiety symptoms - Endpoint (follow-up mean 12 weeks; measured with: HAM-A change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	63	64	-	SMD 0.22 lower (0.57 lower to	LOW	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Acupuncture	Paroxetine	Relative (95% CI)	Absolute		
										0.13 higher)		
Anxiety symptoms- 3-month follow-up (follow-up mean 13 weeks; measured with: HAM-A change score; Better indicated by lower values)												
1	random ised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	63	64	-	SMD 0.3 lower (0.65 lower to 0.05 higher)	LOW	IMPORTANT
Anxiety symptoms - 6-month follow-up (follow-up mean 26 weeks; measured with: HAM-A change score; Better indicated by lower values)												
1	random ised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	63	64	-	SMD 0.21 lower (0.56 lower to 0.14 higher)	LOW	IMPORTANT
Depression symptoms - Endpoint (follow-up mean 12 weeks; measured with: HAMD change score; Better indicated by lower values)												
1	random ised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	63	64	-	SMD 0.36 lower (0.71 to 0.01 lower)	LOW	IMPORTANT
Depression symptoms - 3-month follow-up (follow-up mean 13 weeks; measured with: HAMD change score; Better indicated by lower values)												
1	random ised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	63	64	-	SMD 0.43 lower (0.79 to	LOW	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Acupuncture	Paroxetine	Relative (95% CI)	Absolute		
										0.08 lower)		
Depression symptoms - 6-month follow-up (follow-up mean 26 weeks; measured with: HAMD change score; Better indicated by lower values)												
1	random ised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	63	64	-	SMD 0.45 lower (0.81 to 0.1 lower)	LOW	IMPORTANT
Discontinuation (follow-up mean 12 weeks; assessed with: Number of participants lost to follow-up for any reason)												
1	random ised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[4]	none	6/69 (8.7%)	5/69 (7.2%)	RR 1.2 (0.38 to 3.75)	14 more per 1000 (from 45 fewer to 199 more)	VERY LOW	CRITICAL

CAPS= Clinician-administered PTSD scale; CI=confidence interval; HAM-A/D= Hospital Anxiety and Depression Scale-Anxiety/Depression; RR=risk ratio; SMD=standardised mean difference

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

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

[3] OIS not met (N<400)

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

Exercise

Table 176: Clinical evidence profile: Exercise (+ TAU) versus TAU for delayed treatment (>3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Exercise (+ TAU)	TAU	Relative (95% CI)	Absolute		
PTSD symptomatology self-report (follow-up mean 12 weeks; measured with: PCL change score; Better indicated by lower values)												
1	random ised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	30	28	-	SMD 0.47 lower (0.99 lower to 0.06 higher)	LOW	CRITICAL
PTSD symptomatology clinician-rated (follow-up mean 12 weeks; measured with: CAPS change score; Better indicated by lower values)												
1	random ised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	16	22	-	SMD 1.01 lower (1.7 to 0.32 lower)	LOW	CRITICAL
Anxiety symptoms (follow-up mean 12 weeks; measured with: DASS Anxiety change score; Better indicated by lower values)												
1	random ised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	30	28	-	SMD 0.75 lower (1.28 to 0.22 lower)	LOW	IMPORTANT
Depression symptoms (follow-up mean 12 weeks; measured with: DASS Depression change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	**Design**	**Risk of bias**	**Inconsistency**	**Indirectness**	**Imprecision**	**Other considerations**	**Exercise (+ TAU)**	**TAU**	**Relative (95% CI)**	**Absolute**		
1	random ised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	none	30	28	-	SMD 0.49 lower (1.01 lower to 0.04 higher)	LOW	IMPORTANT
Sleeping difficulties (follow-up mean 12 weeks; measured with: PSQI change score; Better indicated by lower values)												
1	random ised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	30	28	-	SMD 0.72 lower (1.25 to 0.19 lower)	LOW	IMPORTANT
Discontinuation (follow-up mean 12 weeks; assessed with: Number of participants lost to follow-up for any reason)												
2	random ised trials	no serious risk of bias	no serious inconsistency	no serious indirectness	very serious[4]	none	14/60 (23.3%)	18/68 (26.5%)	RR 0.87 (0.48 to 1.59)	34 fewer per 1000 (from 138 fewer to 156 more)	LOW	CRITICAL

CAPS= Clinician-administered PTSD scale; CI=confidence interval; DASS= Depression Anxiety Stress Scales; PCL= PTSD checklist; PSQI=Pittsburgh Sleep Quality Index; RR=risk ratio; SMD=standardised mean difference; TAU=treatment as usual

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

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

[3] OIS not met (N<400)

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

Repetitive transcranial magnetic stimulation (rTMS)

Table 177: Clinical evidence profile: Repetitive transcranial magnetic stimulation (rTMS) versus sham stimulation for delayed treatment (>3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Repetitive transcranial magnetic stimulation (rTMS)	Sham stimulation	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology self-report (follow-up mean 1.4 weeks; measured with: PCL change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	10	10	-	SMD 2.51 lower (3.74 to 1.28 lower)	VERY LOW	CRITICAL
PTSD symptomatology clinician-rated (follow-up mean 1.4 weeks; measured with: CAPS change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	10	10	-	SMD 1.75 lower (2.81 to 0.68 lower)	VERY LOW	CRITICAL
Depression symptoms (follow-up mean 1.4 weeks; measured with: BDI change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[2]	reporting bias[3]	10	10	-	SMD 0.99 lower (1.93 to 0.05 lower)	VERY LOW	IMPORTANT

BDI= Beck Depression Inventory; CAPS= Clinician-administered PTSD scale; CI=confidence interval; PCL= PTSD checklist; RR=risk ratio; SMD=standardised mean difference

[1] *Risk of bias is high or unclear across multiple domains*
[2] *OIS not met (N<400)*
[3] *Data is not reported/cannot be extracted for all outcomes*

Yoga

Table 178: Clinical evidence profile: Yoga (+/- TAU) versus TAU/waitlist/attention-placebo for delayed treatment (>3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Yoga (+/- TAU)	TAU/waitlist/ attention-placebo	Relative (95% CI)	Absolute		
PTSD symptomatology self-report at endpoint (follow-up 6-10 weeks; measured with: PCL/DTS change score; Better indicated by lower values)												
3	random ised trials	very serious[1]	very serious[2]	no serious indirectness	very serious[3]	none	80	68	-	SMD 0.71 lower (1.95 lower to 0.52 higher)	VERY LOW	CRITICAL
PTSD symptomatology self-report at 1-month follow-up (follow-up mean 4 weeks; measured with: PCL change score; Better indicated by lower values)												
1	random ised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	20	18	-	SMD 0.02 higher (0.62 lower to 0.66 higher)	VERY LOW	CRITICAL
PTSD symptomatology clinician-rated (follow-up mean 10 weeks; measured with: CAPS change score; Better indicated by lower values)												
1	random ised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	reporting bias[5]	31	29	-	SMD 0.66 lower (1.18 to	VERY LOW	CRITICAL

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Yoga (+/- TAU)	TAU/waitlist/ attention-placebo	Relative (95% CI)	Absolute		
										0.14 lower)		
Remission (follow-up mean 10 weeks; assessed with: Number of people no longer meeting diagnostic criteria for PTSD)												
1	random ised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[6]	reporting bias[5]	16/31 (51.6%)	6/29 (20.7%)	RR 2.49 (1.13 to 5.5)	308 more per 1000 (from 27 more to 931 more)	VERY LOW	CRITICAL
Dissociative symptoms (follow-up mean 10 weeks; measured with: DES change score; Better indicated by lower values)												
1	random ised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[7]	reporting bias[5]	31	29	-	SMD 0.5 lower (1.01 lower to 0.02 higher)	VERY LOW	IMPORTANT
Anxiety symptoms at endpoint (follow-up 6-12 weeks; measured with: DASS Anxiety/STAI State change score; Better indicated by lower values)												
2	random ised trials	very serious[1]	serious[8]	no serious indirectness	serious[7]	none	49	39	-	SMD 0.2 lower (0.85 lower to 0.44 higher)	VERY LOW	IMPORTANT
Anxiety symptoms at 1-month follow-up (follow-up mean 4 weeks; measured with: STAI State change score; Better indicated by lower values)												
1	random ised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[7]	none	20	18	-	SMD 0.43 lower (1.07	LOW	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Yoga (+/- TAU)	TAU/waitlist/ attention-placebo	Relative (95% CI)	Absolute		
										lower to 0.22 higher)		
Depression symptoms at endpoint (follow-up 6-12 weeks; measured with: BDI-II/DASS Depression/CES-D change score; Better indicated by lower values)												
3	random ised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	80	68	-	SMD 0.04 higher (0.34 lower to 0.41 higher)	VERY LOW	IMPORTANT
Depression symptoms at 1-month follow-up (follow-up mean 4 weeks; measured with: CES-D change score; Better indicated by lower values)												
1	random ised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[3]	none	20	18	-	SMD 0.01 higher (0.62 lower to 0.65 higher)	VERY LOW	IMPORTANT
Symptoms of alcohol use disorder at endpoint (follow-up 6-12 weeks; measured with: AUDIT change score; Better indicated by lower values)												
1	random ised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[7]	none	14	11	-	SMD 0.53 lower (1.34 lower to 0.27 higher)	LOW	IMPORTANT
Symptoms of alcohol use disorder at 1-month follow-up (follow-up mean 4 weeks; measured with: AUDIT change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Yoga (+/- TAU)	TAU/waitlist/ attention-placebo	Relative (95% CI)	Absolute		
1	random ised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[7]	none	13	12	-	SMD 0.76 lower (1.58 lower to 0.06 higher)	LOW	IMPORTANT
Symptoms of drug use disorder at endpoint (follow-up 6-12 weeks; measured with: DUDIT change score; Better indicated by lower values)												
1	random ised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[7]	none	14	11	-	SMD 0.4 lower (1.2 lower to 0.4 higher)	LOW	IMPORTANT
Symptoms of drug use disorder at 1-month follow-up (follow-up mean 4 weeks; measured with: DUDIT change score; Better indicated by lower values)												
1	random ised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[7]	none	13	12	-	SMD 0.43 lower (1.23 lower to 0.36 higher)	LOW	IMPORTANT
Sleeping difficutlies (follow-up mean 8 weeks; measured with: ISI change score; Better indicated by lower values)												
1	random ised trials	very serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	29	21	-	SMD 0.76 lower (1.34 to 0.18 lower)	VERY LOW	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Yoga (+/- TAU)	TAU/waitlist/ attention-placebo	Relative (95% CI)	Absolute		
Discontinuation (follow-up 6-12 weeks; assessed with: Number of participants lost to follow-up for any reason)												
2	random ised trials	serious[1]	very serious[2]	no serious indirectness	very serious[3]	none	36/79 (45.6%)	6/39 (15.4%)	RR 3.88 (0.05 to 282.52)	443 more per 1000 (from 146 fewer to 1000 more)	VERY LOW	CRITICAL

AUDIT= Alcohol Use Disorders Identification Test (AUDIT; change score); BDI= Beck Depression Inventory; CAPS= Clinician-administered PTSD scale; CES-D= Centre of Epidemiological Studies-Depression; CI=confidence interval; DASS= Depression Anxiety Stress Scales; DES= Dissociative Experiences Scales; DTS= Davidson Trauma Scale; DUDIT= Drug Use Disorders Identification Test; ISI= Insomnia Severity Index; PCL= PTSD checklist; RR=risk ratio; SMD=standardised mean difference; STAI=; TAU=treatment as usual

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

[2] *Considerable heterogeneity (I2>80%)*

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

[4] *OIS not met (N<400)*

[5] *Data is not reported/cannot be extracted for all outcomes*

[6] *OIS not met (events<300)*

[7] *95% CI crosses both line of no effect and threshold for clinically important effect*

[8] *Substantial heterogeneity (I2=50-80%)*

Bio-/neuro-feedback

Table 179: Clinical evidence profile: Bio-/neuro-feedback (+/- TAU) versus TAU or no treatment for delayed treatment (>3 months) of clinically important symptoms/PTSD

Quality assessment							No of patients		Effect			
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Bio-/neuro-feedback (+/- TAU)	TAU or no treatment	Relative (95% CI)	Absolute	Quality	Importance
PTSD symptomatology self-rated at endpoint (follow-up 6-12 weeks; measured with: PCL/DTS/IES-R change score; Better indicated by lower values)												
3	randomised trials	serious[1]	very serious[2]	no serious indirectness	serious[3]	none	47	47	-	SMD 1.73 lower (3.15 to 0.3 lower)	VERY LOW	CRITICAL
PTSD symptomatology self-rated at 4-6 week follow-up (follow-up 4-6 weeks; measured with: DTS/IES-R change score; Better indicated by lower values)												
2	randomised trials	serious[1]	very serious[2]	no serious indirectness	serious[3]	none	34	34	-	SMD 2.49 lower (4.41 to 0.57 lower)	VERY LOW	CRITICAL
PTSD symptomatology clinician-rated at endpoint (follow-up 8-12 weeks; measured with: CAPS change score; Better indicated by lower values)												
2	randomised trials	serious[1]	very serious[2]	no serious indirectness	serious[4]	none	32	32	-	SMD 1.25 lower (2.67 lower to 0.18 higher)	VERY LOW	CRITICAL
PTSD symptomatology clinician-rated at 1-month follow-up (follow-up mean 4 weeks; measured with: CAPS change score; Better indicated by lower values)												

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Bio-/neuro-feedback (+/- TAU)	TAU or no treatment	Relative (95% CI)	Absolute		
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	none	19	19	-	SMD 2.21 lower (3.03 to 1.38 lower)	LOW	CRITICAL
Remission at endpoint (follow-up mean 12 weeks; assessed with: Number of people no longer meeting diagnostic criteria)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[4]	none	16/28 (57.1%)	7/24 (29.2%)	RR 1.96 (0.97 to 3.95)	280 more per 1000 (from 9 fewer to 860 more)	LOW	CRITICAL
Remission at 1-month follow-up (follow-up mean 4 weeks; assessed with: Number of people no longer meeting diagnostic criteria)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[5]	none	11/28 (39.3%)	2/24 (8.3%)	RR 4.71 (1.16 to 19.2)	309 more per 1000 (from 13 more to 1000 more)	LOW	CRITICAL
Depression symptoms at endpoint (follow-up mean 6 weeks; measured with: BDI change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	reporting bias[6]	15	15	-	SMD 1.92 lower (2.81 to	VERY LOW	IMPORTANT

Quality assessment							No of patients		Effect		Quality	Importance
No of studies	Design	Risk of bias	Inconsistency	Indirectness	Imprecision	Other considerations	Bio-/neuro-feedback (+/- TAU)	TAU or no treatment	Relative (95% CI)	Absolute		
										1.04 lower)		
Depression symptoms at 6-week follow-up (follow-up mean 6 weeks; measured with: BDI change score; Better indicated by lower values)												
1	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	serious[3]	reporting bias[6]	15	15	-	SMD 2.08 lower (2.99 to 1.17 lower)	VERY LOW	IMPORTANT
Discontinuation (follow-up 8-12 weeks; assessed with: Number of participants lost to follow-up for any reason)												
2	randomised trials	serious[1]	no serious inconsistency	no serious indirectness	very serious[7]	none	6/38 (15.8%)	2/34 (5.9%)	RR 2.57 (0.57 to 11.58)	92 more per 1000 (from 25 fewer to 622 more)	VERY LOW	CRITICAL

BDI= Beck Depression Inventory; CAPS= Clinician-administered PTSD scale; CI=confidence interval; DTS=Davidson Trauma Scale; IES-R= Impact of Event Scale-Revised; PCL= PTSD checklist; RR=risk ratio; SMD=standardised mean difference; TAU=treatment as usual

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

Appendix G - Economic evidence study selection

Economic evidence study selection for "For adults with clinically important post-traumatic stress symptoms, what are the relative benefits and harms of psychological, psychosocial or other non-pharmacological interventions targeted at PTSD symptoms?"

A global health economics search was undertaken for all areas covered in the guideline. The flow diagram of economic article selection across all reviews is provided in Appendix A of Supplement 1 – Methods Chapter'.

Appendix H – Economic evidence tables

Health economic evidence tables for "For adults with clinically important post-traumatic stress symptoms, what are the relative benefits and harms of psychological, psychosocial or other non-pharmacological interventions targeted at PTSD symptoms?"

Psychological interventions - references to included studies

Chatterton ML, Chambers S, Occhipinti S et al. (2016) Economic evaluation of a psychological intervention for high distress cancer patients and carers: costs and quality-adjusted life years. Psychooncology 25(7), 857-64

Dunn NJ, Rehm LP, Schillaci J et al. (2007) A randomized trial of self-management and psychoeducational group therapies for comorbid chronic posttraumatic stress disorder and depressive disorder. Journal of traumatic stress 20(3), 221-37

Mihalopoulos C, Magnus A, Lal A et al. (2015) Is implementation of the 2013 Australian treatment guidelines for posttraumatic stress disorder cost-effective compared to current practice? A cost-utility analysis using QALYs and DALYs. Australian and New Zealand Journal of Psychiatry 49(4), 360-76

Tuerk PW, Wangelin B, Rauch SAM et al. (2013) Health service utilization before and after evidence-based treatment for PTSD. Psychological Services 10(4), 401-9

Study Country Study type	Intervention details	Study population Study design Data sources	Costs and outcomes: description and values	Results: Cost-effectiveness	Comments
Chatterton et al., 2016 Australia Cost-utility analysis	Interventions: Individualised trauma-focused cognitive behavioural therapy comprising 5 sessions led by psychologists (TF-CBT) Psychoeducation comprising one session led by a nurse counsellor (PE)	Distressed carers of adults with cancer, who exceed the IES (impact of event scale) cut-off point of 35 for PTSD; participants divided into low and high distress, based on a cut-off point of BSI=63 (Brief Symptom Inventory) RCT (Chambers 2009) Source of efficacy and resource use data: RCT (N=354; 27% did not complete all follow-up assessments; multiple imputation used) Source of unit costs: national sources	Costs: intervention and other health-care resources (medical and psychological; psychiatrist, psychologist, social worker, GP, nurse) used by cancer patients and carers including out of pocket expenses such as co-payments for medical care or prescription medications Mean cost/person – carers high distress: TF-CBT $4070; PE $5485 Difference -$1415 (95% CI -$4305 to $1474) Mean cost/person – carers low distress: TF-CBT $2971; PE $2362 Difference $610 (95% CI -$774 to $1993) Outcome measure: QALY based on the Assessment of Quality of Life measure (AQoL-8D), Australian values used Mean QALYs/person – carers high distress: TF-CBT 0.674; PE 0.640 Difference 0.035 (95% CI -0.057 to 0.126) Mean QALYs/person – carers low distress: TF-CBT 0.728; PE 0.756 Difference -0.028 (-0.078 to 0.021)	In carers with high distress: TF-CBT dominant over PE In carers with low distress: TF-CBT dominated by PE Probability of cost effectiveness of TF-CBT at WTP $50,000/QALY: • Carers with high distress: 0.89 low distress: 0.21	Perspective: health sector including co-payments Currency: Aus$ Cost year: 2012 Time horizon: 1 year Discounting: NA Applicability: partially applicable Quality: minor limitations

Study Country Study type	Intervention details	Study population Study design Data sources	Costs and outcomes: description and values	Results: Cost-effectiveness	Comments
Dunn et al., 2007 US Cost consequence analysis	Interventions: Non-trauma-focused CBT comprising 1.5-hour weekly group sessions for 14 weeks Psychoeducation comprising 1.5-hour weekly group sessions for 14 weeks Both groups received the standard Trauma Recovery Program care of process oriented and educational groups prior to and throughout the course of the study, plus medications as indicated (mostly antidepressants and mood stabilizers)	Male veterans with chronic combat-related PTSD and depressive disorder RCT (Dunn 2007) Source of efficacy and resource use data: RCT (N=101; at 1-year follow up: n=66) Source of unit costs: national sources	Costs: psychiatric, medical and surgical care; medication Mean cost per person: Self-management $13,129 Psychoeducation $22,416 Outcome measures: PTSD symptoms measured by the PTSD Scale (CAPS) & the Davidson Traumatic Stress Scale (DTSS); depressive symptoms measured by the 18-item Hamilton Depression Rating Scale (HAMD) & the Beck Depression Inventory (BDI-II), treatment compliance, satisfaction measured by the abbreviated Moos Group Environment Scale (GES) and other scales, treatment-targeted constructs, functioning measured by the Brief Symptom Inventory (BSI) & the Addiction Severity Index (ASI) Outcomes: No significant differences between groups at follow-up, except depressive symptoms and functioning, where psychoeducation demonstrated modestly greater improvements	Non-trauma-focused CBT resulted in lower costs and slightly worse outcomes than psychoeducation	Perspective: health service Currency: US$ Cost year: 1999 Time horizon: 12 months Discounting: stated as 3% Applicability: partially applicable Quality: potentially serious limitations

Study Country Study type	Intervention details	Study population Study design Data sources	Costs and outcomes: description and values	Results: Cost-effectiveness	Comments
Mihalopoulos et al., 2015 Australia Cost-utility analysis	Interventions: Trauma-focused cognitive behavioural therapy (TF-CBT) (8-12 individual sessions) delivered by a psychologist Treatment as usual (TAU): non-evidence-based care comprising consultation with healthcare professionals	Prevalent cases of adults with PTSD in Australia in 2012, who sought care and had consulted a health professional for a mental health problem during the previous 12 months, but had not received evidence-based care Decision-analytic economic modelling Source of efficacy data: meta-analyses of TF-CBT trials Source of resource use data: published trial and epidemiological data; expert opinion Source of unit costs: national sources	Costs: intervention (psychologist, psychiatrist, GP) Mean incremental cost (million) per eligible population (95% CI): TF-CBT vs TAU $81 ($44 to $140) Primary outcome measure: QALY based on the Assessment of Quality of Life measure (AQoL-4D), Australian values used [DALY also considered] Mean incremental number of QALYs per eligible population (x1,000) (95% CI): TF-CBT vs TAU 4.4 (2.4 to 7.3)	ICER of TF-CBT versus TAU: $19,000/QALY Probability of TF-CBT being cost-effective 1.0 at a willingness to pay of $50,000/QALY Results most sensitive to utility scores, participation rates, adherence to treatment, likelihood of being offered CBT and effectiveness	Perspective: health sector (government & service user (intervention costs only) Currency: Aus$ Cost year: 2012 Time horizon: 5 years Discounting: 3% Applicability: partially applicable Quality: potentially serious limitations

Study Country Study type	Intervention details	Study population Study design Data sources	Costs and outcomes: description and values	Results: Cost-effectiveness	Comments
Tuerk et al., 2013 US Cost effectiveness analysis	Interventions: Trauma-focused CBT (exposure therapy /prolonged exposure) No treatment	Veterans with combat-related PTSD Before-after study Source of efficacy and resource use data: before-and-after study (N=60) Source of unit costs: national sources – only minimum associated cost per appointment used	Costs: mental health care, including medicine management, psychotherapy, supportive counselling, motivational interviewing, case management, and other relevant resource use; primary care costs excluded. Mean 12-month cost per person: Pre- treatment $41,567 Post-treatment $29,923 Outcome measure: PCL–military version score Mean PCL score: Pre-treatment 61.0 (SD 9.6) Post-treatment and 39.0 (SD 15.3) p < 0.001	Trauma-focused CBT was dominant over no treatment	Perspective: mental health care Currency: US$ Cost year: 2009 Time horizon: 12 months Discounting: NA Applicability: partially applicable Quality: potentially serious limitations

Psychological versus pharmacological interventions - reference to included study

Le QA, Doctor JN, Zoellner LA et al. (2014) Cost-effectiveness of prolonged exposure therapy versus pharmacotherapy and treatment choice in posttraumatic stress disorder (the optimizing ptsd treatment trial): A doubly randomized preference trial. Journal of Clinical Psychiatry 75(3), 222-30

Study Country Study type	Intervention details	Study population Study design Data sources	Costs and outcomes: description and values	Results: Cost-effectiveness	Comments
Le et al., 2014 US Cost-utility analysis	Interventions: Trauma-focused CBT (exposure therapy /prolonged exposure) comprising up to 10 weekly 90 to 120min sessions Sertraline	Adults with PTSD RCT Source of efficacy and resource use data: RCT with preference trial (N=200; preference arm n=97, completers n=69; RCT n=103; completers n=58) Source of unit costs: national sources	Costs: intervention (exposure therapist's or psychiatrist's time, medication), outpatient care (general medical care, mental health care, substance abuse care, professional supportive services), inpatient care, emergency department services, pharmacy and other supportive services, productivity losses due to time spent in weekly treatment sessions and travel time to/from clinic Mean unadjusted cost per person: RCT: CBT: $7,033; sertraline: $8,653 Difference: -$1,620 (-$7,262 to $4,023) Preference trial: CBT: $4,497; sertraline: $8,966 Outcome measures: QALY based on EQ-5D (US tariff) Mean unadjusted QALYs per person: RCT: CBT: 0.823; sertraline: 0.726 Difference: 0.096 (0.026 to 0.167) Preference trial: CBT: 0.803; sertraline: 0.744	CBT dominant in both RCT and preference trial Probability of CBT being cost-effective in RCT at WTP $100,000/QALY 0.93 (range 0.91 to 0.95, for use of highest and lowest estimates of unit costs, respectively); at zero WTP: 0.60	Perspective: societal Currency: US$ Cost year: 2012 Time horizon: 12 months Discounting: NA Applicability: partially applicable Quality: potentially serious limitations

Appendix I – Health economic evidence profiles

Health economic evidence profiles for "For adults with clinically important post-traumatic stress symptoms, what are the relative benefits and harms of psychological, psychosocial or other non-pharmacological interventions targeted at PTSD symptoms?"

Psychological interventions

Economic evidence profile: trauma-focused cognitive behavioural therapy (TF-CBT) versus psychoeducation for the treatment of adults with PTSD

Study and country	Limitations	Applicability	Other comments	Incremental cost (£)[1]	Incremental effect	ICER (£/effect)[1]	Uncertainty[1]
Chatterton *et al.*, 2016 Australia	Minor limitations[2]	Partially applicable[3]	Population: distressed carers of adults with cancer, who exceed the IES (impact of event scale) cut-off point of 35 for PTSD; divided into low and high distress, based on a cut-off point of BSI=63 (Brief Symptom Inventory) Outcome: QALY	high distress -£672 low distress: £290	high distress: 0.035 low distress: -0.028	high distress: TF-CBT dominant low distress: TF-CBT dominated	Probability of cost effectiveness of TF-CBT at WTP £23,750/QALY: high distress: 0.89 low distress: 0.21

1. Costs converted and uplifted to 2016 UK pounds using purchasing power parity (PPP) exchange rates and the UK HCHS index (Curtis & Burns, 2016).
2. Time horizon 1 year; analysis based on RCT (N=354; loss to follow-up 27%, multiple imputation used); national unit costs used; bootstrapping conducted and CEACs presented
3. Australian study; health sector perspective; QALY estimates based on the Assessment of Quality of Life measure (AQoL-8D, Australian values used)

Economic evidence profile: trauma-focused cognitive behavioural therapy (TF-CBT) versus treatment as usual (TAU) or no intervention for the treatment of adults with PTSD

Study and country	Limitations	Applicability	Other comments	Incremental cost (£)[1]	Incremental effect	ICER (£/effect)[1]	Uncertainty[1]

Economic evidence profile: trauma-focused cognitive behavioural therapy (TF-CBT) versus treatment as usual (TAU) or no intervention for the treatment of adults with PTSD							
Mihalopoulos *et al.*, 2015 Australia	Potentially serious limitations[2]	Partially applicable[3]	Population: prevalent cases of adults with PTSD in Australia in 2012, in receipt of non-evidence-based care Outcome: QALY [and DALY]	£36 million	4,400	£8441	Probability of TF-CBT being cost-effective 1.0 at a willingness to pay of £22,214/QALY Results most sensitive to utility scores, participation rates, adherence to treatment, likelihood of being offered CBT and effectiveness
Tuerk *et al.*, 2013 US	Potentially serious limitations[4]	Partially applicable[5]	Population: Veterans with combat-related PTSD Outcome: PCL–military version score	-£8498	-21.0	TF-CBT dominant	
1. Costs converted and uplifted to 2016 UK pounds using purchasing power parity (PPP) exchange rates and the UK HCHS index (Curtis & Burns, 2016). 2. Time horizon 5 years (for benefits); analysis based on economic modelling; effectiveness based on meta-analyses of TF-CBT trials; resource use based on trial and epidemiological data and expert opinion; national unit costs used; PSA conducted; consideration of intervention costs only (measured for up to 12 weeks) 3. Australian study; health sector perspective; QALY estimates based on the Assessment of Quality of Life measure (AQoL-4D, Australian values used) 4. Time horizon 1 year; before-after analysis (N=60); national unit costs used; no statistical analysis of costs 5. US study; mental health care perspective; no QALYs estimated							

Economic evidence profile: non-trauma-focused CBT versus psychoeducation for the treatment of adults with PTSD							
Study and country	**Limitations**	**Applicability**	**Other comments**	**Incremental cost (£)[1]**	**Incremental effect**	**ICER (£/effect)[1]**	**Uncertainty[1]**
Dunn *et al.*, 2016 US	Potentially serious limitations[2]	Partially applicable[3]	Population: Male veterans with chronic combat-related PTSD and depressive disorder Outcomes: PTSD symptoms; depressive symptoms; treatment compliance;	-£9844	Non-trauma-focused CBT had lower effect in depressive symptoms and	No synthesis of costs and outcomes	Not examined

Economic evidence profile: non-trauma-focused CBT versus psychoeducation for the treatment of adults with PTSD							
			satisfaction; treatment-targeted constructs; functioning		functioning; no other significant differences		

1. Costs converted and uplifted to 2016 UK pounds using purchasing power parity (PPP) exchange rates and the UK HCHS index (Curtis & Burns, 2016).
2. Time horizon 1 year; analysis based on RCT (N=110, at 1-year follow up: n=66); national unit costs used; no statistical analysis of costs
3. US study; health sector perspective; no QALYs estimated

Psychological versus pharmacological interventions

Economic evidence profile: Trauma-focused CBT (exposure therapy /prolonged exposure) versus sertraline for the treatment of adults with PTSD							
Study and country	**Limitations**	**Applicability**	**Other comments**	**Incremental cost (£)[1]**	**Incremental effect**	**ICER (£/effect)[1]**	**Uncertainty[1]**
Le *et al.*, 2015 US	Potentially serious limitations[2]	Partially applicable[3]	Population: adults with PTSD Outcome: QALY	RCT -£1,185 Preference trial -£3,270	RCT 0.096 Preference trial 0.059	CBT dominant	Probability of CBT being cost-effective in RCT at WTP £73,153/QALY: 0.93 (range 0.91 to 0.95, for use of highest and lowest estimates of unit costs, respectively); at zero WTP: 0.60

1. Costs converted and uplifted to 2016 UK pounds using purchasing power parity (PPP) exchange rates and the UK HCHS index (Curtis & Burns, 2016).
2. Time horizon 12 months; analysis based on RCT and preference trial (N=200; preference arm n=97, completers n=69; RCT n=103; completers n=58); national unit costs used; PSA conducted
3. US study; societal perspective (direct medical and non-medical costs, productivity losses relating to time spent to therapy and travel to/from clinic); QALY estimates based on the EQ-5D (US values used)

Psychological versus pharmacological versus combined interventions

Economic evidence profile: various interventions for the treatment of adults with PTSD							
Study & country	**Limitations**	**Applicability**	**Other comments**	**Incremental cost vs no treatment (£)[1]**	**Incremental QALY vs no treatment**	**NMB (£)[1]**	**Uncertainty[1]**
Guideline economic analysis UK	Minor limitations [2]	Directly applicable[3]	Outcome: QALY	Psychoed -961 Counsel 560 TF-CBT ind <8 -751 TF-CBT ind 8-12 500 TF-CBT ind >12 848 TF-CBT gr 8-12 103 non-TF-CBT 194 EMDR -456 PCT 764 IPT 264 CS&CT -529 SH +sup -407 SH no sup -226 SSRI -282 TF-CBT ind 8-12 + SSRI 852	Psychoed 0.12 Counsel 0.02 TF-CBT ind <8 0.14 TF-CBT ind 8-12 0.07 TF-CBT ind >12 0.04 TF-CBT gr 8-12 0.03 non-TF-CBT 0.06 EMDR 0.13 PCT 0.07 IPT 0.06 CS&CT 0.10 SH +sup 0.07 SH no sup 0.04 SSRI 0.05 TF-CBT ind 8-12 + SSRI 0.05	TF-CBT ind <8 34,539 Psychoed 34,262 EMDR 34,053 CS&CT 33,448 SH +sup 32,853 SSRI 32,189 TF-CBT ind 8-12 31,958 SH no sup 31,918 non-TF-CBT 31,910 IPT 31,902 PCT 31,549 TF-CBT gr 8-12 31,448 TF-CBT ind 8-12 +SSRI 31,142 No treat 30,991 Counsel 30,927 TF-CBT ind >12 30,910	Prob of cost effectiveness at WTP £20,000/QALY: TF-CBT ind <8 0.26; psychoed 0.44; EMDR 0.14; CS&CT 0.10; SH +sup 0.03; SSRI 0.01; TF-CBT ind 8-12 0.00; SH no sup 0.00; non-TF-CBT 0.00; IPT 0.02; PCT 0.01; TF-CBT gr 8-12 0.00; TF-CBT ind 8-12 + SSRI 0.00; no treat 0.00; counsel 0.00; TF-CBT ind >12 0.00 Results robust to changes in risk of relapse, PTSD costs, utility values
1. Costs uplifted to 2017 UK pounds using the UK hospital & community health services (HCHS) index (Curtis & Burns, 2017). 2. Decision-analytic hybrid model (decision-tree + Markov); time horizon 3 years; relative effects based on guideline systematic review and NMA; baseline effects & other clinical input parameters derived from published literature and the committee's expert advice; resource use based on RCT data, national statistics & other published sources supplemented by the committee's expert advice; national unit costs used; PSA conducted; CEACs & CEAF presented 3. UK study; NHS & PSS perspective; QALY estimates based on the Assessment of Quality of Life measure (AQoL-8D, Australian values used)							

Appendix J – Health economic analysis: cost effectiveness of interventions for the delayed (>3 months) treatment of PTSD in adults

Introduction – objective of economic modelling

The choice of treatment for adults with PTSD was identified by the committee and the guideline health economist as an area with potentially major resource implications. Existing economic evidence in this area is rather limited and does not cover the full range of available interventions for adults with PTSD in the UK. However, there is a solid clinical evidence base that can inform primary economic modelling. An economic model was therefore developed to assess the relative cost effectiveness of interventions for the treatment of PTSD in adults in the UK.

Economic modelling methods

Population

The study population of the economic model comprised adults with PTSD, who initiate treatment for PTSD in a community setting, although they may receive care in other settings over the time horizon of the analysis. This was decided because the majority of adults with PTSD initiate treatment for PTSD in a community setting in UK routine practice.

No distinction was made between adults with single trauma and those with multiple traumas as there was no adequate evidence to demonstrate that the effectiveness of interventions was affected by this factor.

The starting age of the cohorts considered in the economic model was set at 39 years, to reflect the mean age of adults with PTSD presenting to healthcare services. The estimate of 39 years was based on a study of all consecutive patients who were referred for assessment for possible PTSD between April 2001 and August 2008 in a UK NHS outpatient clinic and were subsequently offered cognitive therapy for PTSD (Ehlers et al., 2013).

The percentage of women in each cohort at the start of the model was estimated to be 51.6%, calculated using the proportion of women in the general population aged 39 years (i.e. the average age of population initiating treatment) obtained from general statistics for the UK population (Office for National Statistics, 2017b), and data on the percentage of people screened positive for PTSD by age and sex reported in the most recent adult psychiatric morbidity household survey conducted in England (McManus et al., 2016).

Determining the starting age and gender mix of the cohorts was necessary in order to estimate mortality risks in the model; moreover, the gender mix was used at the estimation of QALYs, as the base-case economic analysis utilised gender-specific utility data, as described later.

Interventions assessed

The range of interventions assessed in the economic analysis was determined by the availability of relevant clinical data included in the guideline systematic review of psychological interventions for the treatment of adults with clinically important PTSD symptoms. Network meta-analysis (NMA) was employed for synthesis of the available

efficacy data. Details of the NMA undertaken to inform the economic analysis are provided in the 'Efficacy data and methods of evidence synthesis' section. The guideline economic analysis assessed psychological, pharmacological and combined psychological and pharmacological interventions that were connected to the network of evidence and were thus possible to include in the NMA. Hypnotherapy and psychosocial interventions such as meditation, mindfulness-based stress reduction, supported employment, peer support and practical support, as well as physical interventions such as exercise, yoga, acupuncture, bio-neuro-feedback and repetitive transcranial magnetic stimulation (r-TMS) were not included in the analysis as they were not part of the decision problem. Relaxation was included as a control intervention that provided additional indirect comparisons across interventions of interest.

Based on the advice of the committee, only effective interventions that had been tested on at least 50 people across the RCTs included in the NMAs assessing efficacy at treatment endpoint were considered in the economic analysis, as this was deemed as the minimum evidence that would be adequate to support a practice recommendation.

Interventions that belonged to the trauma-focused cognitive behavioural therapy (TF-CBT) class were not considered separately according to their type, as the description of the type of TF-CBT was not always clear in the publications. However, based on reported resource use in each RCT included in the NMA, TF-CBT interventions were categorised according to their mode of delivery in individual, group and mixed (where the intervention was delivered by a combination of individual and group sessions). Each of these categories was further subdivided, as relevant, to those comprising fewer than 8 sessions, 8-12 sessions, and more than 12 sessions, and were considered separately in the NMA and the economic analysis, to reflect the different intervention costs and, potentially, different efficacy associated with each sub-category.

Based on the available evidence, the following interventions were considered in the economic analysis of interventions for the treatment of adults with PTSD:

- Psychoeducation
- Counselling
- TF-CBT individual <8 sessions
- TF-CBT individual 8-12 sessions
- TF-CBT individual >12 sessions
- TF-CBT group 8-12 sessions
- non-TF-CBT
- Eye Movement Desensitisation Reprocessing (EMDR)
- Present-centered therapy
- Interpersonal psychotherapy
- Combined somatic and cognitive therapies
- Self-help with support
- Self-help without support
- Selective serotonin reuptake inhibitors (SSRIs)
- TF-CBT individual 8-12 sessions + SSRIs
- No treatment, reflected in the waitlist arms of RCTs included in the guideline systematic review and NMA.

Model structure

A hybrid decision-analytic model consisting of a decision-tree followed by a three-state Markov model was constructed using Microsoft Office Excel 2013. The model estimated the total costs and benefits associated with provision of effective treatment options in adults with PTSD. The structure of the model, which aimed to simulate the course of PTSD and relevant clinical practice in the UK, was also driven by the availability of clinical data.

According to the model structure, hypothetical cohorts of adults with PTSD were initiated on each of the treatment options assessed, including no treatment. The duration of a full course of initial treatment was 12 weeks for drugs and varied between 6 and 16 weeks for non-pharmacological interventions. The duration of combined interventions was determined by the component with the longest duration. For modelling purposes relating to estimation of QALYs, the duration of a full course of treatment was assumed to be 3 months (12 weeks), without this assumption affecting resource use associated with each intervention. Following a course of treatment, people in each cohort either remitted (that is, they did not meet criteria for a PTSD diagnosis) or did not remit. Those initiated on pharmacological or combined treatment were given a further 3 months of maintenance pharmacological therapy if they had remitted. In the 3 months of follow-up after treatment completion, people who remitted ('no PTSD') could remain in remission, relapse to a PTSD state or die. Those who did not remit, could remain in the PTSD state, remit (and move to a 'no PTSD' state) or die. The two distinct periods in the decision-tree (full course of treatment and 3-month follow-up) were informed by the results of respective NMAs (although the 3-month follow-up period was informed by the results of the NMA only in a sensitivity analysis, as discussed later). The length of the follow-up period immediately post-treatment was set at 3 months as this was the period for which most RCT follow-up data were available across interventions.

After that point, people in each cohort, both those who remitted and those who did not remit, were entered into the Markov component of the economic model, in either the 'PTSD' or the 'no PTSD' health states, depending on their state at the end of the decision-tree. In each cycle of the Markov model, they could remain in the same health state or move between the two states of 'PTSD' and 'no PTSD' or move to the death state (absorbing state). The Markov model was run in 3-month cycles, for consistency with the duration of the two periods of the decision-tree, that is, a full course of treatment (which lasted, on average, 3 months) and another 3-month follow-up period (the length of which was determined by data availability). A half-cycle correction was applied. Due to lack of long-term comparative clinical data, transitions between the 'PTSD' and 'no PTSD' health states in the Markov component of the model were assumed to be independent of the intervention received at the decision-tree part of the model. The transition probability to the death state depended on the PTSD status of each person in the population.

The time horizon of the analysis was 3 years, consisting of the 6 months of the decision tree and another 2.5 years (10 x 3-month cycles) in the Markov component of the economic model. This time frame was considered to be long enough to capture longer-term costs and effects of treatment, without significant extrapolation over the course of PTSD.

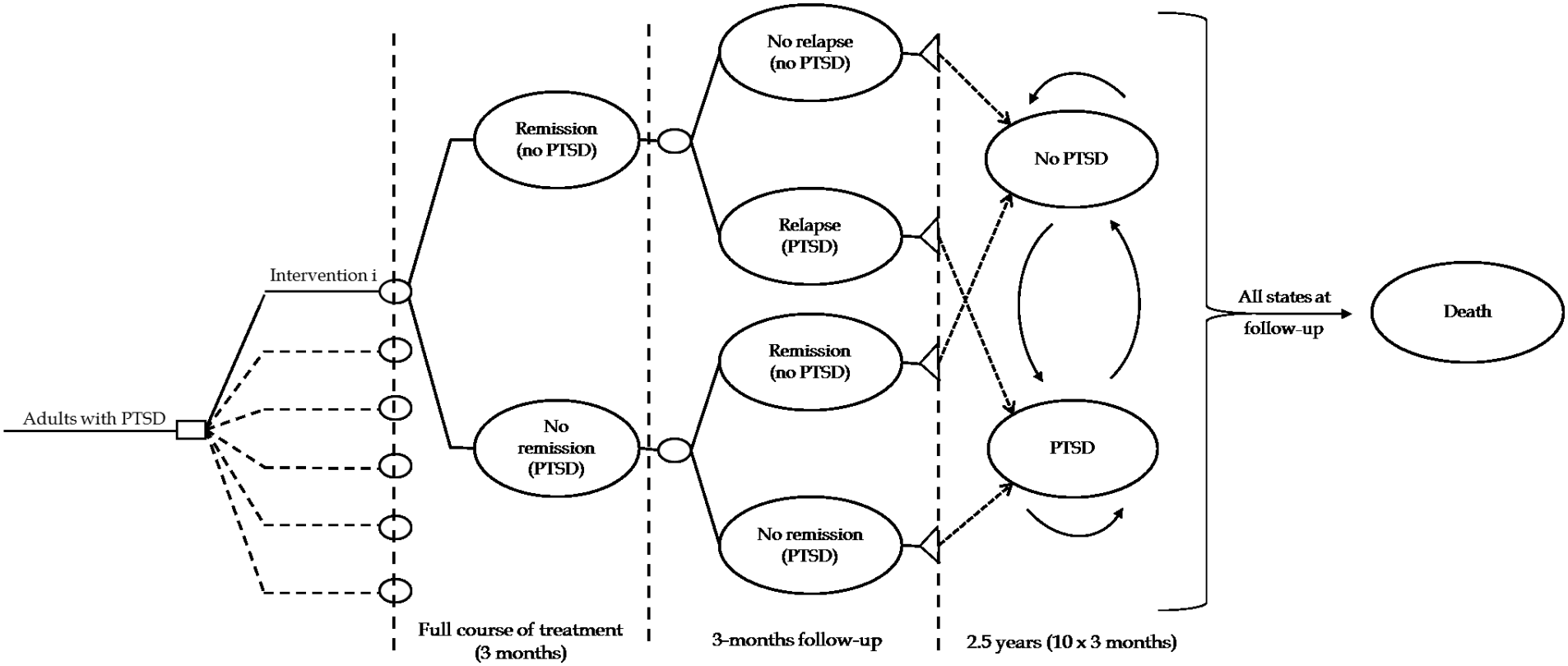
Death was not considered during provision of interventions, as no relevant differential mortality data are available. However, the presence of PTSD is associated with an increase in mortality (Ahmadi et al., 2011). For this reason, death was considered at follow-up, both in the first 3 months of follow-up (decision-tree) and in the Markov component of the model.

A proportion of adults who received pharmacological or combined treatment were assumed to experience side effects from medication which resulted in a reduction in their HRQoL over

the period they received pharmacological treatment (i.e. 3 or 6 months) and incurred extra costs for their management, which comprised GP visits and pharmacological treatment.

The structure of the economic model for interventions for treatment of PTSD in adults is shown in Figure 696.

Figure 696. Schematic diagram of the economic model structure: interventions for the treatment of PTSD in adults



Costs and outcomes considered in the analysis

The economic analysis adopted the perspective of the NHS and personal social services (PSS), as recommended by NICE (NICE, 2014). Costs consisted of intervention costs (healthcare professional time, drug acquisition and equipment/infrastructure required for self-help interventions), as well as other costs incurred by adults PTSD who did not remit following treatment or who experienced a relapse following remission and by those who remitted, including primary, community and secondary health care and personal social services. Costs of management of common side effects from pharmacological treatment in people receiving pharmacological or combined treatment were also considered in the analysis. The cost year was 2017.

The measure of outcome was the Quality Adjusted Life Year (QALY), which incorporated utilities associated with the health states of PTSD and no PTSD, as well as utility decrements due to common side effects associated with pharmacological treatment.

Efficacy data and methods of evidence synthesis

Selection of efficacy data and methods of evidence synthesis

Efficacy data for the interventions for the treatment of PTSD in adults that were considered in the economic modelling were derived from the respective guideline systematic review. The RCTs included in the guideline systematic review can be divided into two broad categories:

- RCTs comparing ‘pure’ interventions versus waitlist or another ‘pure’ inactive control or ‘pure’ active intervention
- RCTs comparing interventions added to treatment as usual (TAU) versus TAU alone or versus another inactive control added to TAU or active intervention added to TAU. The definition of TAU in this set of studies varied widely across studies, including minimum contact comparison, psychoeducation or supportive counselling, psychotropic or other medication, substance misuse treatment, any treatment outside the research setting or any treatment except the intervention assessed in the study.

These two different categories of RCTs created two distinct sub-networks [a ‘waitlist-based’ sub-network and a ‘TAU-based’ sub-network, respectively], with minimal or no comparisons making connections between them, depending on the outcome measure considered. In selecting the most appropriate set of studies for inclusion in the NMA and the economic analysis, the following considerations were made:

- According to the committee’s expert advice, standard care in the UK is more closely represented by waitlist rather than by TAU described in the RCTs, which is very heterogeneous and mostly reflects standard care in the US Veterans Affairs system. The committee advised that people with PTSD in the UK are likely not to actively seek treatment, thus ‘no treatment’, reflected in waitlist arms of studies, is a closer approximation of standard care. However, it is acknowledged that the baseline effect of waitlist may be lower than that of ‘no treatment’ (Furukawa et al., 2014), resulting in the relative effects of active interventions having been potentially exaggerated in waitlist-controlled studies compared with their expected effects versus a ‘no treatment’-control.
- A number of interventions of interest, such as SSRIs, combined TF-CBT with SSRIs and self-help with support were mainly, if not exclusively, tested in the waitlist-based sub-network.
- The waitlist-based sub-network included a larger number of studies and participants.

For the reasons listed above, the waitlist-based sub-network of studies was selected for inclusion in the NMA and economic analysis, with waitlist serving as the baseline treatment.

Two types of efficacy data were extracted from the RCTs included in the review and synthesised in the guideline meta-analyses:

- Continuous data in the form of changes in PTSD symptom scores between baseline and follow-up
- Dichotomous data, either response or remission

Although the latter are more suitable for use in economic modelling as they can be directly translated into probabilities of events that correspond directly to the model health states, the remission data reported in the RCTs included in the guideline systematic review were rather limited and not available for all interventions of interest: continuous PTSD symptom change score data at treatment endpoint were available for 26 interventions assessed in 74 studies; on the other hand, 33 studies reported dichotomous remission at treatment endpoint, and such data were available for 21 interventions. Since continuous PTSD symptom data constituted a wider and more comprehensive evidence base that was available for a wider range of interventions, it was decided to synthesise continuous data and to transform the analysis outputs in a suitable way, as described later, so as to inform the economic model. Two analyses of continuous data were conducted: one utilised PTSD symptom change scores between baseline and treatment endpoint and the other utilised PTSD symptom change scores between baseline and 1-4 month follow-up. Dichotomous remission data were also synthesised and utilised in a secondary economic analysis, to explore whether their consideration would alter conclusions from the base-case analysis that utilised continuous PTSD symptom change scores.

Both continuous symptom scale score data and dichotomous remission data were synthesised using network meta-analytic techniques. Network meta-analysis (NMA) is a generalisation of standard pairwise meta-analysis for A versus B trials, to data structures that include, for example, A versus B, B versus C, and A versus C trials (Dias et al., 2011a; Lu & Ades, 2004). A basic assumption of NMA methods is that direct and indirect evidence estimate the same parameter, that is, the relative effect between A and B measured directly from an A versus B trial, is the same with the relative effect between A and B estimated indirectly from A versus C and B versus C trials. NMA techniques strengthen inference concerning the relative effect of two treatments by including both direct and indirect comparisons between treatments, and, at the same time, allow simultaneous inference on all treatments examined in the pairwise trial comparisons while respecting randomisation (Caldwell et al., 2005; Lu & Ades, 2004). Moreover, the NMA approach assumes that the populations included in all trials are similar and thus the treatment effects are exchangeable across all populations included in the NMA (Mavridis et al., 2015). Simultaneous estimation of the relative effects of any number of treatments is possible provided that treatments participate in a single ‘network of evidence’, that is, every treatment is linked to at least one of the other treatments under assessment through direct comparisons.

NMAs were conducted within a Bayesian framework using Markov Chain Monte Carlo simulation techniques implemented in WinBUGS 1.4.3 (Lunn et al., 2000; Spiegelhalter et al., 2003) for synthesis of continuous scale score data and OpenBUGS 3.2.3 (www.openbugs.net) for dichotomous remission data.

For the synthesis of continuous data (changes in PTSD scale score), a generalised linear model (GLM) with a normal likelihood and identity link was used (Dias et al., 2011a and Dias et al., 2018). Because the RCTs included in the NMAs used different continuous scales to report change in PTSD symptoms, pooling of the differences in means across different

scales was not appropriate. For this reason results were expressed in the form of the Standardised Mean Difference (SMD), where the mean difference is divided by a standardising constant, which can be the population standard deviation for each scale (if known), or its estimate, often obtained by pooling the estimated standard deviations across all arms of the study (Cooper et al. 2009). Pooling of continuous data in the NMAs utilised the Cohen's d SMD measure (Cohen, 1969).

The economic model required probabilities of effect (remission). SMD cannot be directly used to estimate these probabilities. However, it was possible to transform the results of the NMAs, expressed on the SMD scale, to a log-odds ratio of effect using the following formula (Chinn, 2000):

$$LOR = -\frac{\pi}{\sqrt{3}} SMD$$

This transformation assumes that remission status is determined based on a scale with an underlying normal distribution that was dichotomised into a PTSD diagnosis vs no PTSD diagnosis ('remission') using a hypothetical cut-off point on the scale.

The log-odds ratios of remission of each intervention versus no treatment (which served as the baseline treatment) were exponentiated into odds ratios. Subsequently, the probability of remission for each intervention, which was utilised in the economic model, was estimated using the following formulae:

$$intervention\ prob = \frac{odds}{(1+odds)} \quad (1)$$

and

$$odds = \frac{baseline\ prob}{(1-baseline\ prob)} OR \quad (2)$$

where baseline prob is the probability of remission for the baseline treatment (no treatment), OR is the odds ratio of remission for each intervention versus waitlist (no treatment) as estimated following exponentiation of the log-odds ratios obtained from the NMA, and odds is the odds of each intervention to achieve remission.

The WinBUGS code used to synthesise the continuous data (changes in PTSD symptom scale scores), for both random and fixed effect models, is shown in

Table 180 (adapted from Dias et al., 2018). The suitability of both fixed and random effect models was assessed and compared. In random effects models, an uninformative prior distribution of the between-study standard deviation was used.

Table 180. WinBUGS code used to synthesise continuous data (changes in PTSD symptom scale scores) in the NMAs that informed the guideline economic modelling of interventions for the treatment of PTSD in adults

Normal likelihood and identity link model

RANDOM EFFECTS MODEL

```
# Normal likelihood, identity link: SMD with arm-based means;
# output as log Odds Ratios
# Random effects model for multi-arm trials
model{                          # *** PROGRAM STARTS
for(i in 1:ns){                 #   LOOP THROUGH STUDIES
  w[i,1] <- 0   # adjustment for multi-arm trials is zero for control arm
  delta[i,1] <- 0                # treatment effect is zero for control arm
  mu[i] ~ dnorm(0,.0001)            # vague priors for all trial baselines
 }
# CONTINUOUS DATA AS ARM MEANS
for(i in 1:ns){
  # calculate pooled.sd and adjustment for SMD
  df[i] <- sum(n[i,1:na[i]]) - na[i] # denominator for pooled.var
  Pooled.var[i] <- sum(nvar[i,1:na[i]])/df[i]
  Pooled.sd[i] <- sqrt(Pooled.var[i]) # pooled sd for study i, for SMD
#  H[i] <- 1 - 3/(4*df[i]-1)         # use Hedges' g
  H[i] <- 1                       # use Cohen's d (ie no adjustment)
  for (k in 1:na[i]){
    se[i,k] <- sd[i,k]/sqrt(n[i,k])
    var[i,k] <- pow(se[i,k],2)       # calculate variances
    prec[i,k] <- 1/var[i,k]          # set precisions
    y[i,k] ~ dnorm(phi[i,k], prec[i,k]) # normal likelihood
    phi[i,k] <- theta[i,k] * (Pooled.sd[i]/H[i]) # theta is standardised mean
    theta[i,k] <- mu[i] + delta[i,k] # model for linear predictor, delta is SMD
    dev[i,k] <- (y[i,k]-phi[i,k])*(y[i,k]-phi[i,k])*prec[i,k]
    nvar[i,k] <- (n[i,k]-1) * pow(sd[i,k],2) # for pooled.sd
   }
  # summed residual deviance contribution for this trial
  resdev[i] <- sum(dev[i,1:na[i]])
 }
# RE MODEL
for(i in 1:ns){                 # LOOP THROUGH ALL STUDIES
  for (k in 2:na[i]){              # LOOP THROUGH ARMS
    # trial-specific RE distributions
    delta[i,k] ~ dnorm(md[i,k], taud[i,k])
    md[i,k] <- d[t[i,k]] - d[t[i,1]] + sw[i,k]
    # precision of RE distributions (with multi-arm trial correction)
    taud[i,k] <- tau *2*(k-1)/k
    # adjustment, multi-arm RCTs
    w[i,k] <- delta[i,k] - d[t[i,k]] + d[t[i,1]]
    # cumulative adjustment for multi-arm trials
    sw[i,k] <-sum(w[i,1:k-1])/(k-1)
```

Normal likelihood and identity link model

```
  }
 }
#
totresdev <- sum(resdev[])          # Total Residual Deviance (all data)
# Priors distributions
d[1]<-0                    # treatment effect is zero for control arm
# vague prior for treatment effects
for (k in 2:nt){ d[k] ~ dnorm(0, .0001) }
sdev ~ dunif(0,5)                  # vague prior for between-trial SD
tau <- pow(sdev,-2)                  # between-trial precision
for (c in 1:(nt-1)){
  for (k in (c+1):nt){
    diff[c,k] <- d[k] - d[c]        # all pairwise differences (SMD)
    lor[c,k] <- diff[c,k]*(-3.1416/sqrt(3)) # convert to lor (note sign)
  }
 }
# rank treatments
for (k in 1:nt)  {
  rk[k]  <- rank(d[],k)
  best[k]  <- equals(rk[k],1)    # Smallest is best (i.e. rank 1)
  # prob treat k is h-th best, prob[1,k]=best[k]
  for (h in 1:nt) { prob[h,k] <- equals(rk[k],h) }
 }
}                              # *** PROGRAM ENDS
```

Initial values for each chain

- changes in PTSD symptom scale scores between baseline and treatment endpoint

```
# chain 1
list(d = c(NA,0,0,0,0,    0,0,0,0,0,   0,0,0,0,0,  0,0,0,0,0,  0,0,0,0,0,  0),
mu = c(0,0,0,0,0,0,   0,0,0,0,0,   0,0,0,0,0,   0,0,0,0,0,   0,0,0,0,0,   0,0,0,0,0,  0,0,0,0,0,
0,0,0,0,0,      0,0,0,0,0,   0,0,0,0,0,   0,0,0,0,0,   0,0,0,0,0,  0,0,0,0,0,  0,0,0,0), sdev = 1)
# chain 2
list(d = c(NA,-1,1,1,-0.5,    1,1,1,-1,-0.7,   1,-1,0.5,0.7,-1,  -1,0.5,-0.5,1,-0.7,    1,1,0.5,-0.5,-1,   0.5),
mu = c(0.5,1,0.7,1,-1,   -0.5,0,1,-0.5,-1,   0.7,1,-0.7,0.5,0.6,   -0.4,1,-1,0.5,-1,   1,-0.5,-1,-0.7,0.7,
0.6,-0.5,-0.6,1,-0.4,        0.5,1,0.7,1,-1,   -0.5,0,1,-0.5,-1,   0.7,1,-0.7,0.5,0.6,   -0.4,1,-1,0.5,-1,   1,-
0.5,-1,-0.7,0.7,   0.6,-0.5,-0.6,1,-0.4,   0.5,1,0.7,1,-1,   -0.5,0,1,-0.5,-1,   0.7,1,-0.7,0.5), sdev = 0.7)
```

- changes in PTSD symptom scale scores between baseline and 1-4-month follow-up

```
# chain 1
list(d = c(NA,0,0,0,0,    0,0,0,0,0,   0,0,0,0,0),
mu = c(0,0,0,0,0,0,   0,0,0,0,0,   0,0,0,0,0,    0,0,0,0,0,   0,0,0,0), sdev = 1)
# chain 2
list(d = c(NA,-1,1,1,-0.5,    1,1,1,-1,-0.7,  -1,0.5,1,0.5,0.4),
mu = c(0.5,1,0.7,1,-1,   -0.5,0,1,-0.5,-1,  -1,-1,-0.5,0.5,1,    1,1,1,-1,-0.7,    -1,0.5,1,0.5), sdev = 0.5)
```

FIXED EFFECTS MODEL

```
# Normal likelihood, identity link: SMD with arm-based means;
# output as log Odds Ratios
# Fixed effect model
model{                          # *** PROGRAM STARTS
```

Normal likelihood and identity link model

```
for(i in 1:ns){                    #   LOOP THROUGH STUDIES
  mu[i] ~ dnorm(0,.0001)            # vague priors for all trial baselines
# CONTINUOUS DATA AS ARM MEANS
  # calculate pooled.sd and adjustment for SMD
  df[i] <- sum(n[i,1:na[i]]) - na[i] # denominator for pooled.var
  Pooled.var[i] <- sum(nvar[i,1:na[i]])/df[i]
  Pooled.sd[i] <- sqrt(Pooled.var[i]) # pooled sd for study i, for SMD
#  H[i] <- 1 - 3/(4*df[i]-1)          # use Hedges' g
  H[i] <- 1                          # use Cohen's d (ie no adjustment)
  for (k in 1:na[i]){
    se[i,k] <- sd[i,k]/sqrt(n[i,k])
    var[i,k] <- pow(se[i,k],2)       # calculate variances
    prec[i,k] <- 1/var[i,k]          # set precisions
    y[i,k] ~ dnorm(phi[i,k], prec[i,k]) # normal likelihood
    phi[i,k] <- theta[i,k] * (Pooled.sd[i]/H[i]) # theta is standardised mean
    theta[i,k] <- mu[i] + d[t[i,k]] - d[t[i,1]] # model for linear predictor
    dev[i,k] <- (y[i,k]-phi[i,k])*(y[i,k]-phi[i,k])*prec[i,k]
    nvar[i,k] <- (n[i,k]-1) * pow(sd[i,k],2) # for pooled.sd
   }
  # summed residual deviance contribution for this trial
  resdev[i] <- sum(dev[i,1:na[i]])
 }
totresdev <- sum(resdev[])           # Total Residual Deviance (all data)
# Priors distributions
d[1]<-0                      # treatment effect is zero for control arm
# vague prior for treatment effects
for (k in 2:nt){ d[k] ~ dnorm(0, .0001) }

for (c in 1:(nt-1)){
  for (k in (c+1):nt){
    diff[c,k] <- d[k] - d[c]         # all pairwise differences (SMD)
    lor[c,k] <- diff[c,k]*(-3.1416/sqrt(3)) # convert to lor (note sign)
  }
 }
# rank treatments
for (k in 1:nt)  {
  rk[k]  <- rank(d[],k)
  best[k]  <- equals(rk[k],1)    # Smallest is best (i.e. rank 1)
  # prob treat k is h-th best, prob[1,k]=best[k]
  for (h in 1:nt) { prob[h,k] <- equals(rk[k],h) }
 }
}                                # *** PROGRAM ENDS
```

Initial values for each chain

- changes in PTSD symptom scale scores between baseline and treatment endpoint

```
# chain 1
list(d = c(NA,0,0,0,0,    0,0,0,0,0,   0,0,0,0,0,  0,0,0,0,0,  0,0,0,0,0,  0),
```

Normal likelihood and identity link model

```
mu = c(0,0,0,0,0,   0,0,0,0,0,   0,0,0,0,0,   0,0,0,0,0,   0,0,0,0,0,   0,0,0,0,0,  0,0,0,0,0,  0,0,0,0,0,
0,0,0,0,0,      0,0,0,0,0,   0,0,0,0,0,   0,0,0,0,0,   0,0,0,0,0,   0,0,0,0,0,  0,0,0,0,0,  0,0,0,0))
# chain 2
list(d = c(NA,-1,1,1,-0.5,    1,1,1,-1,-0.7,   1,-1,0.5,0.7,-1,  -1,0.5,-0.5,1,-0.7,    1,1,0.5,-0.5,-1,   0.5),
mu = c(0.5,1,0.7,1,-1,   -0.5,0,1,-0.5,-1,   0.7,1,-0.7,0.5,0.6,   -0.4,1,-1,0.5,-1,   1,-0.5,-1,-0.7,0.7,
0.6,-0.5,-0.6,1,-0.4,       0.5,1,0.7,1,-1,   -0.5,0,1,-0.5,-1,   0.7,1,-0.7,0.5,0.6,   -0.4,1,-1,0.5,-1,   1,-
0.5,-1,-0.7,0.7,   0.6,-0.5,-0.6,1,-0.4,   0.5,1,0.7,1,-1,   -0.5,0,1,-0.5,-1,   0.7,1,-0.7,0.5))
```

- changes in PTSD symptom scale scores between baseline and 1-4-month follow-up

```
# chain 1
list(d = c(NA,0,0,0,0,    0,0,0,0,0,   0,0,0,0,0),
mu = c(0,0,0,0,0,   0,0,0,0,0,   0,0,0,0,0,    0,0,0,0,0,   0,0,0,0))
# chain 2
list(d = c(NA,-1,1,1,-0.5,    1,1,1,-1,-0.7,  -1,0.5,1,0.5,0.4),
mu = c(0.5,1,0.7,1,-1,   -0.5,0,1,-0.5,-1,  -1,-1,-0.5,0.5,1,    1,1,1,-1,-0.7,    -1,0.5,1,0.5))
```

For the synthesis of dichotomous data (remission), a binomial likelihood and logit link model was used (Dias et al., 2011a). The output of this analysis was the log-odds ratios between all pairs of interventions assessed. The log-odds ratios of remission of each intervention versus no treatment (which served as the baseline treatment) were exponentiated into odds ratios and subsequently applied onto the baseline probability of remission using the formulae (1) and (2) above, in order to obtain the absolute probability of remission for each intervention, which was utilised in the economic model.

The OpenBUGS code used to synthesise the dichotomous remission data, for both random and fixed effect models, is shown in Table 181 (adapted from Dias et al., 2011a). The suitability of both models was assessed and compared. Uninformative prior parameters were used.

Table 181. OpenBUGS code used to synthesise dichotomous data (remission) in the NMAs that informed the guideline economic modelling of interventions for the treatment of PTSD in adults

Binomial likelihood and logit link model

RANDOM EFFECTS MODEL

```
# Binomial likelihood, logit link
# Random effect model, multi-arm trials
model{                                                  # *** PROGRAM STARTS
for(i in 1:ns){                                          # LOOP THROUGH STUDIES
  w[i,1] <- 0                                           # adjustment for multi-arm trials is zero for
control arm
  delta[i,1] <- 0                                        # treatment effect is zero for control arm
  mu[i] ~ dnorm(0,.0001)                                  # vague priors for all trial baselines
  for (k in 1:na[i]) {                                   # LOOP THROUGH ARMS
    r[i,k] ~ dbin(p[i,k],n[i,k])                         # binomial likelihood
    logit(p[i,k]) <- mu[i] + delta[i,k]                    # model for linear predictor
     rhat[i,k] <- p[i,k] * n[i,k]                        # expected value of the numerators
     dev[i,k] <- 2 * (r[i,k] * (log(r[i,k])-log(rhat[i,k]))          #Deviance contribution
        + (n[i,k]-r[i,k]) * (log(n[i,k]-r[i,k]) - log(n[i,k]-rhat[i,k])))
  }
  resdev[i] <- sum(dev[i,1:na[i]])                  # summed residual deviance contribution for this trial
```

Binomial likelihood and logit link model

```
  for (k in 2:na[i]) {                                    # LOOP THROUGH ARMS
    delta[i,k] ~ dnorm(md[i,k],taud[i,k])                  # trial-specific LOR distributions
    md[i,k] <- d[t[i,k]] - d[t[i,1]] + sw[i,k]             # mean of LOR distributions (with multi-arm
correction)
    taud[i,k] <- tau *2*(k-1)/k                            # precision of LOR distributions (with multi-arm
correction)
    w[i,k] <- (delta[i,k] - d[t[i,k]] + d[t[i,1]])         # adjustment for multi-arm RCTs
    sw[i,k] <- sum(w[i,1:k-1])/(k-1)                       # cumulative adjustment for multi-arm trials
  }
}
totresdev <- sum(resdev[])                                  #Total Residual Deviance
d[1]<- 0                                                    # treatment effect is zero for reference
treatment
for (k in 2:nt)  { d[k] ~ dnorm(0,.0001)}                   # vague priors for treatment effects
sd ~ dunif(0,2)
tau <- pow(sd,-2)

# pairwise ORs and LORs for all possible pair-wise comparisons
for (c in 1:(nt-1)) {  for (k in (c+1):nt) {
      or[c,k] <- exp(d[k] - d[c])
      lor[c,k] <- (d[k]-d[c])
    }
}

# ranking
for (k in 1:nt) {
  rk[k] <- nt+1-rank(d[],k)                 # assumes events are “good”
  best[k] <- equals(rk[k],1)                #calculate probability that treat k is best
}
}                                                           # *** PROGRAM ENDS
```

FIXED EFFECTS MODEL

```
# Binomial likelihood, logit link, MTC
# Fixed effect model
model{                                                      # *** PROGRAM STARTS
for(i in 1:ns){                                             # LOOP THROUGH STUDIES
  mu[i] ~ dnorm(0,.0001)                                    # vague priors for all trial baselines
  for (k in 1:na[i]) {                                      # LOOP THROUGH ARMS
    r[i,k] ~ dbin(p[i,k],n[i,k])                            # binomial likelihood
    logit(p[i,k]) <- mu[i] + d[t[i,k]]-d[t[i,1]]            # model for linear predictor
    rhat[i,k] <- p[i,k] * n[i,k]                            # expected value of the numerators
    dev[i,k] <- 2 * (r[i,k] * (log(r[i,k])-log(rhat[i,k]))      #Deviance contribution
       + (n[i,k]-r[i,k]) * (log(n[i,k]-r[i,k]) - log(n[i,k]-rhat[i,k])))
  }
  resdev[i] <- sum(dev[i,1:na[i]])              # summed residual deviance contribution for this trial
}
totresdev <- sum(resdev[])                      #Total Residual Deviance
d[1]<- 0                                        # treatment effect is zero for reference treatment
for (k in 2:nt)  { d[k] ~ dnorm(0,.0001) }      # vague priors for treatment effects
```

Binomial likelihood and logit link model

```
# pairwise ORs and LORs for all possible pair-wise comparisons
for (c in 1:(nt-1)) {  for (k in (c+1):nt) {
      or[c,k] <- exp(d[k] - d[c])
      lor[c,k] <- (d[k]-d[c])
     }
}

# ranking
for (k in 1:nt) {
   rk[k] <- nt+1-rank(d[],k)              # assumes events are “good”
   best[k] <- equals(rk[k],1)             #calculate probability that treat k is best
}
}                                                    # *** PROGRAM ENDS
```

Goodness of fit of each model was assessed by comparing the posterior mean of the total residual deviance (totresdev) with the number of data points in the model. Models were also compared using the deviance information criterion (DIC), a measure of model fit penalised for model complexity, where lower values are preferred (Dias et al., 2011a; Spiegelhalter et al., 2002). Details on the interventions, data and type of model used (i.e. fixed or random effects) in each NMA are reported in the respective subheadings under the ‘Efficacy data and methods of evidence synthesis’ section. Each model was run with an initial burn-in period of 100,000 iterations, followed by 300,000 further iterations, thinned by 30 so as to obtain 10,000 iterations for use in the probabilistic economic model. Two different sets of initial values were used; convergence was assessed by visually inspecting the mixing of the two chains in the history plots and the Brooks Gelman-Rubin diagram in the software used for the analysis (WinBUGS or OpenBUGS).

Consistency between indirect and direct evidence was explored statistically by comparing the fit of a model assuming consistency with a model which allowed for inconsistency (also known as an unrelated mean effects model). The latter is equivalent to having separate, unrelated meta-analyses for every pair-wise contrast but assumes a common between-study heterogeneity across all comparisons. If the inconsistency model had a meaningfully smaller posterior mean residual deviance or heterogeneity then this indicated potential inconsistency in the data. Deviance plots, in which the posterior mean deviance of the individual data points in the inconsistency model were plotted against their posterior mean deviance in the consistency model, were inspected in order to identify studies which may have contributed to loops of evidence where inconsistency may be present. Further checks were conducted using a node-split approach implemented in R using the *gemtc* package in R (Dias et al., 2011b; van Valkenhoef & Kuiper, 2016).

When evidence of inconsistency was found, studies contributing to loops of evidence where there might be inconsistency were checked for data accuracy and analyses were repeated if corrections in the data extraction were made. However, if evidence of inconsistency was still present following any data corrections, no studies were excluded from the analysis, as their results could not be considered as less valid than those of other studies solely because of the inconsistency findings. Nevertheless, the presence of inconsistency in the NMA was highlighted and results were interpreted accordingly by the committee.

A critique of the NMA models by the NICE Technical Support Unit (TSU) including details of the inconsistency checks undertaken is provided in Appendix M.

Synthesis of changes in PTSD symptom scores between baseline and treatment endpoint

The NMA of changes in PTSD symptom scores between baseline and treatment endpoint in adults with PTSD included 74 RCTs, 26 interventions and 4,986 participants. Prioritisation of clinical scales for inclusion in the analysis followed the prioritisation of scales considered in the guideline systematic review and pairwise meta-analysis. Intention-to-treat (ITT) data, obtained after imputation of missing data, were prioritised over completers' data, if both were available in the same study, in accordance with the guideline systematic review protocols. For the NMA, self-reported scales were prioritised over clinician-rates scales if both were available in the same study, following advice from the committee.

Figure **697** shows the network of interventions considered in the NMA of changes in PTSD symptom scores between baseline and treatment endpoint in adults with PTSD, while Table 182 provides all studies and data included. Table 183 shows the interventions with their NMA codes, the numbers of participants randomised to each intervention across all trials included in the NMA, and the number of studies that tested each intervention.

Figure 697**. Network of interventions included in the NMA of changes in PTSD symptom scores between baseline and treatment endpoint in adults with PTSD**

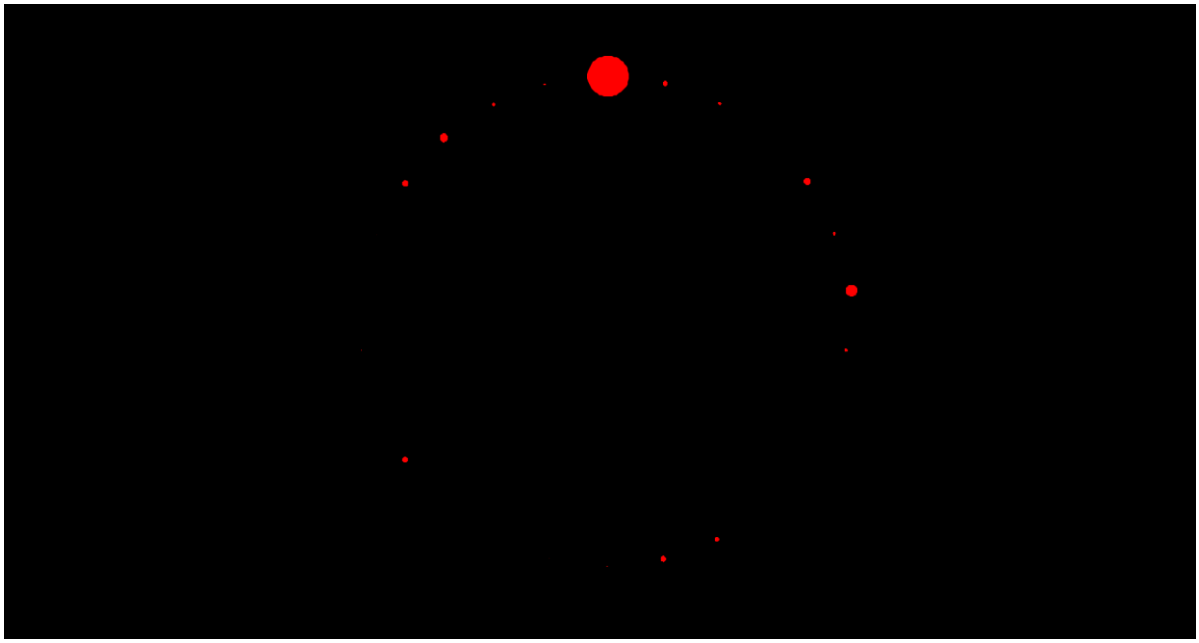


Table 182: RCTs, interventions and efficacy data considered in the NMA of changes in PTSD symptom scores between baseline and treatment endpoint in adults with PTSD

Study	t1	y1	sd1	n1	t2	y2	sd2	n2	t3	y3	sd3	n3	t4	y4	sd4	n4
Blanchard 2002/2003/2004	1	-2.00	9.72	24	5	-11.20	10.36	27	7	-23.10	9.47	27	NA	NA	NA	NA
Difede 2007b	1	-5.00	8.96	16	7	-7.69	10.53	15	NA	NA	NA	NA	NA	NA	NA	NA
Dunne 2012	1	0.00	5.60	11	7	-5.77	6.10	12	NA	NA	NA	NA	NA	NA	NA	NA
Ehlers 2005	1	-1.40	5.56	14	7	-22.10	5.89	14	NA	NA	NA	NA	NA	NA	NA	NA
Zang 2014	1	-2.10	7.68	10	6	-34.55	6.55	20	NA	NA	NA	NA	NA	NA	NA	NA
Alghamdi 2015	1	-0.58	2.98	17	6	-6.65	2.74	17	NA	NA	NA	NA	NA	NA	NA	NA
Buhmann 2016	1	-0.10	0.35	48	8	0.00	0.46	52	25	-0.10	0.40	62	26	0	0.47	55
Chard 2005	1	0.18	18.63	27	11	-50.03	16.93	28	NA	NA	NA	NA	NA	NA	NA	NA
Cloitre 2002	1	-15.00	19.13	24	8	-40.00	18.71	22	NA	NA	NA	NA	NA	NA	NA	NA
Falsetti 2008	1	-6.47	17.48	31	9	-18.37	19.42	22	NA	NA	NA	NA	NA	NA	NA	NA
Jung 2013	1	-1.10	6.50	14	6	-5.80	7.48	14	NA	NA	NA	NA	NA	NA	NA	NA
Ehlers 2014	1	-3.22	6.22	30	5	-14.28	9.48	30	7	-23.05	7.30	31	NA	NA	NA	NA
Hollifield 2007	1	-2.87	8.16	24	9	-12.50	7.10	25	NA	NA	NA	NA	NA	NA	NA	NA
Fecteau 1999	1	-2.70	16.86	10	6	-33.40	21.16	10	NA	NA	NA	NA	NA	NA	NA	NA
Bolton 2014a	1	-0.29	0.65	66	7	-0.60	1.11	101	NA	NA	NA	NA	NA	NA	NA	NA
Lindauer 2008	1	-1.00	2.95	10	8	-8.00	3.85	10	NA	NA	NA	NA	NA	NA	NA	NA
McDonagh 2005	1	-6.50	12.83	23	8	-16.80	19.64	29	14	-20.5	14.98	22	NA	NA	NA	NA
Pacella 2012	1	-3.46	8.16	23	7	-12.85	7.54	41	NA	NA	NA	NA	NA	NA	NA	NA
Popiel 2015	7	-19.03	7.96	89	25	-23.12	6.81	23	26	-20.94	7.16	26	NA	NA	NA	NA
Rothbaum 2006	25	0.40	10.10	31	26	-5.9	7.09	34	NA	NA	NA	NA	NA	NA	NA	NA
Capezzani 2013	9	-8.1	9.346	10	13	-30.36	12.45	11	NA	NA	NA	NA	NA	NA	NA	NA
Foa 1991	5	-6.3	4.885	11	7	-10.38	8.05	10	12	-13.41	4.49	14	NA	NA	NA	NA

Study	t1	y1	sd1	n1	t2	y2	sd2	n2	t3	y3	sd3	n3	t4	y4	sd4	n4
Cottraux 2008	5	-12.06	13.86	15	8	-15.18	12.90	27	NA	NA	NA	NA	NA	NA	NA	NA
Cloitre 2010	5	-25.4	8.995	38	8	-22.70	8.70	33	NA	NA	NA	NA	NA	NA	NA	NA
Katz 2014	5	-2.5	15.48	11	7	-18.30	15.57	10	NA	NA	NA	NA	NA	NA	NA	NA
Castillo 2016	5	-3.38	13.78	42	10	-24.37	11.04	42	NA	NA	NA	NA	NA	NA	NA	NA
Ghafoori 2017	7	-29.30	10.50	47	14	-36.30	10.88	24	NA	NA	NA	NA	NA	NA	NA	NA
Markowitz 2015a	4	-18.50	18.87	13	7	-43.60	17.64	17	15	-32.6	17.27	23	NA	NA	NA	NA
Chambers 2014	3	-7.15	11.42	131	6	-10.01	11.38	99	NA	NA	NA	NA	NA	NA	NA	NA
Echiverri-Cohen 2016	7	-19.56	7.37	29	25	-13.43	6.90	20	NA	NA	NA	NA	NA	NA	NA	NA
Davis 2007	1	2.19	23.02	22	12	-14.26	26.80	21	NA	NA	NA	NA	NA	NA	NA	NA
Krakow 2000	1	-3.48	8.76	41	12	-12.60	7.41	39	NA	NA	NA	NA	NA	NA	NA	NA
Davis 2011	1	-3.47	20.70	23	12	-15.54	20.70	24	NA	NA	NA	NA	NA	NA	NA	NA
Ford 2011	1	-6.20	15.42	45	12	-23.60	16.97	48	14	-22.2	15.10	53	NA	NA	NA	NA
Nakamura 2017	2	-0.20	11.16	27	12	-5.90	11.32	33	NA	NA	NA	NA	NA	NA	NA	NA
Wells 2012	1	-1.40	8.18	10	16	-32.70	12.06	10	NA	NA	NA	NA	NA	NA	NA	NA
Basoglu 2005	1	-7.3	8.97	28	17	-16.70	9.95	31	NA	NA	NA	NA	NA	NA	NA	NA
Basoglu 2007	1	-13.20	13.45	15	17	-32.90	14.37	16	NA	NA	NA	NA	NA	NA	NA	NA
Aldahadha 2012	1	-1.23	4.79	26	13	-14.72	4.41	25	NA	NA	NA	NA	NA	NA	NA	NA
Acarturk 2015	1	-2.72	11.88	14	13	-41.93	13.77	15	NA	NA	NA	NA	NA	NA	NA	NA
Acarturk 2016	1	-3.54	13.82	49	13	-38.33	12.81	49	NA	NA	NA	NA	NA	NA	NA	NA
Carlson 1998	4	-8.40	12.10	12	13	-17.30	16.37	10	NA	NA	NA	NA	NA	NA	NA	NA
Edmond 1999/2004	1	-7.50	11.25	19	13	-24.60	11.43	20	NA	NA	NA	NA	NA	NA	NA	NA
Scheck 1998	5	-8.45	11.26	29	13	-24.64	12.30	28	NA	NA	NA	NA	NA	NA	NA	NA
Ter Heide 2016	12	-0.11	0.41	30	13	-0.23	0.38	32	NA	NA	NA	NA	NA	NA	NA	NA
Karatzias 2011	13	-17.70	15.35	23	18	-15.80	11.20	23	NA	NA	NA	NA	NA	NA	NA	NA
van der Kolk 2007	13	-39.15	15.69	29	25	-33.23	14.66	30	NA	NA	NA	NA	NA	NA	NA	NA

Study	t1	y1	sd1	n1	t2	y2	sd2	n2	t3	y3	sd3	n3	t4	y4	sd4	n4
Krupnick 2008	1	-5.78	12.23	16	15	-24.54	16.92	32	NA	NA	NA	NA	NA	NA	NA	NA
Yeomans 2010	1	0.07	0.37	38	5	-0.26	0.37	75	NA	NA	NA	NA	NA	NA	NA	NA
Church 2013/2014	1	0.52	7.73	25	18	-22.60	9.63	29	NA	NA	NA	NA	NA	NA	NA	NA
Connolly 2011	1	-13.39	30.20	74	18	-21.09	29.70	71	NA	NA	NA	NA	NA	NA	NA	NA
Robson 2016	1	-14.20	9.13	122	18	-31.90	8.43	114	NA	NA	NA	NA	NA	NA	NA	NA
Kent 2011	1	-0.63	6.87	19	19	-12.90	8.10	20	NA	NA	NA	NA	NA	NA	NA	NA
Bar-Haim 2011/Badura-Brack 2015 study 1	2	-12.95	2.51	25	20	-3.82	1.83	27	NA	NA	NA	NA	NA	NA	NA	NA
Bar-Haim 2011/Badura-Brack 2015 study 2	2	-8.76	2.21	24	20	-1.51	2.01	22	NA	NA	NA	NA	NA	NA	NA	NA
Schoorl 2013	2	-5.30	7.61	38	20	-4.90	9.09	34	NA	NA	NA	NA	NA	NA	NA	NA
Sautter 2015	3	-6.90	8.08	21	21	-18.68	7.99	22	NA	NA	NA	NA	NA	NA	NA	NA
Kazak 2004	1	-4.47	4.04	70	22	-3.66	6.56	72	NA	NA	NA	NA	NA	NA	NA	NA
Ivarsson 2014	1	-5.68	12.12	26	23	-23.69	10.68	28	NA	NA	NA	NA	NA	NA	NA	NA
Lange 2003	1	41.89	15.90	32	23	19.54	17.47	69	NA	NA	NA	NA	NA	NA	NA	NA
Lewis 2017	1	1.36	8.34	21	23	-25.34	10.50	21	NA	NA	NA	NA	NA	NA	NA	NA
Knaevelsrud 2015	1	-0.48	5.97	80	23	-10.06	8.32	79	NA	NA	NA	NA	NA	NA	NA	NA
Knaevelsrud 2017	1	-2.85	6.38	47	23	-7.56	6.41	47	NA	NA	NA	NA	NA	NA	NA	NA
Littleton 2016	23	-12.50	4.40	23	24	-12.60	5.70	28	NA	NA	NA	NA	NA	NA	NA	NA
Hirai 2005	1	-15.79	14.61	14	24	-25.15	9.85	13	NA	NA	NA	NA	NA	NA	NA	NA
Kuhn 2017	1	-6.69	9.12	58	24	-11.26	9.37	62	NA	NA	NA	NA	NA	NA	NA	NA
Spence 2011	1	-5.21	8.28	19	24	-16.00	11.81	23	NA	NA	NA	NA	NA	NA	NA	NA
Xu 2016	1	-2.57	6.90	29	24	-10.48	8.99	21	NA	NA	NA	NA	NA	NA	NA	NA
Miner 2016	1	-3.56	8.74	24	24	-6.69	7.74	25	NA	NA	NA	NA	NA	NA	NA	NA
Henderson 2007	2	-0.30	5.64	17	24	-1.32	6.43	19	NA	NA	NA	NA	NA	NA	NA	NA

Study	t1	y1	sd1	n1	t2	y2	sd2	n2	t3	y3	sd3	n3	t4	y4	sd4	n4
Truijens 2014	2	-12.30	9.10	19	24	-17.02	10.03	42	NA	NA	NA	NA	NA	NA	NA	NA
Sloan 2004	2	1.80	4.70	23	24	-6.10	6.58	26	NA	NA	NA	NA	NA	NA	NA	NA
Sloan 2007	2	-0.90	4.11	27	24	-7.54	6.72	55	NA	NA	NA	NA	NA	NA	NA	NA
Sloan 2011	2	-10.20	4.77	21	24	-8.80	5.46	21	NA	NA	NA	NA	NA	NA	NA	NA

t1, t2, t3, t4 indicate the coded treatment in each trial arm; codes of treatments are provided in Table 183

y1, y2, y3, y4 indicate the mean change in effect in each trial arm; sd1, sd2, sd3, sd4 indicate the standard deviation of the mean change in effect in each trial arm

n1, n2, n3, n4 indicate the number of participants in each trial arm; NA: non-applicable

Table 183. NMA of changes in PTSD symptom scores between baseline and treatment endpoint in adults with PTSD: Interventions with NMA codes, numbers of participants (N) randomised to each intervention across RCTs and number of RCTs (k) that tested each intervention

Code	Intervention	N randomised (N total = 4986)	k (k total = 74; 157 arms)
1	Waitlist	1428	46
2	Attention placebo	221	9
3	Psychoeducation	152	2
4	Relaxation	25	2
5	Counselling	278	9
6	TF-CBT individual <8 sessions	160	5
7	TF-CBT individual 8-12 sessions	443	13
8	TF-CBT individual >12 sessions	173	6
9	TF-CBT group 8-12 sessions	57	3
10	TF-CBT group >12 sessions	42	1
11	TF-CBT mixed	28	1
12	non-TF-CBT	209	7
13	EMDR	242	10
14	Present-centered therapy	99	3
15	IPT	55	2
16	Metacognitive therapy	10	1
17	Behavioural therapy	47	2
18	Combined somatic & cognitive therapies	237	4
19	Resilience-oriented treatment	20	1
20	Attention bias modification	83	3
21	Couple intervention	22	1
22	Family therapy	72	1
23	Self-help with support	267	6
24	Self-help without support	335	11
25	SSRI	166	5
26	TF-CBT individual 8-12 sessions + SSRI	115	3

EMDR: eye movement desensitisation reprocessing; IPT: interpersonal psychotherapy; SSRI: selective serotonin reuptake inhibitor; TF-CBT: trauma-focused cognitive behavioural therapy

It is noted that:

- Edmond 1999/2004 was a 3-arm trial; the 3rd arm assessed an active psychological intervention of no interest, and therefore was not included in the NMA
- Brom 1989 was a 4-arm trial; its 4th arm assessed hypnotherapy and was not included in the NMA as it was of no interest
- Hollifield 2007 was a 3-arm trial; its 3rd arm was acupuncture and was not included in the NMA as it was of no interest

- van der Kolk 2007 was a 3-arm trial; its 3rd arm was pill placebo, which was of no interest and therefore was omitted from the NMA

Results of the network meta-analysis: changes in PTSD symptom scores between baseline and treatment endpoint in adults with PTSD

The random effects model demonstrated a better fit for the data (totresdev = 157.4; DIC = 723.47) than the fixed effect model (totresdev = 769.6; DIC = 1283.37). The number of data points (study arms) in the model was 157, suggesting a good fit of the random effects model. The between-study heterogeneity was large compared with treatment effects (sd 0.87). No evidence of inconsistency was identified in the network. Further checks for inconsistency using the node-splitting method also did not find evidence of inconsistency. Details of the inconsistency checks are provided in Appendix M.

The results of the random effects model are shown in Table 184. Interventions have been ordered from those with largest to those with lowest mean effects versus waitlist. Relative effects versus waitlist (mean SMD and log-odds ratio and 95% credible intervals [CrI]) are reported. Posterior mean ranks of each intervention (and 95% CrI) are also provided, where a rank of 1 is best. Only interventions tested on at least 50 people were considered in intervention ranking, as this was deemed as the minimum evidence that would be adequate to support a practice recommendation.

Table 184. Results of the NMA: changes in PTSD symptom scores between baseline and treatment endpoint in adults with PTSD (random effects model)

Intervention	Mean SMD (95% CrI) vs waitlist	Mean LOR (95% CrI) vs waitlist	Mean ranking (95% CrI)
Couple intervention	*-3.48 (-6.21 to -0.74)*	*6.30 (1.34 to 11.26)*	
Metacognitive therapy	*-3.04 (-5.00 to -1.10)*	*5.52 (1.99 to 9.06)*	
TF-CBT mixed	*-2.82 (-4.67 to -1.02)*	*5.11 (1.86 to 8.46)*	
TF-CBT group >12 sessions	*-2.40 (-4.31 to -0.48)*	*4.35 (0.88 to 7.81)*	
TF-CBT individual <8 sessions	-2.27 (-3.21 to -1.34)	4.11 (2.42 to 5.83)	2.51 (1 to 8)
EMDR	-2.11 (-2.75 to -1.47)	3.82 (2.66 to 4.98)	2.72 (1 to 6)
Psychoeducation	-2.02 (-4.04 to -0.01)	3.67 (0.02 to 7.33)	5.04 (1 to 17)
Combined somatic & cognitive therapies	-1.71 (-2.62 to -0.79)	3.09 (1.44 to 4.75)	5.31 (1 to 13)
Resilience-oriented treatment	*-1.64 (-3.46 to 0.19)*	*2.97 (-0.34 to 6.28)*	
TF-CBT individual 8-12 sessions	-1.45 (-1.99 to -0.89)	2.63 (1.62 to 3.61)	6.70 (3 to 12)
Self-help with support	-1.43 (-2.18 to -0.68)	2.59 (1.23 to 3.95)	7.05 (2 to 14)
Present-centered therapy	-1.33 (-2.32 to -0.33)	2.41 (0.61 to 4.20)	7.94 (2 to 15)
non-TF-CBT	-1.21 (-1.90 to -0.52)	2.20 (0.94 to 3.45)	8.85 (3 to 15)
Behavioural therapy	*-1.20 (-2.51 to 0.09)*	*2.18 (-0.16 to 4.55)*	
IPT	-1.18 (-2.45 to 0.10)	2.14 (-0.17 to 4.45)	9.12 (1 to 17)
TF-CBT individual 8-12 sessions + SSRI	-1.10 (-2.17 to 0.00)	1.99 (0.01 to 3.94)	9.82 (2 to 17)
SSRI	-1.06 (-1.97 to -0.15)	1.92 (0.27 to 3.57)	10.18 (4 to 16)
TF-CBT individual >12 sessions	-0.96 (-1.71 to -0.19)	1.74 (0.35 to 3.11)	11.03 (5 to 16)

Intervention	Mean SMD (95% CrI) vs waitlist	Mean LOR (95% CrI) vs waitlist	Mean ranking (95% CrI)
Self-help without support	-0.91 (-1.62 to -0.21)	1.65 (0.37 to 2.94)	11.33 (5 to 16)
Relaxation	*-0.73 (-2.08 to 0.63)*	*1.32 (-1.14 to 3.77)*	
Counselling	-0.72 (-1.39 to -0.05)	1.31 (0.09 to 2.53)	12.98 (7 to 17)
TF-CBT group 8-12 sessions	-0.69 (-1.78 to 0.40)	1.25 (-0.73 to 3.23)	12.71 (4 to 18)
Attention placebo	-0.39 (-1.36 to 0.57)	0.71 (-1.03 to 2.46)	14.80 (8 to 18)
Waitlist	Reference	reference	16.99 (15 to 18)
Family therapy	*0.15 (-1.62 to 1.91)*	*-0.28 (-3.46 to 2.94)*	*15.97 (5 to 19)*
Attention bias modification	*2.14 (0.70 to 3.57)*	*-3.87 (-6.47 to -1.26)*	*18.95 (18 to 19)*
Standard deviation: mean 0.87 (95% CrI 0.72 to 1.08)			
Total residual deviance 157.4 (95% CrI 125 to 194.4)			
CrI: credible intervals; EMDR: eye movement desensitisation reprocessing; IPT: interpersonal psychotherapy; LOR: log-odds ratio; SMD: standardised mean difference; SSRI: selective serotonin reuptake inhibitor; TF-CBT: trauma-focused cognitive behavioural therapy Negative values for the SMD and positive values for the LOR indicate a better effect for the intervention compared with waitlist. Interventions in italics were not considered in the economic analysis due to the low number of people randomised to each of them (N<50) or because they were less effective than waitlist or because they were not part of the decision problem (i.e. they served as controls only).			

Detailed results of all pair-wise comparisons between interventions are shown in Appendix N.

The output of the NMA used in the economic analysis was the log-odds ratio of every intervention versus waitlist.

Synthesis of changes in PTSD symptom scores between baseline and 1-4 month follow-up

The NMA of changes in PTSD symptom scores between baseline and 1-4 month follow-up in adults with PTSD included 24 studies, 15 interventions and 2,036 participants. As with treatment endpoint continuous data, prioritisation of clinical scales for inclusion in the analysis followed the prioritisation of scales considered in the guideline systematic review and pairwise meta-analysis. Intention-to-treat (ITT) data, obtained after imputation of missing data, were prioritised over completers' data, if both were available in the same study, in accordance with the guideline systematic review protocols. For the NMA, self-reported scales were prioritised over clinician-rates scales if both were available in the same study, following advice from the committee.

Table 185 provides all studies and data considered in the NMA of changes in PTSD symptom scores between baseline and 1-4 month follow-up in adults with PTSD, whereas Figure 698 shows the respective network of interventions. Table 186 shows the interventions with their NMA codes, the numbers of participants randomised to each intervention across all trials included in the NMA, and the number of studies that tested each intervention.

Table 185: RCTs, interventions and efficacy data considered in the NMA of changes in PTSD symptom scores between baseline and 1-4 month follow-up in adults with PTSD

Study	t1	y1	sd1	n1	t2	y2	sd2	n2	t3	y3	sd3	n3
van Emmerik 2008	1	-3.48	10.05	41	5	-14.4	13.75	41	14	-13.55	15.26	44
Hijazi 2014	1	-0.11	0.35	22	5	-0.24	0.44	41	NA	NA	NA	NA
Jacob 2014	1	-5.64	11.23	38	6	-13.69	15.69	38	NA	NA	NA	NA
Weiss 2015 (study 1)	1	-0.32	0.90	50	6	-0.91	0.38	99	NA	NA	NA	NA
Weiss 2015 (study 2)	1	-0.92	0.36	64	6	-1.08	0.57	154	NA	NA	NA	NA
Pacella 2012	1	-10	6.90	23	6	-13.47	7.93	41	NA	NA	NA	NA
Hensel-Dittmann 2011	6	-19.74	17.72	11	8	-2.55	12.49	10	NA	NA	NA	NA
Blanchard 2002/2003/2004	4	-14.2	10.29	26	6	-23.3	9.52	26	NA	NA	NA	NA
Cloitre 2010	4	-22.6	8.39	38	7	-24.2	8.69	33	NA	NA	NA	NA
Neuner 2008	4	-21.4	9.05	111	5	-20.5	9.33	111	NA	NA	NA	NA
Ehlers 2014	4	-15.33	8.90	30	6	-22.29	8.09	31	NA	NA	NA	NA
McDonagh 2005	7	-34.3	13.84	17	10	-23.1	11.85	17	NA	NA	NA	NA
Chambers 2014	3	-9.21	11.77	134	5	-8.95	11.17	110	NA	NA	NA	NA
Nakamura 2017	2	-2.6	12.22	27	8	-9.3	11.54	33	NA	NA	NA	NA
Ford 2011	8	-25	17.11	48	10	-24.4	15.53	53	NA	NA	NA	NA
Acarturk 2016	1	-2.18	14.33	49	9	-33.82	14.10	49	NA	NA	NA	NA
Ter Heide 2016	8	-0.14	0.41	32	9	-0.13	0.42	31	NA	NA	NA	NA
Karatzias 2011	9	-16.2	15.17	23	11	-16.8	12.08	23	NA	NA	NA	NA
Krupnick 2008	1	-18.89	18.17	16	12	-26.63	20.54	32	NA	NA	NA	NA
Sautter 2015	3	-9.04	8.06	20	13	-21.3	8.05	21	NA	NA	NA	NA
Ghafoori 2016	1	-4.7	10.37	30	3	-7.22	11.09	29	NA	NA	NA	NA
Lewis 2017	1	-5.13	9.63	21	14	-28.52	11.18	21	NA	NA	NA	NA

Study	t1	y1	sd1	n1	t2	y2	sd2	n2	t3	y3	sd3	n3
Littleton 2016	14	-15.8	4.53	20	15	-16.2	4.83	21	NA	NA	NA	NA
Henderson 2007	2	-0.24	5.72	17	15	-5.95	5.64	19	NA	NA	NA	NA

t1, t2, t3 indicate the coded treatment in each trial arm; codes of treatments are provided in Table 186; y1, y2, y3 indicate the mean change in effect in each trial arm; sd1, sd2, sd3 indicate the standard deviation of the mean change in effect in each trial arm; n1, n2, n3 indicate the number of participants in each trial arm; NA: non-applicable

Figure 698. Network of interventions included in the NMA of changes in PTSD symptom scores between baseline and 1-4 month follow-up in adults with PTSD

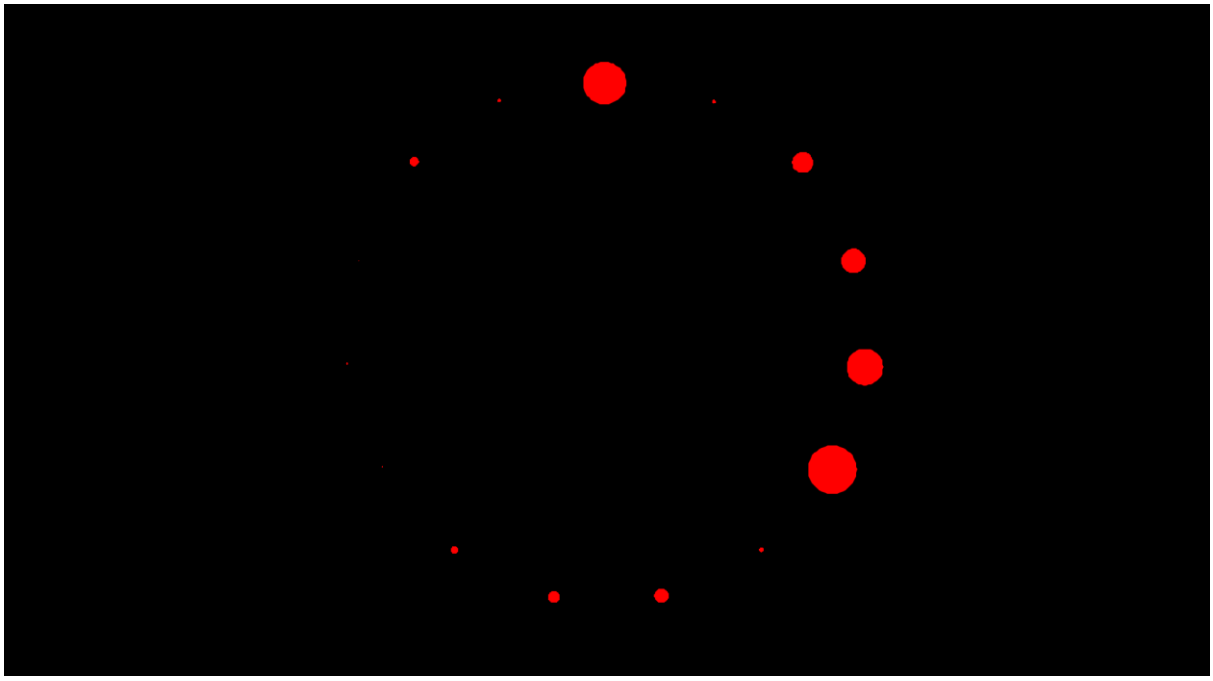


Table 186. NMA of changes in PTSD symptom scores between baseline and 1-4 month follow-up in adults with PTSD: Interventions with NMA codes, numbers of participants (N) randomised to each intervention across RCTs and number of RCTs (k) that tested each intervention

Code	Intervention	N randomised (N total = 2036)	k (k total = 24; 49 arms)
1	Waitlist	354	10
2	Attention placebo	44	2
3	Psychoeducation	183	3
4	Counselling	205	4
5	TF-CBT individual <8 sessions	303	4
6	TF-CBT individual 8-12 sessions	400	7
7	TF-CBT individual >12 sessions	50	2
8	non-TF-CBT	123	4
9	EMDR	103	3
10	Present-centered therapy	70	2
11	Combined somatic & cognitive therapies	23	1
12	IPT	32	1
13	Couple intervention	21	1
14	Self-help with support	85	3
15	Self-help without support	40	2

Code	Intervention	N randomised (N total = 2036)	k (k total = 24; 49 arms)
EMDR: eye movement desensitisation reprocessing; IPT: interpersonal psychotherapy; TF-CBT: trauma-focused cognitive behavioural therapy			

Results of the network meta-analysis: changes in PTSD symptom scores between baseline and 1-4 month follow-up in adults with PTSD

The random effects model demonstrated a better fit for the data (totresdev = 49.47; DIC = 196.38) than the fixed effects model (totresdev = 117.5; DIC = 254.57). The number of data points (study arms) in the model was 49, suggesting good fit of the random effects model. The between-study heterogeneity was large compared with treatment effects (sd 0.65). Inconsistency checks suggested some evidence of inconsistency. Node splitting revealed potential inconsistency between the direct and indirect evidence contributing to the estimates of

- TF-CBT individual 8-12 sessions vs. waitlist
- EMDR vs. waitlist
- EMDR vs. non-TF-CBT.

Details of the inconsistency checks are provided in Appendix M.

The results of the random effects model are shown in Table 187. Interventions have been ordered from those with largest to those with lowest mean effects versus waitlist. Relative effects versus waitlist (mean SMD and log-odds ratio and 95% CrI) are reported. Posterior mean ranks of each intervention (and 95% CrI) are also provided, where a rank of 1 is best. In line with the NMA of PTSD symptom change scores between baseline and endpoint, only interventions tested on at least 50 people were considered in intervention ranking.

Table 187. Results of the NMA: changes in PTSD symptom scores between baseline and 1-4 month follow-up in adults with PTSD (random effects model)

Intervention	Mean SMD (95% CrI) vs waitlist	Mean LOR (95% CrI) vs waitlist	Mean ranking (95% CrI)
Couple intervention	*-1.94 (-3.86 to -0.05)*	*3.51 (0.08 to 7.01)*	
Combined somatic & cognitive therapies	-1.47 (-3.41 to 0.48)	2.67 (-0.86 to 6.18)	
EMDR	-1.42 (-2.61 to -0.22)	2.58 (0.40 to 4.73)	2.24 (1 to 7)
Self-help with support	-1.24 (-2.23 to -0.26)	2.25 (0.48 to 4.05)	2.72 (1 to 7)
Self-help without support	-1.23 (-2.74 to 0.29)	2.22 (-0.53 to 4.97)	
TF-CBT individual 8-12 sessions	-0.88 (-1.56 to -0.22)	1.60 (0.39 to 2.82)	4.05 (1 to 8)
TF-CBT individual >12 sessions	-0.81 (-2.31 to 0.72)	1.47 (-1.30 to 4.19)	4.59 (1 to 10)
non-TF-CBT	-0.59 (-1.73 to 0.57)	1.07 (-1.03 to 3.14)	5.71 (2 to 10)
TF-CBT individual <8 sessions	-0.54 (-1.39 to 0.29)	0.97 (-0.52 to 2.52)	5.99 (2 to 10)
Psychoeducation	-0.41 (-1.55 to 0.72)	0.74 (-1.31 to 2.81)	6.60 (2 to 10)
IPT	-0.39 (-1.94 to 1.18)	0.70 (-2.14 to 3.52)	
Counselling	-0.33 (-1.32 to 0.66)	0.60 (-1.19 to 2.39)	7.11 (3 to 10)
Present-centered therapy	-0.27 (-1.79 to 1.3)	0.48 (-2.36 to 3.25)	7.19 (2 to 10)

Intervention	Mean SMD (95% CrI) vs waitlist	Mean LOR (95% CrI) vs waitlist	Mean ranking (95% CrI)
Attention placebo	*-0.12 (-1.66 to 1.43)*	*0.21 (-2.59 to 3.02)*	
Waitlist	reference	reference	8.80 (6 to 10)
Standard deviation: mean 0.65 (95% CrI 0.40 to 1.19)			
Total residual deviance 49.47 (95% CrI 31.77 to 70.65)			
CrI: credible intervals; EMDR: eye movement desensitisation reprocessing; LOR: log-odds ratio; SMD: standardised mean difference; TF-CBT: trauma-focused cognitive behavioural therapy Negative values for the SMD and positive values for the LOR indicate a better effect for the intervention compared with waitlist. Interventions in italics were not considered in the economic analysis			

Detailed results of all pair-wise comparisons between interventions are provided in Appendix N.

The committee noted that the evidence base of this analysis was limited for a number of interventions and characterised by uncertainty, as relative effects versus waitlist were characterised by wide credible intervals that crossed the line of no effect for most interventions; effects were less uncertain only for EMDR, self-help with support and TF-CBT individual 8-12 sessions. Moreover, there was potential inconsistency between direct and indirect evidence. Therefore, the 1-4 month follow-up data (log-odds ratios of every intervention versus waitlist) were used only in a sensitivity analysis, to obtain probabilities of remission for all active interventions during 3-6 months from treatment initiation. Follow-up data were not available for TF-CBT group 8-12 sessions, SSRI and combined TF-CBT individual 8-12 sessions with SSRI. In the sensitivity analysis that utilised the follow-up data, the probability of remission of TF-CBT group 8-12 sessions over 3-6 months was assumed to equal the baseline probability of remission for no treatment. The respective probability for SSRIs was assumed to equal the probability of remission of SSRIs during initial treatment (0-3 months); for combined TF-CBT individual 8-12 sessions with SSRI, this probability was assumed to equal that for TF-CBT individual 8-12 sessions alone.

In the base-case analysis the model assumed that at 3-6 months the probability of remission of each active intervention was equal to the baseline probability of remission for no treatment.

Synthesis of dichotomous remission data at treatment endpoint

The NMA of dichotomous remission data at treatment endpoint in adults with PTSD included 33 studies, 21 interventions and 2,202 participants. In most studies remission was defined as loss of PTSD diagnosis according to ICD, DSM or similar criteria; a small number of studies defined remission as a PTSD symptom scale score below a predefined cut-off point.

Table 188 provides all studies and data considered in the NMA of dichotomous remission data at treatment endpoint in adults with PTSD, whereas Figure 699 shows the respective network of interventions. Table 189 shows the interventions with their NMA codes, the numbers of participants randomised to each intervention across all trials included in the NMA, and the number of studies that tested each intervention.

Table 188: RCTs, interventions and efficacy data considered in the NMA of dichotomous remission data at treatment endpoint in adults with PTSD

Study	t1	r1	n1	t2	r2	n2	t3	r3	n3
Blanchard 2002/2003/2004	1	5	21	5	10	21	7	16	21
Ehlers 2003	1	8	29	7	24	28	19	6	28
Ehlers 2005	1	0	14	7	10	14	NA	NA	NA
Fecteau 1999	1	0	11	6	5	13	NA	NA	NA
Lindauer 2005	1	3	12	8	10	12	NA	NA	NA
Chard 2005	1	7	35	11	26	36	NA	NA	NA
Cloitre 2002	1	6	27	8	17	31	NA	NA	NA
Falsetti 2008	1	5	31	9	17	29	NA	NA	NA
Gersons 2000	1	10	20	10	20	22	NA	NA	NA
Jung 2013	1	1	17	6	5	17	NA	NA	NA
Lindauer 2008	1	2	10	8	8	10	NA	NA	NA
McDonagh 2005	1	4	23	8	8	29	15	7	22
Ehlers 2014	1	1	30	5	6	30	7	16	31
Hollifield 2007	1	4	27	9	9	28	NA	NA	NA
Popiel 2015	7	72	114	20	13	57	21	20	57
Capezzani 2013	9	1	10	13	10	11	NA	NA	NA
Foa 1991	5	1	14	7	4	14	12	7	17
Bryant 2003a	5	6	18	7	23	40	NA	NA	NA
Cottraux 2008	5	4	29	8	10	31	NA	NA	NA
Cloitre 2010	5	18	38	8	20	33	NA	NA	NA
Markowitz 2015a	3	5	32	7	7	38	14	8	40
Ford 2011	1	0	45	12	10	48	15	8	53

Study	t1	r1	n1	t2	r2	n2	t3	r3	n3
Acarturk 2016	1	3	49	13	30	49	NA	NA	NA
Carletto 2016	3	16	25	13	17	25	NA	NA	NA
van der Kolk 2007	13	8	29	20	4	30	NA	NA	NA
Steinert 2017	1	7	29	16	47	49	NA	NA	NA
Krupnick 2008	1	2	16	14	16	32	NA	NA	NA
Monson 2008/2012	1	4	20	17	13	20	NA	NA	NA
Sautter 2015	4	2	28	17	15	29	NA	NA	NA
Ivarsson 2014	1	14	31	18	22	31	NA	NA	NA
Knaevelsrud 2015	1	5	75	18	31	74	NA	NA	NA
Sloan 2012	1	3	24	19	21	22	NA	NA	NA
Sloan 2011	2	5	23	19	7	24	NA	NA	NA

t1, t2, t3 indicate the coded treatment in each trial arm; codes of treatments are provided in Table 189; r1, r2, r3 indicate the number of events in each trial arm; n1, n2, n3 indicate the number of participants in each trial arm

Figure 699. Network of interventions included in the NMA of dichotomous remission data at treatment endpoint in adults with PTSD

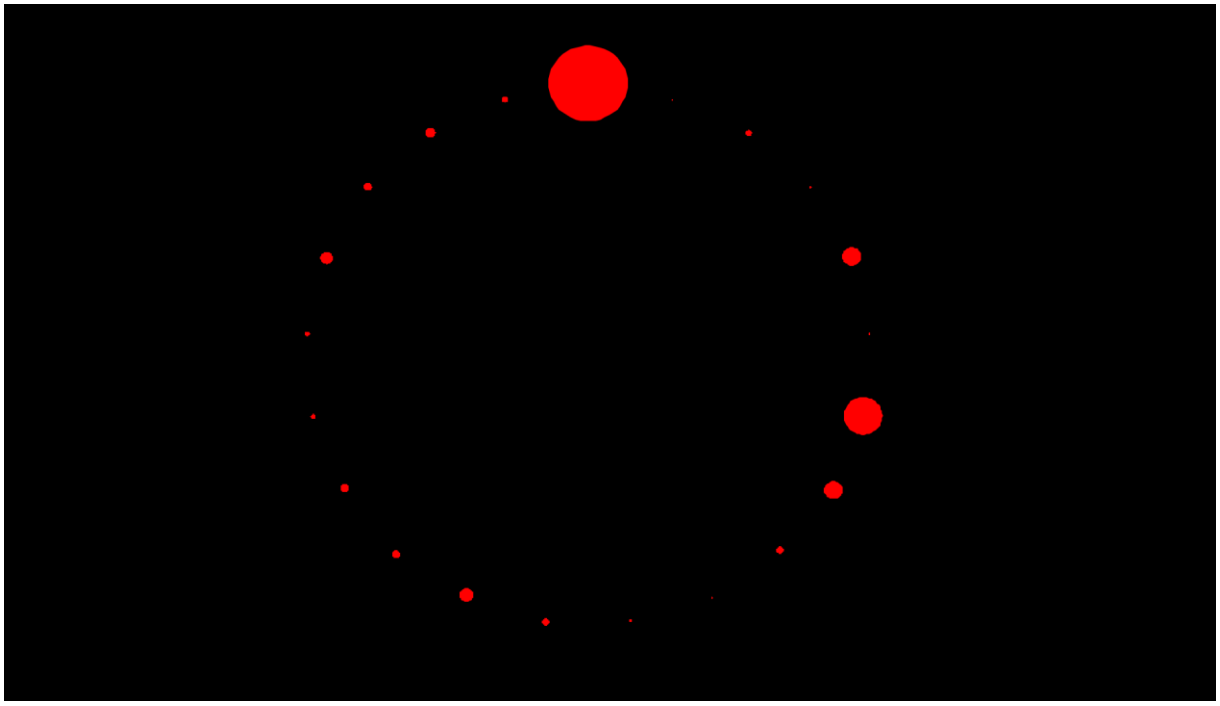


Table 189. NMA of dichotomous remission data at treatment endpoint in adults with PTSD: Interventions with NMA codes, and numbers of participants (N) randomised to each intervention across RCTs and number of RCTs (k) that tested each intervention

Code	Intervention	N randomised (N total = 2202)	k (k total = 33; 74 arms)
1	Waitlist	596	22
2	Attention placebo	23	1
3	Relaxation	57	2
4	Psychoeducation	28	1
5	Counselling	150	6
6	TF-CBT individual <8 sessions	30	2
7	TF-CBT individual 8-12 sessions	300	8
8	TF-CBT individual >12 sessions	146	6
9	TF-CBT group 8-12 sessions	67	3
10	TF-CBT group >12 sessions	22	1
11	TF-CBT mixed	36	1
12	non-TF-CBT	65	2
13	EMDR	114	4
14	IPT	72	2
15	Present-centered therapy	75	2
16	Psychodynamic therapy	49	1
17	Couple intervention	49	2

Code	Intervention	N randomised (N total = 2202)	k (k total = 33; 74 arms)
18	Self-help with support	105	2
19	Self-help without support	74	3
20	SSRI	87	2
21	TF-CBT individual 8-12 sessions + SSRI	57	1
EMDR: eye movement desensitisation reprocessing; IPT: interpersonal psychotherapy; TF-CBT: trauma-focused cognitive behavioural therapy			

Results of the network meta-analysis: remission at treatment endpoint in adults with PTSD

The random effects model demonstrated a better fit for the data (totresdev = 76.05; DIC = 377.7) than the fixed effects model (totresdev = 106.5; DIC = 394.8). The number of data points (study arms) in the model was 74, suggesting satisfactory fit of the random effects model. The between-study heterogeneity was large compared with treatment effects (sd 1.05). Global tests of inconsistency indicated evidence of potential inconsistency. Node splitting suggested evidence of inconsistency between the direct and indirect evidence contributing to the estimate of TF-CBT individual 8-12 sessions vs. self-help without support. In addition, there was a difference between the direct and indirect evidence contributing to the estimate of the following comparisons:

- TF-CBT group 8-12 sessions vs waitlist
- TF-CBT group 8-12 sessions vs EMDR.

Details of inconsistency checks are provided in Appendix M.

The results of the random effects model are shown in Table 190. Interventions have been ordered from those with largest to those with lowest mean effects versus waitlist. Relative effects versus waitlist (log-odds ratio and 95% CrI) are reported. Posterior mean ranks of each intervention (and 95% CrI) are also provided, where a rank of 1 is best. Only interventions tested on at least 50 people were considered in intervention ranking.

Table 190. Results of the NMA: dichotomous remission at treatment endpoint in adults with PTSD (random effects model)

Intervention	Mean LOR (95% CrI) vs waitlist	Mean ranking (95% CrI)
Psychodynamic therapy	*4.60 (1.74 to 7.64)*	
non-TF-CBT	3.71 (1.77 to 5.86)	3.25 (1 to 9)
EMDR	3.69 (2.03 to 5.51)	3.13 (1 to 8)
TF-CBT individual 8-12 sessions	3.45 (2.36 to 4.70)	3.56 (1 to 7)
TF-CBT individual <8 sessions	*3.38 (0.59 to 6.94)*	
Relaxation	*3.20 (1.21 to 5.33)*	*4.81 (1 to 11)*
IPT	3.04 (1.10 to 5.08)	5.32 (1 to 12)
Present-centered therapy	2.62 (0.81 to 4.55)	6.76 (1 to 13)
TF-CBT group >12 sessions	*2.54 (-0.30 to 5.59)*	
TF-CBT individual 8-12 sessions + SSRI	2.51 (0.09 to 5.09)	7.14 (1 to 13)

Intervention	Mean LOR (95% CrI) vs waitlist	Mean ranking (95% CrI)
TF-CBT mixed	*2.42 (-0.07 to 4.99)*	
TF-CBT individual >12 sessions	2.26 (1.07 to 3.53)	7.97 (3 to 12)
Couple intervention	*2.12 (-0.62 to 4.84)*	
SSRI	2.12 (0.10 to 4.33)	8.56 (2 to 13)
Self-help without support	1.83 (0.06 to 3.75)	9.42 (3 to 13)
Self-help with support	1.77 (0.01 to 3.56)	9.51 (3 to 13)
Counselling	1.73 (0.50 to 3.10)	10.02 (6 to 13)
Attention placebo	*1.41 (-1.73 to 4.71)*	
TF-CBT group 8-12 sessions	0.99 (-0.73 to 2.62)	11.76 (7 to 14)
Psychoeducation	*-0.76 (-4.80 to 3.12)*	
Waitlist	reference	13.79 (13 to 14)
Standard deviation: mean 1.05 (95% CrI 0.55 to 1.83)		
Total residual deviance 76.05 (95% CrI 53.79 to 102)		
CrI: credible intervals; EMDR: eye movement desensitisation reprocessing; IPT: interpersonal psychotherapy; LOR: log-odds ratio; SMD: standardised mean difference; SSRI: selective serotonin reuptake inhibitor; TF-CBT: trauma-focused cognitive behavioural therapy Positive values for the LOR indicate a better effect for the intervention compared with waitlist Interventions in italics were not considered in the economic analysis		

Detailed results of all pair-wise comparisons between interventions are shown in Appendix N.

The results of this analysis, as reported earlier, were used only in a secondary economic analysis, which aimed to explore whether the conclusions of the economic analysis based on use of dichotomous remission data would be different from those of the base-case analysis that utilised continuous PTSD symptom change scores.

Dichotomous remission data at 1-4 month follow-up

Dichotomous remission data at 3-month follow-up were very limited; the network comprised 9 studies, 9 interventions and 525 participants. Five of the interventions were tested on fewer than 50 participants; the only active intervention that was tested on N>100 participants was TF-CBT individual 8-12 sessions. For this reason dichotomous follow-up data were not utilised in the economic analysis. Instead, it was assumed that at 3-6 months the probability of remission of each active intervention was equal to the baseline probability of remission for no treatment.

Other clinical input parameters

Other clinical input parameters included

- the baseline (no treatment) probability of remission, which was applied as the baseline in the decision-tree and also across all treatment options in the Markov part of the model

- the risk of relapse following remission, which was independent of the intervention received at the start of the model.
- the risk of development of side effects from SSRIs
- mortality associated with PTSD and no PTSD health states

Baseline probability of remission in adults with PTSD

A number of studies were identified in the literature that reported the probability of remission over time in adults with PTSD (Breslau et al., 1998; Chapman et al., 2012; Morina et al., 2014; Pietrzak et al., 2014; Resick et al., 2012; Rosellini et al., 2017; Solomon et al., 2016; Steinert et al., 2015).

Three of the studies were survey-based studies of the long-term course of PTSD in the community: Breslau and colleagues (1998) estimated the impact of specific type of trauma experienced in the community, by interviewing a representative sample of 2,181 people aged 18-45 years living in the Detroit area, US. The study provided survival curves showing the rates of remission over time (up to 10 years) for 180 people diagnosed with PTSD by gender and trauma type (event to self or event to others). Chapman and colleagues (2012) reported remission rates from post-traumatic stress disorder in the general population, using data obtained from 8,841 respondents of the 2007 Australian National Survey of Mental Health and Wellbeing, aged 16-85 years, 664 of whom had experienced PTSD at some point in their life. The study reported remission rates over time and also provided a survival curve of remission up to 60 years from onset of PTSD in the surveyed population. Rosellini and colleagues (2017) reported remission data from 1575 respondents with PTSD who participated in 22 World Mental Health surveys. Rates of remission were reported for a period of 120 months (10 years) following PTSD onset, which was the longest follow-up period for which a sufficient number of cases were observed for stable estimation of conditional probability of remission. The probability of PTSD remission over time was graphically shown for different age groups, starting from children aged 0-12 years and up to adults aged 60 years and above.

Two studies (Morina et al., 2014; Steinert et al., 2015) were systematic reviews of naturalistic, long term outcome studies on PTSD in adults. Both reviews reported a wide range of remission rates across primary studies, between 6% and 92%.

One study was a prospective cohort study of PTSD risk and resilience in 10,835 World Trade Centre responders (Pietrzak et al., 2014). Another study assessed the trajectories of PTSD in 214 veterans from the 1982 Lebanon War over 20 years (Solomon et al., 2016). Finally, one study was a long-term follow-up (8 years) study of female rape survivors with PTSD that had participated in a RCT that compared cognitive processing therapy with prolonged exposure (Resick et al., 2012).

The committee reviewed the available data and advised that data from Chapman and colleagues (2012) be used to inform the economic model, as the study sample was more likely to be similar to a the UK population presenting to NHS services for PTSD symptoms. Moreover, the study reported detailed remission data, supplemented with survival curves that were possible to extract and use in the economic model over the time horizon of the analysis. Digital software (http://www.digitizeit.de) was used to read and extract the cumulative proportions of adults that remitted from PTSD at 3 months, 12 months, 24 months, and 36 months from PTSD onset and supplement values already reported in the study. The extracted values were used to estimate the probability of remission between 0-3 months, 3-12 months, 12-24 months and 24-36 months, conditional on not having achieved remission prior to the beginning of each interval. The estimated probabilities of remission during these

time periods were subsequently transformed into 3-monthly probabilities that were used to inform the economic model.

Table 191 shows the estimated cumulative probability of remission for adults at 3, 12, 24 and 36 months from PTSD onset, the probability of remission between 0-3, 3-12, 12-24 and 24-36 months (conditional on not having achieved remission prior to the beginning of the interval), and the 3-monthly probability of remission during these time periods.

Table 191: Probability of remission overtime in adults with PTSD, as estimated based on data extracted from Chapman and colleagues (2012)

Time from PTSD onset	Cumulative probability of remission	Time interval	Probability of remission over the time interval*	3-monthly probability during the time interval*
3 months	0.026	0-3 months	0.026	0.026
12 months	0.149	3-12 months	0.126	0.044
24 months	0.266	12-24 months	0.137	0.036
36 months	0.320	24-36 months	0.074	0.019
* conditional on not having achieved remission prior to the beginning of each interval.				

It needs to be noted that the economic analysis evaluated interventions for the delayed (>3 months) treatment of PTSD in adults. The economic model is thus assumed to start at month 3 from PTSD onset. The data reported in Table 191 refer to time periods from PTSD onset, meaning that the remission data corresponding to 0-3 months after PTSD onset refer to a time period just before treatment was received by the model's study population. Therefore these data were not utilised in the economic analysis. The economic model was informed by the following available data:

- The 3-month probability of remission over 3-12 months from PTSD onset informed months 0-9 of the economic model: these data were used to populate the no treatment arm during the first 6 months of the economic model, comprising 3 months of a full course of treatment plus the 3-month follow-up, i.e. over the duration of the decision-tree (months 0-6 of the economic model). It also informed all model arms in months 3-6 of the economic model in the base-case analysis. Finally, it informed all model arms in the first cycle of the Markov model (months 6-9 of the economic model), as the course of PTSD after 6 months of treatment was assumed to be independent of the treatment received.
- The 3-month probability of remission over 12-24 months from PTSD onset informed all model arms in the next 4 cycles of the Markov model (months 9-21 of the economic model).
- The 3-month probability of remission over 24-36 months from PTSD onset informed all model arms in the next 5 cycles of the Markov model (months 21-36 of the economic model); this 3-month probability was also extrapolated to the period of 36-39 months from PTSD onset (i.e. months 33-36 of the economic model) for reasons of simplification.

Risk of relapse following remission of PTSD

No published evidence on the risk of relapse following remission from PTSD in adults was identified in the published literature. Therefore, an annual risk of relapse of 0.10 was assumed, based on the committee's expert advice. This was translated into a 3-month probability of relapse of 0.026, which was applied in the 3-month follow-up period of the

decision-tree and over the whole duration of the Markov model. In deterministic sensitivity analysis the annual risk value of 0.10 was varied between 0.05 and 0.20.

Risk of development of side effects from SSRI treatment

Treatment with SSRIs is associated with the development of various side effects. These can be serious, including death, attempted suicide or self-harm, falls, fractures, stroke or transient ischaemic attack, epilepsy/seizures, myocardial infarction, hyponatraemia and upper gastrointestinal bleeding (Coupland et al., 2011; Jakobsen et al., 2017) or less serious but more common, such as headaches, nausea and other gastrointestinal symptoms, dizziness, agitation, sedation, sexual dysfunction, tremor, sweating, fatigue, and arrhythmia (Anderson et al., 2012; Jakobsen et al., 2017).

The probability of development of common side effects in people treated with SSRIs was estimated based on data reported in Anderson and colleagues (2012). The authors did a retrospective analysis of data derived from a large US managed care claims database on 40,017 people who were newly diagnosed with depression and were initiated on antidepressant monotherapy between 1998 and 2008, and estimated the prevalence of common side effects such as headaches, nausea or vomiting, agitation sedation and sexual dysfunction associated with treatment with various classes of antidepressants. The rate of experiencing at least one of the 5 common side effects considered in the study was 9.7/1000 person-months of therapy in adults taking SSRIs. This translates into 2.9/100 person - 3 months of therapy; this figure was utilised in the economic analysis in every 3-month period people received SSRIs.

Serious side effects from SSRIs are costly to treat and are likely to have a substantial negative impact on people's quality of life. However, the absolute risk of such side effects is low, and therefore their impact on the relative cost effectiveness of SSRIs is likely to be small. For this reason, and as their consideration in the economic analysis would require more complex modelling, such side effects were not considered in the economic analysis. However, omission of these severe side effects is not expected to have considerably affected the results of the economic analysis, due to their low incidence in the study population.

No side effects were assumed for people receiving non-pharmacological interventions; however, people receiving non-pharmacological interventions are also expected to experience a range of events such as headaches, nausea or vomiting, etc. The study by Anderson and colleagues (2012) was uncontrolled and did not examine the rate of side effects that were attributable to SSRIs. Therefore, the economic analysis may have overestimated the impact of common side effects from SSRIs relative to other treatments and thus underestimated their relative cost effectiveness.

Mortality

PTSD is associated with an increased risk of mortality relative to the general population. A Cox regression survival analysis with covariates age, gender, diabetes mellitus, hypertension, hypercholesterolemia, family history of coronary heart disease, smoking status and post-traumatic stress disorder on 637 veterans in the US (aged 61 ± 9 years, of whom 12.2% were women) showed that the adjusted hazard ratio of death relating to PTSD was 1.77 (95% CI 1.02–3.14) (Ahmadi et al., 2011).

The adjusted hazard ratio of death in adults with PTSD relative to adults without PTSD was applied onto the most recent general mortality statistics for the population in England (Office for National Statistics, 2017a), to estimate the absolute annual mortality risk in people experiencing PTSD relative to people without PTSD symptoms within the decision-tree and

also within each cycle of the Markov model. People with PTSD were assumed to be at increased mortality risk due to PTSD only over the time period they experienced PTSD symptoms. The same mortality risk was assumed for both men and women experiencing PTSD, as no gender-specific data were reported in the study. People without PTSD symptoms during the decision-tree or in any Markov cycle were assumed to carry the mortality risk of the general UK population.

Utility data and estimation of quality adjusted life years (QALYs)

In order to express outcomes in the form of QALYs, the health states of the economic model (remission, response not reaching remission, no response or relapse) need to be linked to appropriate utility scores. Utility scores represent the HRQoL associated with specific health states on a scale from 0 (death) to 1 (perfect health); they are estimated using preference-based measures that capture people's preferences on the HRQoL experienced in the health states under consideration.

The systematic review of utility data on PTSD-related heath states identified 2 studies that reported utility data corresponding to PTSD-related health states in adults that met inclusion criteria (Freed et al., 2009; Haagsma et al., 2012; Mihalopoulos et al., 2015). There were 4 studies that were excluded after obtaining full text, and these are reported in Appendix K, together with reasons for exclusion.

Freed and colleagues (2009) reported utility scores derived from a random sample of 808 veterans (79% male; 12% met criteria for PTSD) who attended four primary care clinics in the US and who completed the PTSD Checklist (PCL), the Clinician-Administered PTSD Scale, the Mini-International Neuropsychiatric Interview and the Medical Outcomes Survey Short Form–36 (SF-36). SF-36 ratings were used to estimate utility scores after conversion to SF-6D and use of the UK adult general population algorithm, which was derived using the standard gamble (SG) technique (Brazier et al., 2002). The authors reported utility data for veterans with PTSD (n=711) and veterans without PTSD (n=97), before and after adjustment for confounders such as gender, employment status, presence of disability as well as mental and physical health comorbidities (chronic obstructive pulmonary disorder, mood disorder, anxiety disorder, substance use disorder).

Haagsma and colleagues (2012) reported mean EQ-5D utility scores derived from 1,781 injury patients aged 15 years and older who attended the Emergency Department of the Dutch Injury Surveillance System. The sample consisted of victims of traffic, home and leisure, occupational and sport accidents. Injuries varied from minor to severe injury, single or multiple injury, requiring hospitalisation or not. The Impact of Event Scale (IES) was used to assess symptoms of post-traumatic stress indicative of PTSD. The UK EQ-5D tariff, formed using the time trade-off (TTO) technique, was used (Dolan, 1997). The authors reported utility scores from 73 injury patients with PTSD symptoms (IES-score ≥ 35) and 1,708 patients without PTSD symptoms (IES < 35).

Mihalopoulos and colleagues (2015) reported utility data from adults participating in the National Survey of Mental Health and Wellbeing conducted in Australia in 1997. People were categorised into those with or without a current diagnosis of PTSD (according to DSM-IV criteria) and whether or not they had been receiving evidence-based treatments over the last 12 months. HRQoL was measured using the generic Assessment of Quality of Life (AQoL) measure, which was subsequently converted to the AQoL-4D preference-based measure. The scale includes 12 items (personal care, household tasks, ability to move around the house and community, personal relationships, relationships with other people, relationships with family, vision, hearing, communication with others, sleeping habits, feelings in general, and level of pain or discomfort) rated using 4 levels. Preferences for AQoL-4D health states

have been elicited from a sample of the Australian general population using time trade-off (TTO). The study provided data gender-specific data for people who were PTSD-free following evidence-based treatment [i.e. people with a diagnosis of PTSD within the last 12 months but without a current (30-day) diagnosis, who had received evidence-based treatment over the last 12 months] and people with PTSD [i.e. people with a diagnosis of PTSD within the last 12 months including the last 30-days who had not been receiving evidence-based treatment over the last 12 months].

An overview of the study characteristics, the methods used to define health states, and the health-state utility values reported by each of the two studies is provided in Table 192.

Table 192: Summary of available health-state utility data for PTSD in adults

Study	Definition of health states	Utility measure, valuation method, population valuing	Health states & corresponding utility scores	
Freed et al., 2009	Random sample of 808 veterans (79% male; 12% met criteria for PTSD) in four primary care clinics in the US who completed the PTSD Checklist (PCL), Clinician-Administered PTSD Scale, Mini-International Neuropsychiatric Interview, and the Medical Outcomes Survey Short Form–36 (SF-36). SF-36 was converted to SF-6D.	SF-6D (derived from SF-36) SG UK adult general population	**Health state** no PTSD (n=711) PTSD (n=97) After adjusting for confounders no PTSD PTSD Decrement due to mood disorder Decrement due to anxiety disorder Decrement due to substance use disorder	**Mean** **0.652** **0.535** **0.640** **0.610** **-0.008** **-0.026** **-0.023**
Haagsma et al., 2012	1,781 injury patients aged 15 years and older who attended the Emergency Department of the Dutch Injury Surveillance System. The sample consisted of victims of traffic, home and leisure, occupational and sport accidents. Injuries varied from minor to severe injury, single or multiple injury, requiring hospitalisation or not. The Impact of Event Scale (IES) was used to assess symptoms of post-traumatic stress indicative of PTSD. EQ-5D was used to measure HRQoL.	EQ-5D TTO UK adult general population	**Health state** No PTSD symptoms (IES < 35) (n=1,708) PTSD symptoms (IES-score ≥ 35) (n=73)	**Mean (SD)** **0.87 (0.15)** **0.56 (0.26)**
Mihalopoulos et al., 2015	Adults participating in the National Survey of Mental Health and Wellbeing conducted in Australia in 1997. People were categorised into those with or without a current diagnosis of PTSD (DSM-IV criteria) and whether or not they had been receiving evidence-based treatments over the last 12 months. The 2 health states corresponded to people with a 12-month diagnosis of PTSD who had not been receiving evidence-based treatment over the last 12 months; and those	AQoL-4D TTO Australian general population, aged 16-74 years	**Health state** PTSD-free after evidence-based treatment Male Female PTSD Male Female	**Mean (SE)** **0.63 (0.16)** **0.64 (0.10)** **0.54 (0.07)** **0.57 (0.04)**

Study	Definition of health states	Utility measure, valuation method, population valuing	Health states & corresponding utility scores	
	with a 12-month diagnosis of PTSD but without a current (30-day) diagnosis, who had been receiving evidence-based treatment over the last 12 months. HRQoL was measured using the Assessment of Quality of Life measure (AQoL-4D).			
SE: standard error; SD: standard deviation; SG: standard gamble; TTO: time trade-off				

According to NICE guidance on the selection of utility values for use in cost-utility analysis (NICE, 2013), the measurement of changes in HRQoL should be reported directly from people with the condition examined, or, if this is not possible, by their carers, and the valuation of health states should be based on public preferences elicited using a choice-based method, such as the TTO or SG, in a representative sample of the UK population. NICE recommends the EQ-5D (Brooks, 1996; Dolan, 1997) as the preferred measure of HRQoL in adults for use in cost-utility analysis.

Of the reported data, those from Haagsma and colleagues (2012) are based on EQ-5D ratings and UK population preferences and thus directly meet NICE criteria. However, the committee noted that they reflect HRQoL of people with injuries, so utility values may have been greatly affected by physical symptoms, which are likely to be more severe in people with PTSD. Moreover, utility values in people who have never had PTSD are expected to be higher than those in people who have remitted from PTSD, who are the focus of the economic analysis.

The data from Freed and colleagues (2009) were derived from US veterans and were based on values elicited from the UK population using SG, thus partially meeting NICE criteria. The committee noted the narrow difference between PTSD and no-PTSD health states after adjustment for confounders and the high prevalence of comorbidities characterising the study population (veterans). They also noted that the utility values in people who have never had PTSD are expected to be higher than those in people who have remitted from PTSD, who are the focus of the economic analysis.

The data from Mihalopoulos and colleagues (2015) were derived from Australian adults who had experienced PTSD. The utility values express Australian population's preferences but meet NICE criteria regarding the method of preference elicitation. The committee noted that the utility data correspond directly to the model health states of interest, i.e. people with PTSD and people who remitted from PTSD. The committee noted that the difference between the PTSD and no-PTSD health state values were the narrowest among the 3 datasets (compared with unadjusted data from Freed and colleagues) but expressed the view that they probably reflected a conservative but realistic estimate of the difference in the utility between people experiencing PTSD and those who have remitted.

Based on the above considerations, the committee selected the data from Mihalopoulos and colleagues to inform the guideline economic analysis of interventions for adults with PTSD. The analysis utilised separately the utility data for men and women. Gender-specific data, as reported in the study, were used. The adjusted data from Freed and colleagues, which indicated a narrower utility benefit following remission from PTSD, were used in sensitivity analysis; the same utility values for each health state were used for both men and women, as the paper did not provide gender-specific utility data.

Changes in utility between the states of 'PTSD' and 'no PTSD' were assumed to occur linearly over the time period of the change. When running the probabilistic analysis, the utility value of the 'no PTSD' health state was not allowed to become lower than that of the 'PTSD' health state. In iterations where the utility of the 'no PTSD' health state was lower than the utility of the 'PTSD' health state, the former was forced to equal the latter.

Side effects from SSRIs are expected to have a negative impact on people's HRQoL. Sullivan and colleagues (2004) applied regression analysis on EQ-5D data (UK tariffs)

obtained from participants in the 2000 national US Medical Expenditure Panel Survey to derive age-adjusted utility values for health states associated with depression and with side effects of antidepressants. Health states were defined based on descriptions in the International Classification of Diseases (9th Edition) [ICD-9] and the Clinical Classification Categories (CCC) [clinically homogenous groupings of ICD-9 codes derived by the Agency for Healthcare Research and Quality]. The authors reported a mean utility decrement due to side effects from antidepressants ranging from -0.044 (diarrhoea) to -0.129 (excitation, insomnia and anxiety), with a mean decrement of -0.087; the mean utility of treated depression was 0.848. These data translate into a 10.3% reduction in utility due to side effects of antidepressants, which was applied to people who experienced side effects from SSRIs in the economic model, over the period they received SSRI treatment.

Intervention resource use and costs

Intervention costs were estimated by combining resource use associated with each intervention with appropriate unit costs.

Psychological interventions

Resource use estimates of each psychological therapy in terms of number and duration of sessions, mode of delivery and number of therapists and participants in the case of group interventions were determined by resource use data described in respective RCTs that were included in the guideline NMA that informed the economic analysis, modified by the committee to represent clinical practice in the UK. All psychological interventions with the exception of self-help (with or without support) and psychoeducation were assumed to be delivered by an Agenda for Change (AfC) band 7 clinical psychologist, following the committee's expert advice on optimal delivery of psychological interventions for adults with PTSD. Psychoeducation was assumed to be delivered by an AfC band 5 psychological well-being practitioner (PWP); self-help was assumed to be delivered by an AfC band 6 therapist.

Therapist unit costs were estimated using a combination of data derived from national sources (British Association for Behavioural and Cognitive Therapies, 2016; Curtis & Burns, 2017; National College for Teaching and Leadership, NHS Health Education England, 2016) and included wages/salary, salary oncosts, capital and other overheads, qualification costs and the cost of monthly supervision. Qualification costs were annuitised using the formula reported in Netten and colleagues (1998), assuming a useful working life of 25 years, a time from obtaining the qualification until retirement of 44 years, and an equal distribution of the useful working life over the period of 44 years due to lack of specific information on this distribution. In estimating the unit cost of clinical psychologists per hour of client contact, the ratio of direct (face-to-face) to indirect time (reflecting time for preparation of therapeutic sessions and other administrative tasks) of the clinical psychologists was also taken into account.

The unit cost of a band 7 clinical psychologist was estimated to be £101 per hour of contact with the client. An overview of the cost elements that were taken into account estimation is shown in

Table 193.

Table 193: Unit cost of clinical psychologist band 7 (2017 prices)

Cost element	Unit cost (annual)	Source
Wages – salary	£38,951	Curtis & Burns, 2017; unit cost of community-based scientific & professional staff, including allied health professionals (Agenda for Change band 7)
Salary on-costs	£9,864	
Overheads – staff	£11,960	
Overheads - non-staff	£18,647	
Capital overheads	£5,125	
Qualifications	12,386	Based on a mean clinical psychologist training cost estimate of £159,420 (National College for Teaching and Leadership, NHS Health Education England, 2016), annuitised using the formula reported in Netten and colleagues (1998), assuming a useful working life of 25 years, a time from obtaining the qualification until retirement of 44 years, and an equal distribution of the useful working life over the period of 44 years due to lack of specific information on this distribution.
Supervision	£316	Based on the unit cost of an Agenda for Change band 8a clinical psychologist (Curtis & Burns, 2017) providing 1.5 hour of supervision per month, delivered in groups of 4 participants (British Association for Behavioural and Cognitive Therapies, 2016 and expert advice); qualification costs included, as described above.
SUM of unit costs	**£97,249**	
Working time	42.6 weeks /year 37.5 hours /week (1,599 hours)	Curtis & Burns, 2017
Total cost per hour	**£61**	
Ratio of direct to indirect time*	60:40	Curtis & Burns, 2017; assumption based on the committee's expert opinion and a review of respective ratios reported in the literature for clinical psychologists and other therapists delivering psychological interventions
Estimated cost per hour of direct contact	**£101**	
* ratio of face-to-face time to time for preparation and other administrative tasks		

The unit cost of a band 5 PWP was estimated to be £42 per hour of direct contact with the client. An overview of the cost elements that were taken into account in this estimation is shown in Table 194.

Table 194: Unit cost of psychological well-being practitioner band 5 (2017 prices)

Cost element	Unit cost (annual)	Source
Wages – salary	£23,439	Curtis & Burns, 2017; unit cost of community-based scientific & professional staff, including allied health professionals (Agenda for Change band 5)
Salary on-costs	£5,493	
Overheads – staff	£7,088	
Overheads - non-staff	£11,052	
Capital overheads	£5,125	
Qualifications	494	Based on a training cost estimate of £5,000 (expert advice), annuitised using the formula reported in Netten and colleagues (1998), assuming a useful working life of 20 years, a time from obtaining the qualification until retirement of 44 years, and an equal distribution of the useful working life over the period of 44 years due to lack of specific information on this distribution.
Supervision	£1460	Based on the unit cost per hour of an Agenda for Change band 7 clinical psychologist (as estimated in **Error! Not a valid result for table.**) providing 2 hours of individual supervision per month
SUM of unit costs	**£54,150**	
Working time	42.6 weeks /year 37.5 hours /week (1,599 hours)	Curtis & Burns, 2017
Total cost per hour	**£34**	
Ratio of direct to indirect time*	4:1	assumption based on the committee's expert opinion
Estimated cost per hour of direct contact	**£42**	
* ratio of face-to-face time to time for preparation and other administrative tasks		

The unit cost of a Band 6 therapist was assumed to be £72, which is the mean value of the unit cost of band 7 clinical psychologist and the unit cost of band 5 PWP.

In addition to the healthcare professional's time, the intervention costs of self-help therapies included the cost of the provider of digital mental health programmes and related equipment required for their delivery (personal computers [PCs] and capital overheads), as, in the majority of studies, self-help was delivered via computerised programmes. The cost of provision of a computerised CBT programme per client by the main provider of digital mental health programmes comprises a fixed fee of £36.20, which is independent of the number of sessions attended (expert advice). The annual costs of hardware and capital overheads (space around the PC) were based on reported estimates made for the economic analysis undertaken to inform the NICE Technology Appraisal on computerised CBT for depression and anxiety (Kaltenthaler et al., 2006) and equal £172 and £1,140, respectively (in 2017 prices). Kaltenthaler and colleagues (2006) estimated that one PC can serve around 100 people with mental disorders treated with computerised programmes per year. Assuming that

a PC is used under full capacity (that is, it serves no less than 100 people annually, considering that it is available for use by people with a range of mental health conditions, such as depression and anxiety), the annual cost of hardware and capital overheads was divided by 100 users, leading to a hardware and capital overheads cost per user of £13. It must be noted that if users of such programmes can access them from home or a public library, then the cost of hardware and capital overheads to the NHS is zero.

Details on the resource use and total costs of psychological interventions are provided in Table 195.

Table 195: Intervention costs of psychological therapies for adults with PTSD considered in the guideline economic analysis (2017 prices)

Intervention	Resource use details	Total intervention cost per person
Psychoeducation	3 x 1 hr individual sessions (3 hours) delivered by band 5 PWP	£127
Counselling	10 x 1 hr individual sessions (10 hours) delivered by band 7 clinical psychologist	£1,014
TF-CBT individual <8 sessions	4 x 1.5 hr individual sessions (6 hours) delivered by band 7 clinical psychologist	£608
TF-CBT individual 8-12 sessions	10 x 1.5 hr individual sessions (15 hours) delivered by band 7 clinical psychologist	£1,520
TF-CBT individual >12 sessions	16 x 1 hr individual sessions (16 hours) delivered by band 7 clinical psychologist	£1,622
TF-CBT group 8-12 sessions	12 x 1.5 hr group sessions (18 hours) delivered by band 7 clinical psychologist to groups of 7 people plus 1 x 1 hr individual orientation meeting	£362
non-TF-CBT	9 x 1 hr individual sessions (9 hours) delivered by band 7 clinical psychologist	£912
EMDR	6 x 1.5 hr individual sessions (9 hours) delivered by band 7 clinical psychologist	£912
Present-centered therapy	12 x 1.5 hr individual sessions (18 hours) delivered by band 7 clinical psychologist	£1,825
IPT	16 x 2 hr group sessions (32 hours) delivered by band 7 clinical psychologist to groups of 4 people	£811
Combined somatic & cognitive therapies	4 x 1 hr individual sessions (4 hours) delivered by band 7 clinical psychologist	£405
Self-help with support	Fixed cost of provider of digital mental health programmes is £36.20 per person (information from the committee); cost of hardware & capital overheads £13 per person (2017 price, based on Kaltenthaler et al., 2006); plus 180 min support by a band 6 therapist	£265

Intervention	Resource use details	Total intervention cost per person
Self-help without support	Fixed cost of provider of digital mental health programmes is £36.20 per person (information from the committee); cost of hardware & capital overheads £13 per person (2017 price, based on Kaltenthaler et al., 2006); plus 40 min support by a band 6 therapist	£97
No treatment	No related resource use	£0

EMDR: eye movement desensitisation reprocessing; IPT: interpersonal psychotherapy; PWP: psychological well-being practitioner; TF-CBT: trauma-focused cognitive behavioural therapy

Pharmacological interventions

Pharmacological intervention costs consisted of drug acquisition and GP visit costs. Since in the majority of studies included in the NMA the SSRI used was sertraline, the economic analysis utilised the drug acquisition cost of sertraline. The mean daily dosage of sertraline was determined by the reported mean daily dosage in the RCTs included in the NMA.

The SSRI was administered over 3 months; over this period, 4 GP visits were assumed based on the committee's expert advice; moreover, monitoring lab tests were undertaken. In people who remitted, the SSRI was administered for another 3 months; during this period one more GP visit was assumed.

The drug acquisition costs and the GP unit cost were taken from national sources (NHS Business Services Authority 2018; Curtis & Burns, 2017). The reported GP unit cost included remuneration, direct care staff costs and other practice expenses, practice capital costs and qualification costs. The latter represented the investment costs of pre-registration and postgraduate medical education, annuitised over the expected working life of a GP; ongoing training costs were not considered due to lack of available information. The unit cost per patient contact was estimated taking into account the GPs' working time as well as the ratio of direct (surgeries, clinics, telephone consultations & home visits) to indirect (referral letters, arranging admissions) patient care, and time spent on general administration. The cost of monitoring lab testing was assumed to be on average £5, based on expert advice.

Intervention costs pharmacological treatment are shown in Table 196.

Table 196: Intervention costs of pharmacological interventions for the treatment of adults with PTSD (2017 prices)

Drug	Mean daily dosage	Drug acquisition cost[1]	3-month drug cost	Total intervention cost (drug, monitoring testing and GP[2])
Sertraline	100-200mg	100mg, 28 tab, £0.99	£1.59	0-3 months: £155 3-6 months: £39

1 NHS Business Services Authority 2018

2 GP cost includes 4 visits over first 3 months and 1 visit between 3 and months; GP unit cost £37 per patient contact lasting 9.22 minutes (Curtis & Burns, 2017); monitoring lab testing cost £5

Combined pharmacological and psychological interventions

The intervention cost of combined TF-CBT individual 8-12 sessions and SSRI was estimated as the sum of the intervention costs of the individual treatment components.

Costs associated with the PTSD and 'no PTSD' health states

The costs of the PTSD and PTSD-free states in the Markov component of the economic model were estimated using health and personal social service usage data from the Adult Psychiatry Morbidity Survey conducted in England in 2014 (McManus et al., 2016), supplemented with resource use data from other national sources and the committee's expert opinion. The survey reported the percentage of adults with PTSD and adults without PTSD that were currently receiving pharmacological or psychological treatment and/or had been using a range of health and personal social services over the last quarter or year for a mental or emotional problem. These services included inpatient hospital stays, outpatient visits, and contacts with GPs, psychiatrists, psychologists, community psychiatric nurses, community learning disability nurses, other nursing services, social workers, self-help and support groups, home help or home care, outreach or family support workers and community day-care centres. However, the exact resource use of each service (e.g. number of psychological treatment sessions, number of outpatient visits) was not reported as relevant information was not collected in the survey. The reported percentages of survey respondents using the services over a period of time were extrapolated, where needed, in order to estimate the percentage of adults with and without PTSD using each service on an annual basis. The mean number of sessions for adults receiving psychological treatment was taken from an annual report on the use of IAPT services (NHS Digital, Community and Mental Health team 2016). The average length of stay for adults receiving inpatient care was taken from national hospital episode statistics (NHS Digital, 2017). Furthermore, the committee made estimates on the number of visits and the time spent on each visit where relevant, in order to provide a total resource use estimate for each type of service. Information on the number of GP visits for adults with mental health problems was sought from published UK evidence (Kontopantelis et al., 2015). The resource use estimates were then combined with appropriate unit costs taken from national sources (Curtis and Burns, 2017, NHS Improvement, 2017) in order to estimate an overall annual health and personal social service cost incurred by adults with PTSD and by those without PTSD. Unit costs included wages/salary, salary oncosts, capital and other overheads, as well as qualification costs.

Details on the data and the committee's estimates used to estimate the annual costs associated with the PTSD and no PTSD health states are provided in Table 197.

Table 197 Annual health and personal social service costs incurred by adults with PTSD and adults without PTSD (2017 prices)

Type of service for a mental or emotional problem	% using the service[1]		Estimates on resource use	Unit costs	Weighted costs	
	PTSD+	PTSD-			PTSD+	PTSD-
Current type of treatment[1]						
No treatment	52.1	89.9	Assumed that no treatment is received over the whole year	Not relevant	£0.0	£0.0
Psychotropic medication	38.9	8.8	Reported reasons for medication: sleep problems, anxiety, depression, ADHD, psychosis, BD (McManus et al., 2016). Assumed that medication is received over 12 months.	Drug acquisition cost assumed to be £5/month for each type of medication, to account for some people receiving non-generic drugs or combinations of drugs; moreover, some medication requires monitoring testing (e.g. testing of glucose blood levels), which incurs extra costs. For reference, the monthly cost of citalopram 10, 20 or 40mg/day is approximately £1.5month (NHS Business Services Authority, NHS Prescription Services, February 2018)	£23.4	£5.3
Substance use medication	8.7	0.7	Assumed that medication is received over 12 months.		£5.2	£0.4
Psychological treatment	24.0	1.9	Reported types of treatment: psychotherapy / psychoanalysis; CBT; art, music or drama therapy; social skills training; couple or family therapy; sex therapy; mindfulness; alcohol or drug counselling; counselling; other therapy (McManus et al., 2016). Mean number of sessions for people with PTSD 7, based on the range of number of sessions for high-intensity therapies in IAPT services (2.8 to 8.6, with CBT 7.1 and EMDR 6.5), taking into account that	Unit cost of NHS AfC Band 7 clinical psychologist £101 per hour of patient contact, as estimated in **Error! Not a valid result for table.**	£255.4	20.5

Type of service for a mental or emotional problem	% using the service[1]		Estimates on resource use	Unit costs	Weighted costs	
	PTSD+	PTSD-			PTSD+	PTSD-
			"people with PTSD would be expected to receive high intensity therapies from the start of their treatment" (NHS Digital, Community and Mental Health team, 2016). Same mean number of sessions conservatively assumed for people without PTSD. Duration of each session 1.5 hour (committee's expert advice). Therapy delivered by NHS AfC Band 7 clinical psychologists (committee's expert advice).			
Other healthcare service[1]						
Inpatient stay in past quarter	1.7	0.1	Percentages conservatively multiplied x 2 to reflect more accurately annual resource use (considering that some people may have been hospitalised earlier in the year, and others may have had multiple admissions). Mean LOS 29 days, based on the weighted mean LOS for F30-F39 (Mood [affective] disorders) and F40-F69 (Neurotic, behavioural & personality disorders); mean LOS for PTSD 31 days (NHS Digital, 2017).	Cost per bed-day £404, based on the weighted mental health care cluster per bed-day (NHS Improvement, 2017).	£389.5	£14.9
Outpatient visit in past quarter	6.2	0.4	Percentages conservatively multiplied x 2 to reflect more accurately annual resource use (considering that some people may have had one or more outpatient visits earlier in the year). Estimated number of outpatient visits per year 3 (committee's expert opinion).	Unit cost per outpatient visit £141 (NHS Improvement 2017, "Other Mental Health Specialist Teams, Adult and Elderly")	£52.2	£3.5

Type of service for a mental or emotional problem	% using the service[1]		Estimates on resource use	Unit costs	Weighted costs	
	PTSD+	PTSD-			PTSD+	PTSD-
Spoken with GP in past year	60.2	10.3	9 visits per year based on the committee's expert opinion and supported by evidence that the annual number of GP visits per person are 11 for people with SMI and 5 for people without SMI (Kontopantelis et al., 2015). The committee advised that the number of visits for people with PTSD are more likely to approximate those for people with SMI; conservatively, this number was also used for people without PTSD.	Unit cost per GP visit £37, including direct care staff and qualification costs (Curtis and Burns, 2017)	£200.5	£34.2
Community care - past year[1]						
Psychiatrist	10.5	0.6	1 consultant psychiatrist visit per year lasting 1 hour (committee's expert opinion)	Unit cost of consultant psychiatrist £361 per hour of patient contact, using unit cost data from Curtis and Burns (2017) and a ratio of direct: indirect time of 1:1.58.	£38.0	£2.3
Psychologist	6.4	0.6	1 Band 7 clinical psychologist visit per year lasting 1 hour (committee's expert opinion)	Unit cost of NHS AfC Band 7 clinical psychologist £101 per hour of patient contact, as estimated in **Error! Not a valid result for table.**	£6.5	£0.6
Community Psychiatric Nurse	7.8	0.4	Estimated to reflect care co-ordination; 12 Band 6 nurse visits per year, lasting 45 min each (committee's expert opinion).	Unit cost of Band 6 nurse £85 per hour of patient contact, using unit cost data from Curtis and Burns (2017) and a ratio of direct: indirect time of 60:40.	£59.7	£3.0
Community Learning Disability nurse	-	0.0	2 Band 5 nurse visits per year, lasting 30 min each (committee's expert opinion)	Unit cost of Band 5 nurse £71 per hour of patient contact, using unit cost data from Curtis	£0.0	£0.0

Type of service for a mental or emotional problem	% using the service[1]		Estimates on resource use	Unit costs	Weighted costs	
	PTSD+	PTSD-			PTSD+	PTSD-
				and Burns (2017) and a ratio of direct: indirect time of 60:40.		
Other nursing services	2.4	2.5	2 Band 5 nurse visits per year, lasting 30 min each (committee's expert opinion)	Unit cost of Band 5 nurse £71 per hour of patient contact, using unit cost data from Curtis and Burns (2017) and a ratio of direct: indirect time of 60:40.	£1.7	£1.7
Social worker	5.3	0.8	Estimated to reflect care co-ordination; 12 social worker visits per year, lasting 45 min each (committee's expert opinion).	Unit cost of social worker for adult services £82 per hour of client-related work (Curtis and Burns, 2017)	£38.8	£6.0
Self-help/support group	4.5	0.8	10 sessions of 2 hours each delivery by a Band 5 PWP, 10 participants per group (committee's expert opinion)	Unit cost of Band 5 community-based scientific & professional staff, including allied health professionals (Curtis and Burns, 2017) assuming a ratio of direct: indirect time of 1:0.25 and a £5,000 qualification cost (committee's expert advice), annuitised using a published formula (Netten et al., 1998), assuming a useful working life of 20 years, a period from obtaining the qualification until retirement of 44 years, and even spread of useful working life over the period of 44 years	£3.8	£0.7
Home help/home care	1.6	0.7	Estimated to reflect care co-ordination; 12 Band 5 nurse visits per year, lasting 45 min each (committee's expert opinion).	Unit cost of Band 5 nurse £71 per hour of patient contact, using unit cost data from Curtis and Burns (2017) and a ratio of direct: indirect time of 60:40.	£10.2	£4.5

Type of service for a mental or emotional problem	% using the service[1]		Estimates on resource use	Unit costs	Weighted costs	
	PTSD+	PTSD-			PTSD+	PTSD-
Outreach worker/family support	6.6	0.7	Estimated to consist of a few visits occurring before outpatient visits or a few visits for support; 5 family support worker visits per year, lasting 1 hour each (committee's expert opinion).	Unit cost of Band 5 nurse £54 per hour of patient contact, using unit cost data from Curtis and Burns (2017), a ratio of direct: indirect time of 60:40, and a £5,000 qualification cost (assumption), annuitised using a published formula (Netten et al., 1998), assuming a useful working life of 20 years, a period from obtaining the qualification until retirement of 44 years, and even spread of useful working life over the period of 44 years	£17.7	£1.8
Community day-care centre[3]	9.7	1.4	8 weeks (2 months) of care per year (committee's expert opinion), 3 sessions per week (Curtis and Burns, 2017)	Cost per session £30 (Curtis and Burns, 2017)	£70.1	£10.1
TOTAL ANNUAL COST					£1,173	£110

1 Data from Adult Psychiatry Morbidity Survey, England 2014 (McManus et al., 2016)

2 Some people receive more than one types of therapy and/or services, hence sums of percentages of people receiving individual therapies and/or services may be higher than 100%

3 Includes community mental health centre, sheltered workshop, day activity centre and other day services.

ADHD: attention-deficit hyperactivity disorder; AfC: agenda for change; BD: bipolar disorder; CBT: cognitive behavioural therapy; EMDR: Eye movement desensitisation and reprocessing; IAPT: improving access to psychological therapies; LOS: length of stay; PWP: psychological wellbeing practitioner; SMI: severe mental illness

Using the annual cost figures, 3-monthly health and personal social care costs were then estimated for the two states of 'PTSD' (£293) and 'no PTSD' (£27) of the economic model. People moving between the two health states of PTSD and no PTSD in every cycle of the model were assumed to incur 50% of the PTSD cost and 50% of the no PTSD cost within the cycle they transitioned between the two health states.

Health and personal social service costs were assumed to be the same across all arms of the economic model during the period of initial (3-month) treatment and therefore were excluded from further consideration.

Because the estimated health state-related costs were based to a large degree on the committee's expert opinion, a sensitivity analysis was conducted, in which costs associated with the PTSD state were varied by ±50%, to explore the impact of the health state cost estimates on the results of the economic analysis.

All costs were expressed in 2017 prices, uplifted, where necessary, using the Hospital and Community Health Services Pay and Prices Index (Curtis & Burns, 2017). Costs and QALYs were discounted at an annual rate of 3.5%, according to NICE guidance (NICE, 2014).

Cost of management of side effects from the pharmacological component of combined treatment

People who experienced common side effects were assumed to have one extra GP contact every 3 months costing £37 (Curtis & Burns, 2017) and to incur a cost of £3 over the same period for medication relating to the management of common side effects.

Discounting

Costs and benefits were discounted at an annual rate of 3.5% as recommended by NICE (2014).

Handling uncertainty

Model input parameters were synthesised in a probabilistic analysis. This means that the input parameters were assigned probabilistic distributions (rather than being expressed as point estimates); this approach allowed more comprehensive consideration of the uncertainty characterising the input parameters and captured the non-linearity characterising the economic model structure. Subsequently, 10,000 iterations were performed, each drawing random values out of the distributions fitted onto the model input parameters. Results (mean costs and QALYs for each intervention) were averaged across the 10,000 iterations. This exercise provides more accurate estimates than those derived from a deterministic analysis (which utilises the mean value of each input parameter ignoring any uncertainty around the mean), by capturing the non-linearity characterising the economic model structure (Briggs et al., 2006).

The distributions of the log-odds ratios of relative effects of all treatments versus no treatment were obtained from the respective NMAs, defined directly from values recorded in each of the 10,000 iterations used after thinning the 300,000 iterations performed in WinBUGS or OpenBUGS, as relevant.

Beta distribution was assigned to the following parameters: the baseline probability of remission (probability of remission of no treatment between 0-6 months and probability of remission across all interventions from 6 months onwards); the probability of relapse; the proportion of people experiencing side effects from SSRIs; and the utility values (including the disutility due to side effects from SSRIs), after applying the method of moments on data reported in the relevant literature.

The hazard ratio of death of people with PTSD versus people without PTSD was assigned a log-normal distribution.

Uncertainty in psychological intervention costs was taken into account by assigning probability distributions to the number of individually delivered psychological therapy sessions, based on intervention completion data and data on mean number of sessions reported in the RCTs that informed the economic analysis. The number of therapist sessions per person attending group psychological interventions was not assigned a probability distribution because the number of group sessions remains the same, whether a participant attends the full course of treatment or a lower number of sessions. The therapist time spent on self-help programmes was assigned a normal distribution. The unit cost of therapists delivering psychological interventions, as well as the unit cost of GPs, were also assigned a normal distribution.

NHS/PSS costs associated with the ‘PTSD’ and ‘no PTSD’ health states were assigned a gamma distribution.

Table 198 reports the mean values of all input parameters utilised in the economic model and provides details on the types of distributions assigned to each input parameter and the methods employed to define their range.

Table 198: Input parameters (deterministic values and probability distributions) that informed the economic model of interventions for the treatment of PTSD in adults

Input parameter	Mean deterministic value	Probability distribution	Source of data – comments
General characteristics of population			
Starting age of cohort (years)	39	No distribution	Ehlers et al., 2013; mean age of adults referred for assessment for possible PTSD and offered cognitive therapy for PTSD in a UK NHS outpatient clinic
Proportion of women	0.516	No distribution	Calculated using the proportion of women in the general population aged 39 years, i.e. starting age of the cohort (Office for National Statistics, 2017b), and data on the percentage of people screened positive for PTSD by age and sex (McManus et al., 2016).
Odds ratios of remission versus no treatment/waitlist at treatment endpoint			
Derived from NMA of continuous data		95% CrI	Guideline NMA; distribution based on 10,000 iterations
Psychoeducation	39.45	1.07 to 1,589.22	
Counselling	3.73	1.11 to 12.37	
TF-CBT individual <8 sessions	61.17	11.59 to 341.04	
TF-CBT individual 8-12 sessions	13.85	5.08 to 37.49	
TF-CBT individual >12 sessions	5.69	1.45 to 22.20	
TF-CBT group 8-12 sessions	3.53	0.48 to 25.74	
non-TF-CBT	9.02	2.54 to 31.98	
EMDR	45.49	14.48 to 143.17	
Present-centered therapy	11.10	1.84 to 65.89	
IPT	8.62	0.85 to 85.11	
Combined somatic & cognitive therapies	22.08	4.19 to 116.16	
Self-help with support	13.36	3.49 to 50.60	
Self-help without support	5.18	1.45 to 18.60	
SSRI	6.82	1.31 to 35.16	
TF-CBT individual 8-12 sessions + SSRI	7.36	1.04 to 51.47	

Input parameter	Mean deterministic value	Probability distribution	Source of data – comments
Derived from NMA of remission data			
Counselling	5.66	1.60 to 22.18	
TF-CBT individual 8-12 sessions	31.46	10.61 to 106.91	
TF-CBT individual >12 sessions	9.67	2.91 to 34.47	
TF-CBT group 8-12 sessions	2.70	0.49 to 13.75	
non-TF-CBT	41.29	5.91 to 353.54	
EMDR	39.78	7.92 to 244.69	
Present-centered therapy	13.76	2.24 to 96.74	
IPT	20.83	2.96 to 161.58	
Self-help with support	5.84	1.00 to 35.52	
Self-help without support	6.25	1.08 to 43.60	
SSRI	8.24	1.07 to 72.68	
TF-CBT individual 8-12 sessions + SSRI	12.03	1.05 to 149.01	
Odds ratios of remission versus no treatment/waitlist at 3-month follow-up (sensitivity analysis)			
Derived from NMA of continuous data		95% CrI	Guideline NMA; distribution based on 10,000 iterations 3-6 month probability of remission for TF-CBT group 8-12 sessions assumed to equal that of no treatment (waitlist); 3-6 month probability of remission for SSRI assumed to equal the probability of remission for SSRI at 0-3 months; 3-6 month probability of remission for TF-CBT individual 8-12 sessions + SSRI borrowed from TF-CBT individual 8-12 sessions
Psychoeducation	2.08	0.27 to 16.54	
Counselling	1.82	0.31 to 11.08	
TF-CBT individual <8 sessions	2.63	0.57 to 11.93	
TF-CBT individual 8-12 sessions	4.94	1.44 to 17.17	
TF-CBT individual >12 sessions	4.30	0.26 to 66.82	
TF-CBT group 8-12 sessions	No data	No data	
non-TF-CBT	2.94	0.36 to 22.87	
EMDR	13.18	1.40 to 113.86	
Present-centered therapy	1.63	0.10 to 25.51	
IPT	2.03	0.12 to 34.02	
Combined somatic & cognitive therapies	14.33	0.43 to 492.26	

Input parameter	Mean deterministic value	Probability distribution	Source of data – comments
Self-help with support	9.44	1.66 to 56.49	
Self-help without support	9.13	0.59 to 145.62	
SSRI	No data	No data	
TF-CBT individual 8-12 sessions + SSRI	No data	No data	
Probability of remission – no treatment			
0-3 months from PTSD onset	0.026	Beta: α=17.26; β=646.74	Chapman et al., 2012; 3-month probabilities estimated using the cumulative remission data after excluding the first 3 months from PTSD onset as the model study population received treatment after 3 months from PTSD onset
0-12 months from PTSD onset	0.149	Beta: α=98.94; β=565.06	
0-24 months from PTSD onset	0.266	Beta: α=176.62; β=487.38	
0-36 months from PTSD onset	0.320	Beta: α=212.48; β=451.52	
Risk of relapse – all model arms			
3-month risk	0.026	Beta: α=2.60; β=97.40	Assumption
Probability of developing common side effects from SSRIs (3-month)	0.029	Beta: α=687; β=22,933	Anderson et al., 2012
Mortality		Log-normal	
Hazard ratio – PTSD vs no PTSD	1.77	95% CI 1.02 to 3.14	Ahmadi et al., 2011
Baseline mortality – general population	Age/sex specific	No distribution	General mortality statistics for the UK population (Office for National Statistics, 2017a)
Utility values		Beta distribution	
Base-case analysis			
PTSD, men	0.540	α=26.83; β=22.86	Mihalopoulos et al., 2015; distribution estimated based on method of moments
PTSD, women	0.570	α=86.75; β=65.44	
No PTSD, men	0.630	α=5.11; β=3.00	
No PTSD, women	0.640	α=14.11; β=7.93	
Sensitivity analysis			
PTSD, all	0.61	no distribution	Freed et al., 2009
No PTSD, all	0.64		

Input parameter	Mean deterministic value	Probability distribution	Source of data – comments
Disutility due to side effects from SSRIs (% of health state utility)	0.103	α=89.64; β=784.07	Anderson et al., 2012; disutility applied as a percentage onto the health state (PTSD or no PTSD) utility
Intervention costs – resource use			
Number of sessions			
Psychoeducation	3	0.70: 3, 0.16: 2, 0.14: 1	Probabilities assigned to numbers of sessions
Counselling	10	0.70: 8-10, 0.16: 5-7, 0.14: 3-4	Number of visits and probabilities based on resource use and completion rate data reported in the RCTs included in the NMAs that informed the economic analysis, supplemented by further assumptions. Participants missing one or more group sessions assumed not to be replaced by others; therefore no impact on total intervention cost – hence, no distribution in the number of sessions assumed for group therapies. TF-CBT individual 8-12 sessions + SSRI: resource use assumed to be the sum of the intervention costs of the individual treatment components. Details on costs of psychological therapies are provided in Table 195.
TF-CBT individual <8 sessions	4	0.70: 4, 0.30: 2-3	
TF-CBT individual 8-12 sessions	10	0.70: 8-10, 0.16: 5-7, 0.14: 3-4	
TF-CBT individual >12 sessions	16	0.70: 12-16, 0.16: 7-11, 0.14: 3-6	
TF-CBT group 8-12 sessions	12	No distribution	
non-TF-CBT	9	0.70: 7-9, 0.16: 5-6, 0.14: 3-4	
EMDR	6	0.70: 5-6, 0.16: 4, 0.14: 3	
Present-centered therapy	12	0.70: 9-12, 0.16: 6-8, 0.14: 3-5	
IPT	16	No distribution	
Combined somatic & cognitive therapies	4	0.70: 4, 0.30: 2-3	
Therapist time (minutes)		Normal distribution	SD based on assumption; fixed digital therapy provider (committee's expert advice) + capital cost (Kaltenthaler et al., 2006) of £49.2 added to the therapist cost.
Self-help with support	180	SD = 0.30*mean	
Self-help without support	40	SD = 0.30*mean	
Number of GP contacts – SSRI			
0-3 months	4	0.70: 4, 0.30: 2-3	Probabilities assigned to numbers of sessions; number of visits based on the committee's expert opinion; distribution based on assumption.
3-6 months	1	0.70: 1, 0.30: 0	
Treatment of side effects	1	0.80: 1, 0.20: 2	
Intervention costs - unit costs			
SSRI - drug acquisition		No distribution	NHS Business Services Authority, March 2018

Input parameter	Mean deterministic value	Probability distribution	Source of data – comments
Laboratory testing – SSRIs	See Table 196	No distribution	Assumption
Medication for side effects - SSRIs	£5	No distribution	Assumption
GP unit cost	£3	Normal, SE=0.05*mean	Curtis & Burns, 2017; distribution based on assumption
Band 7 clinical psychologist unit cost	£37	Normal, SE=0.05*mean	See **Error! Not a valid result for table.**; distribution based on assumption
Band 5 PWP unit cost	£101	Normal, SE=0.05*mean	See Table 194; distribution based on assumption
Band 6 therapist unit cost	£42	Determined by distribution of Band 7 and Band 5 therapist unit costs	Assumed to be the mean of Band 7 and Band 5 therapist unit cost
	£72		
3-month NHS/PSS health state cost		Gamma distribution	Based on resource use data reported in the Adult Psychiatric Morbidity Survey conducted in England, 2014 (McManus et al., 2016) for people with PTSD and people without PTSD, combined with the committee's expert opinion, other published sources of relevant resource use data (NHS Digital, Community and Mental Health team 2016; NHS Digital, 2017, Kontopantelis et al., 2015) and national unit costs (Curtis and Burns, 2017, NHS Improvement, 2017); see Table 197 for details
PTSD	£293	SE=0.30*mean	
No PTSD	£27	SE=0.30*mean	
Annual discount rate	0.035	No distribution	Applied to both costs and outcomes. NICE, 2014

CI: confidence intervals; CrI: credible intervals; EMDR: eye movement desensitisation reprocessing; IPT: interpersonal psychotherapy; PWP: psychological well-being practitioner; SD: standard deviation; SE: standard error; SSRI: selective serotonin reuptake inhibitor; TF-CBT: trauma-focused cognitive behavioural therapy

A number of different analyses were undertaken, using the 2 sets of available efficacy data (changes in PTSD symptom scores and dichotomous remission) and 2 alternative assumptions on the efficacy of interventions at the 3-month follow-up (based on the respective continuous change score data). Consequently, 3 separate probabilistic analyses were undertaken:

- Analysis A: efficacy data at treatment endpoint were derived from the NMA of continuous data (changes in PTSD symptom scores), transformed to log-odds ratios of remission; the probability of remission of all active interventions at 3-6 months was conservatively assumed to equal that of no treatment. This analysis formed the base-case economic analysis.
- Analysis B: efficacy data at treatment endpoint were derived from the NMA of continuous data (changes in PTSD symptom scores), transformed to log-odds ratios of remission; the relative effect of active interventions versus no treatment at 3-6 months was derived from the NMA of changes in PTSD symptom scores between baseline and 1-4 month follow-up, also transformed to log-odds ratios of remission,.
- Analysis C: efficacy data at treatment endpoint were derived from the NMA of dichotomous remission data; the probability of remission of all active interventions at 3-6 months was assumed to equal that of no treatment, as dichotomous remission follow-up data were very limited.

A number of deterministic one-way sensitivity analyses were also employed to explore the impact of alternative hypotheses on the results. The following scenarios were explored:

- The annual risk of relapse was varied between 0.05 and 0.20 (base-case value was 0.10)
- Use of alternative utility values of 0.61 and 0.64 for the PTSD and no PTSD health states, respectively, reported in Freed and colleagues (2005)
- The PTSD health state cost was changed by ± 50%.

Presentation of the results

Results of the economic analysis are presented as follows:

Results are reported separately for each cohort examined in the economic model. In each analysis, mean total costs and QALYs are presented for each intervention, averaged across 10,000 iterations of the model. An incremental analysis is provided for each cohort, in table format, where all options have been listed from the most to the least effective (in terms of QALYs gained). Options that are dominated by absolute dominance (that is, they are less effective and more costly than one or more other options) or by extended dominance (that is, they are less effective and more costly than a linear combination of two alternative options) are excluded from further analysis. Subsequently, incremental cost-effectiveness ratios (ICERs) are calculated for all pairs of consecutive options remaining in analysis.

ICERs are calculated by the following formula:

$$ICER = \Delta C / \Delta E$$

where ΔC is the difference in total costs between two interventions and ΔE the difference in their effectiveness (QALYs). ICERs express the extra cost per extra unit of benefit (QALY) associated with one treatment option relative to its comparator. The treatment option with the

highest ICER below the NICE lower cost effectiveness threshold of £20,000/QALY (NICE, 2008) is the most cost-effective option.

In addition to ICERs, the mean net monetary benefit (NMB) of each intervention is presented. This is defined by the following formula:

$$NMB = E \bullet \lambda - C$$

where E and C are the effectiveness (number of QALYs) and costs associated with the treatment option, respectively, and λ is the level of the willingness-to-pay (WTP) per unit of effectiveness, set at the NICE lower cost effectiveness threshold of £20,000/QALY (NICE, 2008). The intervention with the highest NMB is the most cost-effective option (Fenwick et al., 2001).

Incremental mean costs and effects (QALYs) of each intervention versus no treatment are also presented in the form of cost effectiveness planes.

The probability of each intervention being the most cost-effective option at the NICE lower cost effectiveness threshold of £20,000/QALY is provided, calculated as the proportion of iterations (out of the 10,000 iterations run) in which the intervention has had the highest NMB among all interventions considered in the analysis.

The mean ranking in terms of cost effectiveness is also reported for each intervention (out of the 10,000 iterations run), where a rank of 1 is best.

The probabilities of each intervention being cost-effective at various cost effectiveness thresholds are illustrated in cost-effectiveness acceptability curves (CEACs). Finally, the cost-effectiveness acceptability frontiers (CEAFs) are also plotted; these show the treatment option with the highest mean NMB over different cost effectiveness thresholds, and the probability that the option with the highest NMB is the most cost-effective among those assessed (Fenwick et al., 2001).

Validation of the economic model

The economic model (including the conceptual model and the identification and selection of input parameters) was developed by the health economist in collaboration with a health economics sub-group formed by members of the committee. As part of the model validation, all inputs and model formulae were systematically checked; the model was tested for logical consistency by setting input parameters to null and extreme values and examining whether results changed in the expected direction. The base-case results and results of sensitivity analyses were discussed with the committee to confirm their plausibility.

Economic modelling results

Analysis A (base-case): efficacy at treatment endpoint based on NMA of continuous data (changes in PTSD symptom scores); no beneficial effect beyond treatment endpoint

The results of the base-case economic analysis are provided in Table 199. This table provides mean QALYs and mean total costs for each intervention assessed in the economic analysis, as well as the results of incremental analysis, the mean NMB of each intervention, and its mean ranking by cost effectiveness (where a rank of 1 is best). Interventions have

been ordered from the most to the least effective in terms of number of QALYs gained. According to the results, TF-CBT individual < 8 sessions was the most clinically and cost-effective intervention, however, its probability of being the most cost-effective option was only 0.26. Psychoeducation was the second most cost-effective intervention, followed by EMDR, combined somatic and cognitive therapies, self-help with support, SSRI, TF-CBT individual 8-12 sessions, self-help without support, non-TF-CBT, IPT, present-centered therapy, TF-CBT group 8-12 sessions, combined TF-CBT individual 8-12 sessions + SSRI, no treatment, counselling, and TF-CBT individual >12 sessions.

Table 199: Analysis A, base-case results of economic modelling: interventions for the treatment of PTSD in adults [efficacy at treatment endpoint based on NMA of continuous data (changes in PTSD symptom scores); no beneficial effect beyond treatment endpoint]

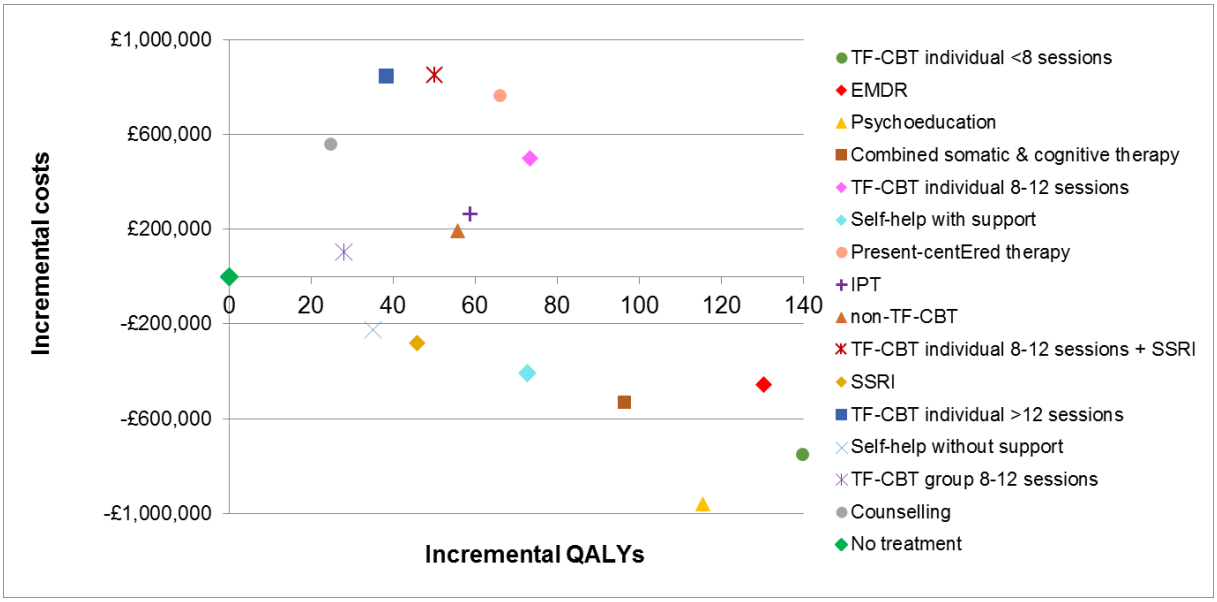
Intervention	Mean per person			ICER (£/QALY)	NMB £/ person	Prob best[1]	Mean rank
	QALY	Inter cost £	Total cost £				
TF-CBT individual <8 sessions	1.812	540	1,709	8,618	34,539	0.26	2.55
EMDR	1.803	746	2,003	Dominated	34,053	0.14	3.27
Psychoeducation	1.788	105	1,498		34,262	0.44	3.62
Combined somatic & cognitive therapies	1.769	361	1,930	Dominated	33,448	0.10	4.52
TF-CBT individual 8-12 sessions	1.746	1,178	2,959	Dominated	31,958	0.00	9.19
SH with support	1.745	264	2,052	Dominated	32,853	0.03	5.69
Present-centered therapy	1.739	1,375	3,224	Dominated	31,549	0.01	10.94
IPT	1.731	810	2,723	Dominated	31,902	0.02	9.66
non-TF-CBT	1.728	706	2,653	Dominated	31,910	0.00	9.13
TF-CBT individual 8-12 sessions + SSRI	1.723	1,324	3,311	Dominated	31,142	0.00	12.35
SSRI	1.718	145	2,177	Dominated	32,189	0.01	7.57
TF-CBT individual >12 sessions	1.711	1,204	3,307	Dominated	30,910	0.00	13.08
SH without support	1.708	98	2,233	Dominated	31,918	0.00	8.35
TF-CBT group 8-12 sessions	1.701	362	2,562	Dominated	31,448	0.00	10.79
Counselling	1.697	788	3,019	Dominated	30,927	0.00	13.07
No treatment	1.673	0	2,459	Dominated	30,991	0.00	12.23

1 at the NICE lower cost-effectiveness threshold of £20,000/QALY

EMDR: eye movement desensitisation reprocessing; ICER: incremental cost effectiveness ratio; Inter: intervention; NMB: net monetary benefit; Prob: probability; SH: self-help; SSRI: selective serotonin reuptake inhibitor; TF-CBT: trauma-focused cognitive behavioural therapy

Figure 700 provides the cost effectiveness plane of the analysis. Each intervention is placed on the plane according to its incremental costs and QALYs compared with no treatment, which is placed at the origin.

Figure 700. Analysis A (base-case): Cost-effectiveness plane of interventions for the treatment of PTSD in adults [efficacy at treatment endpoint based on NMA of continuous data (changes in PTSD symptom scores); no beneficial effect beyond treatment endpoint]



The CEAC and CEAF of the analysis are shown in Figure 701 and **Figure 702**, respectively. It can be seen that psychoeducation is the most cost-effective intervention for up to a cost effectiveness threshold of £9,000/QALY, with a probability that exceeds 0.48. TF-CBT individual < 8 sessions is the most cost-effective option for higher cost effectiveness thresholds and up to £40,000/QALY, but its probability of being cost-effective does not exceed 0.30 at any cost effectiveness threshold. It should be noted that although TF-CBT individual <8 sessions is the most cost-effective option at a cost effectiveness threshold of £9,000/QALY and above, it does not have the highest probability of being cost-effective at any point beyond this threshold. In contrast, psychoeducation shows the highest probability of being cost-effective, despite of the fact that it has a lower mean NMB compared with TF-CBT individual < 8 sessions for cost effectiveness thresholds of £9,000/QALY and above. This means that, for cost effectiveness thresholds of £9,000/QALY and above, TF-CBT individual < 8 sessions has the highest mean NMB across the 10,000 iterations, but psychoeducation has a higher NMB than TF-CBT individual < 8 sessions in a larger number of iterations (which translates into a higher probability of psychoeducation being cost-effective). This finding is explained by the close NMB values between the TF-CBT individual < 8 sessions and psychoeducation across iterations (which, on average, are higher for TF-CBT individual < 8 sessions) and the more positive skew in the distribution of the NMB of psychoeducation, in comparison to the distribution of the NMB of TF-CBT individual < 8 sessions (this phenomenon is explained in detail in Fenwick et al., 2001).

Figure 701. Analysis A (base-case): Cost-effectiveness acceptability curves of interventions for the treatment of PTSD in adults [efficacy at treatment endpoint based on NMA of continuous data (changes in PTSD symptom scores); no beneficial effect beyond treatment endpoint]

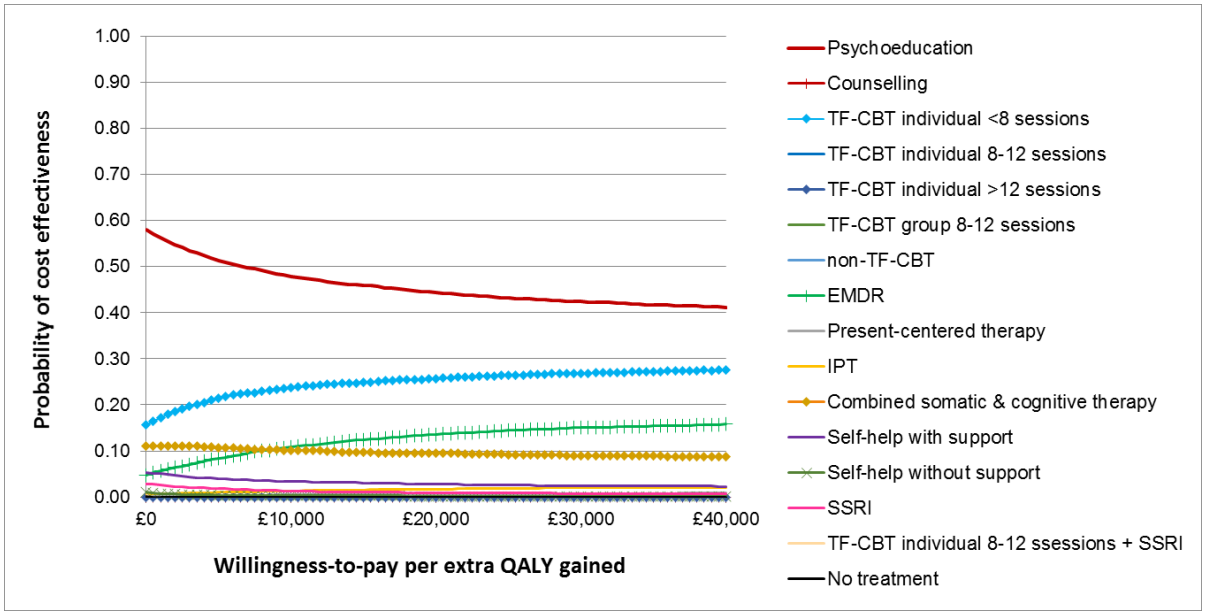
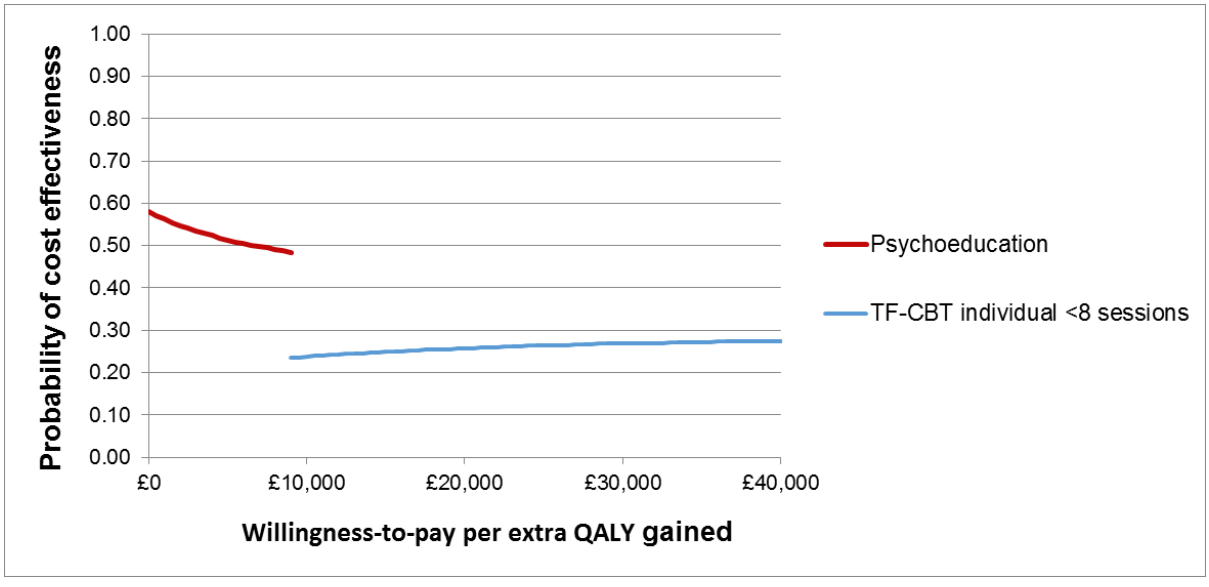


Figure 702 Analysis A (base-case): Cost-effectiveness acceptability frontier of interventions for the treatment of PTSD in adults [efficacy at treatment endpoint based on NMA of continuous data (changes in PTSD symptom scores); no beneficial effect beyond treatment endpoint]



Results were robust to the scenarios explored through deterministic analysis. The top 7 most cost-effective interventions remained the same, although in some of the analyses their ranking changed.

Analysis B: efficacy at treatment endpoint based on NMA of continuous data (changes in PTSD symptoms scores); beneficial effect up to 3-month follow-up (obtained from NMA of continuous data at 1-4 month follow-up)

The results of this analysis are provided in Table 200. TF-CBT individual < 8 sessions was the most cost-effective intervention, followed by combined somatic and cognitive therapies and EMDR. These were followed by psychoeducation, self-help with support, self-help without support, SSRI, IPT, non-TF-CBT, TF-CBT individual 8-12 sessions, TF-CBT individual >12 sessions, present-centered therapy, TF-CBT group 8-12 sessions, TF-CBT individual 8-12 sessions + SSRI, counselling and, finally, no treatment. The probability of TF-CBT individual < 8 sessions being the most cost-effective intervention was only 0.14.

Table 200: Analysis B, results of economic modelling: interventions for the treatment of PTSD in adults [efficacy at treatment endpoint based on NMA of continuous data (changes in PTSD symptoms scores); beneficial effect up to 3-month follow-up (obtained from NMA of continuous data at 1-4 month follow-up)]

Intervention	Mean per person			ICER (£/QALY)	NMB £/ person	Prob best[1]	Mean rank
	QALY	Inter cost £	Total cost £				
EMDR	1.808	746	1,930	21,979	34,239	0.08	3.91
TF-CBT individual <8 sessions	1.807	542	1,739	11,660	34,410	0.14	3.58
Combined somatic & cognitive therapies	1.796	360	1,649	Ext domin	34,264	0.21	3.79
Psychoeducation	1.787	106	1,498		34,238	0.36	4.20
SH with support	1.766	263	1,824	Dominated	33,506	0.04	5.28
SH without support	1.754	97	1,753	Dominated	33,325	0.10	5.77
TF-CBT individual 8-12 sessions	1.747	1,177	2,934	Dominated	31,997	0.00	10.03
SSRI	1.743	145	1,912	Dominated	32,951	0.05	6.64
Present-centered therapy	1.739	1,375	3,202	Dominated	31,576	0.00	11.50
IPT	1.737	811	2,654	Dominated	32,082	0.01	9.82
TF-CBT individual >12 sessions	1.734	1,205	3,062	Dominated	31,618	0.00	11.34
non-TF-CBT	1.732	705	2,596	Dominant	32,042	0.00	9.66
TF-CBT individual 8-12 sessions + SSRI	1.720	1,323	3,323	Dominated	31,076	0.00	12.98
Counselling	1.700	782	2,971	Dominated	31,023	0.00	13.08
TF-CBT group 8-12 sessions	1.698	362	2,576	Dominated	31,375	0.00	11.62
No treatment	1.669	0	2,475	Dominated	30,910	0.00	12.78

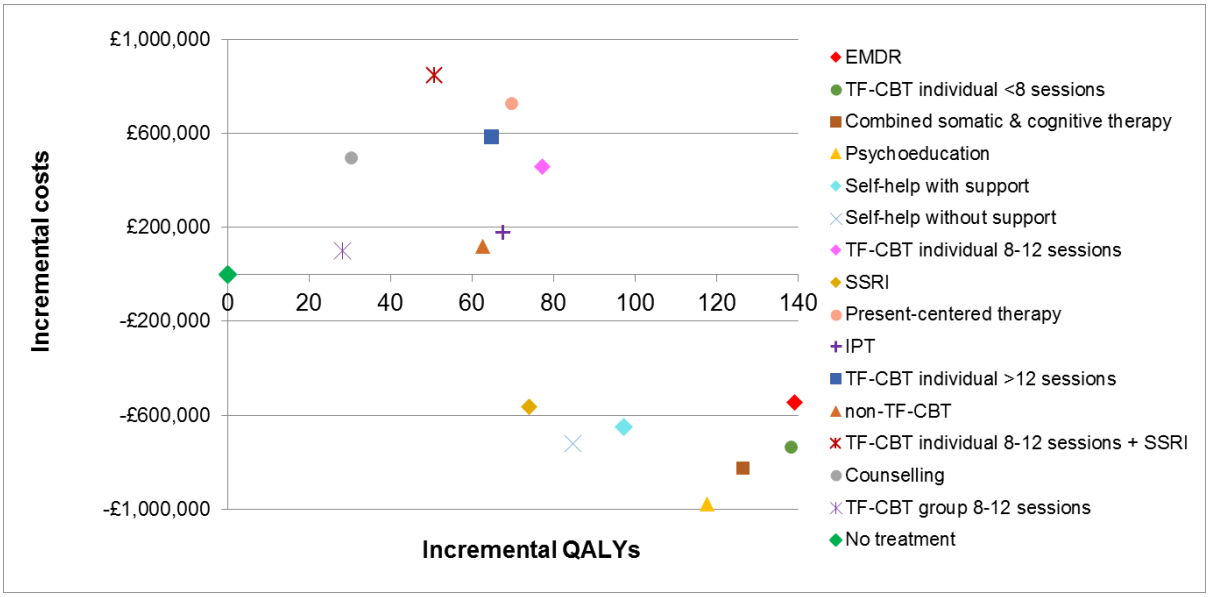
1 at the NICE lower cost-effectiveness threshold of £20,000/QALY

Intervention	Mean per person			ICER (£/QALY)	NMB £/ person	Prob best[1]	Mean rank
	QALY	Inter cost £	Total cost £				

EMDR: eye movement desensitisation reprocessing; Ext domin: extendedly dominated; ICER: incremental cost effectiveness ratio; Inter: intervention; NMB: net monetary benefit; Prob: probability; SH: self-help; SSRI: selective serotonin reuptake inhibitor; TF-CBT: trauma-focused cognitive behavioural therapy

Figure 703 provides the cost effectiveness plane of the analysis. Each intervention is placed on the plane according to its incremental costs and QALYs compared with no treatment.

Figure 703. Analysis B: Cost-effectiveness plane of interventions for the treatment of PTSD in adults [efficacy at treatment endpoint based on NMA of continuous data (changes in PTSD symptoms scores); beneficial effect up to 3-month follow-up (obtained from NMA of continuous data at 1-4 month follow-up)]



The CEAC and CEAF of the analysis are shown in Figure 704 and **Figure 705**, respectively. Psychoeducation is the most cost-effective intervention for up to a cost effectiveness threshold of £12,000/QALY, with a probability that exceeds 0.38. TF-CBT individual < 8 sessions is the most cost-effective option for higher cost effectiveness thresholds and up to £40,000/QALY, but its probability of being cost-effective does not go beyond 0.18 at any cost effectiveness threshold. Similar to analysis A, it can be seen that although TF-CBT individual <8 sessions is the most cost-effective option at a cost effectiveness threshold of £12,000/QALY and above, it does not have the highest probability of being cost-effective at any point beyond this threshold. In contrast, psychoeducation shows the highest probability of being cost-effective, despite of the fact that it has a lower mean NMB compared with TF-CBT individual < 8 sessions for cost effectiveness thresholds of £12,000/QALY and above. As with analysis A, this finding is attributable to the close NMB values between the TF-CBT individual < 8 sessions and psychoeducation across iterations and the more positive skew in the distribution of the NMB of psychoeducation, in comparison to the distribution of the NMB of TF-CBT individual < 8 sessions.

Figure 704. Analysis B: Cost-effectiveness acceptability curves of interventions for the treatment of PTSD in adults [efficacy at treatment endpoint based on NMA of continuous data (changes in PTSD symptoms scores); beneficial effect up to 3-month follow-up (obtained from NMA of continuous data at 1-4 month follow-up)]

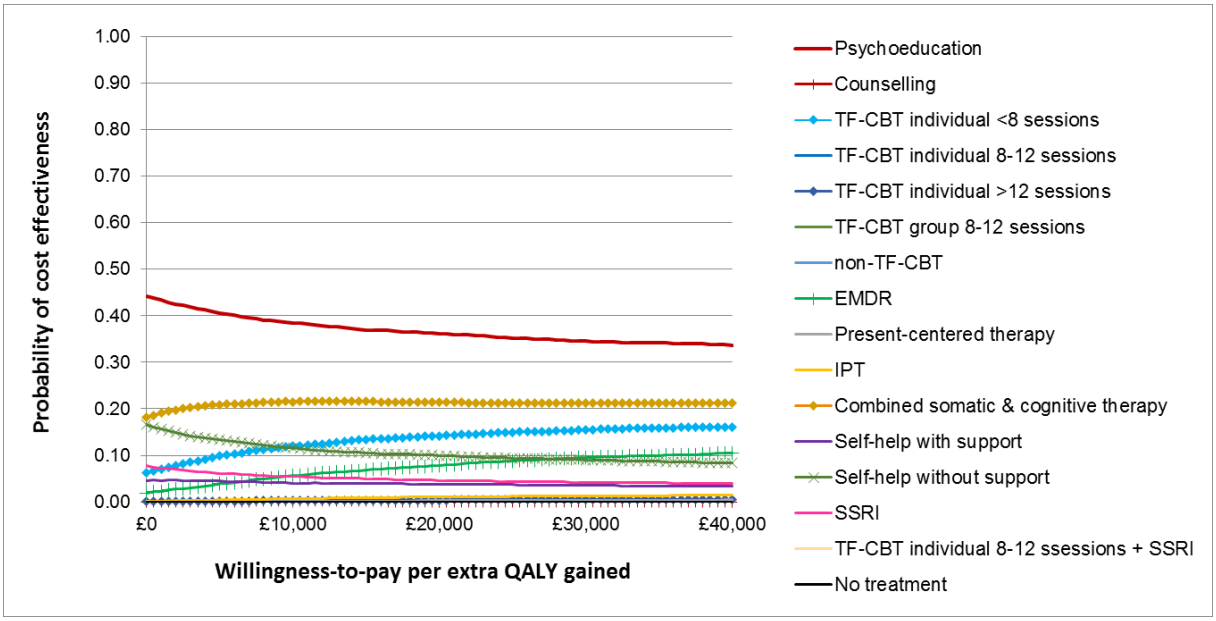
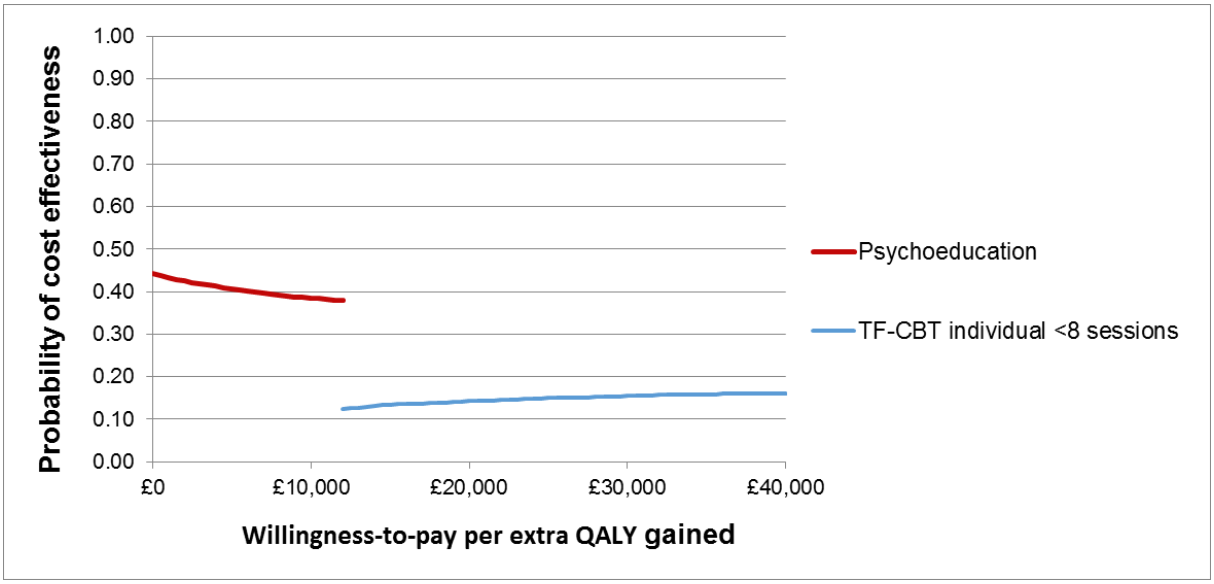


Figure 705 Analysis B: Cost-effectiveness acceptability frontier of interventions for the treatment of PTSD in adults [efficacy at treatment endpoint based on NMA of continuous data (changes in PTSD symptoms scores); beneficial effect up to 3-month follow-up (obtained from NMA of continuous data at 1-4 month follow-up)]



Results were overall robust to the scenarios explored through deterministic analysis. The top 7 most cost-effective interventions remained the same, although in some of the analyses their ranking changed.

Analysis C: efficacy at treatment endpoint based on NMA of dichotomous remission data; no beneficial effect beyond treatment endpoint

The results of this analysis are provided in Table 201. In contrast to the other two analyses, non-TF-CBT was found to be the most effective and cost-effective intervention, followed by EMDR and TF-CBT individual 8-12 sessions. These were followed by IPT, SSRI, self-help without support, self-help with support, present-centered therapy, TF-CBT individual 8-12 sessions + SSRI, TF-CBT individual >12 sessions, counselling, TF-CBT group 8-12 sessions and no treatment. The probability of non-TF-CBT being the most cost-effective intervention was 0.38.

Table 201: Analysis C, results of economic modelling: interventions for the treatment of PTSD in adults [efficacy at treatment endpoint based on NMA of dichotomous remission data; no beneficial effect beyond treatment endpoint]

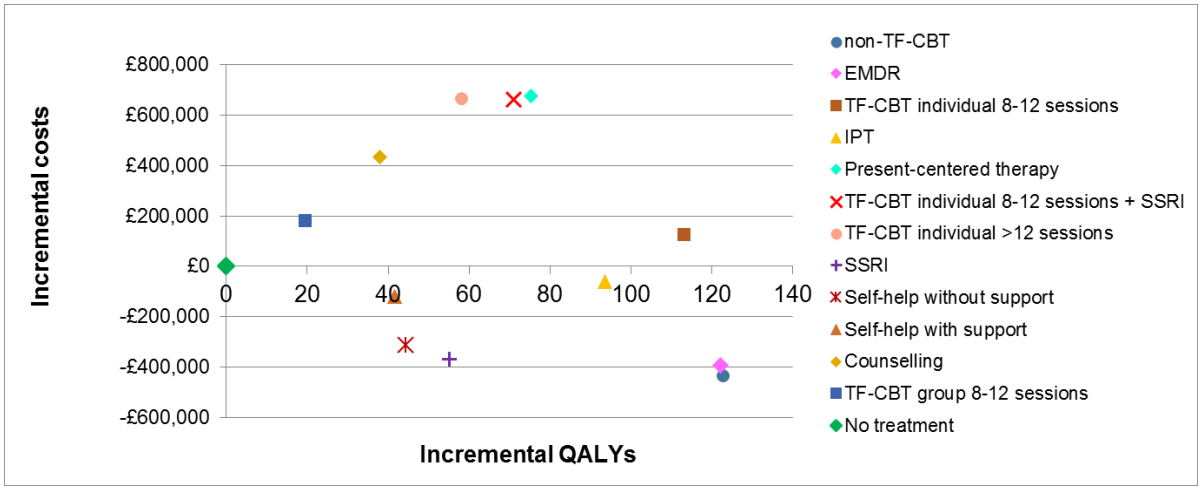
Intervention	Mean per person			ICER (£/QALY)	NMB £/ person	Prob best[1]	Mean rank
	QALY	Inter cost £	Total cost £				
non-TF-CBT	1.793	707	2,043		33,823	0.38	2.89
EMDR	1.793	746	2,084	Dominated	33,771	0.31	2.85
TF-CBT individual 8-12 sessions	1.784	1,180	2,602	Dominated	33,074	0.05	4.58
IPT	1.764	811	2,417	Dominated	32,866	0.10	5.13
SSRI	1.746	1,376	3,152	Dominated	31,768	0.01	8.50
SH without support	1.742	1,328	3,139	Dominated	31,694	0.02	8.83
SH with support	1.729	1,205	3,143	Dominated	31,434	0.00	9.32
Present-centered therapy	1.726	146	2,108	Dominated	32,408	0.06	5.70
TF-CBT individual 8-12 sessions + SSRI	1.715	98	2,164	Dominated	32,135	0.05	6.25
TF-CBT individual >12 sessions	1.712	265	2,356	Dominated	31,890	0.03	7.12
Counselling	1.709	785	2,910	Dominated	31,260	0.00	9.77
TF-CBT group 8-12 sessions	1.690	362	2,659	Dominated	31,143	0.00	9.89
No treatment	1.671	0	2,477	Dominated	30,936	0.00	10.18

1 at the NICE lower cost-effectiveness threshold of £20,000/QALY

EMDR: eye movement desensitisation reprocessing; ICER: incremental cost effectiveness ratio; Inter: intervention; NMB: net monetary benefit; Prob: probability; SH: self-help; SSRI: selective serotonin reuptake inhibitor; TF-CBT: trauma-focused cognitive behavioural therapy

Figure 706 provides the cost effectiveness plane of the analysis. Each intervention is placed on the plane according to its incremental costs and QALYs compared with no treatment.

Figure 706. Analysis C: Cost-effectiveness plane of interventions for the treatment of PTSD in adults [efficacy at treatment endpoint based on NMA of dichotomous remission data; no beneficial effect beyond treatment endpoint]



The CEAC and CEAF of the analysis are shown in Figure 707 and Figure 708, respectively.

Non-TF-CBT is the most cost-effective option at any cost effectiveness threshold between zero and £40,000/QALY, with a probability of being cost-effective of 0.38 at the NICE lower cost effectiveness threshold of £20,000/QALY.

Figure 707. Analysis C: Cost-effectiveness acceptability curves of interventions for the treatment of PTSD in adults [efficacy at treatment endpoint based on NMA of dichotomous remission data; no beneficial effect beyond treatment endpoint]

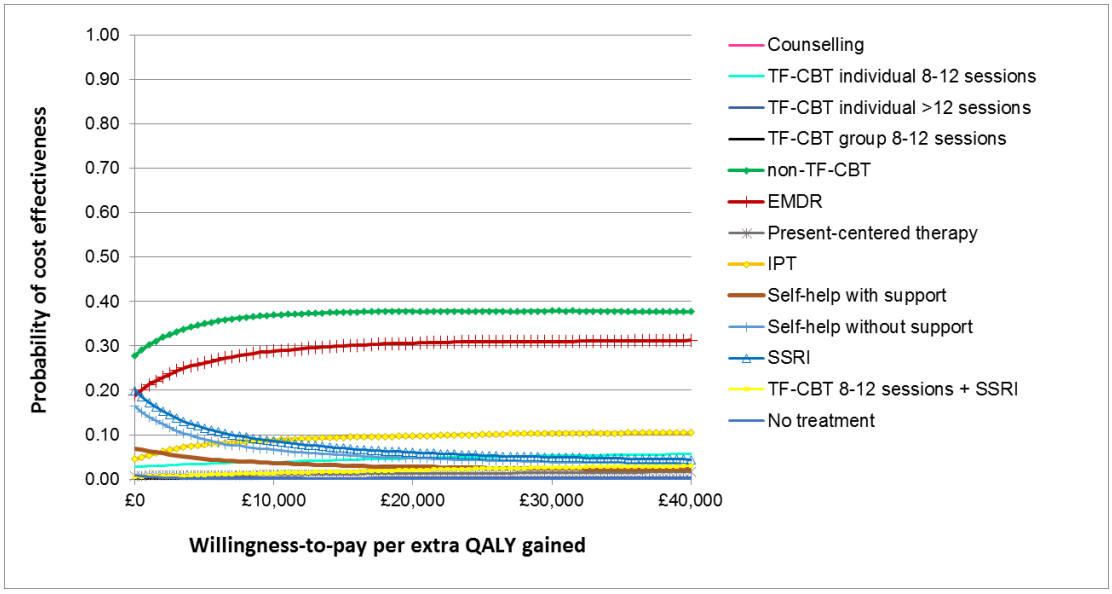
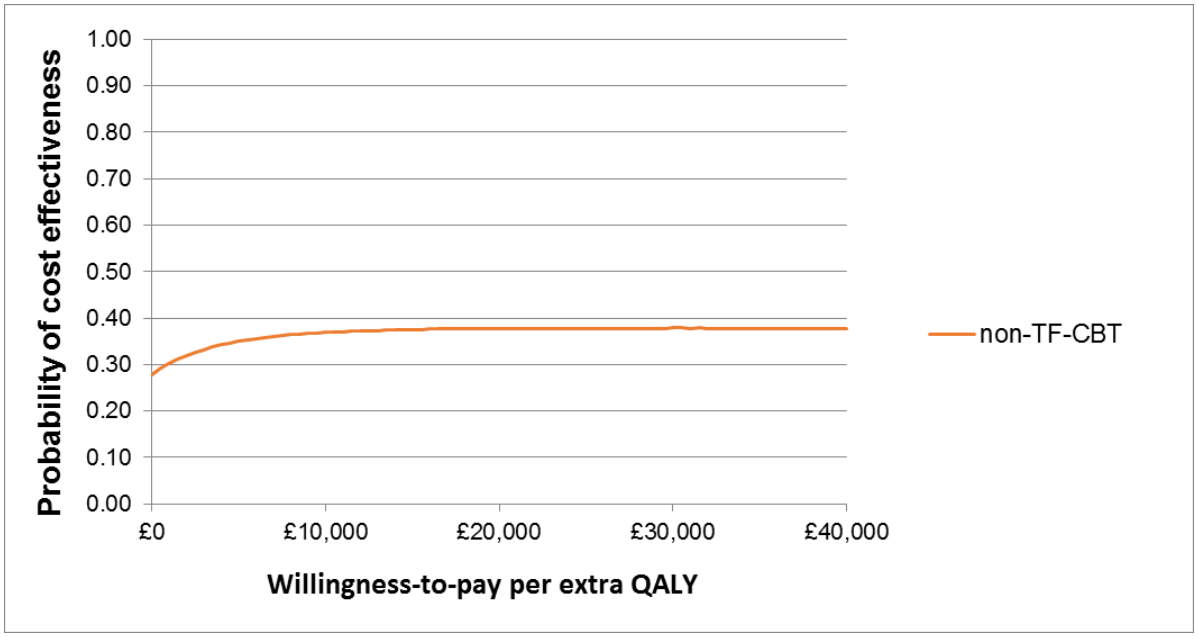


Figure 708 Analysis C: Cost-effectiveness acceptability frontier of interventions for the treatment of PTSD in adults [efficacy at treatment endpoint based on NMA of dichotomous remission data; no beneficial effect beyond treatment endpoint]



Results were overall robust to the scenarios tested through deterministic sensitivity analysis, and the top 7 most cost-effective interventions remained the same, with few changes in ranking. The relative cost effectiveness of TF-CBT individual 8-12 sessions improved when the cost of the PTSD health state was reduced by 50% and decreased when alternative utility data were used.

Discussion – conclusions, strengths and limitations of economic analysis

The guideline economic analysis assessed the cost effectiveness of a range of psychological interventions, as well as SSRIs and combined TF-CBT with SSRIs, for the treatment of PTSD in adults. The interventions assessed were determined by the availability of efficacy data obtained from the NMAs that were conducted to inform this guideline. TF-CBT interventions were categorised according to their mode of delivery in individual, group and mixed (where the intervention was delivered by a combination of individual and group sessions). Each of these categories was further subdivided, as relevant, to those comprising fewer than 8 sessions, 8-12 sessions, and more than 12 sessions, and were considered separately in the NMA and the economic analysis, to reflect the different intervention costs and, potentially, different efficacy associated with each sub-category.

The base-case analysis utilised continuous efficacy data at treatment endpoint, comprising changes in PTSD symptom scores, which were transformed to log-odds ratios of remission using a published formula; this analysis conservatively assumed that the beneficial effect of interventions lasts only until treatment endpoint and that after this period, the probability of remission is equal to that of baseline treatment (no treatment). An alternative scenario, which assumed a beneficial treatment effect of up to 3 months post-treatment (based on continuous follow-up data) was also explored in a second analysis. Finally, a third analysis which utilised more limited dichotomous efficacy data at treatment endpoint, and which also assumed no further treatment effect beyond treatment endpoint, was tested in an attempt to validate the conclusions of the base-case analysis. However, it needs to be noted that the definition of remission is different between this analysis and the base-case analysis: in the analysis that derived remission from continuous data (changes in PTSD symptom scale scores), remission was defined as a final score below a hypothetical cut-off point on a PTSD symptom scale with an underlying normal distribution. In contrast, in the analysis that utilised dichotomous remission data, remission was defined, in most studies, as loss of PTSD diagnosis using DSM, ICD or similar criteria, and, in a small number of studies, as a final score below a cut-off point on a PTSD symptom scale.

In the base-case analysis (which utilised continuous data at treatment endpoint and assumed no treatment effect beyond treatment endpoint), the order of interventions from the most to the least cost-effective for the treatment of PTSD in adults was: TF-CBT individual < 8 sessions, psychoeducation, EMDR, combined somatic and cognitive therapies, self-help with support, SSRI, TF-CBT individual 8-12 sessions, self-help without support, non-TF-CBT, IPT, present-centered therapy, TF-CBT group 8-12 sessions, combined TF-CBT individual 8-12 sessions + SSRI, no treatment, counselling, and TF-CBT individual >12 sessions. The probability of TF-CBT individual < 8 sessions being the most cost-effective treatment option was 0.26.

When a beneficial effect of up to 3 months post-treatment was assumed, there were no dramatic changes in the results; however, the relative cost effectiveness of combined somatic and cognitive therapies and, in a lesser degree, IPT and non-TF-CBT improved. The order of interventions became TF-CBT individual < 8 sessions, combined somatic and cognitive therapies, EMDR, psychoeducation, self-help with support, self-help without support, SSRI, IPT, non-TF-CBT, TF-CBT individual 8-12 sessions, TF-CBT individual >12 sessions, present-centered therapy, TF-CBT group 8-12 sessions, TF-CBT individual 8-12

sessions + SSRI, counselling, and no treatment. The probability of TF-CBT individual < 8 sessions being the most cost-effective treatment option was 0.14.

When dichotomous remission data were used, there were more important changes in the results with non-TF-CBT becoming the most effective and cost-effective intervention followed by EMDR, TF-CBT individual 8-12 sessions, IPT, SSRI, self-help without support, self-help with support, present-centered therapy, TF-CBT individual 8-12 sessions + SSRI, TF-CBT individual >12 sessions, counselling, TF-CBT group 8-12 sessions, and no treatment. The probability of non-TF-CBT being the most cost-effective treatment was 0.38.

Results of the economic analysis were robust to changes in input parameters tested in deterministic sensitivity analysis.

Overall, across the 3 analyses, TF-CBT individual < 8 sessions, psychoeducation, EMDR, combined somatic and cognitive therapies and self-help with support appear to be the most cost-effective interventions for the treatment of PTSD in adults, as they all ranked in the top 5 places in the base-case economic analysis and on at least one of the secondary analyses (it is noted that, with the exception of EMDR and self-help with support, dichotomous remission data were not available for the other 3 interventions and therefore these were not considered in the respective secondary economic analysis). TF-CBT individual > 12 sessions, counselling, combined TF-CBT + SSRI, group TF-CBT and present-centered therapy do not appear to be cost-effective relative to other active interventions assessed, as they all ranked in the bottom 5 places among active interventions in all 3 economic analyses. Counselling and TF-CBT individual > 12 sessions, in particular, were found to be less cost-effective than no treatment in the base-case analysis. In-between, there is another group of interventions (SSRIs, TF-CBT individual 8-12 sessions, self-help without support, non-TF-CBT, IPT) that occupied middle cost effectiveness rankings (i.e. places 6-10) in the 2 analyses that utilised continuous data at treatment endpoint; these interventions showed an improved cost effectiveness in the analysis that utilised dichotomous remission data at treatment endpoint, with non-TF-CBT becoming the most cost-effective option in this analysis; however, this secondary analysis utilised efficacy data from a more limited number of interventions and did not include 3 of the interventions that were shown to be among the most cost-effective options in the analyses that utilised continuous data at treatment endpoint (i.e. TF-CBT individual < 8 sessions, psychoeducation, and combined somatic and cognitive therapies).

One thing worth noting is that increasing the number of sessions of individual TF-CBT does not appear to translate into higher efficacy or cost effectiveness, as shown in the results of the NMA and the economic analysis, respectively. However, this may be attributable to the populations in the studies assessing individual TF-CBT of different intensity: it is likely that participants who were recruited in trials that assessed a higher number of individual TF-CBT sessions had also more severe symptoms of PTSD at baseline, and therefore might have a more limited response to treatment compared with participants in trials that tested a smaller number of individual TF-CBT sessions. It is also worth noting that group TF-CBT does not appear to be effective or cost-effective relative to individual forms of TF-CBT in adults with PTSD.

The analysis utilised clinical effectiveness parameters derived from NMAs. This methodology enabled evidence synthesis from both direct and indirect comparisons between interventions, and allowed simultaneous inference on all treatments examined in pair-wise trial comparisons while respecting randomisation (Caldwell et al., 2005; Lu & Ades, 2004). The

quality and limitations of RCTs considered in the NMAs have unavoidably impacted on the quality of the economic model clinical input parameters. For example, economic results may be have been affected by reporting and publication bias.

Effects for some interventions were informed by limited evidence: TF-CBT group 8-12 sessions, present centered therapy and IPT were tested on 57, 99 and 55 individuals, respectively, regarding the change in PTSD symptoms scores at treatment endpoint. In the outcome of remission, non-TF-CBT, TF-CBT group 8-12 sessions, IPT, present-centered therapy, self-help without support, SSRI and TF-CBT individual 8-12 sessions + SSRI were tested on fewer than 100 participants each. Even more limited evidence was available in the NMA of continuous follow-up data: effects for combined somatic and cognitive therapies, IPT and self-help without support were based on data from fewer than 50 participants for each intervention, whereas effects for TF-CBT individual >12 sessions, present-centered therapy and self-help with support were based on data from 50-100 participants each. It should be noted that TF-CBT individual 8-12 sessions had the most robust evidence base across all outcomes assessed in NMA.

It is also noted that, regarding changes in continuous PTSD symptoms scores at treatment endpoint, psychoeducation has been tested on 152 participants across 2 trials. However, the relative effect of psychoeducation versus no treatment in the respective NMA of continuous was in fact determined by data reported in one trial (Chambers 2014), in which psychoeducation (tested on 131 participants) was compared with TF-CBT individual < 8 sessions. In that trial, psychoeducation had a moderately lower effect than its comparator, which was marginally statistically significant. However, the effect of TF-CBT individual < 8 sessions versus waitlist was very large in the NMA and this resulted in a rather large relative effect of psychoeducation versus waitlist as well (median odds ratio 39.45), which, combined with its low intervention cost, determined its high cost effectiveness in the economic analysis. It is worth noting that the effect of psychoeducation versus wait list was characterised by particularly high uncertainty, as indicated by its very wide 95% credible intervals (1.07 to 1,589.22).

Global inconsistency checks and further inconsistency checks through node-splitting indicated that there was no inconsistency between direct and indirect evidence considered in the NMA that utilised continuous data at treatment endpoint (changes in PTSD symptom scale scores). In contrast, some evidence of inconsistency was identified in the NMA of continuous data at 1-4 month follow-up (which was utilised in analysis B) and the NMA of dichotomous remission data at treatment endpoint (which was utilised in analysis C). Therefore, economic analysis A appears to be the only one that utilised NMA data with no inconsistency between direct and indirect evidence. Moreover, heterogeneity across all NMAs was found to be high. It is also noted that the relative effects of most interventions versus waitlist were very large and characterised, in many cases, by considerably wide 95% credible intervals. These findings need to be taken into account when interpreting the results of the NMAs but also the cost effectiveness results.

The economic model did not consider discontinuation in the model structure due to the relatively limited discontinuation data available. However, for the NMA that informed the economic analysis, ITT continuous data were extracted, where available. This means that discontinuation has been implicitly taken into account in the economic model outcomes. Moreover, the probabilistic analysis took into account the completion rates of the

interventions assessed in the RCTs that informed the economic analysis, so that the number of sessions reflected, up to a degree, the attrition rates characterising each intervention.

The baseline risk of remission was estimated based on 664 people aged 16-85 years, who participated in the 2007 Australian National Survey of Mental Health and Wellbeing and had experienced PTSD at some point in their life. The risk of relapse was not possible to estimate using published evidence, and therefore was based on an assumption following the committee's advice. However, a range of values was tested in deterministic sensitivity analysis. Other data, such as the increased risk of death associated with PTSD, and the risk of developing common side effects from SSRIs were based on published evidence.

The time horizon of the analysis was 3 years, which were considered adequate to capture longer terms and costs associated with a course of treatment for PTSD without significant extrapolation over the course of PTSD.

Utility data used in the economic model were derived from a systematic review of studies reporting utility data for PTSD-related health states. The review included three studies. One study met the NICE preferences for the type of utility data to be used in economic evaluation. However, these data were deemed unsuitable by the committee, due to concerns on the eligibility of the study participants. The economic analysis considered utility data from one study on adults with and without current PTSD diagnosis, who participated in a national mental health survey in Australia and provided HRQoL ratings that were transformed into utility data using the AQoL-4D preference-based measure; deterministic sensitivity analysis used SF-6D utility data derived from veterans with and without PTSD in the US.

Intervention costs were estimated based on relevant information provided in the studies included in the NMA supplemented by the committee's expert opinion, in order to reflect routine NHS practice.

NHS and PSS costs incurred by adults with PTSD and those remitting from PTSD were based on resource use data reported in the most recent (2014) Adult Psychiatric Morbidity Survey conducted in England for people with PTSD and people without PTSD, combined with the committee's expert opinion, other published sources of relevant resource use data and national unit costs. The committee determined the exact resource use associated with each resource use component (e.g. number of visits to health professionals), due to lack of any relevant information. This exercise determined the costs of the PTSD and the no PTSD health states, which were estimated to approximate £1,173 and £110, respectively, per annum.

According to a cost of illness study conducted in Northern Ireland (Ferry et al., 2015), the total direct NHS/PSS cost incurred by people with PTSD in Northern Ireland was 32,975,590 in 2008 prices, and 74,935 people were estimated to have PTSD within 12 months. This translates to a cost per person with PTSD of £518 in 2017 prices, which is a figure considerably lower than that estimated for the guideline economic analysis for adults with PTSD (£1,173). However, the study used a different methodology for the estimation of costs, which may justify, at least partially, the difference between the two figures. On the other hand, annual cost figures for children with PTSD and children recovering from PTSD reported for children (Shearer et al., 2018) [£2,596 and £1,114, respectively] are considerably higher that the respective figures estimated for adults with PTSD in the guideline economic analysis. However, these costs for children were estimated for participants in a RCT, where all utilised healthcare resources. In contrast, the figures

estimated for the guideline economic analysis for adults with/without PTSD were based on survey data, in which a significant proportion of people did not receive any treatment for their mental or emotional problem. In any case, deterministic analysis explored the impact of a ± 50% change in the NHS/PSS cost of the PTSD health state on the results of the economic analysis.

Overall conclusions from the guideline economic analysis

The guideline base-case economic analysis suggests that TF-CBT individual < 8 sessions, psychoeducation, EMDR, combined somatic and cognitive therapies and self-help with support are the 5 most cost-effective interventions for the treatment of PTSD in adults. TF-CBT individual > 12 sessions, counselling, combined TF-CBT + SSRI, group TF-CBT and present-centered therapy appear to be less cost-effective relative to other active interventions. Counselling and TF-CBT individual > 12 sessions were also found to be less cost-effective than no treatment in the base-case analysis. In-between, there is another group of interventions (SSRIs, TF-CBT individual 8-12 sessions, self-help without support, non-TF-CBT, IPT) that occupied middle cost effectiveness rankings (i.e. places 6-10) in the base-case analysis.

The result for psychoeducation, which was found to be among the most cost-effective interventions, should be interpreted with great caution due to limitations in the evidence base and the considerably high uncertainty characterising its efficacy estimate. Moreover, the NMA that informed the base-case analysis was characterised by high between-study heterogeneity, as well as large effects and considerable uncertainty for some interventions, and this should be taken into account when interpreting the results of the analysis.

Results from the alternative scenarios explored in the other two analyses (i.e. consideration of efficacy data derived from the NMAs of continuous 1-4 month follow-up data and of dichotomous remission data) are somewhat different from the base-case analysis, in particular those derived from use of dichotomous remission data, which included a smaller number of interventions due to unavailability of relevant data; the results from these analyses should be interpreted with caution due to the limitations characterising the respective evidence base and the NMAs that informed them (limited evidence base, evidence of inconsistency between direct and indirect evidence, high heterogeneity, large effects and considerable uncertainty for some interventions).

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Appendix K – Excluded studies

Excluded studies for "For adults with clinically important post-traumatic stress symptoms, what are the relative benefits and harms of psychological, psychosocial or other non-pharmacological interventions targeted at PTSD symptoms?"

Clinical studies

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Acosta 2017	RQ 1.1-1.2 & 2.1-2.2 update	Efficacy or safety data cannot be extracted	Acosta MC, Possemato K, Maisto SA, Marsch LA, Barrie K, Lantinga L, Fong C, Xie H, Grabinski M, Rosenblum A. Web-delivered CBT reduces heavy drinking in OEF-OIF veterans in primary care with symptomatic substance use and PTSD. Behavior therapy. 2017 Mar 31;48(2):262-76.	
Adenauer 2011/Catani 2010	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Sample size (N<10/arm)	Adenauer H, Catani C, Gola H, Keil J, Ruf M, Schauer M, Neuner F. Narrative exposure therapy for PTSD increases top-down processing of aversive stimuli-evidence from a randomized controlled treatment trial. BMC neuroscience. 2011 Dec 19;12(1):127.	Catani C, Neuner F. Change of Neural Network Indicators Through Narrative Treatment of PTSD in Torture Victims [NCT00563888]. 2010. Available from: https://clinicaltrials.gov/ct2/show/NCT00563888 [accessed 28.07.2017]
Aderka 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Aderka IM, Gillihan SJ, McLean CP, Foa EB. The relationship between posttraumatic and depressive symptoms during prolonged exposure with and without cognitive restructuring for	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			the treatment of posttraumatic stress disorder. Journal of consulting and clinical psychology. 2013 Jun;81(3):375.	
Adler 2008	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Population outside scope: Trials of soldiers on active service	Adler AB, Litz BT, Castro CA, Suvak M, Thomas JL, Burrell L, McGurk D, Wright KM, Bliese PD. A group randomized trial of critical incident stress debriefing provided to US peacekeepers. Journal of traumatic stress. 2008 Jun 1;21(3):253-63.	
Ahmadi 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Population outside scope: Trials of soldiers on active service	Ahmadi K, Hazrati M, Ahmadizadeh M, Noohi S. REM desensitization as a new therapeutic method for post-traumatic stress disorder: a randomized controlled trial. Acta Medica Indonesiana. 2015;47(2).	
Albright 2010	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Albright DL, Thyer B. Does EMDR reduce post-traumatic stress disorder symptomatology in combat veterans?. Behavioral Interventions. 2010 Feb 1;25(1):1-9.	
Allan 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Efficacy or safety data cannot be extracted	Allan NP, Short NA, Albanese BJ, Keough ME, Schmidt NB. Direct and mediating effects of an anxiety sensitivity intervention on posttraumatic stress disorder symptoms in trauma-exposed individuals. Cognitive behaviour	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			therapy. 2015 Nov 2;44(6):512-24.	
Amir 2008	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Sample size (N<10/arm)	Amir N. Information Processing Modification in the Treatment of PTSD [NCT00604045]. 2014. Available from: https://clinicaltrials.gov/ct2/show/study/NCT00604045 [accessed 08.08.2017]	
Anderson 2010	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Efficacy or safety data cannot be extracted	Anderson T, Fende Guajardo J, Luthra R, Edwards KM. Effects of clinician-assisted emotional disclosure for sexual assault survivors: A pilot study. Journal of interpersonal violence. 2010 Jun;25(6):1113-31.	
Anderson 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis that is not relevant	Anderson ML, Najavits LM. Does seeking safety reduce PTSD symptoms in women receiving physical disability compensation?. Rehabilitation psychology. 2014 Aug;59(3):349.	
Andersson 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Comparison outside scope	Andersson MA, Conley CS. Optimizing the perceived benefits and health outcomes of writing about traumatic life events. Stress and Health. 2013 Feb 1;29(1):40-9.	
Andre 1997	2004 GL (excluded)	Non-English language paper	Andre, C., Lelord, F., Legeron, P., Reignier, A., & Delattre, A. (1997). Effectiveness of early intervention on 132 bus drivers who have	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			been victims of aggression: A controlled study. Encephale, 23, 65-71.	
Angelakis 2010	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Unpublished (registered on clinical trials registry and author contacted for full trial report but not provided)	Angelakis, S. The utility of combining cognitive processing therapy and behavioural activation for individuals with comorbid posttraumatic stress disorder and major depressive disorders: Is there added benefit to combining treatments? 2010. Available from: https://www.anzctr.org.au/Trial/Registration/TrialReview.aspx?ACTRN=12611000541909 [accessed 26.07.2017]	
Anonymous 2004	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Paper unavailable	NCT00055354. Acupuncture Diagnosis and Treatment of DSM-IV PTSD. Available from: https://clinicaltrials.gov/ct2/show/NCT00055354 [accessed 26.07.2017]	
Arabia 2011	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Efficacy or safety data cannot be extracted	Arabia E, Manca ML, Solomon RM. EMDR for survivors of life-threatening cardiac events: results of a pilot study. Journal of EMDR Practice and Research. 2011 Feb 1;5(1):2-13.	
Arntz 2007	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Comparison outside scope	Arntz A, Tiesema M, Kindt M. Treatment of PTSD: A comparison of imaginal exposure with and without imagery rescripting. Journal of behavior	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			therapy and experimental psychiatry. 2007 Dec 31;38(4):345-70.	
Arroyo 2017	RQ 1.1-1.2 & 2.1-2.2 update	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Arroyo K, Lundahl B, Butters R, Vanderloo M, Wood DS. Short-term interventions for survivors of intimate partner violence: a systematic review and meta-analysis. Trauma, Violence, & Abuse. 2017 Apr;18(2):155-71.	
Augedal 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Augedal AW, Hansen KS, Kronhaug CR, Harvey AG, Pallesen S. Randomized controlled trials of psychological and pharmacological treatments for nightmares: A meta-analysis. Sleep Medicine Reviews. 2013 Apr 30;17(2):143-52.	
Back 2011	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Unpublished (registered on clinical trials.gov and author contacted for full trial report but not provided)	Back, S. Integrated Treatment of OEF/OIF Veterans With PTSD & Substance Use Disorders (COPE). NCT01338506. 2011. Available from: https://clinicaltrials.gov/ct2/show/NCT01338506 [accessed 26.07.2017]	
Badour 2017	RQ 1.1-1.2 & 2.1-2.2 update	Subgroup/secondary analysis that is not relevant	Badour CL, Flanagan JC, Gros DF, Killeen T, Pericot-Valverde I, Korte KJ, Allan NP, Back SE. Habituation of distress and craving during treatment as predictors of change in PTSD symptoms and substance use	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			severity. Journal of consulting and clinical psychology. 2017 Mar;85(3):274.	
Badura-Brack 2018	RQ 1.1-1.2 & 2.1-2.2 update	Subgroup/secondary analysis of RCT already included	Badura-Brack A, McDermott TJ, Becker KM, Ryan TJ, Khanna MM, Pine DS, Bar-Haim Y, Heinrichs-Graham E, Wilson TW. Attention training modulates resting-state neurophysiological abnormalities in posttraumatic stress disorder. Psychiatry Research: Neuroimaging. 2018 Jan 30;271:135-41.	
Banerjee 2007	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention not targeted at PTSD symptoms	Banerjee, B., Vadiraj, H. S., Ram, A., Rao, R., Jayapal, M., Gopinath, K. S., Ramesh, B. S., Rao, N., Kumar, A., Raghuram, N., Hegde, S., Nagendra, H. R., Prakash Hande, M. (2007) Effects of an integrated yoga program in modulating psychological stress and radiation-induced genotoxic stress in breast cancer patients undergoing radiotherapy, Integrative Cancer Therapies, 6, 242-250	
Banks 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Banks K, Newman E, Saleem J. An overview of the research on mindfulness-based interventions for treating symptoms of posttraumatic stress disorder: A systematic review. Journal of	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			clinical psychology. 2015 Oct 1;71(10):935-63.	
Banos 2011	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention not targeted at PTSD symptoms	Baños RM, Guillen V, Quero S, Garcia-Palacios A, Alcaniz M, Botella C. A virtual reality system for the treatment of stress-related disorders: A preliminary analysis of efficacy compared to a standard cognitive behavioral program. International Journal of Human-Computer Studies. 2011 Aug 31;69(9):602-13.	
Barabasz 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Non-randomised group assignment	Barabasz A, Barabasz M, Christensen C, French B, Watkins JG. Efficacy of single-session abreactive ego state therapy for combat stress injury, PTSD, and ASD. International Journal of Clinical and Experimental Hypnosis. 2013 Jan 1;61(1):1-9.	
Barrera 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Barrera, TL.; Mott, JM.; Hofstein, RF.; Teng, EJ.; (2013) A meta-analytic review of exposure in group cognitive behavioral therapy for posttraumatic stress disorder. Clin Psych Rev 33 (1): 24-32	
Barton 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Barton, S.; Karner, C.; Salih, F.; Baldwin, DS.; Edwards, SJ.; (2014) Clinical effectiveness of interventions for treatment-resisitant anxiety in older people:	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			a systematic review. Health Tech Ass 18 (50): 1366-5278	
Basoglu (unpublished)	2004 GL (excluded)	Paper unavailable	Basoglu, M., Salcioglu, E., Livanou, M., Kalender, D., Acar, G. Single-session behavioral treatment of earthquake-related posttraumatic stress disorder: A randomized waitlist controlled trial. Journal of Traumatic Stress (in press).	
Basoglu 2003	2004 GL (excluded)	Non-RCT (no control group)	Basoglu, M., Livanou, M., Salcioglu, E., & Kalender, D. (2003). A brief behavioural treatment of chronic post-traumatic stress disorder in earthquake survivors: results from an open clinical trial. Psychol.Med, 33, 647-654.	
Battersby 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Population not relevant for this review (to be considered for other relevant RQ)	Battersby MW, Beattie J, Pols RG, Smith DP, Condon J, Blunden S. A randomised controlled trial of the Flinders Program™ of chronic condition management in Vietnam veterans with co-morbid alcohol misuse, and psychiatric and medical conditions. Australian & New Zealand Journal of Psychiatry. 2013 May;47(5):451-62.	
Bean 2017	RQ 1.1-1.2 & 2.1-2.2 update	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Bean RC, Ong CW, Lee J, Twohig MP. Acceptance and commitment therapy for PTSD and trauma: An	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			empirical review. The Behavior Therapist. 2017;4,145-150.	
Beatty 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Comparison outside scope	Beatty L, Koczwara B, Wade T. Evaluating the efficacy of a self-guided Web-based CBT intervention for reducing cancer-distress: a randomised controlled trial. Supportive Care in Cancer. 2016 Mar 1;24(3):1043-51.	
Beidel 2011	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Comparison outside scope	Beidel DC, Frueh BC, Uhde TW, Wong N, Mentrikoski JM. Multicomponent behavioral treatment for chronic combat-related posttraumatic stress disorder: A randomized controlled trial. Journal of anxiety disorders. 2011 Mar 31;25(2):224-31.	
Beidel 2017	RQ 1.1-1.2 & 2.1-2.2 (searches combined) AND Cochrane allRQ update	Comparison outside scope	Beidel DC, Frueh BC, Neer SM, Bowers CA, Trachik B, Uhde TW, Grubaugh A. Trauma management therapy with virtual-reality augmented exposure therapy for combat-related PTSD: A randomized controlled trial. Journal of anxiety disorders. 2017 Aug 23.	
Bekker 2007	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Bekker, MHJ.; van Mens-Verhulst J.; (2007) Anxiety Disorders: Sex Differences in Prevalence, Degree and Background, But Gender-Neutral Treatment. Gender Med 4 (S2): S178-S193.	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Belleau 2017	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Efficacy or safety data cannot be extracted	Belleau EL, Chin EG, Wanklyn SG, Zambrano-Vazquez L, Schumacher JA, Coffey SF. Pre-treatment predictors of dropout from prolonged exposure therapy in patients with chronic posttraumatic stress disorder and comorbid substance use disorders. Behaviour Research and Therapy. 2017 Apr 30;91:43-50.	
Benish 2008	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Benish, SG.; Imel, ZE.; Wampold, BE.; (2008) The relative efficacy of bona fide psychotherapies for treating post-traumatic stress disorder: A meta-analysis of direct comparisons.	
Bergen-Cico 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Outcomes are not of interest	Bergen-Cico D, Possemato K, Pigeon W. Reductions in cortisol associated with primary care brief mindfulness program for veterans with PTSD. Medical Care. 2014 Dec 1;52:S25-31.	
Berlim 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Berlim, MT.; Wan den Eynde, F.; (2014) Repetitive Transcranial Magnetic Stimulation over the Dorsolateral Prefrontal Cortex for Treating Posttraumatic Stress Disorder: An Exploratory Meta-Analysis of Randomized Double-Blind and Sham-Controlled Trials. The Canadian J of Psychiartry 59 (9)	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Bichescu 2007	ISTSS included lists	Sample size (N<10/arm)	Bichescu D, Neuner F, Schauer M, Elbert T. Narrative exposure therapy for political imprisonment-related chronic posttraumatic stress disorder and depression. Behaviour research and therapy. 2007 Sep 30;45(9):2212-20.	
Bisson 2005	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Bisson, J.; Andrew,; Psychological treatment of post-traumatic stress disorder (PTSD) (2007)Cochrane Database of Systematic Reviews	
Bisson 2007	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Bisson, JI.; Ehlers, A.; Matthews, R.; Pilling, S.; Richards, D.; Turner, S.; (2007) Psychological treatments for chronic post-traumatic stress disorder. Systematic review and meta-analysis. British J Psych 190: 97-104	
Bisson 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Bisson, J.; Roberts, NP.; Andre, M.; Cooper, R.; Lewis, C.; (2013). Psychological therapies for chronic post-traumatice stress disorder (PTSD) in adults. Cochrane Database of Systematic Reviews	
Boals 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Non-randomised group assignment	Boals A, Murrell AR. I am> trauma: Experimentally reducing event centrality and PTSD symptoms in a clinical trial. Journal of Loss and Trauma. 2016 Nov 1;21(6):471-83.	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Boccia 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Boccia, M.; Piccardi, L.; Cordellieri, P.; Guariglia, C.; Giannini, AM.; (2015) EMDR therapy for PTSD after motor vehicle accidents: meta-analytic evidence for specific treatment. Front Hum Neurosci 9: 213	
Boden 2012/2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Non-randomised group assignment	Boden MT, Kimerling R, Jacobs-Lentz J, Bowman D, Weaver C, Carney D, Walser R, Trafton JA. Seeking Safety treatment for male veterans with a substance use disorder and post-traumatic stress disorder symptomatology. Addiction. 2012 Mar 1;107(3):578-86.	Boden MT, Kimerling R, Kulkarni M, Bonn-Miller MO, Weaver C, Trafton J. Coping among military veterans with PTSD in substance use disorder treatment. Journal of substance abuse treatment. 2014 Aug 31;47(2):160-7.
Boggio 2010	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Efficacy or safety data cannot be extracted	Boggio PS, Rocha M, Oliveira MO, Fecteau S, Cohen RB, Campanhã C, Ferreira-Santos E, Meleiro A, Corchs F, Zaghi S, Pascual-Leone A. Noninvasive brain stimulation with high-frequency and low-intensity repetitive transcranial magnetic stimulation treatment for posttraumatic stress disorder. The Journal of clinical psychiatry. 2010 Aug;71(8):992.	
Bolton 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Bolton, AJ.; Dorstyn, DS.; (2015) Telepsychology for Posttraumatic Stress Disorder: A Systematic reivew. J Telemedicine and Telecare 21 (5)	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Bomyea 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Comparison outside scope	Bomyea J, Stein MB, Lang AJ. Interference control training for PTSD: A randomized controlled trial of a novel computer-based intervention. Journal of anxiety disorders. 2015 Aug 31;34:33-42.	
Bomyea 2017	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention not targeted at PTSD symptoms	Bomyea J, Lang AJ, Schnurr PP. TBI and Treatment Response in a Randomized Trial of Acceptance and Commitment Therapy. The Journal of head trauma rehabilitation. 2017 Jan.	
Bordow 1979	2004 GL (excluded)	Non-randomised group assignment	Bordow, S. & Porritt, D. (1979). An experimental evaluation of crisis intervention. Social Science & Medicine, 13A, 251-256.	
Boritz 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention not targeted at PTSD symptoms	Boritz T, Barnhart R, McMain SF. The influence of posttraumatic stress disorder on treatment outcomes of patients with borderline personality disorder. Journal of personality disorders. 2016 Jun;30(3):395-407.	
Bottche 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined) AND Cochrane allRQ update	Subgroup/secondary analysis of RCT already included	Böttche M, Kuwert P, Pietrzak RH, Knaevelsrud C. Predictors of outcome of an Internet-based cognitive-behavioural therapy for post-traumatic stress disorder in older adults. Psychology and Psychotherapy: Theory, Research and Practice. 2016 Mar 1;89(1):82-96.	
Boudewyns 1990	2004 GL (excluded)	Intervention not targeted at PTSD symptoms	Boudewyns, P.A.; Hyer, L. (1990) Physiological response to combat	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			memories and preliminary treatment outcome in Vietnam veteren PTSD patients treated with direct therapeutic exposure. Behavior Therapy, 21, 63-87	
Bowland 2012	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention not targeted at PTSD symptoms	Bowland S, Edmond T, Fallot RD. Evaluation of a spiritually focused intervention with older trauma survivors. Social work. 2012 Jan 1;57(1):73-82.	
Bradley 2003	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Population outside scope: Trials of adults in contact with the criminal justice system (not solely as a result of being a witness or victim)	Bradley, RG.; Follingstad DR.; (2003) Group Therapy for Incarcerated Women Who Experienced Interpersonal Violence: A Pilot Study. J Trau Stress 16(4):337-340	
Bradley 2005	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Bradley, R.; Greene, J.; Russ, E.; Dutra, L.; Westen, D.; (2005) A Multidimensional Meta-Analysis of Psychotherapy for PTSD. Am J Psych 162 (2): 214-227	
Bradshaw 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Sample size (N<10/arm)	Bradshaw RA, McDonald MJ, Grace R, Detwiler L, Austin K. A randomized clinical trial of Observed and Experiential Integration (OEI): A simple, innovative intervention for affect regulation in clients with PTSD. Traumatology. 2014 Sep;20(3):161.	
Bremner 2017	RQ 1.1-1.2 & 2.1-2.2 update	Sample size (N<10/arm)	Bremner JD, Mishra S, Campanella C, Shah M, Kasher	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			N, Evans S, Fani N, Shah AJ, Reiff C, Davis LL, Vaccarino V and Carmody J (2017) A Pilot Study of the Effects of Mindfulness-Based Stress Reduction on Post-traumatic Stress Disorder Symptoms and Brain Response to Traumatic Reminders of Combat in Operation Enduring Freedom/Operation Iraqi Freedom Combat Veterans with Post-traumatic Stress Disorder. Front. Psychiatry 8:157. doi: 10.3389/fpsyt.2017.00157	
Brief 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention not targeted at PTSD symptoms	Brief DJ, Rubin A, Keane TM, Enggasser JL, Roy M, Helmuth E, Hermos J, Lachowicz M, Rybin D, Rosenbloom D. Web intervention for OEF/OIF veterans with problem drinking and PTSD symptoms: A randomized clinical trial. Journal of consulting and clinical psychology. 2013 Oct;81(5):890.	
Brom 1989	2004 GL (included)	Population outside scope: Trials of people with traumatic grief	Brom, D., Kleber, R. J., & Defares, P. B. (1989). Brief psychotherapy for posttraumatic stress disorders. Journal of Consulting & Clinical Psychology, 57, 607-612.	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Brown 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention not targeted at PTSD symptoms	Brown LA, Craske MG, Glenn DE, Stein MB, Sullivan G, Sherbourne C, Bystritsky A, Welch SS, Campbell-Sills L, Lang A, Roy-Byrne P. CBT competence in novice therapists improves anxiety outcomes. Depression and anxiety. 2013 Feb 1;30(2):97-115.	
Brown 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Efficacy or safety data cannot be extracted	Brown AJ, Bollini AM, Craighead LW, Astin MC, Norrholm SD, Bradley B. Self-Monitoring of Reexperiencing Symptoms: A Randomized Trial. Journal of traumatic stress. 2014 Oct 1;27(5):519-25.	
Bryant 2008b	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Comparison outside scope	Bryant RA, Moulds ML, Guthrie RM, Dang ST, Mastrodomenico J, Nixon RD, Felmingham KL, Hopwood S, Creamer M. A randomized controlled trial of exposure therapy and cognitive restructuring for posttraumatic stress disorder. Journal of consulting and clinical psychology. 2008 Aug;76(4):695.	
Bryant 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Paper unavailable	Bryant RA, Mastrodomenico J, Hopwood S, Kenny L, Cahill C, Kandris E, Taylor K. Augmenting cognitive behaviour therapy for post-traumatic stress disorder with emotion tolerance training: a randomized controlled trial. FOCUS. 2013 Jul;11(3):379-86.	
Butollo 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Comparison outside scope	Butollo W, Karl R, König J, Rosner R. A Randomized Controlled Clinical Trial of Dialogical Exposure Therapy versus Cognitive Processing Therapy for Adult Outpatients Suffering from PTSD after Type I	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			Trauma in Adulthood. Psychotherapy and psychosomatics. 2016;85(1):16-26.	
Cabral 2011	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Cabral, P.; Meyer, HB.; Ames, D.; (2011) Effectiveness of Yoga Therapy as a Complementary Treatment for Major Psychiatric Disorders: A Meta-Analysis . Primary Care Companion for CNS Disorders 13 (4)	
Carlson 2013/2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention not targeted at PTSD symptoms	Carlson LE, Doll R, Stephen J, Faris P, Tamagawa R, Drysdale E, Speca M. Randomized controlled trial of mindfulness-based cancer recovery versus supportive expressive group therapy for distressed survivors of breast cancer (MINDSET). Journal of clinical oncology. 2013 Aug 5;31(25):3119-26.	Carlson LE, Tamagawa R, Stephen J, Drysdale E, Zhong L, Speca M. Randomized-controlled trial of mindfulness-based cancer recovery versus supportive expressive group therapy among distressed breast cancer survivors (MINDSET): long-term follow-up results. Psycho-Oncology. 2016 Jul 1;25(7):750-9.
Carlson 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis that is not relevant	Carlson, L.E., Tamagawa, R., Stephen, J., Doll, R., Faris, P., Dirkse, D. and Speca, M., 2014. Tailoring mind-body therapies to individual needs: patients' program preference and psychological traits as moderators of the effects of mindfulness-based cancer recovery and supportive-expressive therapy in distressed breast cancer survivors. Journal of the National	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			Cancer Institute Monographs, 2014(50), pp.308-314.	
Carpenter 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Efficacy or safety data cannot be extracted	Carpenter KM, Stoner SA, Schmitz K, McGregor BA, Doorenbos AZ. An online stress management workbook for breast cancer. Journal of behavioral medicine. 2014 Jun 1;37(3):458-68.	
Carter 2006b	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Paper unavailable	Carter JJ. A controlled breathing course promoting social and emotional health for Vietnam veterans with chronic posttraumatic stress disorder - A randomised controlled trial [NCT00256477]. 2006. Available from: https://clinicaltrials.gov/ct2/show/NCT00256477 [accessed 28.07.2017]	
Carter 2006a	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Design: Non-randomised group assignment	Carter J, Byrne G. A two year study of the use of yoga in a series of pilot studies as an adjunct to ordinary psychiatric treatment in a group of Vietnam War veterans suffering from post traumatic stress disorder. Online document at: www. Therapywithyoga. com Accessed November. 2004;27.	
Carter 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Efficacy or safety data cannot be extracted	Carter J, Gerbarg PL, Brown RP, Ware RS, D'Ambrosio C. Multi-component yoga breath program	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			for Vietnam veteran post traumatic stress disorder: randomized controlled trial. J Trauma Stress Disor Treat 2. 2013;3:2.	
Casement 2012	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Casement, MD.; Swanson, LM.; (2012) A meta-analysis of imagery rehearsal for post-traumatic nightmares: Effects on nightmare frequency, sleep quality and posttraumatic stress. Clinical Psychology Review. 32 (6): 566-574	
Chemtob 1997b	2004 GL (excluded)	Sample size (N<10/arm)	Chemtob, C. M., Novaco, R. W., Hamada, R. S., & Gross, D. M. (1997). Cognitive-behavioral treatment for severe anger in posttraumatic stress disorder. Journal of Consulting & Clinical Psychology, 65, 184-189	
Chen 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Chen, Y-R.; Hung, K-W.; Tsai, J-C.; Chu, H.; Chung, M-H.; Chen, S-R.; Liao, Y-M.; Ou, K-L.; Chang, Y-C.; Chou, K-R.; (2014) Efficacy of Eye-Movement Desensitization and Reprocessing for patients with Posttraumatic-Stress Disorder: A Meta-Analysis of Randomized Controlled Trials. PLOS-One 9 (8)	
Chen 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Chen, L.; Zhang, G.; Hu M.; Liang, X.; (2015) Eye Movement Desensitization and Reprocessing	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			Versus Cognitive-Behavioural Therapy for Adult Posttraumatic Stress Disorder: Systematic Review and Meta-Analysis. J of Nervous and Mental Disease. 203 (6):443-451	
Chiesa 2010	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Chiesa, A.; (2010) Vipassana Meditation: Systematic Review of Current Evidence. The Jornal of Alternative and Complementary Medicine 16 (1): 37-46	
Christensen 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Efficacy or safety data cannot be extracted	Christensen C, Barabasz A, Barabasz M. Efficacy of abreactive ego state therapy for PTSD: Trauma resolution, depression, and anxiety. International Journal of Clinical and Experimental Hypnosis. 2013 Jan 1;61(1):20-37.	
Church 2016b	Handsearch	Sample size (N<10/arm)	Church D, Yount G, Rachlin K, Fox L, Nelms J. Epigenetic Effects of PTSD Remediation in Veterans Using Clinical Emotional Freedom Techniques: A Randomized Controlled Pilot Study. American Journal of Health Promotion. 2016 Aug 12:0890117116661154.	
Cimpianu 2017	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Cimpianu, C-L.; Strube, W.; Falkai, P.; Palm, U.; Hasan, A.; (2017) Vagus nerve stimulation in psychiarty: a systematic review of the available evidence. J Nerual Transmission 124 (1): 145-158	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Clarke 2008	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Clarke SB, Rizvi SL, Resick PA. Borderline personality characteristics and treatment outcome in cognitive-behavioral treatments for PTSD in female rape victims. Behavior therapy. 2008 Mar 31;39(1):72-8.	
Classen 2001	2004 GL (included)	Efficacy or safety data cannot be extracted	Classen, C., Koopman, C., Nevill-Manning, K., & Spiegel, D. (2001). A preliminary report comparing trauma-focused and present-focused group therapy against a wait-listed condition among childhood sexual abuse survivors with PTSD. Journal of Aggression, Maltreatment & Trauma, 4, 265-288.	
Clausen 2012	RQ 5.1_5.2_adhoc	Non-RCT (no control group)	Clausen, J., Ruff, S., Von Wiederhold, W., Heineman, T. (2012) For as long as it takes: Relationship-based play therapy for children in foster care, Psychoanalytic Social Work, 19, 43-53	
Cloitre 2012	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Cloitre M, Petkova E, Wang J. An examination of the influence of a sequential treatment on the course and impact of dissociation among women with PTSD related to childhood abuse. Depression and Anxiety. 2012 Aug 1;29(8):709-17.	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Cloitre 2017	RQ 1.1-1.2 & 2.1-2.2 update	Subgroup/secondary analysis of RCT already included	Cloitre M, Garvert DW, Weiss BJ. Depression as a moderator of STAIR Narrative Therapy for women with post-traumatic stress disorder related to childhood abuse. European journal of psychotraumatology. 2017 Jan 1;8(1):1377028.	
Clond 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Clond, M.; (2016) Emotional Freedom Techniques for Anxiety: A Systematic Review With Meta-analysis. J of Nervous and Mental disease 204 (5):388-395	
Connolly 2013	Handsearch	Non-randomised group assignment	Connolly SM, Roe-Sepowitz D, Sakai C, Edwards J. Utilizing community resources to treat PTSD: A randomized controlled study using Thought Field Therapy. African J Trauma Studies. 2013;3:24-32.	
Coffey 2006	Handsearch	Sample size (N<10/arm)	Coffey SF, Stasiewicz PR, Hughes PM, Brimo ML. Trauma-focused imaginal exposure for individuals with comorbid posttraumatic stress disorder and alcohol dependence: Revealing mechanisms of alcohol craving in a cue reactivity paradigm. Psychology of Addictive Behaviors. 2006 Dec;20(4):425.	
Cohen 2004b	RQ 1.1-1.2 & 2.1-2.2 (searches combined) AND	Sample size (N<10/arm)	Cohen, H., Kaplan, Z., Kotler, M., Kouperman, I., Moisa, R., & Grisaru, N. (2004). Repetitive	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
	2004 GL (included)		transcranial magnetic stimulation of the right dorsolateral prefrontal cortex in posttraumatic stress disorder: a double-blind, placebo-controlled study. American Journal of Psychiatry, 161(3), 515-524.	
Cook 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis that is not relevant	Cook JM, Thompson R, Harb GC, Ross RJ. Cognitive− behavioral treatment for posttraumatic nightmares: An investigation of predictors of dropout and outcome. Psychological Trauma: Theory, Research, Practice, and Policy. 2013 Nov;5(6):545.	
Cooper 1989	2004 GL (included)	Sample size (N<10/arm)	Cooper, N.A.; Clum, G.A. (1989) Imaginal flooding as a supplimentary treatment for PTSD in combat veterens: a controlled study. Behavior Therapy, 20, 381-391	
Cooper 2017a	RQ 1.1-1.2 & 2.1-2.2 update	Subgroup/secondary analysis that is not relevant	Cooper AA, Kline AC, Graham B, Bedard-Gilligan M, Mello PG, Feeny NC, Zoellner LA. Homework “dose,” type, and helpfulness as predictors of clinical outcomes in prolonged exposure for PTSD. Behavior therapy. 2017 Mar 1;48(2):182-94.	
Cooper 2017b	RQ 1.1-1.2 & 2.1-2.2 update	Subgroup/secondary analysis that is not relevant	Cooper AA, Zoellner LA, Roy-Byrne P, Mavissakalian MR, Feeny NC. Do changes in trauma-	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			related beliefs predict PTSD symptom improvement in prolonged exposure and sertraline?. Journal of consulting and clinical psychology. 2017 Sep;85(9):873.	
Cort 2012	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Cort NA, Gamble SA, Smith PN, Chaudron LH, Lu N, He H, Talbot NL. Predictors of treatment outcomes among depressed women with childhood sexual abuse histories. Depression and anxiety. 2012 Jun 1;29(6):479-86.	
Craft 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention not targeted at PTSD symptoms	Craft MA, Davis GC, Paulson RM. Expressive writing in early breast cancer survivors. Journal of Advanced Nursing. 2013 Feb 1;69(2):305-15.	
Craske 2011	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention outside scope	Craske MG, Stein MB, Sullivan G, Sherbourne C, Bystritsky A, Rose RD, Lang AJ, Welch S, Campbell-Sills L, Golinelli D, Roy-Byrne P. Disorder-specific impact of coordinated anxiety learning and management treatment for anxiety disorders in primary care. Archives of General Psychiatry. 2011 Apr 4;68(4):378-88.	
Crawford 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Outcomes are not of interest	Crawford JJ, Vallance JK, Holt NL, Steed H, Courneya KS. A phase I/II pilot study assessing the preliminary efficacy of wall climbing for improving	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			posttraumatic growth and quality of life in gynecologic cancer survivors. Mental Health and Physical Activity. 2016 Oct 31;11:60-6.	
Crespo 2010	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Non-randomised group assignment	Crespo M, Arinero M. Assessment of the efficacy of a psychological treatment for women victims of violence by their intimate male partner. The Spanish journal of psychology. 2010 Nov;13(2):849-63.	
Crumlish 2010	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Crumlish, N.; O'Rourke, K.; (2010) A systematic review of treatments for post-traumatic stress disorder among refugees and asylum-seekers. J Nervous and Mental Disease 198 (4): 237-251	
Cuijpers 2009	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Cuijpers, P.; Marks, IM.; Van Straten, A.; Cavanagh, K.; Gega, L.; Andersson, G.; (2009) Computer-Aided Psychotherapy for Anxiety Disorders: A Meta-Analytic Review. Cog Beh Therapy 38(2): 66-82	
Cuijpers 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Cuijpers, P.; Sijbrandij, M.; Koole, SL.; Andersson, G.; Beekman, AT.; Reynolds, CF.; (2013) The efficacy of psychotherapy and pharmacotherapy in treating depressive and anxiety disorders: a meta-analysis of direct	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			comparisons. World Psychiatry 12 (2): 137-148	
Cusack 1999	2004 GL (excluded)	Non-randomised group assignment	Cusack, K. & Spates, C. R. (1999). The cognitive dismantling of Eye Movement Desensitization and Reprocessing (EMDR) treatment of Posttraumatic Stress Disorder (PTSD). Journal of Anxiety Disorders, 13, 87-99.	
Cusack 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Cusack, K.; Jonas, DE.; Forneris, CA.; Wines, C.; Sonis, J.; Middleton, JC.; Feltner, C.; Brownley, KA.; Olmsted, KR.; Greenblatt, A.; Weil, A.; Gaynes, BN.; (2016) Psychological treamtents for adults with posttraumatic stress disorder: A systematic review and meta-analysis. Clin Pscy Rev 43: 128-141	
Cyniak-Cieciura 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Cyniak-Cieciura M, Popiel A, Zawadzki B. General self-efficacy level and changes in negative postttraumatic cognitions and posttraumatic stress disorder (PTSD) symptoms among motor vehicle accident survivors after PTSD therapy. Psychol Stud. 2015;53:18-29.	
Da Silva	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Da Silva, TL.; Ravindran, LN.; Ravindran, AV.; (2009) Yoga in the treatment of mood and anxiety disorders: A review. Asian J Psychiatry 2 (1): 6-16	
Dalton 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Efficacy or safety data cannot be extracted	Dalton EJ, Greenman PS, Classen CC, Johnson SM. Nurturing connections in the aftermath of childhood trauma: A randomized controlled trial of emotionally focused couple therapy for female survivors of childhood abuse. Couple and	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			Family Psychology: Research and Practice. 2013 Sep;2(3):209.	
Deacon 2004	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Deacon, BJ.; Abramowitz, JS.; (2004) Cognitive and behavioral treatmetns for anxiety disorders: A review of meta-analytic findings. J Clin Psyh 60 (4): 429-441	
Detweiler 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Sample size (N<10/arm)	Detweiler MB, Lane S, Spencer L, Lutgens B, Halling MH, Rudder TF, Lehmann L. Horticultural therapy: A pilot study on modulating cortisol levels and indices of substance craving, posttraumatic stress disorder, depression, and quality of life in veterans. Alternative therapies in health and medicine. 2015 Jul 1;21(4):36.	
Devilly 1998	2004 GL (excluded)	Non-randomised group assignment	Devilly, G. J., Spence, S. H., & Rapee, R. M. (1998). Statistical and reliable change with eye movement desensitization and reprocessing: Treating trauma within a veteran population. Behavior Therapy, 29, 435-455.	
Devilly 1999	2004 GL (included)	Non-randomised group assignment	Devilly GJ, Spence SH. The relative efficacy and treatment distress of EMDR and a cognitive-behavior trauma treatment protocol in the amelioration of posttraumatic stress disorder. Journal of anxiety disorders. 1999 Apr 30;13(1):131-57.	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Devilly 2001	ISTSS included lists	Non-RCT (no control group)	Devilly GJ. The successful treatment of PTSD through overt cognitive behavioral therapy in non-responders to EMDR. Behavioural and Cognitive Psychotherapy. 2001 Jan;29(1):57-70.	
Diehle 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Diehle, J.; Schmitt, K.; Daams, JG.; Boer, F.; Lindauer, RJL.; (2014) Effects of Psychotherapy on Trauma-Related Cognitions in Posttraumatic Stress Disorder: A Meta-Analysis. J Traumatic Stress 27 (3): 257-264	
Difede 2007a	Handsearch	Sample size (N<10/arm)	Difede J, Cukor J, Jayasinghe N, Patt I, Jedel S, Spielman L, Giosan C, Hoffman HG. Virtual reality exposure therapy for the treatment of posttraumatic stress disorder following September 11, 2001. Journal of Clinical Psychiatry. 2007 Nov 11;68(11):1639.	
DiMauro 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	DiMauro, J.; (2014) Exposure Therapy for Posttraumatic Stress Disorder: A Meta-Analysis. Military Psychology 26(2):120-130	
Dinnen 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Dinnen, S.; Simiola, V.; Cook, JM.; (2014) Post-traumatic stress disorder in older adults: a systematic review of the psychotherapy treatment	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			literature. Aging and Mental Health 19 (2): 144-150	
Dodds 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Efficacy or safety data cannot be extracted	Dodds SE, Pace TW, Bell ML, Fiero M, Negi LT, Raison CL, Weihs KL. Feasibility of Cognitively-Based Compassion Training (CBCT) for breast cancer survivors: a randomized, wait list controlled pilot study. Supportive Care in Cancer. 2015 Dec 1;23(12):3599-608.	
Dorrepaal 2010	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Non-RCT (no control group)	Dorrepaal E, Thomaes K, Smit JH, van Balkom AJ, van Dyck R, Veltman DJ, Draijer N. Stabilizing group treatment for complex posttraumatic stress disorder related to childhood abuse based on psycho-education and cognitive behavioral therapy: A pilot study. Child Abuse & Neglect. 2010 Apr 30;34(4):284-8.	
Dorrepaal 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Dorrepaal E, Thomaes K, Smit JH, Veltman DJ, Hoogendoorn AW, van Balkom AJ, Draijer N. Treatment compliance and effectiveness in complex PTSD patients with co-morbid personality disorder undergoing stabilizing cognitive behavioral group treatment: A preliminary study. European journal of psychotraumatology. 2013 Dec 1;4(1):21171.	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Dorrepaal 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Dorrepaal, E.; Thomaes, K.; Hoogendoorn, AW.; Veltman, DJ.; Drijer, N.; Van Balkom, AJLM.; (2014) Evidence-based treatment for adult women with child abouse-related Complex PTSD: a quantitative review. Eur J Psychotraumatology 5(1):	
Dossa 2012	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Dossa, NI.; Hatem, M.; (2012) Cognitive-Behavioral Therapy versus Other PTSD Psychotherapies as Treatmetn for Women Victims of War-Related Violence: A Systematic Review. The Scientific World Journal:ID, 181847	
Drožđek 2010	Handsearch	Non-randomised group assignment	Drožđek B, Bolwerk N. Evaluation of group therapy with traumatized asylum seekers and refugees—The Den Bosch Model. Traumatology. 2010 Dec;16(4):117.	
Drožđek 2012	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Non-randomised group assignment	Droždek B, Kamperman AM, Bolwerk N, Tol WA, Kleber RJ. Group therapy with male asylum seekers and refugees with posttraumatic stress disorder: A controlled comparison cohort study of three day-treatment programs. The Journal of nervous and mental disease. 2012 Sep 1;200(9):758-65.	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Drummond 2009	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Comparison outside scope	Drummond SP. Treating Insomnia & Nightmares After Trauma: Impact on Symptoms & Quality of Life [NCT01009112]. Available from: https://clinicaltrials.gov/ct2/show/NCT01009112 [accessed 08.08.2017]	
Duan-Porter 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Duan-Porter, W.; Coeytaux, RR.; McDuffie, JR.; Goode, AP.; Sharma, P.; Mennella, H.; Nagi, A.; Williams, JW.; (2016) Evidence Map of Yoga for Depression, Anxiety and Posttraumatic Stress Disorder. J Phsyical Activity Health 13: 281-288	
Dybdahl 2001	2004 GL (excluded)	Efficacy or safety data cannot be extracted	Dybdahl, R. (2001) Children and mothers in war: an outcome study of a psychosocial intervention program. Child Development, 72, 4, 1214-1230	
Echeburua 1996	2004 GL (included)	Non-randomised group assignment	Echeburua, E; Corral, P.; Sarasua, B; Zubizarreta, I. (1996) Treatment of acute posttraumatic stress disorder in rape victims: an experimental study. Journal of Anxiety Disorders, 10, 3, 185-199	
Echeburua 1997	2004 GL (included)	Sample size (N<10/arm)	Echeburua, E., de Corral, P., Zubizarreta, I., & Sarasua, B. (1997). Psychological treatment of chronic posttraumatic stress disorder in victims of sexual	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			aggression. Behavior Modification, 21, 433- 456.	
Edzard 2012	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Edzard, E.; Snyder, J.; Dunlop, RA.; (2012) National Centre for Complementary and Alternative Medicine-funded randomised controlled trials of acupuncture: a systematic review. Focus on Alternative and Complementary Therapies, 17(1):15-22.	
Ehring 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Ehring, T.; Welboren, R.; Morina, N.; Wicherts, JM.; Freitag, J.; Emmelkamp, PMG.; (2014) Meta-analysis of psychological treatments for posttraumatic stress disorder in adult survivors of childhood abuse. Clin Pscyh Rev 34(8):645-657	
Elkjaer 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention not targeted at PTSD symptoms	Elkjaer H, Kristensen E, Mortensen EL, Poulsen S, Lau M. Analytic versus systemic group therapy for women with a history of child sexual abuse: 1-Year follow-up of a randomized controlled trial. Psychology and Psychotherapy: Theory, Research and Practice. 2014 Jun 1;87(2):191-208.	
Engel 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Population outside scope: Trials of soldiers on active service	Engel CC, Litz B, Magruder KM, Harper E, Gore K, Stein N, Yeager D, Liu X, Coe TR. Delivery of self training and education for stressful situations (DESTRESS-PC): a randomized trial of nurse assisted online self-management for PTSD in primary care. General hospital psychiatry. 2015 Aug 31;37(4):323-8.	
Erford 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Erford, BT.; Gunther, C.; Duncan, K.; Bardhoshi, G.; Dummett, B.; Kraft, J.; Deferio, K.; Falco, M.; Ross, M.; (2016) Meta-Analysis of Counseling Outcomes for the	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			Treatment of Posttraumatic Stress Dissorder. J Couns Devplt 94 (1); 13-30	
Erickson 2007	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Population outside scope: <80% of the study's participants are eligible for the review and disaggregated data cannot be obtained	Erickson DH, Janeck AS, Tallman K. A cognitive-behavioral group for patients with various anxiety disorders. Psychiatric Services. 2007 Sep;58(9):1205-11.	
Falsetti 2001	2004 GL (excluded)	Cross-over study and first phase data not available	Falsetti, S.A.; Resnick, H.S. & Gallagher, N.G. (2001) Treatment of posttraumatic stress disorder with comorbid panic attacks: combining cognitive processing therapy with panic control treatment techniques. Group Dynamics: Theory, Research, and Practice, 5, 4, 252-260	
Feeny 2002	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Non-randomised group assignment	Feeny, CC.; Zoellner, LA.; Foa, EB.; (2002) Treatment Outcome for Chronic PTSD Among Gemal Assault Victims with Borderline Personality Characteristics: A Preliminary Examination. J Personality Disorders 16 (1): 30-40	
Feeny 2004	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Unpublished (registered on clinical trials.gov and author contacted for full trial report but not provided)	NCT00127673. Effectiveness of PTSD Treatment: CBT Versus Sertraline. Available from: https://clinicaltrials.gov/show/NCT00127673 [accessed 06.01.17]	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Felmingham 2012	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Comparison outside scope	Felmingham KL, Bryant RA. Gender differences in the maintenance of response to cognitive behavior therapy for posttraumatic stress disorder. Journal of Consulting and Clinical Psychology. 2012 Apr;80(2):196.	
Fernandez 2008	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention not targeted at PTSD symptoms	Fernández I, Páez D. The benefits of expressive writing after the Madrid terrorist attack: Implications for emotional activation and positive affect. British Journal of Health Psychology. 2008 Feb 1;13(1):31-4.	
Feske 2008	ISTSS included lists	Sample size (N<10/arm)	Feske U. Treating low-income and minority women with posttraumatic stress disorder: A pilot study comparing prolonged exposure and treatment as usual conducted by community therapists. Journal of interpersonal violence. 2008 Aug;23(8):1027-40.	
Fetzner 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Comparison outside scope	Fetzner MG, Asmundson GJ. Aerobic exercise reduces symptoms of posttraumatic stress disorder: A randomized controlled trial. Cognitive behaviour therapy. 2015 Jul 4;44(4):301-13.	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Foa (unpublished)	2004 GL (excluded)	Paper unavailable	Foa, E.B.; Zoellner, L.A. & Feeny, N.C. (unpublished) Recovery after trauma.	
Foa 1999	2004 GL (included)	Non-randomised group assignment	Foa, EB.; Dancu CV.; Hembree EX.; Joycos LH.; Meadows EA.; Street,GP.; A comparison of exposure therapy, stress incoulation training, and their combination for reducing postraumatic stress disorder in female assult victims (1999). J Consult and Clin Psy 67 (2): 194-200	
Foa 2004	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Outcomes are not of interest	Foa EB, Rauch SA. Cognitive changes during prolonged exposure versus prolonged exposure plus cognitive restructuring in female assault survivors with posttraumatic stress disorder. Journal of consulting and clinical psychology. 2004 Oct;72(5):879.	
Forbes 1994	2004 GL (excluded)	Non-randomised group assignment	Forbes, D.; Creamer, M.; Rycroft, P. (1994) Eye movement desensitization and reprocessing in posttraumatic stress disorder: a pilot study using assessment measures. Journal of Behaviour Therapy & Experimental Psychiatry, 25, 2, 113-120	
Forbes 2001	2004 GL (excluded)	Non-randomised group assignment	Forbes, D., Phelps, A., & McHugh, T. (2001). Treatment of combat-related nightmares using	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			imagery rehearsal: a pilot study. Journal of Traumatic Stress, 14, 433-442	
Ford 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Efficacy or safety data cannot be extracted	Ford J, Rosman L, Wuensch K, Irvine J, Sears SF. Cognitive–Behavioral Treatment of Posttraumatic Stress in Patients With Implantable Cardioverter Defibrillators: Results From a Randomized Controlled Trial. Journal of traumatic stress. 2016 Aug 1;29(4):388-92.	
Forman 2012	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention not targeted at PTSD symptoms	Forman EM, Shaw JA, Goetter EM, Herbert JD, Park JA, Yuen EK. Long-term follow-up of a randomized controlled trial comparing acceptance and commitment therapy and standard cognitive behavior therapy for anxiety and depression. Behavior Therapy. 2012 Dec 31;43(4):801-11.	
Forshay 2011	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Protocol	Forshay, E. Cognitive Behavioral Therapy (CBT) for PTSD in Veterans With Co-Occurring SUDs [NCT01357577]. Available from: https://clinicaltrials.gov/ct2/show/NCT01357577 [accessed 02.08.2017]	
Frank 1998b	2004 GL (excluded)	Non-randomised group assignment	Frank, E.; Anderson, B.; Stewart, B.D.; Dancu, C.; Hughes, C.; West, D. (1988) Efficacy of	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			cognitive behavior therpy and systematic desensitization in the treatment of rape trauma. Behavior therapy, 19, 403-420	
Franklin 2017	RQ 1.1-1.2 & 2.1-2.2 (searches combined) AND RQ 1.1-1.2 & 2.1-2.2 update	Sample size (N<10/arm)	Franklin CL, Cuccurullo LA, Walton JL, Arseneau JR, Petersen NJ. Face to face but not in the same place: A pilot study of prolonged exposure therapy. Journal of Trauma & Dissociation. 2017 Jan 1;18(1):116-30.	
Fredette 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Fredette, C.; El-Baalbaki, G.; Palardy, V.; Rizkallah, E.; Guay, S.; (2016) Social support and cognitive-behavioral therapy for posttraumatic stress disorder: A systematic review. Traumatology 22(2): 131-144.	
Fredman 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined) AND Cochrane allRQ update	Subgroup/secondary analysis that is not relevant	Fredman SJ, Pukay-Martin ND, Macdonald A, Wagner AC, Vorstenbosch V, Monson CM. Partner accommodation moderates treatment outcomes for couple therapy for posttraumatic stress disorder. Journal of consulting and clinical psychology. 2016 Jan;84(1):79.	
Frisman 2008	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Non-randomised group assignment	Frisman L, Ford J, Lin HJ, Mallon S, Chang R. Outcomes of trauma treatment using the TARGET model. Journal of Groups in Addiction & Recovery. 2008 Nov 3;3(3-4):285-303.	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Frommberger 2004	RQ 1.1-1.2 & 2.1-2.2 AND RQ 4.1-4.2	Sample size (N<10/arm)	Frommberger U, Stieglitz RD, Nyberg E, Richter H, Novelli-Fischer U, Angenendt J, Zaninelli R, Berger M. Comparison between paroxetine and behaviour therapy in patients with posttraumatic stress disorder (PTSD): a pilot study. International Journal of Psychiatry in Clinical Practice. 2004 Jan 1;8(1):19-23.	
Frost 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Frost, ND.; Laska, KM.; Wampold, BE.; (2014) The Evidence for Present-Centred Therapy as a Treatmetn for Posttraumatic Stress Disorder. J Trau Stress 27(1):1-8	
Frueh 1996	2004 GL (excluded)	Non-randomised group assignment	Frueh, B.C.; Turner, S.T.; Beidel, D.C.; Mirabella, R.F.; Jones, W.J. (1996) Trauma management therapy: a preliminary evaluation of a multicomponent behavioral treatment for combat-related PTSD. Behavior Research & Therapy, 34, 7, 533-543	
Gallagher 2012	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Gallagher MW, Resick PA. Mechanisms of change in cognitive processing therapy and prolonged exposure therapy for PTSD: Preliminary evidence for the differential effects of hopelessness and habituation.	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			Cognitive therapy and research. 2012 Dec 1;36(6):750-5.	
Gallegos 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Gallegos AM, Streltzov NA, Stecker T. Improving Treatment Engagement for Returning Operation Enduring Freedom and Operation Iraqi Freedom Veterans With Posttraumatic Stress Disorder, Depression, and Suicidal Ideation. The Journal of nervous and mental disease. 2016 May 1;204(5):339-43.	
Gallegos 2017	RQ 1.1-1.2 & 2.1-2.2 update	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Gallegos AM, Crean HF, Pigeon WR, Heffner KL. Meditation and yoga for posttraumatic stress disorder: A meta-analytic review of randomized controlled trials. Clinical psychology review. 2017 Oct 31.	
Galovski 2009	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Galovski TE, Monson C, Bruce SE, Resick PA. Does cognitive–behavioral therapy for PTSD improve perceived health and sleep impairment?. Journal of traumatic stress. 2009 Jun 1;22(3):197-204.	
Galovski 2012	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Cross-over study and first phase data not available	Galovski TE, Blain LM, Mott JM, Elwood L, Houle T. Manualized therapy for PTSD: Flexing the structure of cognitive processing therapy. Journal of consulting and clinical psychology. 2012 Dec;80(6):968.	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Galovski 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis that is not relevant	Galovski TE, Elwood LS, Blain LM, Resick PA. Changes in anger in relationship to responsivity to PTSD treatment. Psychological trauma: theory, research, practice, and policy. 2014 Jan;6(1):56.	
Gamito 2010	ISTSS included lists	Sample size (N<10/arm)	Gamito P, Oliveira J, Rosa P, Morais D, Duarte N, Oliveira S, Saraiva T. PTSD elderly war veterans: A clinical controlled pilot study. Cyberpsychology, Behavior, and Social Networking. 2010 Feb 1;13(1):43-8.	
Geiger-Brown 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Geiger-Brown, JM.; Rogers, VE.; Liu, W.; Ludeman, EM.; Downton, KD.; Diaz-Abad, M.; (2015) Cognitive behavioral therapy in persons with comorbid insomnia: A meta-analysis. Sleep Medicine Reviews 23:54-67	
Gelkopf 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Outcome measures are not validated	Gelkopf M, Hasson-Ohayon I, Bikman M, Kravetz S. Nature adventure rehabilitation for combat-related posttraumatic chronic stress disorder: A randomized control trial. Psychiatry research. 2013 Oct 30;209(3):485-93.	
Gerardi 2010	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Gerardi M, Rothbaum BO, Astin MC, Kelley M. Cortisol response following exposure treatment for PTSD in rape victims. Journal of aggression, maltreatment &	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			trauma. 2010 May 27;19(4):349-56.	
Gerger 2014a	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Gerger, H.; Munder, T.; Barth, J.; (2014) Specific and Nonspecific psychological Interventions for PTSD Symptoms: A Meta-analysis with Problem Complexity as a Moderator. J Clink Psych 70(7): 601-615.	
Gerger 2014b	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Gerger, H.; Munder, T.; Gemperli, A.; Nuesch, E.; Trelle, S.; Juni, P.; Barth,J.; (2014) Integrating fragmented evidence by network meta-analysis: relative effectiveness of psychological interventions for adults with post-traumatic stress disorder. Pscyh Med 44(15): 3151-3164	
Germain 2009	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Non-randomised group assignment	Germain, V.; Marchand, A.; Bouchard, S.; Drouin, MS.; Guay, S.; (2009) Effectiveness of Cognitive Behavioural Therapy Administered by Videoconference for Posttraumatic Stress Disorder. Cog Behav Therapy 38 (1): 42-53	
Gham 2010	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Population outside scope: Trials of soldiers on active service	Gham GA, Reger G. Comparing Virtual Reality Exposure Therapy to Prolonged Exposure in the Treatment of Soldiers With PTSD [NCT01193725]. 2010. Available from: https://clinicaltrials.gov/ct2/show/N	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			CT01193725 [accessed 02.08.2017]	
Ginzburg 2009	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Ginzburg K, Butler LD, Giese-Davis J, Cavanaugh CE, Neri E, Koopman C, Classen CC, Spiegel D. Shame, guilt, and posttraumatic stress disorder in adult survivors of childhood sexual abuse at risk for human immunodeficiency virus: outcomes of a randomized clinical trial of group psychotherapy treatment. The Journal of nervous and mental disease. 2009 Jul 1;197(7):536-42.	
Glavin 2017	RQ 1.1-1.2 & 2.1-2.2 update	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Glavin CE, Montgomery P. Creative bibliotherapy for post-traumatic stress disorder (PTSD): a systematic review. Journal of Poetry Therapy. 2017 Apr 3;30(2):95-107.	
Glynn 1999	2004 GL (excluded)	Efficacy or safety data cannot be extracted	Glynn, S. M., Eth, S., Randolph, E. T., Foy, D. W., Urbaitis, M., Boxer, L. et al. (1999). A test of behavioral family therapy to augment exposure for combat-related posttraumatic stress disorder. Journal of Consulting & Clinical Psychology, 67, 243-251.	
Goetter 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Goetter, EM.; bui, E.; Ojserkis, RA.; Zakarian, RJ.; Brendel, RW.; Simon, NM.; (2015) A systematic Review of Dropout From	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			Psychotherapy for Posttraumatic Stress disorder Among Iraq and Afanistan Combat Veterans. J Traum Stress 28(5): 401-409	
Goncalves 2011	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Goncalves, R.; Lages, AC.; Rodrigues, H.; Pedrozo, AL.; Coutinho, ESF.; Neylan, T.; Figueira, I.; Ventura, P.; (2011) Potenciais biomarcadores da terapia cognitivo-comportamental para o transtorno de estresse pos-traumatico: uma revisao sistematica. Arch of Clin Psyh	
Gonclaves 2012	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Gancalves, R.; Pedrozo, AL.; Coutinho, ESF.; Figueria, I.; Ventura, P.; (2012) Efficacy of Virtual Reality Exposure Therapy in the Treatment of PTSD: A Systematic Review. PLoS ONE 7(12): e48469.	
Goodson 2011	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Goodson, J.; Helstrom, A.; Halpern,JM.; Ferenschak, MP.; Gillihan,SJ.; Powers, MB.; (2011) Treatment of Posttraumatic Stress Disorder in U.S. Combat Veterans: A Meta-Analytic Review. Pscyh Reports 109(2): 573-599	
Grainger 1997	2004 GL (excluded)	Efficacy or safety data cannot be extracted	Grainger, R.D.; Levin, C.; Allen-Byrd, L.; Doctor, R.M., Lee, H. (1997) An empirical evaluation of eye movement desensitization and reprocessing (EMDR) with	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			survivors of a natural disaster. Journal of Traumatic Stress, 10, 4, 665-671	
Green 2006	RQ 4.1-4.2 (maximizing sensitivity)	Intervention not targeted at PTSD symptoms	Green BL, Krupnick JL, Chung J, Siddique J, Krause ED, Revicki D, Frank L, Miranda J. Impact of PTSD comorbidity on one-year outcomes in a depression trial. Journal of clinical psychology. 2006 Jul 1;62(7):815-35.	
Gregg 2007	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Non-systematic review	Gregg, L.; Tarrier, N.; (2007) Virtual realisty in mental health. Social Psychiatry and Psychiactric Epidimilogy 42(5):343-354	
Griffiths 2010	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Non-systematic review	Griffiths, KM.; Farrer, L.; Christensen, H.; (2010) The efficacy of internet interventions for depression and anxiety disorders: a review of randomised controlled trials. MJA 192:S4-S11	
Grist 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Grist, R.; Cavanagh, K.; (2013) Computerised Cognitive Behavioural Therapy for Common Mental Health Disorders, What Works, for Whom Under What Circumstances? A Systematic Review and Meta-analysis. J Contemporary Pscyhotherapy 43(4):243-251	
Gutner 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Gutner CA, Casement MD, Gilbert KS, Resick PA. Change in sleep symptoms across cognitive	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			processing therapy and prolonged exposure: a longitudinal perspective. Behaviour research and therapy. 2013 Dec 31;51(12):817-22.	
Gutner 2016a	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Non-primary study	Gutner CA, Gallagher MW, Baker AS, Sloan DM, Resick PA. Time course of treatment dropout in cognitive–behavioral therapies for posttraumatic stress disorder. Psychological Trauma: Theory, Research, Practice, and Policy. 2016 Jan;8(1):115.	
Gutner 2016b	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Gutner CA, Suvak MK, Sloan DM, Resick PA. Does timing matter? Examining the impact of session timing on outcome. Journal of consulting and clinical psychology. 2016 Dec;84(12):1108.	
Gwodzdziewycz 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Gwozdziewycz, N.; Mehl-Madrona, L.; (2013) Meta-Analysis of the Use of Narrative Exposure Therapy for the Effects of Trauma Among Refuge Populations. Permanente Journal 17(1): 70-76	
Haagen 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Haagen, JFG.; Smid, GE.; Knipscgeer, JW.; Kleber, RJ.; (2015) The efficacy of recommended treatmetns for veterans with PTSD: A metaregression analysis	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Haagen 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis that is not relevant	Haagen JF, Heide F, Mooren TM, Knipscheer JW, Kleber RJ. Predicting post-traumatic stress disorder treatment response in refugees: Multilevel analysis. British Journal of Clinical Psychology. 2017 Mar 1;56(1):69-83.	
Halvorsen 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis that is not relevant	Halvorsen JØ, Stenmark H, Neuner F, Nordahl HM. Does dissociation moderate treatment outcomes of narrative exposure therapy for PTSD? A secondary analysis from a randomized controlled clinical trial. Behaviour Research and Therapy. 2014 Jun 30;57:21-8.	
Hansen 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Hansen, K.; Hofling, V.; Kroner-Borowik, T.; Stangier, U.; Steil, R.; (2013) Efficacy of psychological interventions aiming to reduce chronic nightmares: A meta-analysis. Clinical Psychology Review 33(1): 146-155	
Harned 2014	Handsearch	Sample size (N<10/arm)	Harned MS, Korslund KE, Linehan MM. A pilot randomized controlled trial of Dialectical Behavior Therapy with and without the Dialectical Behavior Therapy Prolonged Exposure protocol for suicidal and self-injuring women with borderline	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			personality disorder and PTSD. Behaviour research and therapy. 2014 Apr 30;55:7-17.	
Hart 2011	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Unpublished (registered on clinical trials.gov and author contacted for full trial report but not provided)	Hart J. Novel Treatment of Emotional Dysfunction in Post Traumatic Stress Disorder (PTSD) [NCT01391832]. 2011. Available from: https://clinicaltrials.gov/show/NCT01391832 [accessed 03.08.2017]	
Haug 2012	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Haug, t.; Nordgreen, T.; Ost, LG.; Havik, OE.; (2012) Self-help treatment of anxiety disorders: A meta-analysis and meta-regression of effects and potential moderators. Clinical Psychology Review 32(5): 425-445.	
Haugen 2012	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Haugen, PT.; Evces, M.; Weiss, DS.; (2012) Treating posttraumatic stress disorder in first responders: A systematic review. Clinical Psychology Review 32(5): 370-380	
Hembree 2003	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Unpublished (registered on clinical trials registry and author contacted for full trial report but not provided)	Hembree EA, Foa EB, Gaulin AE. Effectiveness of treatment for PTSD in community agencies [NCT00057629]. 2003. Available from: https://clinicaltrials.gov/ct2/show/NCT00057629 [accessed 03.08.2017]	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Hembree 2004	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Comparison outside scope	Hembree EA, Cahill SP, Foa EB. Impact of personality disorders on treatment outcome for female assault survivors with chronic posttraumatic stress disorder. Journal of Personality Disorders. 2004 Feb 1;18(1):117-27.	
Hertlein 2004	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Hertlein, KM.; Ricci, RJ.; (2004) A Systematic Research Synthesis of EMDR Studies. Implementation of the Platinum Standard. Trauma, Violence and Abuse 5(3): 285-300	
Hickling 1997	2004 GL (excluded)	Non-randomised group assignment	Hickling, E.J.; Blanchard, E.B. (1997) The private practice psychologist and manual-based treatments: post-traumatic stress disorder secondary to motor vehicle accidents. Behavior Research & Therapy, 35, 3, 191-203	
Hien 2004	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Comparison outside scope	Hien DA, Cohen LR, Miele GM, Litt LC, Capstick C. Promising treatments for women with comorbid PTSD and substance use disorders. American journal of Psychiatry. 2004 Aug 1;161(8):1426-32.	
Hien 2010a/2010b/2010c/2012	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Hien DA, Campbell AN, Killeen T, Hu MC, Hansen C, Jiang H, Hatch-Maillette M, Miele GM, Cohen LR, Gan W, Resko SM. The impact of trauma-focused	Hien DA, Campbell AN, Ruglass LM, Hu MC, Killeen T. The role of alcohol misuse in PTSD outcomes for women in community treatment: A secondary analysis of NIDA's Women and

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			group therapy upon HIV sexual risk behaviors in the NIDA Clinical Trials Network "Women and trauma" multi-site study. AIDS and Behavior. 2010 Apr 1;14(2):421-30.	Trauma Study. Drug and Alcohol Dependence. 2010 Sep 1;111(1):114-9.
Hien 2017	RQ 1.1-1.2 & 2.1-2.2 update	Subgroup/secondary analysis of RCT already included	Hien DA, Lopez-Castro T, Papini S, Gorman B, Ruglass LM. Emotion dysregulation moderates the effect of cognitive behavior therapy with prolonged exposure for co-occurring PTSD and substance use disorders. Journal of anxiety disorders. 2017 Dec 31;52:53-61.	
Hilton 2017	RQ 1.1-1.2 & 2.1-2.2 (searches combined) AND RQ 1.1-1.2 & 2.1-2.2 update	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Hilton, L.; Maher, AR.; Colaiaco, B.; Apaydin, E.; Sorbero, ME.; Booth, M.; Shanman, RM.; Hempel, S.; (2017) Meditation for Posttraumatic Stress: Systematic Review and Meta-Analysis. Psychological Trauma: Theory, Research, Practice and Policy 9(4): 453-460	
Hirai 2012	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Comparison outside scope	Hirai M, Skidmore ST, Clum GA, Dolma S. An investigation of the efficacy of online expressive writing for trauma-related psychological distress in Hispanic individuals. Behavior therapy. 2012 Dec 31;43(4):812-24.	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Ho 2012	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Ho, MSK.; Lee, CW.; (2012) Cognitive behaviour therapy versus eye movement desensitization and reprocessing for post-traumatic disorder- is it all in the homework then? European Review of Applied Psychology 62 (4): 253-260	
Ho 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined) AND RQ 1.1-1.2 & 2.1-2.2 update	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Ho, FY-Y.; Chan, CS.; Tang,KN-S.; (2016) Cognitive-behavioral therapy for sleep disturbances in treating posttraumatic stress disorder symptoms: A met-analysis of randomised controlled trials. Clinical Pscyhology Review 43: 90-102	
Hoffart 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Comparison outside scope	Hoffart A, Øktedalen T, Langkaas TF. Self-compassion influences PTSD symptoms in the process of change in trauma-focused cognitive-behavioral therapies: a study of within-person processes. Frontiers in psychology. 2015;6.	
Holder 2017	RQ 1.1-1.2 & 2.1-2.2 update	Subgroup/secondary analysis of RCT already included	Holder N, Holliday R, Pai A, Surís A. Role of Borderline Personality Disorder in the Treatment of Military Sexual Trauma-related Posttraumatic Stress Disorder with Cognitive Processing Therapy. Behavioral Medicine. 2017 Jul 3;43(3):184-90.	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Hopwood 2017	RQ 1.1-1.2 & 2.1-2.2 update	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Hopwood TL, Schutte NS. A meta-analytic investigation of the impact of mindfulness-based interventions on post traumatic stress. Clinical psychology review. 2017 Nov 1;57:12-20.	
Hinsberger 2016	Handsearch	Efficacy or safety data cannot be extracted	Hinsberger, M., Holtzhausen, L., Sommer, J., Kaminer, D., Elbert, T., Seedat, S., ... & Weierstall, R. (2016). Feasibility and Effectiveness of Narrative Exposure Therapy and Cognitive Behavioral Therapy in a Context of Ongoing Violence in South Africa.	
Hofman 2008	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Hofman, SG.; Smits,JAJ.; (2008) Cognitive-behavioral therapy for adult anxiety disorders: A meta-analysis of randomised placebo-controlled trials. J Clinical Psychiatry 69(4): 621-632	
Hofman 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Hofman, SG.l Wu, JQ.; Boettcher, H.; (2014) Effect of Cognitive-Behavioral Therapy for Anxiety Disorders on Quality of Life: A Meta-Analysis. J Cons and Clin Psychology 82(3): 375-391	
Hofmann 1996	2004 GL (excluded)	Non-randomised group assignment	Hofmann, A. (1996). Eye movement desensitization and reprocessing: A new treatment method for post-traumatic stress	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			disorder. Psychotherapeut, 41, 368-372.	
Hogberg 2007	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Sample size (N<10/arm)	Högberg G, Pagani M, Sundin Ö, Soares J, Åberg-Wistedt A, Tärnell B, Hällström T. On treatment with eye movement desensitization and reprocessing of chronic post-traumatic stress disorder in public transportation workers–A randomized controlled trial. Nordic journal of psychiatry. 2007 Jan 1;61(1):54-61.	
Holliday 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Efficacy or safety data cannot be extracted	Holliday R, Link-Malcolm J, Morris EE, Surís A. Effects of cognitive processing therapy on PTSD-related negative cognitions in veterans with military sexual trauma. Military medicine. 2014 Oct;179(10):1077-82.	
Holliday 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Efficacy or safety data cannot be extracted	Holliday R, Williams R, Bird J, Mullen K, Surís A. The role of cognitive processing therapy in improving psychosocial functioning, health, and quality of life in veterans with military sexual trauma-related posttraumatic stress disorder. Psychological services. 2015 Nov;12(4):428.	
Holliday 2017	RQ 1.1-1.2 & 2.1-2.2 update	Efficacy or safety data cannot be extracted	Holliday RP, Holder ND, Williamson ML, Surís A. Therapeutic response to Cognitive Processing Therapy in White and Black female veterans	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			with military sexual trauma-related PTSD. Cognitive behaviour therapy. 2017 Sep 3;46(5):432-46.	
Hollifield 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Hollifield, M.; Gory, A.; Siedjak, J.; Nguyen, L.; Holmgreen, L.; Hobfoll, S.; (2016) The Benefit of Conserving and Gaining Resources after Trauma: A Systematic Review. J Clin Med 5(11: 104	
Hossack 1996	2004 GL (excluded)	Non-randomised group assignment	Hossack, Alex and Bentall, Richard P. (1996) Elimination of Post-traumatic Symptomatology by Relaxation and Visual-Kinesthetic Dissociation. Journal of Traumatic Stress, Vol 9, No1, 99-110	
Hunt 2014	RQ 5.1_5.2_adhoc	Population outside scope: Trials of people without PTSD	Hunt, M., Chizkov, R. (2014) Are therapy dogs like Xanax? Does animal-assisted therapy impact processes relevant to cognitive behavioral psychotherapy?, Anthrozoos, 27, 457-469	
Igreja 2004	RQ 1.1-1.2 & 2.1-2.2 (searches combined) AND 2004 GL (excluded)	Non-randomised group assignment	Igreja, V., Kleijn, W. C., Schreuder, B. J., Van Dijk, J. A., & Verschuur, M. (2004). Testimony method to ameliorate post-traumatic stress symptoms. Community-based intervention study with Mozambican civil war survivors. Br.J.Psychiatry, 184, 251-257	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Imel 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Imel, ZE.; Laska, K.; Jakupcak, M.; Simpson, TL.; (2013) Meta-Analysis of Dropout in Treatment for Posttrumatic Stress Disorder. J Cons and Clin Psyh 81(3): 394-404	
Ironson 2002	2004 GL (included)	Sample size (N<10/arm)	Ironson, G.I., Freund, B., Strauss, J.L., & Williams, J. (2002). A comparison of two treatments for traumatic stress: A community based study of EMDR and prolonged exposure. Journal of Clinical Psychology, 58, 113-128	
Isserles 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Sample size (N<10/arm)	Isserles M, Shalev AY, Roth Y, Peri T, Kutz I, Zlotnick E, Zangen A. Effectiveness of deep transcranial magnetic stimulation combined with a brief exposure procedure in post-traumatic stress disorder–a pilot study. Brain stimulation. 2013 May 31;6(3):377-83.	
Iverson 2011	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis that is not relevant	Iverson KM, Gradus JL, Resick PA, Suvak MK, Smith KF, Monson CM. Cognitive–behavioral therapy for PTSD and depression symptoms reduces risk for future intimate partner violence among interpersonal trauma survivors. Journal of consulting and clinical psychology. 2011 Apr;79(2):193.	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Jayakody 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Jayakody, K.; Gunadasa, S.; Hosker, C.; (2013) Exercise for anxiety disorders: systematic review. Br J Sports Med 00:1-11	
Jayawickreme 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Jayawickreme, N.; Cahill, SP.; Riggs, DS.; Rauch, SAM.; Resick, PA.; Rothbaum, BO.; Foa, EB.; (2014) Primum non nocere (first do no harm): Symptom worsening and improvement in female assault victims after prolonged exposure for PTSD. Depression and Anxiety 31(5): 412-419	
Jerud 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis that is not relevant	Jerud AB, Pruitt LD, Zoellner LA, Feeny NC. The effects of prolonged exposure and sertraline on emotion regulation in individuals with posttraumatic stress disorder. Behaviour research and therapy. 2016 Feb 29;77:62-7.	
Johnson 2002	2004 GL (excluded)	Non-randomised group assignment	Johnson, D. R. & Lubin, H. (2002). Effect of brief versus long-term inpatient treatment on homecoming stress in combat-related posttraumatic stress disorder: Three-year follow-up. Journal of Nervous & Mental Disease, 190, 47-51	
Johnson 2006	Handsearch	Sample size (N<10/arm)	Johnson DR, Lubin H. The Counting Method: Applying the Rule of Parsimony to the Treatment of Posttraumatic Stress	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			Disorder. Traumatology. 2006 Mar;12(1):83.	
Johnson 2018	RQ 1.1-1.2 & 2.1-2.2 update	Cross-over study and first phase data not available	Johnson RA, Albright DL, Marzolf JR, Bibbo JL, Yaglom HD, Crowder SM, Carlisle GK, Willard A, Russell CL, Grindler K, Osterlind S. Effects of therapeutic horseback riding on post-traumatic stress disorder in military veterans. Military Medical Research. 2018 Dec;5(1):3.	
Jonas 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Jonas, DE.; Cusack, K.; Forneris, CA.; (2103) Psychological and Pharmacological Treatments for Adults with Posttraumatic Stress Disorder (PTSD). Comparative Effectiveness Reviews 92	
Jun 2013	RQ 1.1-1.2 & 2.1-2.2 AND RQ 4.1-4.2	Efficacy or safety data cannot be extracted	Jun JJ, Zoellner LA, Feeny NC. Sudden gains in prolonged exposure and sertraline for chronic PTSD. Depression and anxiety. 2013 Jul 1;30(7):607-13.	
Kar 2011	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Non-systematic review	Kar, N.; (2011) Cognitive behavioral therapy for the treatment of post-traumatic stress disorder: a review. Neuropsychiatric Disase and Treatment 7: 167-181	
Karatzias 2007	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Karatzias A, Power K, McGoldrick T, Brown K, Buchanan R, Sharp D, Swanson V. Predicting treatment outcome on three	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			measures for post-traumatic stress disorder. European archives of psychiatry and clinical neuroscience. 2007 Feb 1;257(1):40-6.	
Keane 1982	2004 GL (excluded)	Non-RCT (no control group)	Keane TM, Kaloupek DG. Imaginal flooding in the treatment of a posttraumatic stress disorder. Journal of Consulting and Clinical Psychology. 1982 Feb;50(1):138.	
Keane 1989	2004 GL (included)	Efficacy or safety data cannot be extracted	Keane, T. M., Fairbank, J. A., Caddell, J. M., & Zimering, R. T. (1989). Implosive (flooding) therapy reduces symptoms of PTSD in Vietnam combat veterans. Behavior Therapy, 20, 245-260.	
Keefe 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined) AND 2004 GL (included)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Keefe, JR.; McCarthy, KS.; Dinger, U.; Zilcha-Mano, S.; Barber, JP.; (2014) A meta-analytic review of psychodynamic therapies for anxiety disorders. Clinc Psych Rev 34(4): 309-323	
Kehle-Forbes 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Kehle-Forbes, SM.; Polusny, MA.; MacDonald, R.; Murdoch, M.; Meis, LA.; Wilt, TJ.; (2013) A Systematic Review of the Efficacy of Adding Nonexposure Components to Exposure Therapy for Posttraumatic Stress Disorder. Psychological Trauma: Theory, Research, Practice and Policy 5(4): 317-322.	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Killeen 2008	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Efficacy or safety data cannot be extracted	Killeen T, Hien D, Campbell A, Brown C, Hansen C, Jiang H, Kristman-Valente A, Neuenfeldt C, Rocz-de la Luz N, Sampson R, Suarez-Morales L. Adverse events in an integrated trauma-focused intervention for women in community substance abuse treatment. Journal of substance abuse treatment. 2008 Oct 31;35(3):304-11.	
Kim 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Kim, Y-D.; Heo, I.; Shin, B-C.; Crawford, C.; Kang, H-W.; Lim, J-H.; (2013) Acupuncture for Posttraumatic Stress Disorder: A systematic Reivew of Randomised Controlled Trials and Prospective Clinical Trials. Evidence-Based Complementary and Alternative Medicine: ID 615857	
Kimbrell 2009	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Sample size (N<10/arm)	Kimbrell TA. Adjunctive Biofeedback Intervention for OIF-OEF PTSD [NCT00920036]. Available from: https://clinicaltrials.gov/show/NCT00920036 [accessed 08.08.2017]	
King 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Non-randomised group assignment	King AP, Erickson TM, Giardino ND, Favorite T, Rauch SA, Robinson E, Kulkarni M, Liberzon I. A pilot study of group mindfulness-based cognitive therapy (MBCT) for combat	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			veterans with posttraumatic stress disorder (PTSD). Depression and anxiety. 2013 Jul 1;30(7):638-45.	
King 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Sample size (N<10/arm)	King HC, Spence DL, Hickey AH, Sargent P, Elesh R, Connelly CD. Auricular acupuncture for sleep disturbance in veterans with post-traumatic stress disorder: a feasibility study. Military medicine. 2015 May;180(5):582-90.	
Kip 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Cross-over study and first phase data not available	Kip KE, Rosenzweig L, Hernandez DF, Shuman A, Sullivan KL, Long CJ, Taylor J, McGhee S, Girling SA, Wittenberg T, Sahebzamani FM. Randomized controlled trial of accelerated resolution therapy (ART) for symptoms of combat-related post-traumatic stress disorder (PTSD). Military Medicine. 2013 Dec;178(12):1298-309.	
Kip 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis that is not relevant	Kip KE, Rosenzweig L, Hernandez DF, Shuman A, Diamond DM, Ann Girling S, Sullivan KL, Wittenberg T, Witt AM, Lengacher CA, Anderson B. Accelerated Resolution Therapy for treatment of pain secondary to symptoms of combat-related posttraumatic stress disorder. European journal of psychotraumatology. 2014 Dec 1;5(1):24066.	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Kitchiner 2012	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Kitchiner, NP.; Roberts, NJ.; Wilcox, D.; Bisson, JI.; (2012) Systematic review and meta-analsyis of psychosocial interventions for veterans of the military. Eur J Pscyhotraumatology 3(1)	
Kline 2018	RQ 1.1-1.2 & 2.1-2.2 update	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Kline AC, Cooper AA, Rytwinksi NK, Feeny NC. Long-term efficacy of psychotherapy for posttraumatic stress disorder: A meta-analysis of randomized controlled trials. Clinical psychology review. 2017 Nov 21.	
Knaevelsrud 2011	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Comparison outside scope	Knaevelsrud C. Additive Effect of Cognitive Restructuring in a Web-based Treatment for Traumatized Arab People [NCT01508377]. 2011. Available from: https://clinicaltrials.gov/ct2/show/NCT01508377 [accessed 04.08.2017]	
Kobach 2015	Handsearch	Non-randomised group assignment	Köbach, A., Schaal, S., Hecker, T., & Elbert, T. (2015). Psychotherapeutic Intervention in the Demobilization Process: Addressing Combat-related Mental Injuries with Narrative Exposure in a First and Second Dissemination Stage. Clinical psychology & psychotherapy.	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Konig 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis that is not relevant	König J, Karl R, Rosner R, Butollo W. Sudden gains in two psychotherapies for posttraumatic stress disorder. Behaviour research and therapy. 2014 Sep 30;60:15-22.	
Konuk 2006	2004 GL (excluded)	Non-randomised group assignment	Konuk E, Knipe J, Eke I, Yuksek H, Yurtsever A, Ostep S. The effects of eye movement desensitization and reprocessing (EMDR) therapy on posttraumatic stress disorder in survivors of the 1999 Marmara, Turkey, earthquake. International Journal of Stress Management. 2006 Aug;13(3):291.	
Korte 2017	RQ 1.1-1.2 & 2.1-2.2 (searches combined) AND Cochrane allRQ update	Efficacy or safety data cannot be extracted	Korte KJ, Bountress KE, Tomko RL, Killeen T, Moran-Santa Maria M, Back SE. Integrated Treatment of PTSD and Substance Use Disorders: The Mediating Role of PTSD Improvement in the Reduction of Depression. Journal of clinical medicine. 2017 Jan 13;6(1):9.	
Krakow 2001a	2004 GL (included)	Efficacy or safety data cannot be extracted	Krakow B, Hollifield M, Johnston L, Koss M, Schrader R, Warner TD, Tandberg D, Lauriello J, McBride L, Cutchen L, Cheng D. Imagery rehearsal therapy for chronic nightmares in sexual assault survivors with posttraumatic stress disorder: a	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			randomized controlled trial. Jama. 2001 Aug 1;286(5):537-45.	
Krakow 2001b	2004 GL (excluded)	Non-RCT (no control group)	Krakow, B., Johnston, L., Melendrez, D., Hollifield, M., Warner, T. D., Chavez-Kennedy, D. et al. (2001). An open-label trial of evidence-based cognitive behavior therapy for nightmares and insomnia in crime victims with PTSD. American Journal of Psychiatry, 158, 2043-2047.	
Kredlow 2017	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis that is not relevant	Kredlow MA, Szuhany KL, Lo S, Xie H, Gottlieb JD, Rosenberg SD, Mueser KT. Cognitive behavioral therapy for posttraumatic stress disorder in individuals with severe mental illness and borderline personality disorder. Psychiatry research. 2017 Mar 31;249:86-93.	
Krinsley 2011	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Unpublished (registered on clinical trials.gov and author contacted for full trial report but not provided)	Krinsley K. Pilot Study of an Integrated Exposure-Based Model for Posttraumatic Stress Disorder and Substance Use Disorder [NCT01274741]. Available from: https://clinicaltrials.gov/ct2/show/NCT01274741 [accessed 08.08.2017]	
Kruger 2014a	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Krüger A, Ehring T, Priebe K, Dyer AS, Steil R, Bohus M. Sudden losses and sudden gains during a DBT-PTSD treatment for posttraumatic stress disorder	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			following childhood sexual abuse. European journal of psychotraumatology. 2014 Dec 1;5(1):24470.	
Kruger 2014b	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Krüger A, Kleindienst N, Priebe K, Dyer AS, Steil R, Schmahl C, Bohus M. Non-suicidal self-injury during an exposure-based treatment in patients with posttraumatic stress disorder and borderline features. Behaviour research and therapy. 2014 Oct 31;61:136-41.	
Krupnick 2017	RQ 1.1-1.2 & 2.1-2.2 (searches combined) AND RQ 1.1-1.2 & 2.1-2.2 update	Sample size (N<10/arm)	Krupnick JL, Green BL, Amdur R, Alaoui A, Belouali A, Roberge E, Cueva D, Roberts M, Melnikoff E, Dutton MA. An Internet-based writing intervention for PTSD in veterans: A feasibility and pilot effectiveness trial. Psychological Trauma: Theory, Research, Practice, and Policy. 2017 Jul;9(4):461.	
Kruse 2009	Handsearch	Non-randomised group assignment	Kruse J, Joksimovic L, Cavka M, Wöller W, Schmitz N. Effects of trauma-focused psychotherapy upon war refugees. Journal of Traumatic Stress. 2009 Dec 1;22(6):585-92.	
Kuckertz 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Population outside scope: Trials of soldiers on active service	Kuckertz JM, Amir N, Boffa JW, Warren CK, Rindt SE, Norman S, Ram V, Ziajko L, Webb-Murphy J, McLay R. The effectiveness of an	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			attention bias modification program as an adjunctive treatment for post-traumatic stress disorder. Behaviour research and therapy. 2014 Dec 31;63:25-35.	
Kuester 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Kuester, A. Niemeyer, H.; Knaevelsrud, C.; (2016) Internet-based interventions for posttraumatic stress: A meta-analysis of randomised controlled trials. Clin Pscyh Rev 43:1-16	
Lambert 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Lambert, JE.; Alhassoon, OM.; (2015) Trauma-Focused therapy for Refugees: Meta-Analytic Findings. J Counseling Pscychology 62(1): 28-37	
Lamprecht 2004	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Non-randomised group assignment	Lamprecht F, Köhnke C, Lempa W, Sack M, Matzke M, Münte TF. Event-related potentials and EMDR treatment of post-traumatic stress disorder. Neuroscience Research. 2004 Jun 30;49(2):267-72.	
Lancee 2010	Handsearch	Population outside scope: <80% of the study's participants are eligible for the review and disaggregated data cannot be obtained	Lancee J, Van Den Bout J, Spoormaker VI. Expanding self-help imagery rehearsal therapy for nightmares with sleep hygiene and lucid dreaming: a waiting-list controlled trial. Universitätsbibliothek der Universität Heidelberg; 2010	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Langkaas 2017	RQ 1.1-1.2 & 2.1-2.2 update	Comparison outside scope	Langkaas TF, Hoffart A, Øktedalen T, Ulvenes PG, Hembree EA, Smucker M. Exposure and non-fear emotions: A randomized controlled study of exposure-based and rescripting-based imagery in PTSD treatment. Behaviour research and therapy. 2017 Oct 1;97:33-42.	
Lau 2007	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Comparison outside scope	Lau M, Kristensen E. Outcome of systemic and analytic group psychotherapy for adult women with history of intrafamilial childhood sexual abuse: a randomized controlled study. Acta Psychiatrica Scandinavica. 2007 Aug 1;116(2):96-104.	
Lawrence 2010	RQ 5.1_5.2_adhoc	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Lawrence, S., De Silva, M., Henley, R. (2010) Sports and games for post-traumatic stress disorder (PTSD), Cochrane database of systematic reviews, CD007171	
Lawrence 2010	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Lawrence, S.; De Silva, M.; Henley, R.; (2010) Sports and games for post-traumatic stress disorder (PTSD). Cochrane Database of Systematic Reviews: CD007171	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Le 2013/2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Efficacy or safety data cannot be extracted	Le QA, Doctor JN, Zoellner LA, Feeny NC. Minimal clinically important differences for the EQ-5D and QWB-SA in Post-traumatic Stress Disorder (PTSD): results from a Doubly Randomized Preference Trial (DRPT). Health and quality of life outcomes. 2013 Apr 12;11(1):1.	Le QA, Doctor JN, Zoellner LA, Feeny NC. Cost-effectiveness of prolonged exposure therapy versus pharmacotherapy and treatment choice in posttraumatic stress disorder (the Optimizing PTSD Treatment Trial): a doubly randomized preference trial. The Journal of clinical psychiatry. 2014 Mar 15;75(3):222-30.
LeBouthillier 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis that is not relevant	LeBouthillier DM, Fetzner MG, Asmundson GJ. Lower cardiorespiratory fitness is associated with greater reduction in PTSD symptoms and anxiety sensitivity following aerobic exercise. Mental Health and Physical Activity. 2016 Mar 31;10:33-9.	
Lee 2002	2004 GL (included)	Non-randomised group assignment	Lee, C., Gavriel, H., Drummond, P., Richards, J., & Greenwald, R. (2002). Treatment of PTSD: stress inoculation training with prolonged exposure compared to EMDR. Journal of Clinical Psychology, 58, 1071-1089.	
Lee 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined) AND Cochrane allRQ update	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Lee, DJ.; Schnitzlein, CW.; Wolf, JP.; Vythilingam, M.; Rasmusson, AM.; Hoge,CW.; (2016) Psychotherapy versus Pharmacotherapy for posttraumatic stress disorder: Systemic Review and meta-analyses to determine first line	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			treatments. Depression and Anxiety. 33: 792-806	
Leeman 2017	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Leeman, RF.; Hefner, K.; Frohe, T.; Murrany, A.; Rosenheck, RA.; Watts, BV.; Sofuoglu, M.; (2017) Exclusion of participants based on substance use status: Findings from randomized controlled trials of treatments for PTSD. Behviour Research and Therapsy 89: 33-40	
Leichsenring 2005	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Non-systematic review	Leichsenring, F.; 92005) Are psychodynamic and psychoanalytic therapies effective? A review of empirical data. Int j Psychoanalysis 86(3): 841-868.	
Leichsenring 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Non-systematic review	Leichsenring, F.; Klein, S.; (2014) Evidence for psychodynamic psychotherapy in specific mental disorders: a systematic review. Psychoanalytic Psychotherapy 28(1): 4-32	
Leichsenring 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Leichsenring, F.; Luyten, P.; Hilsenroth, MJ.; Abbas, A.; Barber, JP.; Keefe, JR.; Leweke, F.; Rabung, S.; Steinert, C.; (2015) Psychodynamic therapy meets evidence-based medicine: a systematic review using updated criteria. The Lancet 2(7): 648-660.	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Leiner 2012	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Leiner AS, Kearns MC, Jackson JL, Astin MC, Rothbaum BO. Avoidant coping and treatment outcome in rape-related posttraumatic stress disorder. Journal of consulting and clinical psychology. 2012 Apr;80(2):317.	
Lenz 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Non-systematic review	Lenz, SA.; Henesy, R.; Callender, K.; (2016) Effectiveness of Seeking Safety for Co-Occurring Posttraumatic Stress Disorder and Substance Use. J Counseling and Development 94(1): 51-61	
Lenz 2017	RQ 1.1-1.2 & 2.1-2.2 update	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Lenz AS, Haktanir A, Callender K. Meta-Analysis of Trauma-Focused Therapies for Treating the Symptoms of Posttraumatic Stress Disorder. Journal of Counseling & Development. 2017 Jul 1;95(3):339-53.	
Lester 2010	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis that is not relevant	Lester K, Artz C, Resick PA, Young-Xu Y. Impact of race on early treatment termination and outcomes in posttraumatic stress disorder treatment. Journal of consulting and clinical psychology. 2010 Aug;78(4):480.	
Lester 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis that is not relevant	Lester P, Liang LJ, Milburn N, Mogil C, Woodward K, Nash W, Aralis H, Sinclair M, Semaan A, Klosinski L, Beardslee W. Evaluation of a family-centered preventive intervention for military	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			families: parent and child longitudinal outcomes. Journal of the American Academy of Child & Adolescent Psychiatry. 2016 Jan 31;55(1):14-24.	
Liedl 2011	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Article has been retracted	Liedl A, Müller J, Morina N, Karl A, Denke C, Knaevelsrud C. Retracted: physical activity within a CBT intervention improves coping with pain in traumatized refugees: results of a randomized controlled design. Pain Medicine. 2011 Feb 1;12(2):234-45.	
Lindauer 2006	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis that is not relevant	Lindauer RT, van Meijel EP, Jalink M, Olff M, Carlier IV, Gersons BP. Heart rate responsivity to script-driven imagery in posttraumatic stress disorder: specificity of response and effects of psychotherapy. Psychosomatic medicine. 2006 Jan 1;68(1):33-40.	
Litz 2007	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Comparison outside scope	Litz BT, Engel CC, Bryant RA, Papa A. A randomized, controlled proof-of-concept trial of an Internet-based, therapist-assisted self-management treatment for posttraumatic stress disorder. American Journal of Psychiatry. 2007 Nov;164(11):1676-84.	
Liverant 2012	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis that is not relevant	Liverant GI, Suvak MK, Pineles SL, Resick PA. Changes in posttraumatic stress disorder and	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			depressive symptoms during cognitive processing therapy: Evidence for concurrent change. Journal of Consulting and Clinical Psychology. 2012 Dec;80(6):957.	
Lloyd 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Efficacy or safety data cannot be extracted	Lloyd D, Nixon RD, Varker T, Elliott P, Perry D, Bryant RA, Creamer M, Forbes D. Comorbidity in the prediction of Cognitive Processing Therapy treatment outcomes for combat-related posttraumatic stress disorder. Journal of anxiety disorders. 2014 Mar 31;28(2):237-40.	
Lopez-Castro 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis that is not relevant	López-Castro T, Hu MC, Papini S, Ruglass LM, Hien DA. Pathways to change: Use trajectories following trauma-informed treatment of women with co-occurring post-traumatic stress disorder and substance use disorders. Drug and alcohol review. 2015 May 1;34(3):242-51.	
Lunney 2007	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Lunney CA, Schnurr PP. Domains of quality of life and symptoms in male veterans treated for posttraumatic stress disorder. Journal of traumatic stress. 2007 Dec 1;20(6):955-64.	
Macdonald 2011	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Macdonald A, Monson CM, Doron-Lamarca S, Resick PA, Palfai TP. Identifying patterns of	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			symptom change during a randomized controlled trial of cognitive processing therapy for military-related posttraumatic stress disorder. Journal of Traumatic Stress. 2011 Jun 1;24(3):268-76.	
Macdonald 2016b	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Macdonald A, Pukay-Martin ND, Wagner AC, Fredman SJ, Monson CM. Cognitive–behavioral conjoint therapy for PTSD improves various PTSD symptoms and trauma-related cognitions: Results from a randomized controlled trial. Journal of Family Psychology. 2016 Feb;30(1):157.	
Marcus 1997/2004	RQ 1.1-1.2 & 2.1-2.2 (searches combined) AND 2004 GL (included)	Efficacy or safety data cannot be extracted	Marcus, S. V., Marquis, P., & Sakai, C. (1997). Controlled study of treatment of PTSD using EMDR in an HMO setting. Psychotherapy: Theory, Research, Practice, Training, 34, 307-315.	Marcus S, Marquis P, Sakai C. Three- and 6-Month Follow-Up of EMDR Treatment of PTSD in an HMO Setting. International Journal of Stress Management. 2004 Aug;11(3):195.
Markowitz 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Non-systematic review	Markowitz, JC.; Lipsitz, J.; Milrod, BL.; (2014) Critical review of outcome research on interpersonal psychotherapy for anxiety disorders. Depression and Anxiety 31(4): 316-325	
Markowitz 2015b	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Markowitz JC, Petkova E, Biyanova T, Ding K, Suh EJ, Neria Y. Exploring personality	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			diagnosis stability following acute psychotherapy for chronic posttraumatic stress disorder. Depression and anxiety. 2015 Dec 1;32(12):919-26.	
Markowitz 2017	RQ 1.1-1.2 & 2.1-2.2 update	Subgroup/secondary analysis of RCT already included	Markowitz JC, Neria Y, Lovell K, Meter PE, Petkova E. History of sexual trauma moderates psychotherapy outcome for posttraumatic stress disorder. Depression and anxiety. 2017 Aug 1;34(8):692-700.	
Marks 1998/Lovell 2001	2004 GL (included)	Efficacy or safety data cannot be extracted	Marks, I., Lovell, K., Noshirvani, H., Livanou, M., & Thrasher, S. (1998). Treatment of posttraumatic stress disorder by exposure and/or cognitive restructuring: a controlled study. Archives of General Psychiatry, 55, 317-325.	Lovell, K., Marks, I. M., Noshirvani, H., Thrasher, S., & Livanou, M. (2001). Do cognitive and exposure treatments improve various PTSD symptoms differently? A randomized controlled trial. Behavioural & Cognitive Psychotherapy, 29, 107-112.
Martin 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Outcomes are not of interest	Martin EC, Dick AM, Scioli-Salter ER, Mitchell KS. Impact of a yoga intervention on physical activity, self-efficacy, and motivation in women with PTSD symptoms. The Journal of Alternative and Complementary Medicine. 2015 Jun 1;21(6):327-32.	
Marzabadi 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention not targeted at PTSD symptoms	Marzabadi A, SM HZ. The Effectiveness of Mindfulness Training in Improving the Quality of Life of the War Victims with Post Traumatic stress disorder	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			(PTSD). Iranian journal of psychiatry. 2014 Oct;9(4):228-36.	
Maxwell 2016	RQ 1.1-1.2 & 2.1-2.2 update	Sample size (N<10/arm)	Maxwell K, Callahan JL, Holtz P, Janis BM, Gerber MM, Connor DR. Comparative study of group treatments for posttraumatic stress disorder. Psychotherapy. 2016 Dec;53(4):433.	
Mayo-Wilson 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Mayo-Wilson, E.; Montgomery, P.; (2013) Media-delivered cognitive behavioural therapy and behavioural therapy (self-help) for anxiety disorders in adults. Cochrane database of Systematic Reviews.	
McCann 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Non-systematic review	McCann, RA.; Armstrong, CM.; Skopp, NA.; Edwards-Stewart, A.; Smolenshi, DJ.; June, JD.; Metger-Abamukong, M.; Reger, GM.; (2014) Virtual reality exposure therapy for the treatment of anxiety disorders: An evaluation of research quality. J of Anxiety Disorders 28(6): 625-631	
McFarlane 2012	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Non-systematic review	McFarlane, CA.; Kaplan, I.; (2012) Evidence-based psychological interventions for adult survivors of torture and trauma: A 30-year review. Transcultural Psychiatry 49: 3-4	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
McHugh 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis that is not relevant	McHugh RK, Hu MC, Campbell AN, Hilario E, Weiss RD, Hien DA. Changes in sleep disruption in the treatment of co-occurring posttraumatic stress disorder and substance use disorders. Journal of traumatic stress. 2014 Feb 1;27(1):82-9.	
McLay 2009	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Population outside scope: Trials of soldiers on active service	McLay RN. A Head-to-head Comparison of Virtual Reality Treatment for Post Traumatic Stress Disorder [NCT00978484]. 2009. Available from: https://clinicaltrials.gov/ct2/show/NCT00978484 [accessed 08.08.2017]	
McLay 2011	ISTSS included lists	Population outside scope: Trials of soldiers on active service	McLay RN, Wood DP, Webb-Murphy JA, Spira JL, Wiederhold MD, Pyne JM, Wiederhold BK. A randomized, controlled trial of virtual reality-graded exposure therapy for post-traumatic stress disorder in active duty service members with combat-related post-traumatic stress disorder. Cyberpsychology, behavior, and social networking. 2011 Apr 1;14(4):223-9.	
McLay 2017	RQ 1.1-1.2 & 2.1-2.2 update	Comparison outside scope	McLay RN, Baird A, Webb-Murphy J, Deal W, Tran L, Anson H, Klam W, Johnston S. A randomized, head-to-head study of virtual reality exposure therapy	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			for posttraumatic stress disorder. Cyberpsychology, Behavior, and Social Networking. 2017 Apr 1;20(4):218-24.	
McLean 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Non-systematic review	McLean, CP.; Fitzgerald, H.; (2016) Treating Posttraumatic Stress Symptoms Among people Living with HIV: a Critical Review of Intervention Trials. Current Psychiatry Reports	
McPherson 2011	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Non-systematic review	McPherson, J.; (2011) Does Narrative Exposure Therapy Reduce PTSD in Survivors of Mass Violence? Reseach on Social Work Practice 22(1): 29-42	
Meffert 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Sample size (N<10/arm)	Meffert SM, Abdo AO, Alla OA, Elmakki YO, Omer AA, Yousif S, Metzler TJ, Marmar CR. A pilot randomized controlled trial of interpersonal psychotherapy for Sudanese refugees in Cairo, Egypt. Psychological Trauma: Theory, Research, Practice, and Policy. 2014 May;6(3):240.	
Meier 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis that is not relevant	Meier A, McGovern MP, Lambert-Harris C, McLeman B, Franklin A, Saunders EC, Xie H. Adherence and competence in two manual-guided therapies for co-occurring substance use and posttraumatic stress disorders: clinician factors and patient outcomes. The American journal of drug and	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			alcohol abuse. 2015 Nov 2;41(6):527-34.	
Mello 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Mello, PG.; Silva, GR.; Donat, JC.; Kristensen, CH.; (2014) An Update on the Efficacy of Cognitive-Behavioral Therapy, Cognitive Therapy, and Exposure Therapy for Posttraumatic Stress Disorder. The Int J Psychiatry in Med 46(4): 339-357	
Mendes 2008	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Mendes, DD.; Mello, MF.; Ventura, P.; Passarela, CDM.; Mari,JDJ.; (2008) A Systematic Review on the Effectiveness of Cognitive Behavioral Therapy for Posttraumatic Stress Disorder. The Int J Psychiatry in Med 38(3): 241-259	
Metcalf 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Metcalf, O.; Varker, T.; Forbes, D.; Phelps, A.; Dell, L.; DiBattista, A.; Ralph, N.; O'Donnell, M.; (2016) Efficacy of Fifteen Emerging Interventions for the Treatment of Posttraumatic Stress Disorder: A Systematic Review. 29(1): 88-92	
Meyerbroker 2010	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Meyerbroker, K.; Emmelkamp, PMG.; (2010) Virtual reality exposure therapy in anxiety disorders: a systematic review of the process-and-outcome studies. Depresion and Aniety 27(10): 9330944	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Mills 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined) AND Cochrane allRQ update	Subgroup/secondary analysis of RCT already included	Mills KL, Barrett EL, Merz S, Rosenfeld J, Ewer PL, Sannibale C, Baker AL, Hopwood S, Back SE, Brady KT, Teesson M. Integrated Exposure-Based Therapy for Co-Occurring Post Traumatic Stress Disorder (PTSD) and Substance Dependence: Predictors of Change in PTSD Symptom Severity. Journal of clinical medicine. 2016 Nov 15;5(11):101.	
Minnen 2006	2004 GL (excluded)	Non-randomised group assignment	Minnen AV, Foa EB. The effect of imaginal exposure length on outcome of treatment for PTSD. Journal of Traumatic Stress. 2006 Aug 1;19(4):427-38.	
Mitchell 2012	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis that is not relevant	Mitchell KS, Wells SY, Mendes A, Resick PA. Treatment improves symptoms shared by PTSD and disordered eating. Journal of traumatic stress. 2012 Oct 1;25(5):535-42.	
Miyahira 2012	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Population outside scope: Trials of soldiers on active service	Miyahira SD, Folen RA, Hoffman HG, Garcia-Palacios A, Spira JL, Kawasaki M. The effectiveness of VR exposure therapy for PTSD in returning warfighters. Annual Review of Cybertherapy and Telemedicine. 2012 Sep 14;181:128-32.	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Mogk 2006	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Mogk, C.; Otte, S.; Reinhold-Hurley, B.; Kroner-Herwig, B.; (2006) Health effects of expressive writing on stressful or traumatic experiences - a meta-analysis. Psychosoc Med, 3 Doc06	
Monson 2005	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Non-randomised group assignment	Monson CM, Rodriguez BF, Warner R. Cognitive-Behavioral therapy for PTSD in the real world: Do interpersonal relationships make a real difference?. Journal of Clinical Psychology. 2005 Jun 1;61(6):751-61.	
Moradi 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Efficacy or safety data cannot be extracted	Moradi AR, Moshirpanahi S, Parhon H, Mirzaei J, Dalgleish T, Jobson L. A pilot randomized controlled trial investigating the efficacy of MEmory Specificity Training in improving symptoms of posttraumatic stress disorder. Behaviour research and therapy. 2014 May 31;56:68-74.	
Morgan-Lopez 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Morgan-Lopez AA, Saavedra LM, Hien DA, Campbell AN, Wu E, Ruglass L, Patock-Peckham JA, Bainter SC. Indirect effects of 12-session seeking safety on substance use outcomes: Overall and attendance class-specific effects. The American journal on	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			addictions. 2014 May 1;23(3):218-25.	
Morina 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Mornina, N.; Wicherts, JM.; Lobbrecht, J.; Priebe, S.; (2014) Remission from post-traumatic stress disorder in adults: A systematic review and meta-analysis of long term outcome studies. Clin Psych Rev 34(3): 249-255	
Morina 2017a	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Mornina, N.; Lancee, J.; Arntz, A.; (2017) Imagery rescripting as a clinical intervention for aversive memories: A meta-analysis. J Behaviour Therapy and Experimental Psychiatry 55: 6-15	
Morina 2017c	RQ 1.1-1.2 & 2.1-2.2 update	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Morina N, Malek M, Nickerson A, Bryant RA. Meta-analysis of interventions for posttraumatic stress disorder and depression in adult survivors of mass violence in low-and middle-income countries. Depression and anxiety. 2017 Apr 1.	
Morkved 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Morkved, N.; Hartmann, K.; Aarsheim, LM.; Holen, D.; Milde, AM.; Bomyea, J.; Thorp SR.; (2014) A comparison of Naarative Exposure Therapy and Prolonged Exposure therapy for PTSD. Clinical Psychology Review 34(6): 453-467	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Moser 2010	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis that is not relevant	Moser JS, Cahill SP, Foa EB. Evidence for poorer outcome in patients with severe negative trauma-related cognitions receiving prolonged exposure plus cognitive restructuring: implications for treatment matching in posttraumatic stress disorder. The Journal of nervous and mental disease. 2010 Jan 1;198(1):72-5.	
Motraghi 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Motraghi, TE.; Seim, RW.; Meyer, EC.; Morissette, SB.; (2014) Virtual Reality Exposure Therapy for the Treatment of Posttraumatic Stress Disorder: A Methodological Review Using CONSORT Guidelines. J Clin Psyh 70(3): 197-208	
Muss 1991	2004 GL (excluded)	Non-randomised group assignment	Muss D.C. (1991) A New Technique for treating post-traumatic stress disorder. British Journal of Clinical Psychology, Vol 30, pp 91-92.	
Myers 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Myers US, Browne KC, Norman SB. Treatment engagement: female survivors of intimate partner violence in treatment for PTSD and alcohol use disorder. Journal of dual diagnosis. 2015 Oct 2;11(3-4):238-47.	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Nacasch 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Comparison outside scope	Nacasch N, Huppert JD, Su YJ, Kivity Y, Dinshtein Y, Yeh R, Foa EB. Are 60-minute prolonged exposure sessions with 20-minute imaginal exposure to traumatic memories sufficient to successfully treat PTSD? A randomized noninferiority clinical trial. Behavior therapy. 2015 May 31;46(3):328-41.	
Nakeyar 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Nakeyar, C.; Frewen, PA.; (2016) Evidence-Based Care for Iraqi, Kurdish, and Syrian Asylum Seekers and Refugees of the Syrian Civil War: A systematic review. Canadian Psychology 57(4): 233-245	
Nelson 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Non-systematic review	Nelson, RJ.; (2013) Is Virtual Reality Exposure Therapy Effective for Service Members and Veterans Experiencing Combat-Related PTSD? Traumatology 19(3): 171-178	
Nicholl 2009	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Non-systematic review	Nicholl, C.; Thompson, A.; (2004) The psychological treatment of Post Traumatic Stress Disorder (PTSD) in adult refugees: A review of the current state of psychological therapies. J Ment Health 13(4): 351-362	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Nijdam 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Nijdam MJ, Van Amsterdam JG, Gersons BP, Olff M. Dexamethasone-suppressed cortisol awakening response predicts treatment outcome in posttraumatic stress disorder. Journal of affective disorders. 2015 Sep 15;184:205-8.	
Nijdam 2018	RQ 1.1-1.2 & 2.1-2.2 update	Subgroup/secondary analysis of RCT already included	Nijdam MJ, van der Meer CA, van Zuiden M, Dashtgard P, Medema D, Qing Y, Zhutovsky P, Bakker A, Olff M. Turning wounds into wisdom: Posttraumatic growth over the course of two types of trauma-focused psychotherapy in patients with PTSD. Journal of affective disorders. 2018 Feb 1;227:424-31.	
Niles 2012	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Comparison outside scope	Niles BL, Klunk-Gillis J, Ryngala DJ, Silberbogen AK, Paysnick A, Wolf EJ. Comparing mindfulness and psychoeducation treatments for combat-related PTSD using a telehealth approach. Psychological Trauma: Theory, Research, Practice, and Policy. 2012 Sep;4(5):538.	
Nolan 2016	RQ 1.1-1.2 & 2.1-2.2 update	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Nolan CR. Bending without breaking: A narrative review of trauma-sensitive yoga for women with PTSD. Complementary therapies in clinical practice. 2016 Aug 1;24:32-40.	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Noordik 2010	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Noordik, E.; Van der Kling, JJL.; Klingen, EF.; Nieuwenhuijsen, K.; Van Dijk, FJH.; (2010) Exposure-in-vivo containing interventions to improve work functioning of workers with anxiety disorder: a systematic review. BMC Public Health 10:598	
Norman 2007	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Unpublished (registered on clinical trials.gov and author contacted for full trial report but not provided)	Norman S. AUDs and PTSD Treatment for Victims of Partner Violence [NCT00607412]. 2007. Available from: https://clinicaltrials.gov/ct2/show/NCT00607412 [accessed 08.08.2017]	
Norton 2007	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Norton, P.; Price, EC.; (2007) A Meta-Analytic Review of Adult Cognitive-Behavioral Treatment Outcome Across the Anxiety Disorders. The J Nervous and Mental Disease 195(6): 521-531	
Nose 2017	RQ 1.1-1.2 & 2.1-2.2 update	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Nosè M, Ballette F, Bighelli I, Turrini G, Purgato M, Tol W, Priebe S, Barbui C. Psychosocial interventions for post-traumatic stress disorder in refugees and asylum seekers resettled in high-income countries: Systematic review and meta-analysis. PloS one. 2017 Feb 2;12(2):e0171030.	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Nosen 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Nosen E, Littlefield AK, Schumacher JA, Stasiewicz PR, Coffey SF. Treatment of co-occurring PTSD–AUD: Effects of exposure-based and non-trauma focused psychotherapy on alcohol and trauma cue-reactivity. Behaviour research and therapy. 2014 Oct 31;61:35-42.	
Nyssen 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Nyssen, OP.; Taylor, SJ.; Wong, G.; Steed, E.; Bourke, L.; Lord, J.; Ross, CA.; Hayman, S.; Field, V.; Higgins, A.; Greenhalgh, T.; Meads, C.; (2016) Does herapeutic writing help people with long-term conditions? Systematic review, realist synthesis and economic considerations. Health Technlogy Assessment 20(27)	
Oktedalen 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Comparison outside scope	Øktedalen T, Hoffart A, Langkaas TF. Trauma-related shame and guilt as time-varying predictors of posttraumatic stress disorder symptoms during imagery exposure and imagery rescripting—A randomized controlled trial. Psychotherapy Research. 2015 Sep 3;25(5):518-32.	
Olatunji 2010a	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Paper unavailable	Olatunji, B.; Cisler, JM.; Deacon, BJ.; (2010) Efficacy of Cognitive Behavioral Therapy for Anxiety	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			Disorders: A Review of Meta-Analytic Findings. Psychiatric Clinics of North America 33(3): 557-577	
Olatunji 2010b	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Olatunji, BO.; Cisler, JM.; Tolin, DF.; (2010) A meta-analysis of the influence of comorbidity on treatment outcome in the anxiety disorders. Clin Psych Rew 30(6): 642-654	
Olthuis 2016	RQ 1.1-1.2 & 2.1-2.2 update	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Olthuis JV, Wozney L, Asmundson GJ, Cramm H, Lingley-Pottie P, McGrath PJ. Distance-delivered interventions for PTSD: A systematic review and meta-analysis. Journal of anxiety disorders. 2016 Dec 1;44:9-26.	
Oman 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Efficacy or safety data cannot be extracted	Oman D, Bormann JE. Mantram repetition fosters self-efficacy in veterans for managing PTSD: A randomized trial. Psychology of Religion and Spirituality. 2015 Feb;7(1):34.	
Omidi 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Outcome measures are not validated	Omidi A, Mohammadi A, Zargar F, Akbari H. Efficacy of mindfulness-based stress reduction on mood States of veterans with post-traumatic stress disorder. Archives of trauma research. 2013;1(4):151.	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Onton 2012	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Population outside scope: Trials of soldiers on active service	Onton JA. Placebo-controlled Study of EEG Biofeedback Therapy as an Adjunct Treatment for PTSD, Evaluating Symptoms and EEG Dynamics [NCT01591408]. 2012. Available from: https://clinicaltrials.gov/show/NCT01591408 [accessed 08.08.2017]	
Ost 2003	2004 GL (included)	Paper unavailable	Ost, L.G.; Paunovic, N.; Gillow, A.M. (Unpublished) Cognitive behavior therapy in the prevention of chronic PTSD in crime victims.	
Ost 2009	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Non-systematic review	Ost, LG.; (2009) Cognitive behaviour therapy for anxiety disorders: 40 years of progress. Nordic J Psychiatry 62(S47): 5-10	
Otis 2005	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Sample size (N<10/arm)	Otis J. Integrated Treatment for Chronic Pain and PTSD [NCT00127413]. 2005. Available from: https://clinicaltrials.gov/ct2/show/NCT00127413 [accessed 11.05.2017]	
Otis 2010	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention not targeted at PTSD symptoms	Otis J. Intensive Treatment of Chronic Pain and PTSD for OEF/OIF Veterans [NCT01120067]. 2010. Available from: https://clinicaltrials.gov/ct2/show/study/NCT01120067 [accessed 08.08.2017]	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
O'Toole 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	O'Toole, SK.; Solomon, SL.; Bergdahl, SA.; (2016) A Meta-Analysis of Hypnotherapeutic Techniques in the Treatment of PTSD Symptoms. J Traumatic Stress 29(1): 97-100	
Otto 2003	2004 GL (included)	Sample size (N<10/arm)	Otto, M.W. et al (2003) Treatment of pharmacotherapy-refratory posttraumatic stress disorder among Cambodian refugees: a pilot study of combination treatment with cognitive-behavior therapy vs sertraline alone. Behaviour Research and Therapy, 41, 1271-1276	
Ougrin 2011	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Ougrin, D.; (2011) Efficacy of exposure versus cognitive therapy in anxiety disorders: systematic review and meta-analysis. BMC Psychiatry 11:200	
Ovaert 2003	2004 GL (excluded)	Non-randomised group assignment	Ovaert, L. B., Cashel, M. L., & Sewell, K. W. (2003). Structured group therapy for posttraumatic stress disorder in incarcerated male juveniles. Am.J.Orthopsychiatry, 73, 294-301.	
Pacella 2014	RQ 1.1-1.2 & 2.1-2.2 AND RQ 4.1-4.2	Efficacy or safety data cannot be extracted	Pacella ML, Feeny N, Zoellner L, Delahanty DL. The impact of PTSD treatment on the cortisol awakening response. Depression	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			and anxiety. 2014 Oct 1;31(10):862-9.	
Paivio 2010	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Comparison outside scope	Paivio SC, Jarry JL, Chagigiorgis H, Hall I, Ralston M. Efficacy of two versions of emotion-focused therapy for resolving child abuse trauma. Psychotherapy Research. 2010 May 1;20(3):353-66.	
Palic 2011	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Palic, S.; Elklit, A.; (2011) Psychosocial treatment of posttraumatic stress disorder in adult refugees. A systematic review of prospective treatment outcome studies and a critique. J Affective Disorders 131(1-3): 8-23	
Pantalon 1998	2004 GL (excluded)	Non-randomised group assignment	Pantalon, M. V. & Motta, R. W. (1998). Effectiveness of anxiety management training in the treatment of posttraumatic stress disorder: a preliminary report. Journal of Behavior Therapy & Experimental Psychiatry, 29, 21-29.	
Parcesepe 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Parcesepe, AM>; Martin, SL.; Pollock, MD.; Garcia-Moreno, C.; (2015) The effectiveness of mental health interventions for adult female survivors of sexual assault: A systematic review. Aggression and Violent Behvior 25(A): 15-25	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Paunovic 2001	2004 GL (included)	Sample size (N<10/arm)	Paunovic, N. & Ost, L. G. (2001). Cognitive-behavior therapy vs exposure therapy in the treatment of PTSD in refugees. Behaviour Research & Therapy, 39, 1183-1197.	
Pease 2009	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Non-RCT (no control group)	Pease, M., Sollom, R., Wayne, P. (2009) Acupuncture for Refugees With Posttraumatic Stress Disorder: Initial Experiences Establishing a Community Clinic, Explore: The Journal of Science and Healing, 5, 51-54	
Peleikis 2005	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Peleikis, DE.; Dahl, AA.; (2005) A systematic review of empirical studies of psychotherapy with women who were sexually abused as children. Psychotherapy Research 15(3): 304-315	
Peniston 1991	2004 GL (included)	Outcomes are not of interest	Peniston, E.G. & Kulkosky, P.J. (1991) Alpha-theta brainwave neuro-feedback therapy for Vietnam veterans with combat-related post-traumatic stress disorder. Medical Psychotherapy, 4, 47-60	
Pigeon 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Protocol	Pigeon WR, Heffner KL, Crean H, Gallegos AM, Walsh P, Seehuus M, Cerulli C. Responding to the need for sleep among survivors of interpersonal violence: A randomized controlled trial of a	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			cognitive–behavioral insomnia intervention followed by PTSD treatment. Contemporary clinical trials. 2015 Nov 30;45:252-60.	
Pitman 1996	2004 GL (excluded)	Non-randomised group assignment	Pitman, R. K., Orr, S. P., Altman, B., Longpre, R. E., Poire, R. E., & Macklin, M. L. (1996). Emotional processing during eye movement desensitization and reprocessing therapy of Vietnam veterans with chronic posttraumatic stress disorder. Comprehensive Psychiatry, 37, 419-429.	
Possemato 2010	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Efficacy or safety data cannot be extracted	Possemato K, Ouimette P, Geller PA. Internet-based expressive writing for kidney transplant recipients: Effects on posttraumatic stress and quality of life. Traumatology. 2010 Mar;16(1):49-54.	
Postel 2008	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Postel MG.; de Hann, HA.; De Jong, CAJ.; (2008) E-Therapy for Mental Health Problems: A Systematic Review. Telemedicine and e-Health 14(7):707-714	
Powers 2010	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Powers, MB.; Halpern, JM.; Ferenschak, MP.; Gilihan, SJ.; Foa, EB.; (2010) A meta-analytic review of prolonged exposure for posttraumatic stress disorder. Clin Psych Rev 30(6): 635-641	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Pratchett 2011	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Pratchett, LC.; Daly, K.; Bierer, LM.; Yehuda, R.; (2011) New approaches to combining pharmacotherapy and psychotherapy for posttraumatic stress disorder. Expert Opinion on Pharmacotherapy 12(15): 2339-2354	
Prisco 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Sample size (N<10/arm)	Prisco MK, Jecmen MC, Bloeser KJ, McCarron KK, Akhter JE, Duncan AD, Balish MS, Amdur RL, Reinhard MJ. Group auricular acupuncture for PTSD-related insomnia in veterans: a randomized trial. Medical Acupuncture. 2013 Dec 1;25(6):407-22.	
Pruiksma 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Comparison outside scope	Pruiksma, K. E., Cranston, C. C., Rhudy, J. L., Micol, R. L., & Davis, J. L. (2016, December 15). Randomized Controlled Trial to Dismantle Exposure, Relaxation, and Rescripting Therapy (ERRT) for Trauma-Related Nightmares. Psychological Trauma: Theory, Research, Practice, and Policy. Advance online publication. http://dx.doi.org/10.1037/tra0000238	
Rabe 2006	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Rabe S, Dörfel D, Zöllner T, Maercker A, Karl A. Cardiovascular correlates of motor vehicle accident related	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			posttraumatic stress disorder and its successful treatment. Applied psychophysiology and biofeedback. 2006 Dec 1;31(4):315-30.	
Rabe 2008	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Rabe S, Zoellner T, Beauducel A, Maercker A, Karl A. Changes in brain electrical activity after cognitive behavioral therapy for posttraumatic stress disorder in patients injured in motor vehicle accidents. Psychosomatic medicine. 2008 Jan 1;70(1):13-9.	
Ragsdale 1996	2004 GL (excluded)	Non-randomised group assignment	Ragsdale, K. G., Cox, R. D., Finn, P., & Eisler, R. M. (1996). Effectiveness of short-term specialized inpatient treatment for war-related posttraumatic stress disorder: A role for adventure-based counseling and psychodrama. Journal of Traumatic Stress, 9, 269-283.	
Rauch 2009	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Rauch SA, Grunfeld TE, Yadin E, Cahill SP, Hembree E, Foa EB. Changes in reported physical health symptoms and social function with prolonged exposure therapy for chronic posttraumatic stress disorder. Depression and anxiety. 2009 Aug 1;26(8):732-8.	
Ready 2010	ISTSS included lists	Sample size (N<10/arm)	Ready DJ, Gerardi RJ, Backscheider AG, Mascaro N, Rothbaum BO. Comparing virtual	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			reality exposure therapy to present-centered therapy with 11 US Vietnam veterans with PTSD. Cyberpsychology, Behavior, and Social Networking. 2010 Feb 1;13(1):49-54.	
Rees 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Non-randomised group assignment	Rees B, Travis F, Shapiro D, Chant R. Reduction in posttraumatic stress symptoms in Congolese refugees practicing transcendental meditation. Journal of traumatic stress. 2013 Apr 1;26(2):295-8.	
Reiter 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Reiter, K.; Anderson, S.; Carlsson, J.; (2016) Neurofeedback Treatment and Posttraumatic Stress Disorder: Efectiveness of Neurofeedback on Posttraumatic Stress Disorder and the Optimal Choice of Protocol. J Nervous and Mental Disease 204(2): 69-77	
Renfrey 1994	2004 GL (excluded)	Non-randomised group assignment	Renfrey, G. & Spates, C. R. (1994). Eye movement desensitization: a partial dismantling study. Journal of Behavior Therapy & Experimental Psychiatry, 25, 231-239.	
Renner 2011	Handsearch	Efficacy or safety data cannot be extracted	Renner, W., Banninger-Huber, E. & Peltzer, K. (2011) Culture-sensitive and resource oriented peer (CROP) - groups as a community based intervention for	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			trauma survivors: a randomized controlled pilot study with refugees and asylum seekers from Chechnya. The Australasian Journal of Disaster and Trauma Studies. 2011-1:1-13	
Resick 1992	2004 GL (excluded)	Non-randomised group assignment	Resick, P.A.; Schnicke, M.K. (1992) Cognitive processing therapy for sexual assault victims. Journal of consulting and clinical psychology, 60, 5, 748-756	
Resick 2003	2004 GL (excluded)	Subgroup/secondary analysis of RCT already included	Resick, P. A., Nishith, P., & Griffin, M. G. (2003). How well does cognitive-behavioral therapy treat symptoms of complex PTSD? An examination of child sexual abuse survivors within a clinical trial. CNS.Spectr, 8, 340-355.	
Resick 2008	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Comparison outside scope	Resick PA, Galovski TE, Uhlmansiek MO, Scher CD, Clum GA, Young-Xu Y. A randomized clinical trial to dismantle components of cognitive processing therapy for posttraumatic stress disorder in female victims of interpersonal violence. Journal of consulting and clinical psychology. 2008 Apr;76(2):243.	
Resick 2012a	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Comparison outside scope	Resick PA, Suvak MK, Johnides BD, Mitchell KS, Iverson KM. The impact of dissociation on PTSD	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			treatment with cognitive processing therapy. Depression and Anxiety. 2012 Aug 1;29(8):718-30.	
Resick 2012b	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis that is not relevant	Resick PA, Suvak MK, Johnides BD, Mitchell KS, Iverson KM. The impact of dissociation on PTSD treatment with cognitive processing therapy. Depression and Anxiety. 2012 Aug 1;29(8):718-30.	
Resick 2015	ISTSS included lists	Population outside scope: Trials of soldiers on active service	Resick PA, Wachen JS, Mintz J, Young-McCaughan S, Roache JD, Borah AM, Borah EV, Dondanville KA, Hembree EA, Litz BT, Peterson AL. A randomized clinical trial of group cognitive processing therapy compared with group present-centered therapy for PTSD among active duty military personnel. Journal of consulting and clinical psychology. 2015 Dec;83(6):1058.	
Rhodes 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Efficacy or safety data cannot be extracted	Rhodes A, Spinazzola J, van der Kolk B. Yoga for adult women with chronic PTSD: A long-term follow-up study. The journal of alternative and complementary medicine. 2016 Mar 1;22(3):189-96.	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Rhudy 2010	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Outcomes are not of interest	Rhudy JL, Davis JL, Williams AE, McCabe KM, Bartley EJ, Byrd PM, Pruiksma KE. Cognitive-behavioral treatment for chronic nightmares in trauma-exposed persons: assessing physiological reactions to nightmare-related fear. Journal of clinical psychology. 2010 Apr 1;66(4):365-82.	
Richards 1994	2004 GL (excluded)	Non-randomised group assignment	Richards, D. A., Lovell, K., & Marks, I. M. (1994). Post-traumatic stress disorder: evaluation of a behavioral treatment program. Journal of Traumatic Stress, 7, 669-680.	
Rizvi 2009	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Rizvi SL, Vogt DS, Resick PA. Cognitive and affective predictors of treatment outcome in cognitive processing therapy and prolonged exposure for posttraumatic stress disorder. Behaviour Research and Therapy. 2009 Sep 30;47(9):737-43.	
Roberts 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Roberts, NP.; Roberts, PA.; Jones, N.; Bisson, JI.; (2015) Psychological interventions for post-traumatic stress disorder and comorbid substance use disorder: A systematic review and meta-analysis. Clin Psyc Rev 38: 25-38	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Roberts 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Roberts, NP.; Roberts, PA.; Jones, N.; Bisson, JI.; (2016) Psychological therapies for post-traumatic stress disorder and comorbid substance use disorder. Cochrane Database of Systematic Reviews.	
Robjant 2010	RQ 5.1_5.2_adhoc	Non-systematic review	Robjant, K., Fazel, M. (2010) The emerging evidence for Narrative Exposure Therapy: A review, Clinical Psychology Review, 1030-1039	
Rodrigues 2011	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Rodrigues, H.; Figueira, I.; Goncalves, R.; Mendlowicz, M.; Macedo, T.; Ventura, P.; (2011) CBT for pharmacotherapy non-remitters - a systetmatic review of a next-step strategy. J Affective Disorders 129(1-3): 219-228	
Rogers 1999	2004 GL (excluded)	Sample size (N<10/arm)	Rogers, S.; Silver, S.M.; Goss, J.; Obenchain, J.; Willis, A.; Whitney, R.L. (1999) A single session, group study of exposure and eye movement desensitization and reprocessing in treating posttraumatic stress disorder among Vietnam war veterens: Preliminary data. Journal of Anxiety Disorders, 13, 1-2, 119-130	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Ronconi 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Ronconi, JM.; Shiner, B.; Watts, BV.; (2015) A Meta-Analysis of Depresive Symptom Outcomes in Randomized, Controlled Trials for PTSD. J Nervous and Mental Disease 203(7): 522-529.	
Rosendbaum 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Rosenbaum, S.; Vancampfort, D.; Steel, Z.; Newby, J.; Ward, PB.; Stubbs, B.; (2015) Physical activity in the treatment of Post-traumatic stress disorder: A systematic review and meta-analysis. Psychiatry resarch 230(2): 130-136	
Rotaru 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined) AND RQ 1.1-1.2 & 2.1-2.2 update	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Rotaru,T-S.; Rusu A.; (2016) A Meta-Analysis for the Efficacy of Hypnotherapy in Alleviating PTSD Symptoms. Int J Clin and Expt Hypnosis 64(1): 116-136	
Rothbaum (unpublished)	2004 GL (excluded)	Paper unavailable	Rothbaum, B, et al. Randomised controlled trial of Exposure, EMDR and waitlist treatment for rape survivors with PTSD. (unpublished)	
Rothbaum 1997	2004 GL (included)	Sample size (N<10/arm)	Rothbaum, B. O. (1997). A controlled study of eye movement desensitization and reprocessing in the treatment of posttraumatic stress disordered sexual assault victims. Bulletin of the Menninger Clinic, 61, 317-334.	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Rothbaum 2001	2004 GL (excluded)	Non-randomised group assignment	Rothbaum, B. O., Hodges, L. F., Ready, D., Graap, K., & Alarcon, R. D. (2001). Virtual reality exposure therapy for Vietnam veterans with posttraumatic stress disorder. Journal of Clinical Psychiatry, 62, 617-622	
Roy 2006	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Protocol	Roy MJ, Law W, Patt I, Difede J, Rizzo A, Graap K, Rothbaum B. Randomized controlled trial of CBT with virtual reality exposure therapy for PTSD. Annu. Rev. Cyberther. Telemed. 2006;4:39-44.	
Ruglass 2012	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Ruglass LM, Miele GM, Hien DA, Campbell AN, Hu MC, Caldeira N, Jiang H, Litt L, Killeen T, Hatch-Maillette M, Najavits L. Helping alliance, retention, and treatment outcomes: A secondary analysis from the NIDA clinical trials network women and trauma study. Substance use & misuse. 2012 Apr 17;47(6):695-707.	
Ruglass 2014a	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Ruglass LM, Hien DA, Hu MC, Campbell AN. Associations between post-traumatic stress symptoms, stimulant use, and treatment outcomes: A secondary analysis of NIDA's women and trauma study. The American journal on addictions. 2014 Jan 1;23(1):90-5.	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Ruglass 2014b	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Efficacy or safety data cannot be extracted	Ruglass LM, Hien DA, Hu MC, Campbell AN, Caldeira NA, Miele GM, Chang DF. Racial/ethnic match and treatment outcomes for women with PTSD and substance use disorders receiving community-based treatment. Community mental health journal. 2014 Oct 1;50(7):811-22.	
Russell (unpublished)	2004 GL (excluded)	Non-randomised group assignment	Russell, M.C., Treating combat related stress disorder: A multiple case study utilizing eye movement desensitization and reprocessing procedure with battlefield casualties from the Iraqi war	
Ryan 2005	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Comparison outside scope	Ryan M, Nitsun M, Gilbert L, Mason H. A prospective study of the effectiveness of group and individual psychotherapy for women CSA survivors. Psychology and Psychotherapy: Theory, Research and Practice. 2005 Dec 1;78(4):465-80.	
Sack 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Comparison outside scope	Sack M, Zehl S, Otti A, Lahmann C, Henningsen P, Kruse J, Stingl M. A Comparison of Dual Attention, Eye Movements, and Exposure Only during Eye Movement Desensitization and Reprocessing for Posttraumatic Stress Disorder: Results from a Randomized Clinical Trial. Psychotherapy and	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			psychosomatics. 2016;85(6):357-65.	
Salcioglu 2007	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Şalcıoğlu E, Başoğlu M, Livanou M. Effects of live exposure on symptoms of posttraumatic stress disorder: The role of reduced behavioral avoidance in improvement. Behaviour Research and Therapy. 2007 Oct 31;45(10):2268-79.	
Salcioglu 2010	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Non-systematic review	Şalcıoğlu E, Başoğlu M. Control-focused behavioral treatment of earthquake survivors using live exposure to conditioned and simulated unconditioned stimuli. Cyberpsychology, Behavior, and Social Networking. 2010 Feb 1;13(1):13-9.	
Saunders 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Saunders EC, McGovern MP, Lambert-Harris C, Meier A, McLeman B, Xie H. The impact of addiction medications on treatment outcomes for persons with co-occurring PTSD and opioid use disorders. The American journal on addictions. 2015 Dec 1;24(8):722-31.	
Saunders 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Saunders EC, McLeman BM, McGovern MP, Xie H, Lambert-Harris C, Meier A. The influence of family and social problems on treatment outcomes of persons with co-occurring substance use	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			disorders and PTSD. Journal of substance use. 2016 May 3;21(3):237-43.	
Sautter 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Sautter FJ, Glynn SM, Becker-Cretu JJ, Senturk D, Armelie AP, Wielt DB. Structured Approach Therapy for Combat-Related PTSD in Returning US Veterans: Complementary Mediation by Changes in Emotion Functioning. Journal of traumatic stress. 2016 Aug 1;29(4):384-7.	
Schaal 2009	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Non-randomised group assignment	Schaal S, Elbert T, Neuner F. Narrative exposure therapy versus interpersonal psychotherapy. Psychotherapy and psychosomatics. 2009;78(5):298-306.	
Scher 2017	RQ 1.1-1.2 & 2.1-2.2 update	Efficacy or safety data cannot be extracted	Scher CD, Suvak MK, Resick PA. Trauma cognitions are related to symptoms up to 10 years after cognitive behavioral treatment for posttraumatic stress disorder. Psychological trauma: theory, research, practice, and policy. 2017 Nov;9(6):750.	
Schnurr 2001	2004 GL (excluded)	Non-randomised group assignment	Schnurr, P. P., Friedman, M. J., Lavori, P. W., & Hsieh, F. Y. (2001). Design of Department of Veterans Affairs Cooperative Study no. 420: group treatment of posttraumatic stress disorder.	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			Controlled Clinical Trials, 22, 74-88.	
Schnurr 2009	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Schnurr PP, Lunney CA, Forshay E, Thurston VL, Chow BK, Resick PA, Foa EB. Sexual function outcomes in women treated for posttraumatic stress disorder. Journal of Women's Health. 2009 Oct 1;18(10):1549-57.	
Schnurr 2012	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Schnurr PP, Lunney CA. Work-related outcomes among female veterans and service members after treatment of posttraumatic stress disorder. Psychiatric Services. 2012 Nov;63(11):1072-9.	
Schnurr 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Schnurr PP, Lunney CA. Differential effects of prolonged exposure on posttraumatic stress disorder symptoms in female veterans. Journal of consulting and clinical psychology. 2015 Dec;83(6):1154.	
Schnurr 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Schnurr PP, Lunney CA. Symptom benchmarks of improved quality of life in PTSD. Depression and anxiety. 2016 Mar 1;33(3):247-55.	
Schnyder 2011	Handsearch	Efficacy or safety data cannot be extracted	Schnyder U, Müller J, Maercker A, Wittmann L. Brief eclectic psychotherapy for PTSD: a randomized controlled trial. The	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			Journal of clinical psychiatry. 2011 Apr;72(4):564.	
Schouten 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Schouten, KA.; de Niet, GJ.; Knipscheer, JW.; Kleber, RJ.; Hutschemaekers, GJM.; (2014) The Effectiveness of Art Therapy in the Treatment of Traumatized Adults. A Systematic Review on Art Therapy and Trauma. Trauma, Viloence and Abuse 16(2): 220-228	
Sciarrino 2017	RQ 1.1-1.2 & 2.1-2.2 update	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Sciarrino NA, DeLucia C, O'Brien K, McAdams K. Assessing the Effectiveness of Yoga as a Complementary and Alternative Treatment for Post-Traumatic Stress Disorder: A Review and Synthesis. The Journal of Alternative and Complementary Medicine. 2017 Oct 1;23(10):747-55.	
Scott 2017	RQ 1.1-1.2 & 2.1-2.2 (searches combined) AND RQ 1.1-1.2 & 2.1-2.2 update	Subgroup/secondary analysis that is not relevant	Scott JC, Harb G, Brownlow JA, Greene J, Gur RC, Ross RJ. Verbal memory functioning moderates psychotherapy treatment response for PTSD-Related nightmares. Behaviour research and therapy. 2017 Apr 30;91:24-32.	
Seal 2010	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention not targeted at PTSD symptoms	Scott K. Enhancing Cognitive Function and Reintegration in Iraq and Afghanistan Veterans With PTSD Using Computer-Based	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			Cognitive Training [NCT01087775]. 2010. Available from: https://clinicaltrials.gov/show/NCT01552278 [accessed 09.08.2017]	
Seal 2012	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention not targeted at PTSD symptoms	Seal, K. H., Abadjian, L., McCamish, N., Shi, Y., Tarasovsky, G., Weingardt, K. (2012) A randomized controlled trial of telephone motivational interviewing to enhance mental health treatment engagement in Iraq and Afghanistan veterans, General Hospital Psychiatry, 34, 450-459	
Sebastian 2017	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Sebastian, B.; Nelms, J.; (2017) the Effectiveness of Emotional Freedom Techniques in te Treatmetn of Posttraumatic Stress Disorder: A Meta-Analysis. EXPOLRE: the J of Science and Healing 13(1): 16-25	
Seda 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Seda, G.; Sanchez-Ortuno, MM.; Welsh, CH.; Halbower, AC.; Edinger, JD.; (2015) Comparative Meta-Analysis of Prazosin and Imagery Rehersal Therapy for Nightmare Frequency, Sleep Quality, and Posttraumatic Stress. J Clin Sleep Med 11)1): 11-22	
Seehausen 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Non-randomised group assignment	Seehausen A, Ripper S, Germann G, Hartmann B, Wind G, Renneberg B. Efficacy of a burn-	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			specific cognitive-behavioral group training. Burns. 2015 Mar 31;41(2):308-16.	
Seidler 2006	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Seidler, GH.; Wagner, FE.; (2006) Comparing the efficacy of EMDR and trauma-focued cognitive-behavioral therapy in the treatment of PTSD: a meta-analytic study. Psychological medicine 36: 1515-1522	
Seligowski 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Seligowski, AV.; Lee, DJ.; Bardeen, JR.; Orcutt, HK.; (2015) Emotion Regulation and Posttraumatic Stress Symptoms: A Meta-Analysis. Cognitive Behaviour Therapy 44(2): 87-102	
Serfaty 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Sample size (N<10/arm)	Serfaty M, Ridgewell A, Drennan V, Kessel A, Brewin CR, Wright A, Laycock G, Blanchard M. Helping Aged Victims of Crime (the HAVoC Study): Common crime, older people and mental illness. Behavioural and cognitive psychotherapy. 2016 Mar;44(2):140-55.	
Servan-Schreiber 2006	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Comparison outside scope	Servan-Schreiber D, Schooler J, Dew MA, Carter C, Bartone P. Eye movement desensitization and reprocessing for posttraumatic stress disorder: a pilot blinded, randomized study of stimulation type. Psychotherapy	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			and Psychosomatics. 2006;75(5):290-7.	
Shapiro 1989	2004 GL (excluded)	Non-RCT (no control group)	Shapiro, F. Eye movement desensitization: a new treatment for post-traumatic stress disorder (1989) Journal of Behaviour Therapy and Experimental Psychiatry, 20, 3, 211-217	
Shapiro 2002	2004 GL (excluded)	Non-RCT (no control group)	Shapiro, F. & Maxfield, L. (2002). Eye movement desensitization and reprocessing (EMDR): Information processing in the treatment of trauma. Journal of Clinical Psychology, 58, 933-946	
Shemesh 2011	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Efficacy or safety data cannot be extracted	Shemesh E, Annunziato RA, Weatherley BD, Cotter G, Feaganes JR, Santra M, Yehuda R, Rubinstein D. A randomized controlled trial of the safety and promise of cognitive-behavioral therapy using imaginal exposure in patients with posttraumatic stress disorder resulting from cardiovascular illness. Journal of Clinical Psychiatry. 2011 Feb 1;72(2):168.	
Sherr 2011	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Sherr, L.; Nagra, N.; Kulubya, G.; Catalan, J.; Clucas, C.; Harding, R.; (2011) HIV infection associated post-traumatic stress disorder and post-traumatic growth - A systematic review.	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			Psychology, Health & Medicine, 16(5): 612-629	
Shnaider 2017	RQ 1.1-1.2 & 2.1-2.2 (searches combined) AND RQ 1.1-1.2 & 2.1-2.2 update	Subgroup/secondary analysis of RCT already included	Shnaider P, Sijercic I, Wanklyn SG, Suvak MK, Monson CM. The Role of Social Support in Cognitive-Behavioral Conjoint Therapy for Posttraumatic Stress Disorder. Behavior Therapy. 2017 May 31;48(3):285-94.	
Sijbrandik 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Sijbrandij, M.; Kunovski, I.; Cuijpers, P.; (2016) Effectiveness of internet-delivered cognitive behavioral therapy for posttraumatic stress disorder: A systematic review and meta-analysis. Depression and Anxiety 33: 783-791	
Silver 2005	2004 GL (excluded)	Non-randomised group assignment	Silver SM, Rogers S, Knipe J, Colelli G. EMDR therapy following the 9/11 terrorist attacks: a community-based intervention project in New York City. International Journal of Stress Management. 2005 Feb;12(1):29.	
Skowronek 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Non-systematic review	Skowronek, IB.; Handler, L.; Guthmann, R.; (2014) Can yoga reduce symtpoms of anxiety and depression? J Fam Prac 63(7): 398-399	
Sloan 2011	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Sloan, DM.; Gallagher, MW.; Feinstein, BA.; Lee, DJ.; Pruneau, GM.; (2011) Efficacy of Telehealth	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			Treatments for Posttraumatic Stress-Related Symptoms: A Meta-Analysis. Cognitive Behaviour Therapy 40(2): 111-125	
Sloan 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Sloan, DM.; Feinstein, BA.; Gallagher, MW.; Beck, GJ.; Keane, TM.; (2013) Efficacy of Group Treatmetn for Posttraumatic Stress Disorder Symptoms: A Meta-Analysis. Psychological Trauma: Theory, Research, Practice, and Policy 5(2): 176-183	
Slobodin 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Non-systematic review	Slobodin, O.; De Jong JTVM.; (2015) Mental health interventions for traumatized asylum seekers and refugees: What do we know about their efficacy? Int J Social Psychiartry 61(1): 17-26	
Smith 2005	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Non-systematic review	Smith, MT.; Huany, MI.; Manber, R.; (2005) Cognitive behaviour therapy for chronic insomnia occurring within the context of medical and psychiatric disorders. Clin Psych Rev 25(5): 559-592	
Smith 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Outcomes are not of interest	Smith MJ, Boteler Humm L, Fleming MF, Jordan N, Wright MA, Ginger EJ, Wright K, Olsen D, Bell MD. Virtual reality job interview training for veterans with posttraumatic stress disorder. Journal of vocational	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			rehabilitation. 2015 Jan 1;42(3):271-9.	
Smyth 2008	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Efficacy or safety data cannot be extracted	Smyth JM, Hockemeyer JR, Tulloch H. Expressive writing and post-traumatic stress disorder: Effects on trauma symptoms, mood states, and cortisol reactivity. British Journal of Health Psychology. 2008 Feb 1;13(1):85-93.	
Soo 2007	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Soo, C.; Tate, RL.; (2007) Psychological treatment for anxiety in people with traumatic brain injury. Cochrane Database of Systematic Reviews. CD005239	
Spence 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Comparison outside scope	Spence J, Titov N, Johnston L, Jones MP, Dear BF, Solley K. Internet-based trauma-focused cognitive behavioural therapy for PTSD with and without exposure components: a randomised controlled trial. Journal of affective disorders. 2014 Jun 20;162:73-80.	
Stalker 1999	2004 GL (excluded)	Comparison outside scope	Stalker CA, Fry R. A comparison of short-term group and individual therapy for sexually abused women. The Canadian Journal of Psychiatry. 1999 Mar 1;44(2):168-74.	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Stapleton 2006	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Outcomes are not of interest	Stapleton, JA.; Taylor, S.; Asmundson, GJG.; (2006) Effects of Three PTSD Treatments on Anger and Guilt: Exposure Therapy, Eye Movement Desensitization and Reprocessing, and Relaxation. J Traumatic Stress 19 (1): 19-28	
Steenkamp 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Steenkamp, MM.; Litz, BT.; Hoge, CW.; (2015) Psychotherapy for Military-Related PTSD. A Review of Randomized Clinical Trials. JAMA 314(5): 489-500	
Steinmetz 2012	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Comparison outside scope	Steinmetz SE, Benight CC, Bishop SL, James LE. My Disaster Recovery: a pilot randomized controlled trial of an Internet intervention. Anxiety, Stress & Coping. 2012 Sep 1;25(5):593-600.	
Stephenson 2017	RQ 1.1-1.2 & 2.1-2.2 update	Efficacy or safety data cannot be extracted	Stephenson KR, Simpson TL, Martinez ME, Kearney DJ. Changes in mindfulness and posttraumatic stress disorder symptoms among veterans enrolled in mindfulness-based stress reduction. Journal of clinical psychology. 2017 Mar 1;73(3):201-17.	
Stergiopoulos 2011	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Stergiopoulos, E.; Cimo, A.; Cheng, C.; Bonato, S.; Dewa, CS.; (2011) Interventions to improve work outcomes in wrok-	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			related PTSD: a systematic review. BMC Public Health 11:838	
Stewart 2009a	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Stewart, CL.; Wrobel, TA.; (2009) Evaluation of the Efficacy of Pharmacotherapy and Psychotherapy in Treatmetn of Combat-Related Post-Traumatic Stress Disorder: A Meta-Analytic Review of Outcome Studies. Military Medicine 174.5: 460-469	
Stewart 2009b	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Stewart, RE.; Chambless, DL.; (2009) Cognitive-Behavioral Therapy for Adult Anxiety Disorders in Clinical Practice: A Meta-Analysis of Effectiveness Studies. J Consulting and Clinical Psychology 77(4): 595-606	
Strauss 2009	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Non-RCT (no control group)	Strauss JL, Calhoun PS, Marx CE. Guided Imagery as a Therapeutic Tool in Post-Traumatic Stress Disorder. InPost-Traumatic Stress Disorder 2009 (pp. 363-373). Humana Press.	
Stubbs 2017	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Stubbs, B.; Vancampfort, D.; Rosenbaum, S.; Firth, J.; Cosco, T.; Veronese, N.; Salum, GA.; Schuch, FB.; (2017) An examination of the anxiolytic effects of exercise for people with anxiety and stress-related disorders: A meta-analysis.	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			Psychiatry Research 249: 102-108	
Swift 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Swift, JK.; Greenberg, RP.; (2014) A Treatment by Disorder Meta-Analysis of Dropout From Psychotherapy. J Psychotherapy Integration 24(3): 193-207	
Tarrier 1999a/1999b	2004 GL (included)	Comparison outside scope	Tarrier, N., Sommerfield, C., Pilgrim, H., & Humphreys, L. (1999). Cognitive therapy or imaginal exposure in the treatment of post- traumatic stress disorder: Twelve-month follow-up. British Journal of Psychiatry, 175, 571-575.	Tarrier, N., Pilgrim, H., Sommerfield, C., Faragher, B., Reynolds, M., Graham, E. et al. (1999). A randomized trial of cognitive therapy and imaginal exposure in the treatment of chronic posttraumatic stress disorder. Journal of Consulting & Clinical Psychology, 67, 13-18.
Tarrier 2004	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis that is not relevant	Tarrier N, Sommerfield C. Treatment of chronic PTSD by cognitive therapy and exposure: 5-year follow-up. Behavior Therapy. 2004 May 31;35(2):231-46.	
Taylor 2009	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Taylor, JE.; Harvey, ST.; (2009) Effects of psychotherapy with people who have been sexually assaulted: A meta-analysis. 14(5): 273-285	
Taylor 2010	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Taylor, JE.; Harvey, ST.; (2010) A meta-analysis of the effects of psychotherapy with adults sexually abused in childhood. Clinical Psychology Review 30(6): 749-767	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Taylor 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Taylor, DJ.; Pruiksma, KE.; (2014) Cognitive and behavioural therapy for insomnia (CBT-I) in psychiatric populations: A systematic review. Int Rev Psychiatry 26(2): 205-213	
Taylor 2017	RQ 1.1-1.2 & 2.1-2.2 update	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Taylor M, Petrakis I, Ralevski E. Treatment of alcohol use disorder and co-occurring PTSD. The American journal of drug and alcohol abuse. 2017 Jul 4;43(4):391-401.	
Teng 2008	Handsearch	Intervention not targeted at PTSD symptoms	Teng, EJ.; Bailey, SD.; Chaison, AD.; Peterson, NJ.; Hamilton, JD.; Dunn, NJ.; (2008) Treating Comorbid Panic Disorder in Veterans with Posttraumatic Stress Disorder. J Consul and Clin Psych 76(4): 704-710	
Teng 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Teng, EJ.; Hiatt, EL.; McClair, V.; Kunik, ME.; Frueh, BC.; Stanley, MA.; (2013) Efficacy of Posttraumatic Stress Disorder Treatment for Comorbid Panic Disorder: A Critical Review and Future Directions for Treatment Research. Clinical Psychology, Science and Practice 20(3): 268-284	
Ter Heide 2011	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Sample size (N<10/arm)	Ter Heide FJ, Mooren T, Kleijn W, de Jongh A, Kleber R. EMDR versus stabilisation in traumatised asylum seekers and refugees: Results of a pilot study. European	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			journal of psychotraumatology. 2011 Jan 1;2(1):5881.	
Thompson 1995	Handsearch	Intervention outside protocol	Thompson J, Chung MC, Jackson G, Rosser R. A comparative trial of psychotherapy in the treatment of post-trauma stress reactions. Clinical Psychology & Psychotherapy. 1995 Oct 1;2(3):168-76.	
Thrasher 2010	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Thrasher S, Power M, Morant N, Marks I, Dalgleish T. Social support moderates outcome in a randomized controlled trial of exposure therapy and (or) cognitive restructuring for chronic posttraumatic stress disorder. The Canadian Journal of Psychiatry. 2010 Mar;55(3):187-90.	
Thunker 2012	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Sample size (N<10/arm)	Thünker J, Pietrowsky R. Effectiveness of a manualized imagery rehearsal therapy for patients suffering from nightmare disorders with and without a comorbidity of depression or PTSD. Behaviour Research and Therapy. 2012 Sep 30;50(9):558-64.	
Tirado-Munoz 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Tirado-Munoz, J.; Gilchrist, G.; Farre, M.; Hegarty, K.; Torrens, M.; (2014) The efficay of cognitive behavioural therap and advocacy interventions for women who have experienced intimate	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			partner violence: A systematic review and meta-analysis. Annals of Medicine 46(8): 567-586	
Torchalla 2012	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Torchally, I.; Nosen, L.; Rostam, H.; Allen, P.; (2012) Integrated treatment programs for individulas with concurrent substance use disorders and trauma experiences: A systematic review and meta-analysis. J Substance Abuse Treatment 42(1): 65-77	
Tran 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined) AND Cochrane allRQ update	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Tran, US.; Gregor, B.; (2016) The relative efficacy of bona fide psychotherapies for post-traumatic stress disorder: a meta-analytical evaluatoin of randomized controlled trials. BMC Psychiatry 16:266	
Triffleman 2000	2004 GL (excluded)	Sample size (N<10/arm)	Triffleman, E. (2000). Gender differences in a controlled pilot study of psychosocial treatments in substance dependent patients with post-traumatic stress disorder: Design considerations and outcomes. Alcoholism Treatment Quarterly, 18, 113-126.	
Turner 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Turner, WA.; Casey, LM.; (2014) Outcomes associated with virtual reality in psychological interventions: where are we now? Clinical Psychology Review 34(8): 634-644	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Ulmer 2008/2011	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Sample size (N<10/arm)	Ulmer CS.Treating Co-Morbid Sleep Difficulties in Veterans With PTSD: A Pilot Study [NCT00734799]. 2008. Available from: https://www.clinicaltrials.gov/ct2/show/NCT00734799 [accessed 09.08.2017]	Ulmer CS, Edinger JD, Calhoun PS. A multi-component cognitive-behavioral intervention for sleep disturbance in veterans with PTSD: a pilot study. Journal of clinical sleep medicine: JCSM: official publication of the American Academy of Sleep Medicine. 2011 Feb 15;7(1):57.
Uttley 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Uttley, L.; Stevenson, M.; Scope, A.; Rawdin, A.; Sutton, A.; (2015) The clinical and cost effectiveness of group art therapy for people with non-psychotic mental health disorders: a systematic review and cost effectiveness analysis. BMS Psychiatry 15:151	
Valentine (unpublished a)	2004 GL (excluded)	Paper unavailable	Valentine, P. V. & Smith, T. E. (US). Evaluating traumatic incident reduction therapy with female inmates: A randomized controlled clinical trial. Research on Social Work Practice, 11, Jan-52.	
Valentine (unpublished b)	2004 GL (excluded)	Paper unavailable	Valentine, P. V. (US). Traumatic Incident Reduction I: Traumatized women inmates: Particulars of practice and research. Journal of Offender Rehabilitation, 31, 2000-2015.	
Vally 2016	RQ 1.1-1.2 & 2.1-2.2 update	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Vally Z, Abrahams L. The effectiveness of peer-delivered services in the management of mental health conditions: a meta-	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			analysis of studies from low-and middle-income countries. International Journal for the Advancement of Counselling. 2016 Dec 1;38(4):330-44.	
Valmaggia 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Valmaggia, LR.; Latif, L.; Kempton, MJ.; Rus-Calafell, MR.; (2016) Virtual reality in the psychological treatment for mental health problems: An systematic review of recent evidence. Psychiatry Research 236(28): 189-195	
Van Dam 2012	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Van Dam, D.; Vedel, E.; Ehring, T.; Emmelkamp, PMG.; (2012) Psychological treatments for concurrent posttraumatic stess disorder and substance use disorder: A systematic review. Clinical Psychology Review 32(3): 202-214	
Van Emmerik 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Van Emmerik, AP.; Reijntes, A.; Kamphuis, JH.; (2013) Writing Therapy for Posttraumatic Stress: A Meta-Analysis. Psychotherapy and Psychosomatics 82(2): 82-88	
Van Loon 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Van Loon, A.; Van Schaik, A.; Dekker, J.; Beekman, A.; (2013) Bridging the gap for ethnic minority adult outpatients with depression and anxiety disorders by culturally adapted treatments.	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			J Affective Disorders 147(1-3): 9-16	
van Minnen 2006	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Comparison outside scope	van Minnen A, Foa EB. The effect of imaginal exposure length on outcome of treatment for PTSD. Journal of Traumatic Stress. 2006 Aug 1;19(4):427-38.	
Van Minnen 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Non-systematic review	Van Minnen, A.; Zoellner, LA.; Harned, MS.; Mills, K.; (2015) Changes in Comorbid Conditions After Prolonged Exposure for PTSD: a Literature Review. Current Psychiatry Reports 17:17	
Van Til 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Van Til, L.; Fikretogul, D.; Pranger, T.; Patten, S.; Wang, J.; Wong, M.; Zamorski, M.; Loisel, P.; Corbiere, M.; Shields, N.; Thompson, J.; Pedler, D.; (2013) Work Reintegration for Veterans With Mental Disorders: A Systematic Literature Review to Inform Research. Physical Therapy 93(9): 1163-1174	
Van't Hof 2011	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Paper unavailable	Van't Hof, E.; Stein, DJ.; Van't Hof, E.; Cuijpers, P.; Waheed, W.; (2011) Psychological treatments for depression and anxiety disorders in low- and middle-income countries: a meta-analysis: a review. African Journal of Psychiatry 14(3): 200-207	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Vaughan 1994a	2004 GL (included)	Cross-over study and first phase data not available	Vaughan, K., Armstrong, M. S., Gold, R., O'Connor, N., Jenneke, W., & Tarrier, N. (1994). A trial of eye movement desensitization compared to image habituation training and applied muscle relaxation in post-traumatic stress disorder. Journal of Behavior Therapy & Experimental Psychiatry, 25, 283-291.	
Vaughan 1994b	2004 GL (excluded)	Non-randomised group assignment	Vaughan, K.; Wiese, M.; Gold, R, Tarrier, N. (1994) Eye movement desensitization. Symptom change in post-traumatic stress disorder. British Journal of Psychiatry, 164, 533-541	
Verhey 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Verhey, R.; Chibanda, D.; Brakarsh, J.; Seedat, S.; (2016) Psychological interventions for post-traumatic stress disorder in peple living with HIV in Resource poor settings: a systematic review. Tropical Medicine and and Int Health 21(10): 1198-1208	
Voshaar 2009	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Non-systematic review	Voshaar, RCO.; Hendriks, GJ.; Keijsers, G.; Van Balkom, AJ.; (2009) Cognitive behavioural therapy for anxiety disorders in later life. Cochrane Database for Systematic Reveiws. CD007674	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Wade 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Wade, D.; Varker, T.; Kartal, D.; Hetrick, S.; O'Donnell, M.; Forbes, D.; (2016) Gender Differences in Outcomes Following Trauma-Focused Interventions for Posttraumatic Stress Disorder: Systematic Review and Meta-Analysis. Psychological Trauma: Theory, Research, Practice and Policy. 8(3): 356-364	
Wagner 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Wagner AC, Torbit L, Jenzer T, Landy MS, Pukay-Martin ND, Macdonald A, Fredman SJ, Monson CM. The Role of Posttraumatic Growth in a Randomized Controlled Trial of Cognitive–Behavioral Conjoint Therapy for PTSD. Journal of traumatic stress. 2016 Aug 1;29(4):379-83.	
Wahbeh 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Wahbeh, H.; Senders, A.; Neuendorf, R.; (2014) Complementary and Alternative Medicine for Posttraumatic Stress Disorder Symtoms. A Systematic Review. J Evidence-Based Complementary and Alternative Medicine 19(3): 161-175	
Wang 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Efficacy or safety data cannot be extracted	Wang Z, Wang J, Maercker A. Chinese My Trauma Recovery, a Web-based intervention for traumatized persons in two parallel samples: randomized	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			controlled trial. Journal of medical Internet research. 2013 Sep;15(9).	
Watson 1997	2004 GL (excluded)	Comparison outside scope	Watson, C. G., Tuorila, J. R., Vickers, K. S., Gearhart, L. P., & Mendez, C. M. (1997). The efficacies of three relaxation regimens in the treatment of PTSD in Vietnam war veterans. Journal of Clinical Psychology, 53, 917-923.	
Watts 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Paper unavailable	Watts, BV.; Schnurr, PP.; Mayo, L.; Young-Xu, Y.; Weeks, WB.; Friedman, MJ.; (2013) Meta-analysis of the efficacy of treatments for posttraumatic stress disorder. Journal Clinical Psychiatry 74)6): e541-550	
Weine 1998	2004 GL (excluded)	Non-randomised group assignment	Weine, S. M., Kulenovic, A. D., Pavkovic, I., & Gibbons, R. (1998). Testimony psychotherapy in Bosnian refugees: A pilot study. American Journal of Psychiatry, 155, 1720-1726.	
Weine 2008	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention not targeted at PTSD symptoms	Weine S, Kulauzovic Y, Klebic A, Besic S, Mujagic A, Muzurovic J, Spahovic D, Sclove S, Pavkovic I, Feetham S, Rolland J. Evaluating a multiple-family group access intervention for refugees with PTSD. 2008. April; 34(2):149-64.	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Wells 2004	ISTSS included lists	Non-RCT (no control group)	Wells A, Sembi S. Metacognitive therapy for PTSD: A preliminary investigation of a new brief treatment. Journal of Behavior Therapy and Experimental Psychiatry. 2004 Dec 31;35(4):307-18.	
Whitworth 2016	RQ 1.1-1.2 & 2.1-2.2 update	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Whitworth JW, Ciccolo JT. Exercise and post-traumatic stress disorder in military veterans: a systematic review. Military medicine. 2016 Sep 1;181(9):953-60.	
Williams 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined) AND 2004 GL (included)	Intervention not targeted at PTSD symptoms	Williams JK, Glover DA, Wyatt GE, Kisler K, Liu H, Zhang M. A sexual risk and stress reduction intervention designed for HIV-positive bisexual African American men with childhood sexual abuse histories. Am J Public Health. 2013 Aug;103(8):1476-84. doi: 10.2105/AJPH.2012.301121.	
Wilson 1995/1997	2004 GL (excluded)	Efficacy or safety data cannot be extracted	Wilson, S. A., Becker, L. A., & Tinker, R. H. (1995). Eye movement desensitization and reprocessing (EMDR) treatment for psychologically traumatized individuals. Journal of Consulting & Clinical Psychology, 63, 928-937.	Wilson, S.A.; Becker, L.A.; Tinker, R.H. (1997) Fifteen-month follow-up of eye movement desensitization and reprocessing (EMDR) treatment for posttraumatic stress disorder and psychological trauma. Journal of Consulting & Clinical Psychology, 65, 6, 1047-1056
Wilson 1996	2004 GL (excluded)	Sample size (N<10/arm)	Wilson, D. L., Silver, S. M., Covi, W. G., & Foster, S. (1996). Eye movement desensitization and	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			reprocessing: effectiveness and autonomic correlates. Journal of Behavior Therapy & Experimental Psychiatry, 27, 219-229.	
Wilson unpublished	Handsearch	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Wilson, G., Farrell, D., Kiernan, M. An examination of evidence for the use of eye-moveemnt desensitisation reprocessing therapy (EMDR) in treating post-traumatic stress disorder - a systematic narrative review	
Winhusen 2012	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Winhusen T, Winstanley EL, Somoza E, Brigham G. The potential impact of recruitment method on sample characteristics and treatment outcomes in a psychosocial trial for women with co-occurring substance use disorder and PTSD. Drug and alcohol dependence. 2012 Jan 1;120(1):225-8.	
Wisco 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Wisco BE, Sloan DM, Marx BP. Cognitive emotion regulation and written exposure therapy for posttraumatic stress disorder. Clinical Psychological Science. 2013 Oct;1(4):435-42.	
Wisco 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Wisco BE, Baker AS, Sloan DM. Mechanisms of change in written exposure treatment of posttraumatic stress disorder. Behavior therapy. 2016 Jan 31;47(1):66-74.	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Wolf 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Wolf EJ, Lunney CA, Schnurr PP. The influence of the dissociative subtype of posttraumatic stress disorder on treatment efficacy in female veterans and active duty service members. Journal of consulting and clinical psychology. 2016 Jan;84(1):95.	
Woodward 2017	RQ 1.1-1.2 & 2.1-2.2 update	Subgroup/secondary analysis of RCT already included	Woodward E, Hackmann A, Wild J, Grey N, Clark DM, Ehlers A. Effects of psychotherapies for posttraumatic stress disorder on sleep disturbances: Results from a randomized clinical trial. Behaviour research and therapy. 2017 Oct 1;97:75-85.	
Wynn 2015	RQ 5.1_5.2_adhoc	Non-systematic review	Wynn, G. (2015) Complementary and Alternative Medicine Approaches in the Treatment of PTSD, Current Psychiatry Reports, 62	
York 2011	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Non-systematic review	York, A.; Crawford, C.; Walter, JAG.; Jonas, WB.; Coeytaux,R.; (2011) Acupuncture Research in Military and Veteran Populations: A Rapid Evidence Assessment of the Literature. Medical Acupuncture 23(4): 229-236	
Yun 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Efficacy or safety data cannot be extracted	Yun YH, Lee MK, Bae Y, Shon EJ, Shin BR, Ko H, Lee ES, Noh DY, Lim JY, Kim S, Kim SY. Efficacy of a training program for long-term disease-free cancer	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			survivors as health partners: a randomized controlled trial in Korea. Asian Pacific Journal of Cancer Prevention. 2013;14(12):7229-35.	
Zandberg 2016a	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Zandberg LJ, Rosenfield D, McLean CP, Powers MB, Asnaani A, Foa EB. Concurrent treatment of posttraumatic stress disorder and alcohol dependence: Predictors and moderators of outcome. Journal of consulting and clinical psychology. 2016 Jan;84(1):43.	
Zandberg 2016b	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Zandberg LJ, Rosenfield D, Alpert E, McLean CP, Foa EB. Predictors of dropout in concurrent treatment of posttraumatic stress disorder and alcohol dependence: Rate of improvement matters. Behaviour research and therapy. 2016 May 31;80:1-9.	
Zang 2017	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Zang Y, Yu J, Chazin D, Asnaani A, Zandberg LJ, Foa EB. Changes in coping behavior in a randomized controlled trial of concurrent treatment for PTSD and alcohol dependence. Behaviour research and therapy. 2017 Mar 31;90:9-15.	
Zoellner 1999	Handsearch	Efficacy or safety data cannot be extracted	Zoellner LA, Feeny NC, Fitzgibbons LA, Foa EB.	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			Response of African American and Caucasian women to cognitive behavioral therapy for PTSD. Behavior Therapy. 1999 Nov 30;30(4):581-95.	
Zucker 2009	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Comparison outside scope	Zucker TL, Samuelson KW, Muench F, Greenberg MA, Gevirtz RN. The effects of respiratory sinus arrhythmia biofeedback on heart rate variability and posttraumatic stress disorder symptoms: A pilot study. Applied psychophysiology and biofeedback. 2009 Jun 1;34(2):135.	
Lee 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Sample size (N<10/arm)	Adenauer H, Catani C, Gola H, Keil J, Ruf M, Schauer M, Neuner F. Narrative exposure therapy for PTSD increases top-down processing of aversive stimuli-evidence from a randomized controlled treatment trial. BMC neuroscience. 2011 Dec 19;12(1):127.	
Leeman 2017	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Aderka IM, Gillihan SJ, McLean CP, Foa EB. The relationship between posttraumatic and depressive symptoms during prolonged exposure with and without cognitive restructuring for the treatment of posttraumatic stress disorder. Journal of	Catani C, Neuner F. Change of Neural Network Indicators Through Narrative Treatment of PTSD in Torture Victims [NCT00563888]. 2010. Available from: https://clinicaltrials.gov/ct2/show/NCT00563888 [accessed 28.07.2017]

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			consulting and clinical psychology. 2013 Jun;81(3):375.	
Leichsenring 2005	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Population outside scope: Trials of soldiers on active service	Adler AB, Litz BT, Castro CA, Suvak M, Thomas JL, Burrell L, McGurk D, Wright KM, Bliese PD. A group randomized trial of critical incident stress debriefing provided to US peacekeepers. Journal of traumatic stress. 2008 Jun 1;21(3):253-63.	
Leichsenring 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Population outside scope: Trials of soldiers on active service	Ahmadi K, Hazrati M, Ahmadizadeh M, Noohi S. REM desensitization as a new therapeutic method for post-traumatic stress disorder: a randomized controlled trial. Acta Medica Indonesiana. 2015;47(2).	
Leichsenring 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Albright DL, Thyer B. Does EMDR reduce post-traumatic stress disorder symptomatology in combat veterans?. Behavioral Interventions. 2010 Feb 1;25(1):1-9.	
Leiner 2012	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Efficacy or safety data cannot be extracted	Allan NP, Short NA, Albanese BJ, Keough ME, Schmidt NB. Direct and mediating effects of an anxiety sensitivity intervention on posttraumatic stress disorder symptoms in trauma-exposed individuals. Cognitive behaviour therapy. 2015 Nov 2;44(6):512-24.	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Lenz 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Sample size (N<10/arm)	Amir N. Information Processing Modification in the Treatment of PTSD [NCT00604045]. 2014. Available from: https://clinicaltrials.gov/ct2/show/study/NCT00604045 [accessed 08.08.2017]	
Lenz 2017	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Efficacy or safety data cannot be extracted	Anderson T, Fende Guajardo J, Luthra R, Edwards KM. Effects of clinician-assisted emotional disclosure for sexual assault survivors: A pilot study. Journal of interpersonal violence. 2010 Jun;25(6):1113-31.	
Lester 2010	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis that is not relevant	Anderson ML, Najavits LM. Does seeking safety reduce PTSD symptoms in women receiving physical disability compensation?. Rehabilitation psychology. 2014 Aug;59(3):349.	
Lester 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Comparison outside scope	Andersson MA, Conley CS. Optimizing the perceived benefits and health outcomes of writing about traumatic life events. Stress and Health. 2013 Feb 1;29(1):40-9.	
Liedl 2011	2004 GL (excluded)	Non-English language paper	Andre, C., Lelord, F., Legeron, P., Reignier, A., & Delattre, A. (1997). Effectiveness of early intervention on 132 bus drivers who have been victims of aggression: A	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			controlled study. Encephale, 23, 65-71.	
Lindauer 2006	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Unpublished (registered on clinical trials registry and author contacted for full trial report but not provided)	Angelakis, S. The utility of combining cognitive processing therapy and behavioural activation for individuals with comorbid posttraumatic stress disorder and major depressive disorders: Is there added benefit to combining treatments? 2010. Available from: https://www.anzctr.org.au/Trial/Registration/TrialReview.aspx?ACTRN=12611000541909 [accessed 26.07.2017]	
Litz 2007	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Paper unavailable	NCT00055354. Acupuncture Diagnosis and Treatment of DSM-IV PTSD. Available from: https://clinicaltrials.gov/ct2/show/NCT00055354 [accessed 26.07.2017]	
Liverant 2012	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Efficacy or safety data cannot be extracted	Arabia E, Manca ML, Solomon RM. EMDR for survivors of life-threatening cardiac events: results of a pilot study. Journal of EMDR Practice and Research. 2011 Feb 1;5(1):2-13.	
Lloyd 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Comparison outside scope	Arntz A, Tiesema M, Kindt M. Treatment of PTSD: A comparison of imaginal exposure with and without imagery rescripting. Journal of behavior therapy and experimental	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			psychiatry. 2007 Dec 31;38(4):345-70.	
Lopez-Castro 2015	RQ 1.1-1.2 & 2.1-2.2 update	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Arroyo K, Lundahl B, Butters R, Vanderloo M, Wood DS. Short-term interventions for survivors of intimate partner violence: a systematic review and meta-analysis. Trauma, Violence, & Abuse. 2017 Apr;18(2):155-71.	
Lunney 2007	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Augedal AW, Hansen KS, Kronhaug CR, Harvey AG, Pallesen S. Randomized controlled trials of psychological and pharmacological treatments for nightmares: A meta-analysis. Sleep Medicine Reviews. 2013 Apr 30;17(2):143-52.	
Macdonald 2011	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Unpublished (registered on clinical trials.gov and author contacted for full trial report but not provided)	Back, S. Integrated Treatment of OEF/OIF Veterans With PTSD & Substance Use Disorders (COPE). NCT01338506. 2011. Available from: https://clinicaltrials.gov/ct2/show/NCT01338506 [accessed 26.07.2017]	
Macdonald 2016b	RQ 1.1-1.2 & 2.1-2.2 update	Subgroup/secondary analysis that is not relevant	Badour CL, Flanagan JC, Gros DF, Killeen T, Pericot-Valverde I, Korte KJ, Allan NP, Back SE. Habituation of distress and craving during treatment as predictors of change in PTSD symptoms and substance use severity. Journal of consulting and	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			clinical psychology. 2017 Mar;85(3):274.	
Marcus 1997/2004	RQ 1.1-1.2 & 2.1-2.2 update	Subgroup/secondary analysis of RCT already included	Badura-Brack A, McDermott TJ, Becker KM, Ryan TJ, Khanna MM, Pine DS, Bar-Haim Y, Heinrichs-Graham E, Wilson TW. Attention training modulates resting-state neurophysiological abnormalities in posttraumatic stress disorder. Psychiatry Research: Neuroimaging. 2018 Jan 30;271:135-41.	
Markowitz 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention not targeted at PTSD symptoms	Banerjee, B., Vadiraj, H. S., Ram, A., Rao, R., Jayapal, M., Gopinath, K. S., Ramesh, B. S., Rao, N., Kumar, A., Raghuram, N., Hegde, S., Nagendra, H. R., Prakash Hande, M. (2007) Effects of an integrated yoga program in modulating psychological stress and radiation-induced genotoxic stress in breast cancer patients undergoing radiotherapy, Integrative Cancer Therapies, 6, 242-250	
Markowitz 2015b	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Banks K, Newman E, Saleem J. An overview of the research on mindfulness-based interventions for treating symptoms of posttraumatic stress disorder: A systematic review. Journal of clinical psychology. 2015 Oct 1;71(10):935-63.	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Markowitz 2017	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention not targeted at PTSD symptoms	Baños RM, Guillen V, Quero S, Garcia-Palacios A, Alcaniz M, Botella C. A virtual reality system for the treatment of stress-related disorders: A preliminary analysis of efficacy compared to a standard cognitive behavioral program. International Journal of Human-Computer Studies. 2011 Aug 31;69(9):602-13.	
Marks 1998/Lovell 2001	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Non-randomised group assignment	Barabasz A, Barabasz M, Christensen C, French B, Watkins JG. Efficacy of single-session abreactive ego state therapy for combat stress injury, PTSD, and ASD. International Journal of Clinical and Experimental Hypnosis. 2013 Jan 1;61(1):1-9.	
Martin 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Barrera, TL.; Mott, JM.; Hofstein, RF.; Teng, EJ.; (2013) A meta-analytic review of exposure in group cognitive behavioral therapy for posttraumatic stress disorder. Clin Psych Rev 33 (1): 24-32	
Marzabadi 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Barton, S.; Karner, C.; Salih, F.; Baldwin, DS.; Edwards, SJ.; (2014) Clinical effectiveness of interventions for treatment-resisitant anxiety in older people: a systematic review. Health Tech Ass 18 (50): 1366-5278	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Maxwell 2016	2004 GL (excluded)	Paper unavailable	Basoglu, M., Salcioglu, E., Livanou, M., Kalender, D., Acar, G. Single-session behavioral treatment of earthquake-related posttraumatic stress disorder: A randomized waitlist controlled trial. Journal of Traumatic Stress (in press).	
Mayo-Wilson 2013	2004 GL (excluded)	Non-RCT (no control group)	Basoglu, M., Livanou, M., Salcioglu, E., & Kalender, D. (2003). A brief behavioural treatment of chronic post-traumatic stress disorder in earthquake survivors: results from an open clinical trial. Psychol.Med, 33, 647-654.	
McCann 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Population not relevant for this review (to be considered for other relevant RQ)	Battersby MW, Beattie J, Pols RG, Smith DP, Condon J, Blunden S. A randomised controlled trial of the Flinders Program™ of chronic condition management in Vietnam veterans with co-morbid alcohol misuse, and psychiatric and medical conditions. Australian & New Zealand Journal of Psychiatry. 2013 May;47(5):451-62.	
McFarlane 2012	RQ 1.1-1.2 & 2.1-2.2 update	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Bean RC, Ong CW, Lee J, Twohig MP. Acceptance and commitment therapy for PTSD and trauma: An empirical review. The Behavior Therapist. 2017;4,145-150.	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
McHugh 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Comparison outside scope	Beatty L, Koczwara B, Wade T. Evaluating the efficacy of a self-guided Web-based CBT intervention for reducing cancer-distress: a randomised controlled trial. Supportive Care in Cancer. 2016 Mar 1;24(3):1043-51.	
McLay 2009	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Comparison outside scope	Beidel DC, Frueh BC, Uhde TW, Wong N, Mentrikoski JM. Multicomponent behavioral treatment for chronic combat-related posttraumatic stress disorder: A randomized controlled trial. Journal of anxiety disorders. 2011 Mar 31;25(2):224-31.	
McLay 2011	RQ 1.1-1.2 & 2.1-2.2 (searches combined) AND Cochrane allRQ update	Comparison outside scope	Beidel DC, Frueh BC, Neer SM, Bowers CA, Trachik B, Uhde TW, Grubaugh A. Trauma management therapy with virtual-reality augmented exposure therapy for combat-related PTSD: A randomized controlled trial. Journal of anxiety disorders. 2017 Aug 23.	
McLay 2017	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Bekker, MHJ.; van Mens-Verhulst J.; (2007) Anxiety Disorders: Sex Differences in Prevalence, Degree and Background, But Gender-Neutral Treatment. Gender Med 4 (S2): S178-S193.	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
McLean 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Efficacy or safety data cannot be extracted	Belleau EL, Chin EG, Wanklyn SG, Zambrano-Vazquez L, Schumacher JA, Coffey SF. Pre-treatment predictors of dropout from prolonged exposure therapy in patients with chronic posttraumatic stress disorder and comorbid substance use disorders. Behaviour Research and Therapy. 2017 Apr 30;91:43-50.	
McPherson 2011	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Benish, SG.; Imel, ZE.; Wampold, BE.; (2008) The relative efficacy of bona fide psychotherapies for treating post-traumatic stress disorder: A meta-analysis of direct comparisons.	
Meffert 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Outcomes are not of interest	Bergen-Cico D, Possemato K, Pigeon W. Reductions in cortisol associated with primary care brief mindfulness program for veterans with PTSD. Medical Care. 2014 Dec 1;52:S25-31.	
Meier 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Berlim, MT.; Wan den Eynde, F.; (2014) Repetitive Transcranial Magnetic Stimulation over the Dorsolateral Prefrontal Cortex for Treating Posttraumatic Stress Disorder: An Exploratory Meta-Analysis of Randomized Double-Blind and Sham-Controlled Trials. The Canadian J of Psychiartry 59 (9)	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Mello 2014	ISTSS included lists	Sample size (N<10/arm)	Bichescu D, Neuner F, Schauer M, Elbert T. Narrative exposure therapy for political imprisonment-related chronic posttraumatic stress disorder and depression. Behaviour research and therapy. 2007 Sep 30;45(9):2212-20.	
Mendes 2008	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Bisson, J.; Andrew,; Psychological treatment of post-traumatic stress disorder (PTSD) (2007)Cochrane Database of Systematic Reviews	
Metcalf 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Bisson, JI.; Ehlers, A.; Matthews, R.; Pilling, S.; Richards, D.; Turner, S.; (2007) Psychological treatments for chronic post-traumatic stress disorder. Systematic review and meta-analysis. British J Psych 190: 97-104	
Meyerbroker 2010	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Bisson, J.; Roberts, NP.; Andre, M.; Cooper, R.; Lewis, C.; (2013). Psychological therapies for chronic post-traumatice stress disorder (PTSD) in adults. Cochrane Database of Systematic Reviews	
Mills 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Non-randomised group assignment	Boals A, Murrell AR. I am> trauma: Experimentally reducing event centrality and PTSD symptoms in a clinical trial. Journal of Loss and Trauma. 2016 Nov 1;21(6):471-83.	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Minnen 2006	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Boccia, M.; Piccardi, L.; Cordellieri, P.; Guariglia, C.; Giannini, AM.; (2015) EMDR therapy for PTSD after motor vehicle accidents: meta-analytic evidence for specific treatment. Front Hum Neurosci 9: 213	
Mitchell 2012	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Non-randomised group assignment	Boden MT, Kimerling R, Jacobs-Lentz J, Bowman D, Weaver C, Carney D, Walser R, Trafton JA. Seeking Safety treatment for male veterans with a substance use disorder and post-traumatic stress disorder symptomatology. Addiction. 2012 Mar 1;107(3):578-86.	
Miyahira 2012	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Efficacy or safety data cannot be extracted	Boggio PS, Rocha M, Oliveira MO, Fecteau S, Cohen RB, Campanhã C, Ferreira-Santos E, Meleiro A, Corchs F, Zaghi S, Pascual-Leone A. Noninvasive brain stimulation with high-frequency and low-intensity repetitive transcranial magnetic stimulation treatment for posttraumatic stress disorder. The Journal of clinical psychiatry. 2010 Aug;71(8):992.	Boden MT, Kimerling R, Kulkarni M, Bonn-Miller MO, Weaver C, Trafton J. Coping among military veterans with PTSD in substance use disorder treatment. Journal of substance abuse treatment. 2014 Aug 31;47(2):160-7.
Mogk 2006	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Bolton, AJ.; Dorstyn, DS.; (2015) Telepsychology for Posttraumatic Stress Disorder: A Systematic reivew. J Telemedicine and Telecare 21 (5)	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Monson 2005	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Comparison outside scope	Bomyea J, Stein MB, Lang AJ. Interference control training for PTSD: A randomized controlled trial of a novel computer-based intervention. Journal of anxiety disorders. 2015 Aug 31;34:33-42.	
Moradi 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention not targeted at PTSD symptoms	Bomyea J, Lang AJ, Schnurr PP. TBI and Treatment Response in a Randomized Trial of Acceptance and Commitment Therapy. The Journal of head trauma rehabilitation. 2017 Jan.	
Morgan-Lopez 2014	2004 GL (excluded)	Non-randomised group assignment	Bordow, S. & Porritt, D. (1979). An experimental evaluation of crisis intervention. Social Science & Medicine, 13A, 251-256.	
Morina 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention not targeted at PTSD symptoms	Boritz T, Barnhart R, McMain SF. The influence of posttraumatic stress disorder on treatment outcomes of patients with borderline personality disorder. Journal of personality disorders. 2016 Jun;30(3):395-407.	
Morina 2017a	RQ 1.1-1.2 & 2.1-2.2 (searches combined) AND Cochrane allRQ update	Subgroup/secondary analysis of RCT already included	Böttche M, Kuwert P, Pietrzak RH, Knaevelsrud C. Predictors of outcome of an Internet-based cognitive-behavioural therapy for post-traumatic stress disorder in older adults. Psychology and Psychotherapy: Theory, Research and Practice. 2016 Mar 1;89(1):82-96.	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Morina 2017c	2004 GL (excluded)	Intervention not targeted at PTSD symptoms	Boudewyns, P.A.; Hyer, L. (1990) Physiological response to combat memories and preliminary treatment outcome in Vietnam veteren PTSD patients treated with direct therapeutic exposure. Behavior Therapy, 21, 63-87	
Morkved 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention not targeted at PTSD symptoms	Bowland S, Edmond T, Fallot RD. Evaluation of a spiritually focused intervention with older trauma survivors. Social work. 2012 Jan 1;57(1):73-82.	
Moser 2010	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Population outside scope: Trials of adults in contact with the criminal justice system (not solely as a result of being a witness or victim)	Bradley, RG.; Follingstad DR.; (2003) Group Therapy for Incarcerated Women Who Experienced Interpersonal Violence: A Pilot Study. J Trau Stress 16(4):337-340	
Motraghi 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Bradley, R.; Greene, J.; Russ, E.; Dutra, L.; Westen, D.; (2005) A Multidimensional Meta-Analysis of Psychotherapy for PTSD. Am J Psych 162 (2): 214-227	
Muss 1991	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Sample size (N<10/arm)	Bradshaw RA, McDonald MJ, Grace R, Detwiler L, Austin K. A randomized clinical trial of Observed and Experiential Integration (OEI): A simple, innovative intervention for affect regulation in clients with PTSD. Traumatology. 2014 Sep;20(3):161.	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Myers 2015	RQ 1.1-1.2 & 2.1-2.2 update	Sample size (N<10/arm)	Bremner JD, Mishra S, Campanella C, Shah M, Kasher N, Evans S, Fani N, Shah AJ, Reiff C, Davis LL, Vaccarino V and Carmody J (2017) A Pilot Study of the Effects of Mindfulness-Based Stress Reduction on Post-traumatic Stress Disorder Symptoms and Brain Response to Traumatic Reminders of Combat in Operation Enduring Freedom/Operation Iraqi Freedom Combat Veterans with Post-traumatic Stress Disorder. Front. Psychiatry 8:157. doi: 10.3389/fpsyt.2017.00157	
Nacasch 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention not targeted at PTSD symptoms	Brief DJ, Rubin A, Keane TM, Enggasser JL, Roy M, Helmuth E, Hermos J, Lachowicz M, Rybin D, Rosenbloom D. Web intervention for OEF/OIF veterans with problem drinking and PTSD symptoms: A randomized clinical trial. Journal of consulting and clinical psychology. 2013 Oct;81(5):890.	
Nakeyar 2016	2004 GL (included)	Population outside scope: Trials of people with traumatic grief	Brom, D., Kleber, R. J., & Defares, P. B. (1989). Brief psychotherapy for posttraumatic stress disorders. Journal of Consulting & Clinical Psychology, 57, 607-612.	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Nelson 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention not targeted at PTSD symptoms	Brown LA, Craske MG, Glenn DE, Stein MB, Sullivan G, Sherbourne C, Bystritsky A, Welch SS, Campbell-Sills L, Lang A, Roy-Byrne P. CBT competence in novice therapists improves anxiety outcomes. Depression and anxiety. 2013 Feb 1;30(2):97-115.	
Nicholl 2009	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Efficacy or safety data cannot be extracted	Brown AJ, Bollini AM, Craighead LW, Astin MC, Norrholm SD, Bradley B. Self-Monitoring of Reexperiencing Symptoms: A Randomized Trial. Journal of traumatic stress. 2014 Oct 1;27(5):519-25.	
Nijdam 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Comparison outside scope	Bryant RA, Moulds ML, Guthrie RM, Dang ST, Mastrodomenico J, Nixon RD, Felmingham KL, Hopwood S, Creamer M. A randomized controlled trial of exposure therapy and cognitive restructuring for posttraumatic stress disorder. Journal of consulting and clinical psychology. 2008 Aug;76(4):695.	
Nijdam 2018	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Paper unavailable	Bryant RA, Mastrodomenico J, Hopwood S, Kenny L, Cahill C, Kandris E, Taylor K. Augmenting cognitive behaviour therapy for post-traumatic stress disorder with emotion tolerance training: a	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			randomized controlled trial. FOCUS. 2013 Jul;11(3):379-86.	
Niles 2012	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Comparison outside scope	Butollo W, Karl R, König J, Rosner R. A Randomized Controlled Clinical Trial of Dialogical Exposure Therapy versus Cognitive Processing Therapy for Adult Outpatients Suffering from PTSD after Type I Trauma in Adulthood. Psychotherapy and psychosomatics. 2016;85(1):16-26.	
Nolan 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Cabral, P.; Meyer, HB.; Ames, D.; (2011) Effectiveness of Yoga Therapy as a Complementary Treatment for Major Psychiatric Disorders: A Meta-Analysis . Primary Care Companion for CNS Disorders 13 (4)	
Noordik 2010	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention not targeted at PTSD symptoms	Carlson LE, Doll R, Stephen J, Faris P, Tamagawa R, Drysdale E, Speca M. Randomized controlled trial of mindfulness-based cancer recovery versus supportive expressive group therapy for distressed survivors of breast cancer (MINDSET). Journal of clinical oncology. 2013 Aug 5;31(25):3119-26.	
Norman 2007	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis that is not relevant	Carlson, L.E., Tamagawa, R., Stephen, J., Doll, R., Faris, P., Dirkse, D. and Speca, M., 2014.	Carlson LE, Tamagawa R, Stephen J, Drysdale E, Zhong L, Speca M. Randomized-controlled trial of

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			Tailoring mind-body therapies to individual needs: patients' program preference and psychological traits as moderators of the effects of mindfulness-based cancer recovery and supportive-expressive therapy in distressed breast cancer survivors. Journal of the National Cancer Institute Monographs, 2014(50), pp.308-314.	mindfulness-based cancer recovery versus supportive expressive group therapy among distressed breast cancer survivors (MINDSET): long-term follow-up results. Psycho-Oncology. 2016 Jul 1;25(7):750-9.
Norton 2007	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Efficacy or safety data cannot be extracted	Carpenter KM, Stoner SA, Schmitz K, McGregor BA, Doorenbos AZ. An online stress management workbook for breast cancer. Journal of behavioral medicine. 2014 Jun 1;37(3):458-68.	
Nose 2017	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Paper unavailable	Carter JJ. A controlled breathing course promoting social and emotional health for Vietnam veterans with chronic posttraumatic stress disorder - A randomised controlled trial [NCT00256477]. 2006. Available from: https://clinicaltrials.gov/ct2/show/NCT00256477 [accessed 28.07.2017]	
Nosen 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Design: Non-randomised group assignment	Carter J, Byrne G. A two year study of the use of yoga in a series of pilot studies as an adjunct to ordinary psychiatric	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			treatment in a group of Vietnam War veterans suffering from post traumatic stress disorder. Online document at: www. Therapywithyoga. com Accessed November. 2004;27.	
Nyssen 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Efficacy or safety data cannot be extracted	Carter J, Gerbarg PL, Brown RP, Ware RS, D'Ambrosio C. Multi-component yoga breath program for Vietnam veteran post traumatic stress disorder: randomized controlled trial. J Trauma Stress Disor Treat 2. 2013;3:2.	
Oktedalen 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Casement, MD.; Swanson, LM.; (2012) A meta-analysis of imagery rehearsal for post-traumatic nightmares: Effects on nightmare frequency, sleep quality and posttraumatic stress. Clinical Psychology Review. 32 (6): 566-574	
Olatunji 2010a	2004 GL (excluded)	Sample size (N<10/arm)	Chemtob, C. M., Novaco, R. W., Hamada, R. S., & Gross, D. M. (1997). Cognitive-behavioral treatment for severe anger in posttraumatic stress disorder. Journal of Consulting & Clinical Psychology, 65, 184-189	
Olatunji 2010b	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Chen, Y-R.; Hung, K-W.; Tsai, J-C.; Chu, H.; Chung, M-H.; Chen, S-R.; Liao, Y-M.; Ou, K-L.; Chang, Y-C.; Chou, K-R.; (2014) Efficacy	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			of Eye-Movement Desensitization and Reprocessing for patients with Posttraumatic-Stress Disorder: A Meta-Analysis of Randomized Controlled Trials. PLOS-One 9 (8)	
Olthuis 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Chen, L.; Zhang, G.; Hu M.; Liang, X.; (2015) Eye Movement Desensitization and Reprocessing Versus Cognitive-Behavioural Therapy for Adult Posttraumatic Stress Disorder: Systematic Review and Meta-Analysis. J of Nervous and Mental Disease. 203 (6):443-451	
Oman 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Chiesa, A.; (2010) Vipassana Meditation: Systematic Review of Current Evidence. The Jornal of Alternative and Complementary Medicine 16 (1): 37-46	
Omidi 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Efficacy or safety data cannot be extracted	Christensen C, Barabasz A, Barabasz M. Efficacy of abreactive ego state therapy for PTSD: Trauma resolution, depression, and anxiety. International Journal of Clinical and Experimental Hypnosis. 2013 Jan 1;61(1):20-37.	
Onton 2012	Handsearch	Sample size (N<10/arm)	Church D, Yount G, Rachlin K, Fox L, Nelms J. Epigenetic Effects of PTSD Remediation in Veterans Using Clinical Emotional Freedom Techniques: A Randomized	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			Controlled Pilot Study. American Journal of Health Promotion. 2016 Aug 12:0890117116661154.	
Ost 2003	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Cimpianu, C-L.; Strube, W.; Falkai, P.; Palm, U.; Hasan, A.; (2017) Vagus nerve stimulation in psychiarty: a systematic review of the available evidence. J Nerual Transmission 124 (1): 145-158	
Ost 2009	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Clarke SB, Rizvi SL, Resick PA. Borderline personality characteristics and treatment outcome in cognitive-behavioral treatments for PTSD in female rape victims. Behavior therapy. 2008 Mar 31;39(1):72-8.	
Otis 2005	2004 GL (included)	Efficacy or safety data cannot be extracted	Classen, C., Koopman, C., Nevill-Manning, K., & Spiegel, D. (2001). A preliminary report comparing trauma-focused and present-focused group therapy against a wait-listed condition among childhood sexual abuse survivors with PTSD. Journal of Aggression, Maltreatment & Trauma, 4, 265-288.	
Otis 2010	RQ 5.1_5.2_adhoc	Non-RCT (no control group)	Clausen, J., Ruff, S., Von Wiederhold, W., Heineman, T. (2012) For as long as it takes: Relationship-based play therapy for children in foster care, Psychoanalytic Social Work, 19, 43-53	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
O'Toole 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Cloitre M, Petkova E, Wang J. An examination of the influence of a sequential treatment on the course and impact of dissociation among women with PTSD related to childhood abuse. Depression and Anxiety. 2012 Aug 1;29(8):709-17.	
Otto 2003	RQ 1.1-1.2 & 2.1-2.2 update	Subgroup/secondary analysis of RCT already included	Cloitre M, Garvert DW, Weiss BJ. Depression as a moderator of STAIR Narrative Therapy for women with post-traumatic stress disorder related to childhood abuse. European journal of psychotraumatology. 2017 Jan 1;8(1):1377028.	
Ougrin 2011	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Clond, M.; (2016) Emotional Freedom Techniques for Anxiety: A Systematic Review With Meta-analysis. J of Nervous and Mental disease 204 (5):388-395	
Ovaert 2003	Handsearch	Non-randomised group assignment	Connolly SM, Roe-Sepowitz D, Sakai C, Edwards J. Utilizing community resources to treat PTSD: A randomized controlled study using Thought Field Therapy. African J Trauma Studies. 2013;3:24-32.	
Pacella 2014	Handsearch	Sample size (N<10/arm)	Coffey SF, Stasiewicz PR, Hughes PM, Brimo ML. Trauma-focused imaginal exposure for individuals with comorbid posttraumatic stress disorder and	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			alcohol dependence: Revealing mechanisms of alcohol craving in a cue reactivity paradigm. Psychology of Addictive Behaviors. 2006 Dec;20(4):425.	
Paivio 2010	RQ 1.1-1.2 & 2.1-2.2 (searches combined) AND 2004 GL (included)	Sample size (N<10/arm)	Cohen, H., Kaplan, Z., Kotler, M., Kouperman, I., Moisa, R., & Grisaru, N. (2004). Repetitive transcranial magnetic stimulation of the right dorsolateral prefrontal cortex in posttraumatic stress disorder: a double-blind, placebo-controlled study. American Journal of Psychiatry, 161(3), 515-524.	
Palic 2011	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis that is not relevant	Cook JM, Thompson R, Harb GC, Ross RJ. Cognitive− behavioral treatment for posttraumatic nightmares: An investigation of predictors of dropout and outcome. Psychological Trauma: Theory, Research, Practice, and Policy. 2013 Nov;5(6):545.	
Pantalon 1998	2004 GL (included)	Sample size (N<10/arm)	Cooper, N.A.; Clum, G.A. (1989) Imaginal flooding as a supplimentary treatment for PTSD in combat veterens: a controlled study. Behavior Therapy, 20, 381-391	
Parcesepe 2015	RQ 1.1-1.2 & 2.1-2.2 update	Subgroup/secondary analysis that is not relevant	Cooper AA, Kline AC, Graham B, Bedard-Gilligan M, Mello PG, Feeny NC, Zoellner LA. Homework “dose,” type, and	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			helpfulness as predictors of clinical outcomes in prolonged exposure for PTSD. Behavior therapy. 2017 Mar 1;48(2):182-94.	
Paunovic 2001	RQ 1.1-1.2 & 2.1-2.2 update	Subgroup/secondary analysis that is not relevant	Cooper AA, Zoellner LA, Roy-Byrne P, Mavissakalian MR, Feeny NC. Do changes in trauma-related beliefs predict PTSD symptom improvement in prolonged exposure and sertraline?. Journal of consulting and clinical psychology. 2017 Sep;85(9):873.	
Pease 2009	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Cort NA, Gamble SA, Smith PN, Chaudron LH, Lu N, He H, Talbot NL. Predictors of treatment outcomes among depressed women with childhood sexual abuse histories. Depression and anxiety. 2012 Jun 1;29(6):479-86.	
Peleikis 2005	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention not targeted at PTSD symptoms	Craft MA, Davis GC, Paulson RM. Expressive writing in early breast cancer survivors. Journal of Advanced Nursing. 2013 Feb 1;69(2):305-15.	
Peniston 1991	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention outside scope	Craske MG, Stein MB, Sullivan G, Sherbourne C, Bystritsky A, Rose RD, Lang AJ, Welch S, Campbell-Sills L, Golinelli D, Roy-Byrne P. Disorder-specific impact of coordinated anxiety learning and management treatment for anxiety	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			disorders in primary care. Archives of General Psychiatry. 2011 Apr 4;68(4):378-88.	
Pigeon 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Outcomes are not of interest	Crawford JJ, Vallance JK, Holt NL, Steed H, Courneya KS. A phase I/II pilot study assessing the preliminary efficacy of wall climbing for improving posttraumatic growth and quality of life in gynecologic cancer survivors. Mental Health and Physical Activity. 2016 Oct 31;11:60-6.	
Pitman 1996	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Non-randomised group assignment	Crespo M, Arinero M. Assessment of the efficacy of a psychological treatment for women victims of violence by their intimate male partner. The Spanish journal of psychology. 2010 Nov;13(2):849-63.	
Possemato 2010	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Crumlish, N.; O'Rourke, K.; (2010) A systematic review of treatments for post-traumatic stress disorder among refugees and asylum-seekers. J Nervous and Mental Disease 198 (4): 237-251	
Postel 2008	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Cuijpers, P.; Marks, IM.; Van Straten, A.; Cavanagh, K.; Gega, L.; Andersson, G.; (2009) Computer-Aided Psychotherapy for Anxiety Disorders: A Meta-Analytic Review. Cog Beh Therapy 38(2): 66-82	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Powers 2010	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Cuijpers, P.; Sijbrandij, M.; Koole, SL.; Andersson, G.; Beekman, AT.; Reynolds, CF.; (2013) The efficacy of psychotherapy and pharmacotherapy in treating depressive and anxiety disorders: a meta-analysis of direct comparisons. World Psychiatry 12 (2): 137-148	
Pratchett 2011	2004 GL (excluded)	Non-randomised group assignment	Cusack, K. & Spates, C. R. (1999). The cognitive dismantling of Eye Movement Desensitization and Reprocessing (EMDR) treatment of Posttraumatic Stress Disorder (PTSD). Journal of Anxiety Disorders, 13, 87-99.	
Prisco 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Cusack, K.; Jonas, DE.; Forneris, CA.; Wines, C.; Sonis, J.; Middleton, JC.; Feltner, C.; Brownley, KA.; Olmsted, KR.; Greenblatt, A.; Weil, A.; Gaynes, BN.; (2016) Psychological treamtents for adults with posttraumatic stress disorder: A systematic review and meta-analysis. Clin Pscy Rev 43: 128-141	
Pruiksma 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Cyniak-Cieciura M, Popiel A, Zawadzki B. General self-efficacy level and changes in negative postttraumatic cognitions and posttraumatic stress disorder (PTSD) symptoms among motor	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			vehicle accident survivors after PTSD therapy. Psychol Stud. 2015;53:18-29.	
Rabe 2006	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Da Silva, TL.; Ravindran, LN.; Ravindran, AV.; (2009) Yoga in the treatment of mood and anxiety disorders: A review. Asian J Psychiatry 2 (1): 6-16	
Rabe 2008	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Efficacy or safety data cannot be extracted	Dalton EJ, Greenman PS, Classen CC, Johnson SM. Nurturing connections in the aftermath of childhood trauma: A randomized controlled trial of emotionally focused couple therapy for female survivors of childhood abuse. Couple and Family Psychology: Research and Practice. 2013 Sep;2(3):209.	
Ragsdale 1996	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Deacon, BJ.; Abramowitz, JS.; (2004) Cognitive and behavioral treatmetns for anxiety disorders: A review of meta-analytic findings. J Clin Psyh 60 (4): 429-441	
Rauch 2009	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Sample size (N<10/arm)	Detweiler MB, Lane S, Spencer L, Lutgens B, Halling MH, Rudder TF, Lehmann L. Horticultural therapy: A pilot study on modulating cortisol levels and indices of substance craving, posttraumatic stress disorder, depression, and quality of life in veterans. Alternative therapies in	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			health and medicine. 2015 Jul 1;21(4):36.	
Ready 2010	2004 GL (excluded)	Non-randomised group assignment	Devilly, G. J., Spence, S. H., & Rapee, R. M. (1998). Statistical and reliable change with eye movement desensitization and reprocessing: Treating trauma within a veteran population. Behavior Therapy, 29, 435-455.	
Rees 2013	2004 GL (included)	Non-randomised group assignment	Devilly GJ, Spence SH. The relative efficacy and treatment distress of EMDR and a cognitive-behavior trauma treatment protocol in the amelioration of posttraumatic stress disorder. Journal of anxiety disorders. 1999 Apr 30;13(1):131-57.	
Reiter 2016	ISTSS included lists	Non-RCT (no control group)	Devilly GJ. The successful treatment of PTSD through overt cognitive behavioral therapy in non-responders to EMDR. Behavioural and Cognitive Psychotherapy. 2001 Jan;29(1):57-70.	
Renfrey 1994	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Diehle, J.; Schmitt, K.; Daams, JG.; Boer, F.; Lindauer, RJL.; (2014) Effects of Psychotherapy on Trauma-Related Cognitions in Posttraumatic Stress Disorder: A Meta-Analysis. J Traumatic Stress 27 (3): 257-264	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Renner 2011	Handsearch	Sample size (N<10/arm)	Difede J, Cukor J, Jayasinghe N, Patt I, Jedel S, Spielman L, Giosan C, Hoffman HG. Virtual reality exposure therapy for the treatment of posttraumatic stress disorder following September 11, 2001. Journal of Clinical Psychiatry. 2007 Nov 11;68(11):1639.	
Resick 1992	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	DiMauro, J.; (2014) Exposure Therapy for Posttraumatic Stress Disorder: A Meta-Analysis. Military Psychology 26(2):120-130	
Resick 2003	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Dinnen, S.; Simiola, V.; Cook, JM.; (2014) Post-traumatic stress disorder in older adults: a systematic review of the psychotherapy treatment literature. Aging and Mental Health 19 (2): 144-150	
Resick 2008	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Efficacy or safety data cannot be extracted	Dodds SE, Pace TW, Bell ML, Fiero M, Negi LT, Raison CL, Weihs KL. Feasibility of Cognitively-Based Compassion Training (CBCT) for breast cancer survivors: a randomized, wait list controlled pilot study. Supportive Care in Cancer. 2015 Dec 1;23(12):3599-608.	
Resick 2012a	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Non-RCT (no control group)	Dorrepaal E, Thomaes K, Smit JH, van Balkom AJ, van Dyck R, Veltman DJ, Draijer N. Stabilizing group treatment for complex	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			posttraumatic stress disorder related to childhood abuse based on psycho-education and cognitive behavioral therapy: A pilot study. Child Abuse & Neglect. 2010 Apr 30;34(4):284-8.	
Resick 2012b	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Dorrepaal E, Thomaes K, Smit JH, Veltman DJ, Hoogendoorn AW, van Balkom AJ, Draijer N. Treatment compliance and effectiveness in complex PTSD patients with co-morbid personality disorder undergoing stabilizing cognitive behavioral group treatment: A preliminary study. European journal of psychotraumatology. 2013 Dec 1;4(1):21171.	
Resick 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Dorrepaal, E.; Thomaes, K.; Hoogendoorn, AW.; Veltman, DJ.; Drijer, N.; Van Balkom, AJLM.; (2014) Evidence-based treatment for adult women with child abouse-related Complex PTSD: a quantitative review. Eur J Psychotraumatology 5(1):	
Rhodes 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Dossa, NI.; Hatem, M.; (2012) Cognitive-Behavioral Therapy versus Other PTSD Psychotherapies as Treatmetn for Women Victims of War-Related Violence: A Systematic Review.	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			The Scientific World Journal:ID, 181847	
Rhudy 2010	Handsearch	Non-randomised group assignment	Drožđek B, Bolwerk N. Evaluation of group therapy with traumatized asylum seekers and refugees—The Den Bosch Model. Traumatology. 2010 Dec;16(4):117.	
Richards 1994	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Non-randomised group assignment	Droždek B, Kamperman AM, Bolwerk N, Tol WA, Kleber RJ. Group therapy with male asylum seekers and refugees with posttraumatic stress disorder: A controlled comparison cohort study of three day-treatment programs. The Journal of nervous and mental disease. 2012 Sep 1;200(9):758-65.	
Rizvi 2009	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Comparison outside scope	Drummond SP. Treating Insomnia & Nightmares After Trauma: Impact on Symptoms & Quality of Life [NCT01009112]. Available from: https://clinicaltrials.gov/ct2/show/NCT01009112 [accessed 08.08.2017]	
Roberts 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Duan-Porter, W.; Coeytaux, RR.; McDuffie, JR.; Goode, AP.; Sharma, P.; Mennella, H.; Nagi, A.; Williams, JW.; (2016) Evidence Map of Yoga for Depression, Anxiety and Posttraumatic Stress Disorder. J	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			Phsyical Activity Health 13: 281-288	
Roberts 2016	2004 GL (excluded)	Efficacy or safety data cannot be extracted	Dybdahl, R. (2001) Children and mothers in war: an outcome study of a psychosocial intervention program. Child Development, 72, 4, 1214-1230	
Robjant 2010	2004 GL (included)	Non-randomised group assignment	Echeburua, E; Corral, P.; Sarasua, B; Zubizarreta, I. (1996) Treatment of acute posttraumatic stress disorder in rape victims: an experimental study. Journal of Anxiety Disorders, 10, 3, 185-199	
Rodrigues 2011	2004 GL (included)	Sample size (N<10/arm)	Echeburua, E., de Corral, P., Zubizarreta, I., & Sarasua, B. (1997). Psychological treatment of chronic posttraumatic stress disorder in victims of sexual aggression. Behavior Modification, 21, 433- 456.	
Rogers 1999	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Edzard, E.; Snyder, J.; Dunlop, RA.; (2012) National Centre for Complementary and Alternative Medicine-funded randomised controlled trials of acupuncture: a systematic review. Focus on Alternative and Complementary Therapies, 17(1):15-22.	
Ronconi 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Ehring, T.; Welboren, R.; Morina, N.; Wicherts, JM.; Freitag, J.; Emmelkamp, PMG.; (2014) Meta-analysis of psychological	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			treatments for posttraumatic stress disorder in adult survivors of childhood abuse. Clin Pscyh Rev 34(8):645-657	
Rosendbaum 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention not targeted at PTSD symptoms	Elkjaer H, Kristensen E, Mortensen EL, Poulsen S, Lau M. Analytic versus systemic group therapy for women with a history of child sexual abuse: 1-Year follow-up of a randomized controlled trial. Psychology and Psychotherapy: Theory, Research and Practice. 2014 Jun 1;87(2):191-208.	
Rotaru 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Population outside scope: Trials of soldiers on active service	Engel CC, Litz B, Magruder KM, Harper E, Gore K, Stein N, Yeager D, Liu X, Coe TR. Delivery of self training and education for stressful situations (DESTRESS-PC): a randomized trial of nurse assisted online self-management for PTSD in primary care. General hospital psychiatry. 2015 Aug 31;37(4):323-8.	
Rothbaum (unpublished)	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Erford, BT.; Gunther, C.; Duncan, K.; Bardhoshi, G.; Dummett, B.; Kraft, J.; Deferio, K.; Falco, M.; Ross, M.; (2016) Meta-Analysis of Counseling Outcomes for the Treatment of Posttraumatic Stress Dissorder. J Couns Devplt 94 (1); 13-30	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Rothbaum 1997	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Population outside scope: <80% of the study's participants are eligible for the review and disaggregated data cannot be obtained	Erickson DH, Janeck AS, Tallman K. A cognitive-behavioral group for patients with various anxiety disorders. Psychiatric Services. 2007 Sep;58(9):1205-11.	
Rothbaum 2001	2004 GL (excluded)	Cross-over study and first phase data not available	Falsetti, S.A.; Resnick, H.S. & Gallagher, N.G. (2001) Treatment of posttraumatic stress disorder with comorbid panic attacks: combining cognitive processing therapy with panic control treatment techniques. Group Dynamics: Theory, Research, and Practice, 5, 4, 252-260	
Roy 2006	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Non-randomised group assignment	Feeny, CC.; Zoellner, LA.; Foa, EB.; (2002) Treatment Outcome for Chronic PTSD Among Gemal Assault Victims with Borderline Personality Characteristics: A Preliminary Examination. J Personality Disorders 16 (1): 30-40	
Ruglass 2012	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Unpublished (registered on clinical trials.gov and author contacted for full trial report but not provided)	NCT00127673. Effectiveness of PTSD Treatment: CBT Versus Sertraline. Available from: https://clinicaltrials.gov/show/NCT00127673 [accessed 06.01.17]	
Ruglass 2014a	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Comparison outside scope	Felmingham KL, Bryant RA. Gender differences in the maintenance of response to cognitive behavior therapy for posttraumatic stress disorder.	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			Journal of Consulting and Clinical Psychology. 2012 Apr;80(2):196.	
Ruglass 2014b	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention not targeted at PTSD symptoms	Fernández I, Páez D. The benefits of expressive writing after the Madrid terrorist attack: Implications for emotional activation and positive affect. British Journal of Health Psychology. 2008 Feb 1;13(1):31-4.	
Russell (unpublished)	ISTSS included lists	Sample size (N<10/arm)	Feske U. Treating low-income and minority women with posttraumatic stress disorder: A pilot study comparing prolonged exposure and treatment as usual conducted by community therapists. Journal of interpersonal violence. 2008 Aug;23(8):1027-40.	
Ryan 2005	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Comparison outside scope	Fetzner MG, Asmundson GJ. Aerobic exercise reduces symptoms of posttraumatic stress disorder: A randomized controlled trial. Cognitive behaviour therapy. 2015 Jul 4;44(4):301-13.	
Sack 2016	2004 GL (excluded)	Paper unavailable	Foa, E.B.; Zoellner, L.A. & Feeny, N.C. (unpublished) Recovery after trauma.	
Salcioglu 2007	2004 GL (included)	Non-randomised group assignment	Foa, EB.; Dancu CV.; Hembree EX.; Joycos LH.; Meadows EA.; Street,GP.; A comparison of exposure therapy, stress	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			incoulation training, and their combination for reducing postraumatic stress disorder in female assult victims (1999). J Consult and Clin Psy 67 (2): 194-200	
Salcioglu 2010	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Outcomes are not of interest	Foa EB, Rauch SA. Cognitive changes during prolonged exposure versus prolonged exposure plus cognitive restructuring in female assault survivors with posttraumatic stress disorder. Journal of consulting and clinical psychology. 2004 Oct;72(5):879.	
Saunders 2015	2004 GL (excluded)	Non-randomised group assignment	Forbes, D.; Creamer, M.; Rycroft, P. (1994) Eye movement desensitization and reprocessing in posttraumatic stress disorder: a pilot study using assessment measures. Journal of Behaviour Therapy & Experimental Psychiatry, 25, 2, 113-120	
Saunders 2016	2004 GL (excluded)	Non-randomised group assignment	Forbes, D., Phelps, A., & McHugh, T. (2001). Treatment of combat-related nightmares using imagery rehearsal: a pilot study. Journal of Traumatic Stress, 14, 433-442	
Sautter 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Efficacy or safety data cannot be extracted	Ford J, Rosman L, Wuensch K, Irvine J, Sears SF. Cognitive–Behavioral Treatment of Posttraumatic Stress in Patients	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			With Implantable Cardioverter Defibrillators: Results From a Randomized Controlled Trial. Journal of traumatic stress. 2016 Aug 1;29(4):388-92.	
Schaal 2009	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Intervention not targeted at PTSD symptoms	Forman EM, Shaw JA, Goetter EM, Herbert JD, Park JA, Yuen EK. Long-term follow-up of a randomized controlled trial comparing acceptance and commitment therapy and standard cognitive behavior therapy for anxiety and depression. Behavior Therapy. 2012 Dec 31;43(4):801-11.	
Scher 2017	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Protocol	Forshay, E. Cognitive Behavioral Therapy (CBT) for PTSD in Veterans With Co-Occurring SUDs [NCT01357577]. Available from: https://clinicaltrials.gov/ct2/show/NCT01357577 [accessed 02.08.2017]	
Schnurr 2001	2004 GL (excluded)	Non-randomised group assignment	Frank, E.; Anderson, B.; Stewart, B.D.; Dancu, C.; Hughes, C.; West, D. (1988) Efficacy of cognitive behavior therpy and systematic desensitization in the treatment of rape trauma. Behavior therapy, 19, 403-420	
Schnurr 2009	RQ 1.1-1.2 & 2.1-2.2 (searches combined) AND	Sample size (N<10/arm)	Franklin CL, Cuccurullo LA, Walton JL, Arseneau JR, Petersen NJ. Face to face but not	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
	RQ 1.1-1.2 & 2.1-2.2 update		in the same place: A pilot study of prolonged exposure therapy. Journal of Trauma & Dissociation. 2017 Jan 1;18(1):116-30.	
Schnurr 2012	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Fredette, C.; El-Baalbaki, G.; Palardy, V.; Rizkallah, E.; Guay, S.; (2016) Social support and cognitive-behavioral therapy for posttraumatic stress disorder: A systematic review. Traumatology 22(2): 131-144.	
Schnurr 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined) AND Cochrane allRQ update	Subgroup/secondary analysis that is not relevant	Fredman SJ, Pukay-Martin ND, Macdonald A, Wagner AC, Vorstenbosch V, Monson CM. Partner accommodation moderates treatment outcomes for couple therapy for posttraumatic stress disorder. Journal of consulting and clinical psychology. 2016 Jan;84(1):79.	
Schnurr 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Non-randomised group assignment	Frisman L, Ford J, Lin HJ, Mallon S, Chang R. Outcomes of trauma treatment using the TARGET model. Journal of Groups in Addiction & Recovery. 2008 Nov 3;3(3-4):285-303.	
Schnyder 2011	RQ 1.1-1.2 & 2.1-2.2 AND RQ 4.1-4.2	Sample size (N<10/arm)	Frommberger U, Stieglitz RD, Nyberg E, Richter H, Novelli-Fischer U, Angenendt J, Zaninelli R, Berger M. Comparison between paroxetine and behaviour therapy in patients with posttraumatic stress disorder	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			(PTSD): a pilot study. International Journal of Psychiatry in Clinical Practice. 2004 Jan 1;8(1):19-23.	
Schouten 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Frost, ND.; Laska, KM.; Wampold, BE.; (2014) The Evidence for Present-Centred Therapy as a Treatmetn for Posttraumatic Stress Disorder. J Trau Stress 27(1):1-8	
Sciarrino 2017	2004 GL (excluded)	Non-randomised group assignment	Frueh, B.C.; Turner, S.T.; Beidel, D.C.; Mirabella, R.F.; Jones, W.J. (1996) Trauma management therapy: a preliminary evaluation of a multicomponent behavioral treatment for combat-related PTSD. Behavior Research & Therapy, 34, 7, 533-543	
Scott 2017	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Gallagher MW, Resick PA. Mechanisms of change in cognitive processing therapy and prolonged exposure therapy for PTSD: Preliminary evidence for the differential effects of hopelessness and habituation. Cognitive therapy and research. 2012 Dec 1;36(6):750-5.	
Seal 2010	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Gallegos AM, Streltzov NA, Stecker T. Improving Treatment Engagement for Returning Operation Enduring Freedom and Operation Iraqi Freedom Veterans With Posttraumatic Stress	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			Disorder, Depression, and Suicidal Ideation. The Journal of nervous and mental disease. 2016 May 1;204(5):339-43.	
Seal 2012	RQ 1.1-1.2 & 2.1-2.2 update	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Gallegos AM, Crean HF, Pigeon WR, Heffner KL. Meditation and yoga for posttraumatic stress disorder: A meta-analytic review of randomized controlled trials. Clinical psychology review. 2017 Oct 31.	
Sebastian 2017	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Galovski TE, Monson C, Bruce SE, Resick PA. Does cognitive–behavioral therapy for PTSD improve perceived health and sleep impairment?. Journal of traumatic stress. 2009 Jun 1;22(3):197-204.	
Seda 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Cross-over study and first phase data not available	Galovski TE, Blain LM, Mott JM, Elwood L, Houle T. Manualized therapy for PTSD: Flexing the structure of cognitive processing therapy. Journal of consulting and clinical psychology. 2012 Dec;80(6):968.	
Seehausen 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis that is not relevant	Galovski TE, Elwood LS, Blain LM, Resick PA. Changes in anger in relationship to responsivity to PTSD treatment. Psychological trauma: theory, research, practice, and policy. 2014 Jan;6(1):56.	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Seidler 2006	ISTSS included lists	Sample size (N<10/arm)	Gamito P, Oliveira J, Rosa P, Morais D, Duarte N, Oliveira S, Saraiva T. PTSD elderly war veterans: A clinical controlled pilot study. Cyberpsychology, Behavior, and Social Networking. 2010 Feb 1;13(1):43-8.	
Seligowski 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Geiger-Brown, JM.; Rogers, VE.; Liu, W.; Ludeman, EM.; Downton, KD.; Diaz-Abad, M.; (2015) Cognitive behavioral therapy in persons with comorbid insomnia: A meta-analysis. Sleep Medicine Reviews 23:54-67	
Serfaty 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Outcome measures are not validated	Gelkopf M, Hasson-Ohayon I, Bikman M, Kravetz S. Nature adventure rehabilitation for combat-related posttraumatic chronic stress disorder: A randomized control trial. Psychiatry research. 2013 Oct 30;209(3):485-93.	
Servan-Schreiber 2006	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Gerardi M, Rothbaum BO, Astin MC, Kelley M. Cortisol response following exposure treatment for PTSD in rape victims. Journal of aggression, maltreatment & trauma. 2010 May 27;19(4):349-56.	
Shapiro 1989	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Gerger, H.; Munder, T.; Barth, J.; (2014) Specific and Nonspecific psychological Interventions for PTSD Symptoms: A Meta-	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			analysis with Problem Complexity as a Moderator. J Clink Psych 70(7): 601-615.	
Shapiro 2002	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Gerger, H.; Munder, T.; Gemperli, A.; Nuesch, E.; Trelle, S.; Juni, P.; Barth,J.; (2014) Integrating fragmented evidence by network meta-analysis: relative effectiveness of psychological interventions for adults with post-traumatic stress disorder. Pscyh Med 44(15): 3151-3164	
Shemesh 2011	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Non-randomised group assignment	Germain, V.; Marchand, A.; Bouchard, S.; Drouin, MS.; Guay, S.; (2009) Effectiveness of Cognitive Behavioural Therapy Administered by Videoconference for Posttraumatic Stress Disorder. Cog Behav Therapy 38 (1): 42-53	
Sherr 2011	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Population outside scope: Trials of soldiers on active service	Gham GA, Reger G. Comparing Virtual Reality Exposure Therapy to Prolonged Exposure in the Treatment of Soldiers With PTSD [NCT01193725]. 2010. Available from: https://clinicaltrials.gov/ct2/show/NCT01193725 [accessed 02.08.2017]	
Shnaider 2017	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Ginzburg K, Butler LD, Giese-Davis J, Cavanaugh CE, Neri E, Koopman C, Classen CC, Spiegel D. Shame, guilt, and posttraumatic stress disorder in	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			adult survivors of childhood sexual abuse at risk for human immunodeficiency virus: outcomes of a randomized clinical trial of group psychotherapy treatment. The Journal of nervous and mental disease. 2009 Jul 1;197(7):536-42.	
Sijbrandik 2016	RQ 1.1-1.2 & 2.1-2.2 update	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Glavin CE, Montgomery P. Creative bibliotherapy for post-traumatic stress disorder (PTSD): a systematic review. Journal of Poetry Therapy. 2017 Apr 3;30(2):95-107.	
Silver 2005	2004 GL (excluded)	Efficacy or safety data cannot be extracted	Glynn, S. M., Eth, S., Randolph, E. T., Foy, D. W., Urbaitis, M., Boxer, L. et al. (1999). A test of behavioral family therapy to augment exposure for combat-related posttraumatic stress disorder. Journal of Consulting & Clinical Psychology, 67, 243-251.	
Skowronek 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Goetter, EM.; bui, E.; Ojserkis, RA.; Zakarian, RJ.; Brendel, RW.; Simon, NM.; (2015) A systematic Review of Dropout From Psychotherapy for Posttraumatic Stress disorder Among Iraq and Afanistan Combat Veterans. J Traum Stress 28(5): 401-409	
Sloan 2011	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Goncalves, R.; Lages, AC.; Rodrigues, H.; Pedrozo, AL.; Coutinho, ESF.; Neylan, T.;	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			Figueira, I.; Ventura, P.; (2011) Potenciais biomarcadores da terapia cognitivo-comportamental para o transtorno de estresse pos-traumatico: uma revisao sistematica. Arch of Clin Psyh	
Sloan 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Gancalves, R.; Pedrozo, AL.; Coutinho, ESF.; Figueria, I.; Ventura, P.; (2012) Efficacy of Virtual Reality Exposure Therapy in the Treatment of PTSD: A Systematic Review. PLoS ONE 7(12): e48469.	
Slobodin 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Goodson, J.; Helstrom, A.; Halpern,JM.; Ferenschak, MP.; Gillihan,SJ.; Powers, MB.; (2011) Treatment of Posttraumatic Stress Disorder in U.S. Combat Veterans: A Meta-Analytic Review. Pscyh Reports 109(2): 573-599	
Smith 2005	2004 GL (excluded)	Efficacy or safety data cannot be extracted	Grainger, R.D.; Levin, C.; Allen-Byrd, L.; Doctor, R.M., Lee, H. (1997) An empirical evaluation of eye movement desensitization and reprocessing (EMDR) with survivors of a natural disaster. Journal of Traumatic Stress, 10, 4, 665-671	
Smith 2015	RQ 4.1-4.2 (maximizing sensitivity)	Intervention not targeted at PTSD symptoms	Green BL, Krupnick JL, Chung J, Siddique J, Krause ED, Revicki D, Frank L, Miranda J. Impact of PTSD comorbidity on one-year	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			outcomes in a depression trial. Journal of clinical psychology. 2006 Jul 1;62(7):815-35.	
Smyth 2008	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Non-systematic review	Gregg, L.; Tarrier, N.; (2007) Virtual realisty in mental health. Social Psychiatry and Psychiactric Epidimilogy 42(5):343-354	
Soo 2007	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Non-systematic review	Griffiths, KM.; Farrer, L.; Christensen, H.; (2010) The efficacy of internet interventions for depression and anxiety disorders: a review of randomised controlled trials. MJA 192:S4-S11	
Spence 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Grist, R.; Cavanagh, K.; (2013) Computerised Cognitive Behavioural Therapy for Common Mental Health Disorders, What Works, for Whom Under What Circumstances? A Systematic Review and Meta-analysis. J Contemporary Pscyhotherapy 43(4):243-251	
Stalker 1999	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Gutner CA, Casement MD, Gilbert KS, Resick PA. Change in sleep symptoms across cognitive processing therapy and prolonged exposure: a longitudinal perspective. Behaviour research and therapy. 2013 Dec 31;51(12):817-22.	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Stapleton 2006	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Non-primary study	Gutner CA, Gallagher MW, Baker AS, Sloan DM, Resick PA. Time course of treatment dropout in cognitive–behavioral therapies for posttraumatic stress disorder. Psychological Trauma: Theory, Research, Practice, and Policy. 2016 Jan;8(1):115.	
Steenkamp 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Gutner CA, Suvak MK, Sloan DM, Resick PA. Does timing matter? Examining the impact of session timing on outcome. Journal of consulting and clinical psychology. 2016 Dec;84(12):1108.	
Steinmetz 2012	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Gwozdziewycz, N.; Mehl-Madrona, L.; (2013) Meta-Analysis of the Use of Narrative Exposure Therapy for the Effects of Trauma Among Refuge Populations. Permanente Journal 17(1): 70-76	
Stephenson 2017	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Haagen, JFG.; Smid, GE.; Knipscgeer, JW.; Kleber, RJ.; (2015) The efficacy of recommended treatmetns for veterans with PTSD: A metaregression analysis	
Stergiopoulos 2011	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis that is not relevant	Haagen JF, Heide F, Mooren TM, Knipscheer JW, Kleber RJ. Predicting post-traumatic stress disorder treatment response in refugees: Multilevel analysis.	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			British Journal of Clinical Psychology. 2017 Mar 1;56(1):69-83.	
Stewart 2009a	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis that is not relevant	Halvorsen JØ, Stenmark H, Neuner F, Nordahl HM. Does dissociation moderate treatment outcomes of narrative exposure therapy for PTSD? A secondary analysis from a randomized controlled clinical trial. Behaviour Research and Therapy. 2014 Jun 30;57:21-8.	
Stewart 2009b	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Hansen, K.; Hofling, V.; Kroner-Borowik, T.; Stangier, U.; Steil, R.; (2013) Efficacy of psychological interventions aiming to reduce chronic nightmares: A meta-analysis. Clinical Psychology Review 33(1): 146-155	
Strauss 2009	Handsearch	Sample size (N<10/arm)	Harned MS, Korslund KE, Linehan MM. A pilot randomized controlled trial of Dialectical Behavior Therapy with and without the Dialectical Behavior Therapy Prolonged Exposure protocol for suicidal and self-injuring women with borderline personality disorder and PTSD. Behaviour research and therapy. 2014 Apr 30;55:7-17.	
Stubbs 2017	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Unpublished (registered on clinical trials.gov and author contacted for full trial report but not provided)	Hart J. Novel Treatment of Emotional Dysfunction in Post Traumatic Stress Disorder (PTSD)	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			[NCT01391832]. 2011. Available from: https://clinicaltrials.gov/show/NCT01391832 [accessed 03.08.2017]	
Swift 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Haug, t.; Nordgreen, T.; Ost, LG.; Havik, OE.; (2012) Self-help treatment of anxiety disorders: A meta-analysis and meta-regression of effects and potential moderators. Clinical Psychology Review 32(5): 425-445.	
Tarrier 1999a/1999b	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Haugen, PT.; Evces, M.; Weiss, DS.; (2012) Treating posttraumatic stress disorder in first responders: A systematic review. Clinical Psychology Review 32(5): 370-380	
Tarrier 2004	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Unpublished (registered on clinical trials registry and author contacted for full trial report but not provided)	Hembree EA, Foa EB, Gaulin AE. Effectiveness of treatment for PTSD in community agencies [NCT00057629]. 2003. Available from: https://clinicaltrials.gov/ct2/show/NCT00057629 [accessed 03.08.2017]	
Taylor 2009	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Comparison outside scope	Hembree EA, Cahill SP, Foa EB. Impact of personality disorders on treatment outcome for female assault survivors with chronic posttraumatic stress disorder. Journal of Personality Disorders. 2004 Feb 1;18(1):117-27.	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Taylor 2010	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Hertlein, KM.; Ricci, RJ.; (2004) A Systematic Research Synthesis of EMDR Studies. Implementation of the Platinum Standard. Trauma, Violence and Abuse 5(3): 285-300	
Taylor 2014	2004 GL (excluded)	Non-randomised group assignment	Hickling, E.J.; Blanchard, E.B. (1997) The private practice psychologist and manual-based treatments: post-traumatic stress disorder secondary to motor vehicle accidents. Behavior Research & Therapy, 35, 3, 191-203	
Taylor 2017	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Comparison outside scope	Hien DA, Cohen LR, Miele GM, Litt LC, Capstick C. Promising treatments for women with comorbid PTSD and substance use disorders. American journal of Psychiatry. 2004 Aug 1;161(8):1426-32.	
Teng 2008	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Hien DA, Campbell AN, Killeen T, Hu MC, Hansen C, Jiang H, Hatch-Maillette M, Miele GM, Cohen LR, Gan W, Resko SM. The impact of trauma-focused group therapy upon HIV sexual risk behaviors in the NIDA Clinical Trials Network “Women and trauma” multi-site study. AIDS and Behavior. 2010 Apr 1;14(2):421-30.	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Teng 2013	RQ 1.1-1.2 & 2.1-2.2 update	Subgroup/secondary analysis of RCT already included	Hien DA, Lopez-Castro T, Papini S, Gorman B, Ruglass LM. Emotion dysregulation moderates the effect of cognitive behavior therapy with prolonged exposure for co-occurring PTSD and substance use disorders. Journal of anxiety disorders. 2017 Dec 31;52:53-61.	Hien DA, Campbell AN, Ruglass LM, Hu MC, Killeen T. The role of alcohol misuse in PTSD outcomes for women in community treatment: A secondary analysis of NIDA's Women and Trauma Study. Drug and Alcohol Dependence. 2010 Sep 1;111(1):114-9.
Ter Heide 2011	RQ 1.1-1.2 & 2.1-2.2 (searches combined) AND RQ 1.1-1.2 & 2.1-2.2 update	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Hilton, L.; Maher, AR.; Colaiaco, B.; Apaydin, E.; Sorbero, ME.; Booth, M.; Shanman, RM.; Hempel, S.; (2017) Meditation for Posttraumatic Stress: Systematic Review and Meta-Analysis. Psychological Trauma: Theory, Research, Practice and Policy 9(4): 453-460	
Thompson 1995	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Comparison outside scope	Hirai M, Skidmore ST, Clum GA, Dolma S. An investigation of the efficacy of online expressive writing for trauma-related psychological distress in Hispanic individuals. Behavior therapy. 2012 Dec 31;43(4):812-24.	
Thrasher 2010	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Ho, MSK.; Lee, CW.; (2012) Cognitive behaviour therapy versus eye movement desensitization and reprocessing for post-traumatic disorder- is it all in the homework then? European Review of Applied Psychology 62 (4): 253-260	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Thunker 2012	RQ 1.1-1.2 & 2.1-2.2 (searches combined) AND RQ 1.1-1.2 & 2.1-2.2 update	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Ho, FY-Y.; Chan, CS.; Tang,KN-S.; (2016) Cognitive-behavioral therapy for sleep disturbances in treating posttraumatic stress disorder symptoms: A met-analysis of randomised controlled trials. Clinical Pscyhology Review 43: 90-102	
Tirado-Munoz 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Comparison outside scope	Hoffart A, Øktedalen T, Langkaas TF. Self-compassion influences PTSD symptoms in the process of change in trauma-focused cognitive-behavioral therapies: a study of within-person processes. Frontiers in psychology. 2015;6.	
Torchalla 2012	RQ 1.1-1.2 & 2.1-2.2 update	Subgroup/secondary analysis of RCT already included	Holder N, Holliday R, Pai A, Surís A. Role of Borderline Personality Disorder in the Treatment of Military Sexual Trauma-related Posttraumatic Stress Disorder with Cognitive Processing Therapy. Behavioral Medicine. 2017 Jul 3;43(3):184-90.	
Tran 2016	RQ 1.1-1.2 & 2.1-2.2 update	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Hopwood TL, Schutte NS. A meta-analytic investigation of the impact of mindfulness-based interventions on post traumatic stress. Clinical psychology review. 2017 Nov 1;57:12-20.	
Triffleman 2000	Handsearch	Efficacy or safety data cannot be extracted	Hinsberger, M., Holtzhausen, L., Sommer, J., Kaminer, D., Elbert, T., Seedat, S., ... & Weierstall, R. (2016). Feasibility and	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			Effectiveness of Narrative Exposure Therapy and Cognitive Behavioral Therapy in a Context of Ongoing Violence in South Africa.	
Turner 2014	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Hofman, SG.; Smits,JAJ.; (2008) Cognitive-behavioral therapy for adult anxiety disorders: A meta-analysis of randomised placebo-controlled trials. J Clinical Psychiatry 69(4): 621-632	
Ulmer 2008/2011	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Hofman, SG.l Wu, JQ.; Boettcher, H.; (2014) Effect of Cognitive-Behavioral Therapy for Anxiety Disorders on Quality of Life: A Meta-Analysis. J Cons and Clin Psychology 82(3): 375-391	
Uttley 2015	2004 GL (excluded)	Non-randomised group assignment	Hofmann, A. (1996). Eye movement desensitization and reprocessing: A new treatment method for post-traumatic stress disorder. Psychotherapeut, 41, 368-372.	
Valentine (unpublished a)	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Sample size (N<10/arm)	Högberg G, Pagani M, Sundin Ö, Soares J, Åberg-Wistedt A, Tärnell B, Hällström T. On treatment with eye movement desensitization and reprocessing of chronic post-traumatic stress disorder in public transportation workers–A randomized controlled trial. Nordic journal of psychiatry. 2007 Jan 1;61(1):54-61.	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Valentine (unpublished b)	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Efficacy or safety data cannot be extracted	Holliday R, Link-Malcolm J, Morris EE, Surís A. Effects of cognitive processing therapy on PTSD-related negative cognitions in veterans with military sexual trauma. Military medicine. 2014 Oct;179(10):1077-82.	
Vally 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Efficacy or safety data cannot be extracted	Holliday R, Williams R, Bird J, Mullen K, Surís A. The role of cognitive processing therapy in improving psychosocial functioning, health, and quality of life in veterans with military sexual trauma-related posttraumatic stress disorder. Psychological services. 2015 Nov;12(4):428.	
Valmaggia 2016	RQ 1.1-1.2 & 2.1-2.2 update	Efficacy or safety data cannot be extracted	Holliday RP, Holder ND, Williamson ML, Surís A. Therapeutic response to Cognitive Processing Therapy in White and Black female veterans with military sexual trauma-related PTSD. Cognitive behaviour therapy. 2017 Sep 3;46(5):432-46.	
Van Dam 2012	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Hollifield, M.; Gory, A.; Siedjak, J.; Nguyen, L.; Holmgreen, L.; Hobfoll, S.; (2016) The Benefit of Conserving and Gaining Resources after Trauma: A Systematic Review. J Clin Med 5(11: 104	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Van Emmerik 2013	2004 GL (excluded)	Non-randomised group assignment	Hossack, Alex and Bentall, Richard P. (1996) Elimination of Post-traumatic Symptomatology by Relaxation and Visual-Kinesthetic Dissociation. Journal of Traumatic Stress, Vol 9, No1, 99-110	
Van Loon 2013	RQ 5.1_5.2_adhoc	Population outside scope: Trials of people without PTSD	Hunt, M., Chizkov, R. (2014) Are therapy dogs like Xanax? Does animal-assisted therapy impact processes relevant to cognitive behavioral psychotherapy?, Anthrozoos, 27, 457-469	
van Minnen 2006	RQ 1.1-1.2 & 2.1-2.2 (searches combined) AND 2004 GL (excluded)	Non-randomised group assignment	Igreja, V., Kleijn, W. C., Schreuder, B. J., Van Dijk, J. A., & Verschuur, M. (2004). Testimony method to ameliorate post-traumatic stress symptoms. Community-based intervention study with Mozambican civil war survivors. Br.J.Psychiatry, 184, 251-257	
Van Minnen 2015	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Imel, ZE.; Laska, K.; Jakupcak, M.; Simpson, TL.; (2013) Meta-Analysis of Dropout in Treatment for Posttrumatic Stress Disorder. J Cons and Clin Psyh 81(3): 394-404	
Van Til 2013	2004 GL (included)	Sample size (N<10/arm)	Ironson, G.I., Freund, B., Strauss, J.L., & Williams, J. (2002). A comparison of two treatments for traumatic stress: A community based study of EMDR and	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			prolonged exposure. Journal of Clinical Psychology, 58, 113-128	
Van't Hof 2011	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Sample size (N<10/arm)	Isserles M, Shalev AY, Roth Y, Peri T, Kutz I, Zlotnick E, Zangen A. Effectiveness of deep transcranial magnetic stimulation combined with a brief exposure procedure in post-traumatic stress disorder–a pilot study. Brain stimulation. 2013 May 31;6(3):377-83.	
Vaughan 1994a	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis that is not relevant	Iverson KM, Gradus JL, Resick PA, Suvak MK, Smith KF, Monson CM. Cognitive–behavioral therapy for PTSD and depression symptoms reduces risk for future intimate partner violence among interpersonal trauma survivors. Journal of consulting and clinical psychology. 2011 Apr;79(2):193.	
Vaughan 1994b	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Jayakody, K.; Gunadasa, S.; Hosker, C.; (2013) Exercise for anxiety disorders: systematic review. Br J Sports Med 00:1-11	
Verhey 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Jayawickreme, N.; Cahill, SP.; Riggs, DS.; Rauch, SAM.; Resick, PA.; Rothbaum, BO.; Foa, EB.; (2014) Primum non nocere (first do no harm): Symptom worsening and improvement in female assault victims after prolonged exposure for PTSD. Depression and Anxiety 31(5): 412-419	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Voshaar 2009	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis that is not relevant	Jerud AB, Pruitt LD, Zoellner LA, Feeny NC. The effects of prolonged exposure and sertraline on emotion regulation in individuals with posttraumatic stress disorder. Behaviour research and therapy. 2016 Feb 29;77:62-7.	
Wade 2016	2004 GL (excluded)	Non-randomised group assignment	Johnson, D. R. & Lubin, H. (2002). Effect of brief versus long-term inpatient treatment on homecoming stress in combat-related posttraumatic stress disorder: Three-year follow-up. Journal of Nervous & Mental Disease, 190, 47-51	
Wagner 2016	Handsearch	Sample size (N<10/arm)	Johnson DR, Lubin H. The Counting Method: Applying the Rule of Parsimony to the Treatment of Posttraumatic Stress Disorder. Traumatology. 2006 Mar;12(1):83.	
Wahbeh 2014	RQ 1.1-1.2 & 2.1-2.2 update	Cross-over study and first phase data not available	Johnson RA, Albright DL, Marzolf JR, Bibbo JL, Yaglom HD, Crowder SM, Carlisle GK, Willard A, Russell CL, Grindler K, Osterlind S. Effects of therapeutic horseback riding on post-traumatic stress disorder in military veterans. Military Medical Research. 2018 Dec;5(1):3.	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Wang 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Jonas, DE.; Cusack, K.; Forneris, CA.; (2103) Psychological and Pharmacological Treatments for Adults with Posttraumatic Stress Disorder (PTSD). Comparative Effectiveness Reviews 92	
Watson 1997	RQ 1.1-1.2 & 2.1-2.2 AND RQ 4.1-4.2	Efficacy or safety data cannot be extracted	Jun JJ, Zoellner LA, Feeny NC. Sudden gains in prolonged exposure and sertraline for chronic PTSD. Depression and anxiety. 2013 Jul 1;30(7):607-13.	
Watts 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Non-systematic review	Kar, N.; (2011) Cognitive behavioral therapy for the treatment of post-traumatic stress disorder: a review. Neuropsychiatric Disase and Treatment 7: 167-181	
Weine 1998	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis of RCT already included	Karatzias A, Power K, McGoldrick T, Brown K, Buchanan R, Sharp D, Swanson V. Predicting treatment outcome on three measures for post-traumatic stress disorder. European archives of psychiatry and clinical neuroscience. 2007 Feb 1;257(1):40-6.	
Weine 2008	2004 GL (excluded)	Non-RCT (no control group)	Keane TM, Kaloupek DG. Imaginal flooding in the treatment of a posttraumatic stress disorder. Journal of Consulting and Clinical Psychology. 1982 Feb;50(1):138.	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Wells 2004	2004 GL (included)	Efficacy or safety data cannot be extracted	Keane, T. M., Fairbank, J. A., Caddell, J. M., & Zimering, R. T. (1989). Implosive (flooding) therapy reduces symptoms of PTSD in Vietnam combat veterans. Behavior Therapy, 20, 245-260.	
Whitworth 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined) AND 2004 GL (included)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Keefe, JR.; McCarthy, KS.; Dinger, U.; Zilcha-Mano, S.; Barber, JP.; (2014) A meta-analytic review of psychodynamic therapies for anxiety disorders. Clinc Psych Rev 34(4): 309-323	
Williams 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Kehle-Forbes, SM.; Polusny, MA.; MacDonald, R.; Murdoch, M.; Meis, LA.; Wilt, TJ.; (2013) A Systematic Review of the Efficacy of Adding Nonexposure Components to Exposure Therapy for Posttraumatic Stress Disorder. Psychological Trauma: Theory, Research, Practice and Policy 5(4): 317-322.	
Wilson 1995/1997	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Efficacy or safety data cannot be extracted	Killeen T, Hien D, Campbell A, Brown C, Hansen C, Jiang H, Kristman-Valente A, Neuenfeldt C, Rocz-de la Luz N, Sampson R, Suarez-Morales L. Adverse events in an integrated trauma-focused intervention for women in community substance abuse treatment. Journal of substance	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			abuse treatment. 2008 Oct 31;35(3):304-11.	
Wilson 1996	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Kim, Y-D.; Heo, I.; Shin, B-C.; Crawford, C.; Kang, H-W.; Lim, J-H.; (2013) Acupuncture for Posttraumatic Stress Disorder: A systematic Reivew of Randomised Controlled Trials and Prospective Clinical Trials. Evidence-Based Complementary and Alternative Medicine: ID 615857	
Wilson unpublished	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Sample size (N<10/arm)	Kimbrell TA. Adjunctive Biofeedback Intervention for OIF-OEF PTSD [NCT00920036]. Available from: https://clinicaltrials.gov/show/NCT00920036 [accessed 08.08.2017]	
Winhusen 2012	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Non-randomised group assignment	King AP, Erickson TM, Giardino ND, Favorite T, Rauch SA, Robinson E, Kulkarni M, Liberzon I. A pilot study of group mindfulness-based cognitive therapy (MBCT) for combat veterans with posttraumatic stress disorder (PTSD). Depression and anxiety. 2013 Jul 1;30(7):638-45.	
Wisco 2013	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Sample size (N<10/arm)	King HC, Spence DL, Hickey AH, Sargent P, Elesh R, Connelly CD. Auricular acupuncture for sleep disturbance in veterans with post-traumatic stress disorder: a	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			feasibility study. Military medicine. 2015 May;180(5):582-90.	
Wisco 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Cross-over study and first phase data not available	Kip KE, Rosenzweig L, Hernandez DF, Shuman A, Sullivan KL, Long CJ, Taylor J, McGhee S, Girling SA, Wittenberg T, Sahebzamani FM. Randomized controlled trial of accelerated resolution therapy (ART) for symptoms of combat-related post-traumatic stress disorder (PTSD). Military Medicine. 2013 Dec;178(12):1298-309.	
Wolf 2016	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis that is not relevant	Kip KE, Rosenzweig L, Hernandez DF, Shuman A, Diamond DM, Ann Girling S, Sullivan KL, Wittenberg T, Witt AM, Lengacher CA, Anderson B. Accelerated Resolution Therapy for treatment of pain secondary to symptoms of combat-related posttraumatic stress disorder. European journal of psychotraumatology. 2014 Dec 1;5(1):24066.	
Woodward 2017	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Kitchiner, NP.; Roberts, NJ.; Wilcox, D.; Bisson, JI.; (2012) Systematic review and meta-analsyis of psychosocial interventions for veterans of the military. Eur J Pscyhotraumatology 3(1)	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
Wynn 2015	RQ 1.1-1.2 & 2.1-2.2 update	Systematic review with no new useable data and any meta-analysis results not appropriate to extract	Kline AC, Cooper AA, Rytwinksi NK, Feeny NC. Long-term efficacy of psychotherapy for posttraumatic stress disorder: A meta-analysis of randomized controlled trials. Clinical psychology review. 2017 Nov 21.	
York 2011	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Comparison outside scope	Knaevelsrud C. Additive Effect of Cognitive Restructuring in a Web-based Treatment for Traumatized Arab People [NCT01508377]. 2011. Available from: https://clinicaltrials.gov/ct2/show/NCT01508377 [accessed 04.08.2017]	
Yun 2013	Handsearch	Non-randomised group assignment	Köbach, A., Schaal, S., Hecker, T., & Elbert, T. (2015). Psychotherapeutic Intervention in the Demobilization Process: Addressing Combat-related Mental Injuries with Narrative Exposure in a First and Second Dissemination Stage. Clinical psychology & psychotherapy.	
Zandberg 2016a	RQ 1.1-1.2 & 2.1-2.2 (searches combined)	Subgroup/secondary analysis that is not relevant	König J, Karl R, Rosner R, Butollo W. Sudden gains in two psychotherapies for posttraumatic stress disorder. Behaviour research and therapy. 2014 Sep 30;60:15-22.	
Zandberg 2016b	2004 GL (excluded)	Non-randomised group assignment	Konuk E, Knipe J, Eke I, Yuksek H, Yurtsever A, Ostep S. The effects of eye movement	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			desensitization and reprocessing (EMDR) therapy on posttraumatic stress disorder in survivors of the 1999 Marmara, Turkey, earthquake. International Journal of Stress Management. 2006 Aug;13(3):291.	
Zang 2017	RQ 1.1-1.2 & 2.1-2.2 (searches combined) AND Cochrane allRQ update	Efficacy or safety data cannot be extracted	Korte KJ, Bountress KE, Tomko RL, Killeen T, Moran-Santa Maria M, Back SE. Integrated Treatment of PTSD and Substance Use Disorders: The Mediating Role of PTSD Improvement in the Reduction of Depression. Journal of clinical medicine. 2017 Jan 13;6(1):9.	
Zoellner 1999	2004 GL (included)	Efficacy or safety data cannot be extracted	Krakow B, Hollifield M, Johnston L, Koss M, Schrader R, Warner TD, Tandberg D, Lauriello J, McBride L, Cutchen L, Cheng D. Imagery rehearsal therapy for chronic nightmares in sexual assault survivors with posttraumatic stress disorder: a randomized controlled trial. Jama. 2001 Aug 1;286(5):537-45.	
Zucker 2009	2004 GL (excluded)	Non-RCT (no control group)	Krakow, B., Johnston, L., Melendrez, D., Hollifield, M., Warner, T. D., Chavez-Kennedy, D. et al. (2001). An open-label trial of evidence-based cognitive behavior therapy for nightmares and insomnia in crime victims with	

Study ID	Search	Reason for exclusion	Ref 1	Ref 2
			PTSD. American Journal of Psychiatry, 158, 2043-2047.	

Economic studies

Study ID	Search	Reason for exclusion	Ref
Issakidis et al., 2004	Global HE search	assessment of a mixture of interventions ("optimal" versus "current" treatment)	Issakidis C, Sanderson K, Corry J, et al. H (2004). Modelling the population cost-effectiveness of current and evidence-based optimal treatment for anxiety disorders. Psychological Medicine, 34(1), 19-35.
Meyers et al., 2013	Global HE search	results for each arm not provided	Meyers LL, Strom TQ, Leskela J, et al. (2013). Service utilization following participation in cognitive processing therapy or prolonged exposure therapy for post-traumatic stress disorder. Military medicine, 178, 95-99.
Slade et al., 2017	Global HE search update	>50% of population had psychosis	Slade EP, Gottlieb JD, Lu W, et al. (2017). Cost-effectiveness of a PTSD intervention tailored for individuals with severe mental illness. Psychiatric Services, 68(12), 1225-1231.
Wood et al., 2009	Global HE search	military setting; effects for two arms taken from different sources (effect: non-comparative study for exposure therapy; TAU: published literature); intervention cost based on personal communication	Wood DP, Murphy J, McLay R, et al. (2009). Cost effectiveness of virtual reality graded exposure therapy with physiological monitoring for the treatment of combat related post traumatic stress disorder. Studies in health technology and informatics, 144, 223-229.

Studies reporting utility data

Study ID	Search	Reason for exclusion	Ref
Doctor et al., 2011	Global HE search	People with PTSD valuing own health	Doctor JN, Zoellner LA, Feeny NC (2011) Predictors of health-related quality-of-life utilities among persons with posttraumatic stress disorder. Psychiatric Services 62(3), 272-7

Study ID	Search	Reason for exclusion	Ref
Lamoureux-Lamarche et al., 2016	Global HE search update	No health state utility data reported	Lamoureux-Lamarche CH, Vasiliadis M, Preville M et al. (2016) Post-traumatic stress syndrome in a large sample of older adults: determinants and quality of life. Aging & mental health 20(4), 401-6
Le et al., 2013	Global HE search	No health state utility data reported	Le QA, Doctor JN, Zoellner LA et al. (2013) Minimal clinically important differences for the EQ-5D and QWB-SA in Post-traumatic Stress Disorder (PTSD): Results from a Doubly Randomized Preference Trial (DRPT). Health and Quality of Life Outcomes 11:59
Mancino et al., 2006	Global HE search	Data based on Quality of Well Being Visual Analoge Scale (QWB-VAS); method used for elicitation of preferences was not choice-based	Mancino MJ, Pyne JM, Tripathi S, et al. (2006) Quality-adjusted health status in veterans with posttraumatic stress disorder. Journal of Nervous and Mental Disease 194(11), 877-9

Appendix L – Research recommendations

Research recommendations for "For adults with clinically important post-traumatic stress symptoms, what are the relative benefits and harms of psychological, psychosocial or other non-pharmacological interventions targeted at PTSD symptoms?"

1. What is the clinical and cost effectiveness of sequencing and further line treatment in PTSD?

Why is this important

There is encouraging evidence that psychological treatments such as trauma-focused CBT are effective for treating PTSD. However, not everyone will have a significant remission in their symptoms or recovery and there is very little evidence to help professionals decide what to do next to treat or manage PTSD symptoms. Understanding the most effective next steps to take – for example, whether to offer psychological therapies or medication – is an important part of guiding clinicians in their work with this vulnerable group. It is essential to provide effective support to people who have not responded well to a first-line treatment, especially given the damaging effect of persistent PTSD on quality of life and mental and physical health.

Research question	Sequencing and further line treatment
Importance to 'patients' or the population	Opportunity to receive more care if a "first-line" intervention does not work.
Relevance to NICE guidance	Would inform the development of future guidelines concerning sequencing recommendations.
Relevance to NHS	Improved therapeutic efficacy would reduce long-term physical and mental health care costs.
National priorities	Improving cost-effectiveness of mental health services.
Current evidence base	There is no evidence that currently pertains to this question.
Equalities	May be of particular importance to groups with complex trauma histories, e.g. refugees and asylum seekers.

Criterion	Explanation
Population	Adults or children and young people who continue to have clinically significant PTSD symptoms following receipt of adequate dose of a NICE-recommended intervention.
Intervention	Wide-range of options, e.g. drug treatment, further or different psychological therapy, therapy with a more qualified therapist, combination treatments (i.e. medication plus psychological therapy).

Criterion	Explanation
Comparator	Compare a second-line treatment to usual care (e.g. active case management) for this population.
Outcomes	PTSD severity at post-treatment 12 months follow up.
Study design	Randomised controlled trial
Timeframe	To inform a guidance review

2. What prognostic and prescriptive factors are important in determining the choice of PTSD?

Why is this important

There are some indications in the evidence that certain subpopulations with PTSD, such as military veterans, have a different prognosis from other subpopulations. There is also some indication of a differential response to alternative psychological treatments among PTSD subpopulations, but the evidence for prescriptive factors is just as limited as that for prognostic factors. For professionals this means that when they are discussing treatment options with people there is no good evidence on which to base advice about which treatment they are most likely to benefit from (for example, a drug or psychological treatment). This increases the chance that people will have ineffective treatments. Large data sets using high-quality individual patient (IPD) data from clinical trials and large national data sets (for example, the IAPT Data Set) could identify both prognostic and prescriptive factors for PTSD treatment.

Research question	
Importance to 'patients' or the population	Identification of prognostic and prescriptive factors should lead to better information to patients on their likelihood of recovery and also on those treatments that might be more effective.
Relevance to NICE guidance	Current evidence offers little guidance on differential prognosis or prescription for current treatments. Information on these factors would lead to more personalised treatment of PTSD.
Relevance to NHS	More personalised interventions will likely lead to improved outcomes and reduced costs arising from the inappropriate use of treatments.
National priorities	The development of personalised treatments is a key research priority for the NHS. It will support the further development of the IAPT leading to more effective targeting of PTSD treatments.
Current evidence base	Although the current evidence base identifies effective treatments for PTSD there is little or no evidence on prognostic on prescriptive factors.

Research question	
Equalities	None identified

Criterion	Explanation
Population	People with PTSD
Intervention	Identifying relevant prognostic (for example severity of PTSD symptoms) and prescriptive (type of trauma) factors
Comparator	N/A
Outcomes	Better targeted treatments Better symptom improvement
Study design	Identify potential factors Prospective and retrospective analysis of large datasets (IPD or cohort studies) to explore the relationship of prospective prognostic factors to outcomes. Further testing of prognostic and prescriptive in randomised trials .
Timeframe	To inform a guidance review

3. What is the clinical and cost-effectiveness of interventions to deliver stabilisation and reintegration for people with complex PTSD?

Why is this important

Complex PTSD appears to be more likely in people who have suffered multiple or repeated trauma or conflict, for example survivors of early abuse, military veterans and displaced people (asylum seekers and refugees). There is good evidence that many people with PTSD do not fully recover with current treatments, and many of these are likely to have complex PTSD. Although there is debate about the best approaches for treating complex PTSD, an accepted method based on expert consensus is a three-stage approach of stabilisation, trauma processing (that is, a trauma-focused psychotherapy) and reintegration or reconnection. However, there is limited evidence about the best ways to deliver stabilisation and reintegration or reconnection. In particular, more evidence is needed on about the timing, duration and content of these interventions.

Research question	TBC
Importance to 'patients' or the population	Complex PTSD (CPTSD) is a new diagnosis within modern diagnostic classifications (i.e. ICD11) and there is no formal data on the best evidence based care pathway for people with CPTSD
Relevance to NICE guidance	There seems to be expert consensus that standard PTSD treatments may form the central part of a three-phase care pathway for CPTSD (stabilisation, trauma processing and reintegration/reconnection) but less is understood about how to provide effective stabilisation and reintegration/reconnection.

Research question	TBC
Relevance to NHS	People suffering with CPTSD are likely to be heavy users of services: physical health services (e.g. GPs, secondary care); mental health services; social care; and the criminal justice system. Effective treatment of CPTSD would likely decrease the costs of chronic disease management on other parts of the NHS.
National priorities	Providing effective care within mental healthcare is a current government agenda. Improved care for CPTSD should lead to less resources being required in the criminal justice system and social services. Children of parents with CPTSD may perform less well at school and experience mental health difficulties of their own. Hence treatment of CPTSD may accrue intergenerational benefits.
Current evidence base	The evidence base for stabilisation and reintegration/reconnection is limited. The development of ICD11 has finally allowed a common understanding of CPTSD which should pave the way for important research.
Equalities	CPTSD affects people from all walks of life

Criterion	Explanation
Population	Patients with CPTSD
Intervention	Studies of treatment phasing (stabilisation, trauma processing and reintegration/reconnection interventions)
Comparator	Treatment as usual (CMHT care)
Outcomes	Improvement in symptoms, functioning (e.g. work, relationships), and quality of life
Study design	Initially systematic reviews to establish most likely interventions to trial, followed by service evaluations to establish interventions most suitable for RCTs
Timeframe	To inform a guidance review

Appendix M – Network Meta-Analysis: inconsistency checks

TSU, Bristol (Caitlin Daly and Sofia Dias)

Introduction

The purpose of this analysis was to assess the consistency assumption in the network meta-analysis (NMA) models used to estimate the comparative effectiveness of interventions for treating post-traumatic stress disorder (PTSD). The outcomes included in this analysis were 1) changes in PTSD symptom scores between baseline and treatment endpoint, 2) changes in PTSD symptom scores between baseline and 1-4 month follow-up, and 3) remission status at treatment endpoint.

Methods

Note on Zero Cells

The modelling framework used by the TSU permits the inclusion of zero cells, so typically a continuity correction (e.g., add 0.5 to the number of events and 1 to number of individuals) is not needed. A continuity correction may be helpful when there are many small trials and trials with zero cells, resulting in numerical instability or slow convergence (Dias et al., 2011a & 2018a). For the remission outcome, this was not an issue and models were run in OpenBUGS using the raw data.

Note on Conversion of Results Synthesised on Continuous Scale

The economic model required probabilities of effect, which were informed by studies reporting continuous measures. To obtain these probabilities for the continuous outcomes, i.e. 1) changes in PTSD symptom scores between baseline and treatment endpoint and 2) changes in PTSD symptom scores between baseline and 1-4 month follow-up, the results of the evidence synthesis on the standardized mean difference (SMD) scale had to be transformed to a dichotomous scale. The log-odds ratio (LOR) of effect can be related to a notional SMD for effect using the formula (Chin, 2000; Higgins & Green, 2011):

$$LOR_{ck} = -\frac{\pi}{\sqrt{3}} SMD_{ck} \quad (1)$$

noting the change in sign to retain the interpretation of a positive LOR favouring treatment k.

The LORs were obtained by transforming the pooled treatment effects on the SMD scale using Equation (1).

Inconsistency checks

An important assumption made in NMA concerns the consistency, that is, the agreement of the direct and indirect evidence informing the treatment contrasts (Dias et al., 2011b & 2013b). There should be no meaningful differences between these two sources of evidence.

To conduct consistency checks, an appropriate base-case model (fixed or random effects) must be determined beforehand. We assessed and compared the fit of a fixed effect model and a random effects model with a vague prior distribution on the between-study standard deviation (Uniform(0,5)). To determine if there is evidence of inconsistency, the selected consistency model (fixed or random effects) was compared to an "inconsistency", or unrelated mean effects, model (Dias et al., 2011b & 2013b). The latter is equivalent to having separate, unrelated, meta-analyses for every pairwise contrast, with a common variance parameter assumed in the case of random effects models. Note that the consistency assumption can only be assessed when there are closed loops of direct evidence on 3 treatments that are informed by at least 3 independent sources of evidence (van Valkenhoef et al., 2016).

The posterior mean of the residual deviance, which measures the magnitude of the differences between the observed data and the model predictions of the data, was used to assess and compare the goodness of fit of each model (Spiegelhalter et al., 2002). Smaller values are preferred, and in a well-fitting model the posterior mean residual deviance should be close to the number of data points in the network (each study arm contributes 1 data point) (Spiegelhalter et al., 2002).

In addition to assessing how well the models fit the data using the posterior mean of the residual deviance, models were compared using the deviance information criterion (DIC). This is equal to the sum of the posterior mean deviance and the effective number of parameters, and thus penalizes model fit with model complexity (Spiegelhalter et al., 2002). Lower values are preferred and differences of 3 points were considered meaningful (Spiegelhalter et al., 2002).

The posterior median between-study standard deviation, which measures the heterogeneity of treatment effects estimated by trials making the same treatment comparisons, was also used to compare models. If the inconsistency model has smaller heterogeneity compared to the consistency model, then this indicates potential inconsistency in the data.

We performed further checks for evidence of inconsistency through node-splitting using the *gemtc* package in R (Dias et al., 2010, 2011b & 2013b, van Valkenhoef et al., 2016). This method permits the direct and indirect evidence contributing to an estimate of a relative effect to be split and compared (Dias et al., 2010 & 2011b). To apply the node splitting method to the two continuous outcomes ('changes in PTSD symptom scores between baseline and treatment endpoint' and 'changes in PTSD symptom scores between baseline and 1-4 month follow-up') using the *gemtc* package, data were inputted at contrast level, where the SMDs of the treatment in arm *k* compared to the treatment in arm 1 for study *i* were calculated as

$$SMD_{ik} = \frac{\bar{x}_{ik} - \bar{x}_{i1}}{SD_{pooled_i}}, \quad SD_{pooled_i} = \begin{cases} \sqrt{\frac{(n_{i1}-1)sd_{i1}^2 + (n_{i2}-1)sd_{i2}^2}{n_{i1}+n_{i2}-2}} & \text{2-arm trial} \\ \sqrt{\frac{(n_{i1}-1)sd_{i1}^2 + (n_{i2}-1)sd_{i2}^2 + (n_{i3}-1)sd_{i3}^2}{n_{i1}+n_{i2}+n_{i3}-3}} & \text{3-arm trial} \\ \sqrt{\frac{(n_{i1}-1)sd_{i1}^2 + (n_{i2}-1)sd_{i2}^2 + (n_{i3}-1)sd_{i3}^2 + (n_{i4}-1)sd_{i4}^2}{n_{i1}+n_{i2}+n_{i3}+n_{i4}-4}} & \text{4-arm trial} \end{cases}$$

with standard error

$$SE\left(SMD_{ik}\right) = \sqrt{Var\left(SMD_{ik}\right)} \approx \begin{cases} \sqrt{\frac{1}{n_{i1}} + \frac{1}{n_{i2}} + \frac{SMD_{ik}^2}{2\left(n_{i1}+n_{i2}-2\right)}} & \text{2-arm trial} \\ \sqrt{\frac{1}{n_{i1}} + \frac{1}{n_{ik}} + \frac{SMD_{ik}^2}{2\left(n_{i1}+n_{i2}+n_{i3}-3\right)}} & \text{3-arm trial} \\ \sqrt{\frac{1}{n_{i1}} + \frac{1}{n_{ik}} + \frac{SMD_{ik}^2}{2\left(n_{i1}+n_{i2}+n_{i3}+n_{i4}-4\right)}} & \text{4-arm trial} \end{cases}$$

For trials with more than two arms, the *gemtc* package requires specification of the standard error of the mean of the baseline arm, as this determines the covariance of the differences. On a standardized scale, this is calculated as (Dias et al., 2018b):

$$se_{i1_{\text{standardized}}} = \frac{sd_{i1}}{SD_{pooled_i}\sqrt{n_{i1}}}$$

To apply the node splitting method to the binary outcome ('remission status at treatment endpoint') using the *gemtc* package, data were inputted at arm-level. However, in the node-split model for the non-TF-CBT vs. Waitlist comparison, results were unstable. Consequently, we ran the node-split model for this comparison with data inputted at contrast level so that 0.5 could be added to zero cells to stabilise results. The LORs of the treatment in arm *k* relative to the treatment in arm 1 for study *i* were calculated as

$$\ln\left(OR_{ik}\right) = \ln\left(\frac{\left(a_{ik}+0.5\right)\left(d_{i1}+0.5\right)}{\left(b_{ik}+0.5\right)\left(c_{i1}+0.5\right)}\right)$$

with standard error

$$se\left(\ln\left(OR_{ik}\right)\right) = \sqrt{\frac{1}{a_{ik}+0.5} + \frac{1}{b_{ik}+0.5} + \frac{1}{c_{i1}+0.5} + \frac{1}{d_{i1}+0.5}}$$

where a_{ik} and b_{ik} are the numbers of patients who received the treatment in arm k and achieved and did not achieve remission at treatment endpoint, respectively, and c_{i1} and d_{i1} are the numbers of patients who received the treatment in arm 1 and achieved and did not achieve remission at treatment endpoint, respectively. For trials with more than two arms, the standard error of the log odds of the baseline arm was calculated as

$$se_{i1} = \sqrt{\frac{1}{c_{i1}} + \frac{1}{d_{i1}}}$$

Results

Outcome: Changes in PTSD symptom scores between baseline and treatment endpoint

Inconsistency checks were performed using the random effects model, as smaller posterior mean residual deviance and DIC suggests this model is preferred (Table 202). The posterior mean residual deviance, 157.4, is close to the number of expected data points, suggesting a good fit of the random effects model which is greatly improved when compared to the fixed effect model.

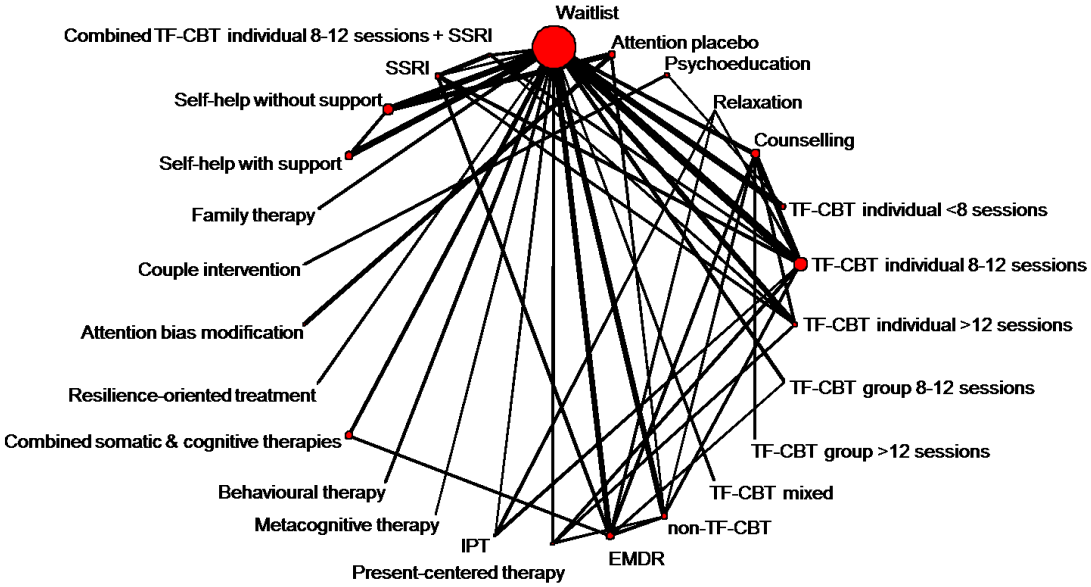
Table 202. Model fit statistics: changes in PTSD symptom scores between baseline and treatment endpoint

Model	Between Study Heterogeneity - Standard Deviation (95% Crla)	Residual devianceb	DICc
Fixed effect - consistency	---	769.6	1283.370
Random effects - consistency	0.87 (0.72, 1.08)	157.4	723.467
Random effects - inconsistency	0.96 (0.76, 1.24)	157.5	725.966

[a] Credible Interval (CrI)
[b] Posterior mean residual deviance compared to 157 total data points
[c] Deviance information criteria (DIC) – lower values preferred

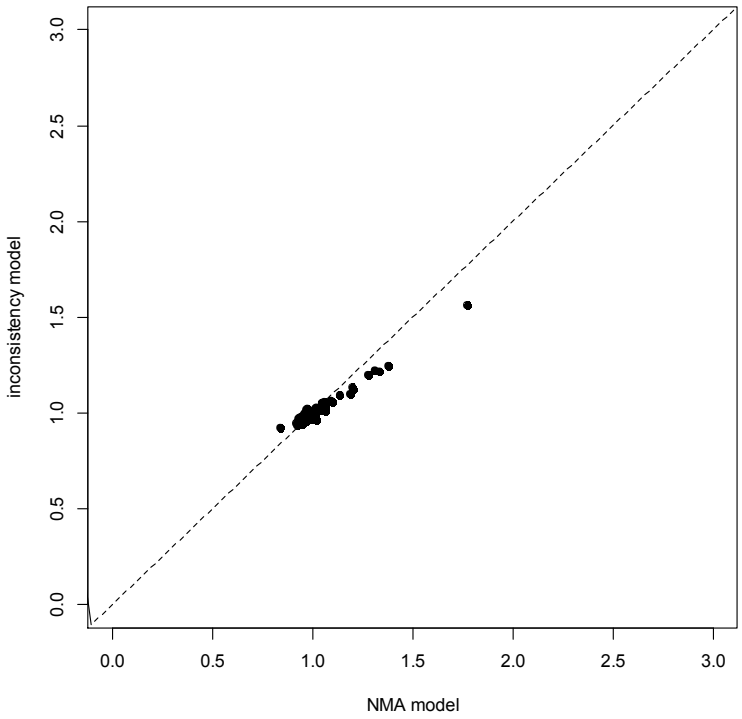
Since there were closed loops of direct evidence within the network (Figure 709) that were informed by at least 3 distinct sets of trials, inconsistency checks were carried out for this outcome. Convergence was satisfactory for the random effects model assuming inconsistency after 20,000 iterations, and the consistency and inconsistency models were compared using results based on samples from a further 40,000 iterations on two chains. WinBUGS code for the inconsistency model is provided in Appendix O.

Figure 709. Network diagram of comparisons for which direct evidence on 'changes in PTSD symptom scores between baseline and treatment endpoint' was available.



There are no meaningful differences between the fit of the random effects consistency and inconsistency models, and the between-study standard deviation is smaller in the consistency model (Table 202). The area below the line of equality in Figure 710 highlights where the inconsistency model better predicted data points, and the improvements were minimal.

Figure 710. Deviance contributions for the random effects consistency and inconsistency models: changes in PTSD symptom scores between baseline and treatment endpoint



Further checks for inconsistency using the node-splitting method (random effects model) did not find any evidence of inconsistency between the direct and indirect estimates (Table 203, Figure 711). However, the difference between the direct and indirect evidence contributing to the pooled estimate of TF-CBT individual 8-12 sessions + SSRI (26) vs. Waitlist (1) is worth noting. Buhmann 2016 is the only study directly comparing these treatments. However, as noted in Figure 710, the inconsistency model does not make any considerable improvements in the prediction of data points in this study, compared to the consistency model.

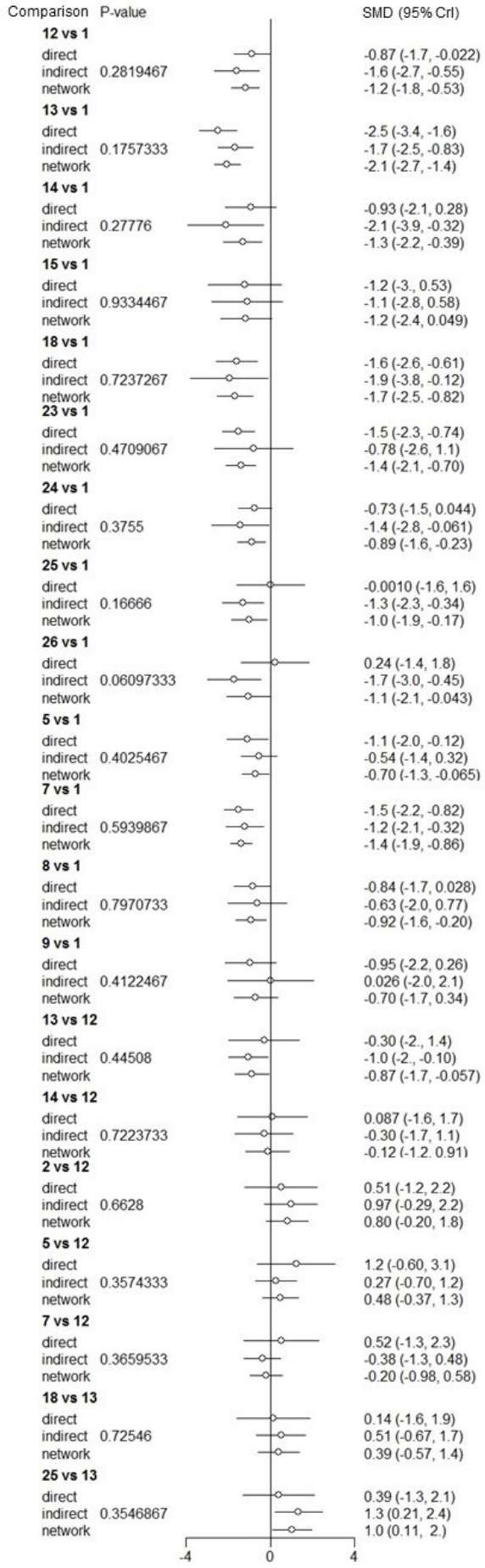
In addition to the relative treatment effects estimated through NMA, we present direct and indirect estimates in the “Change Score_Endpoint” worksheet of the “Supplementary File to Evidence Report D_Appendix M” Excel file. The direct and indirect estimates are reported based on results given by the node-split models. All NMA estimates are reported based on the results from the random effects model that assumes consistency (Dias et al., 2011a & 2013a).

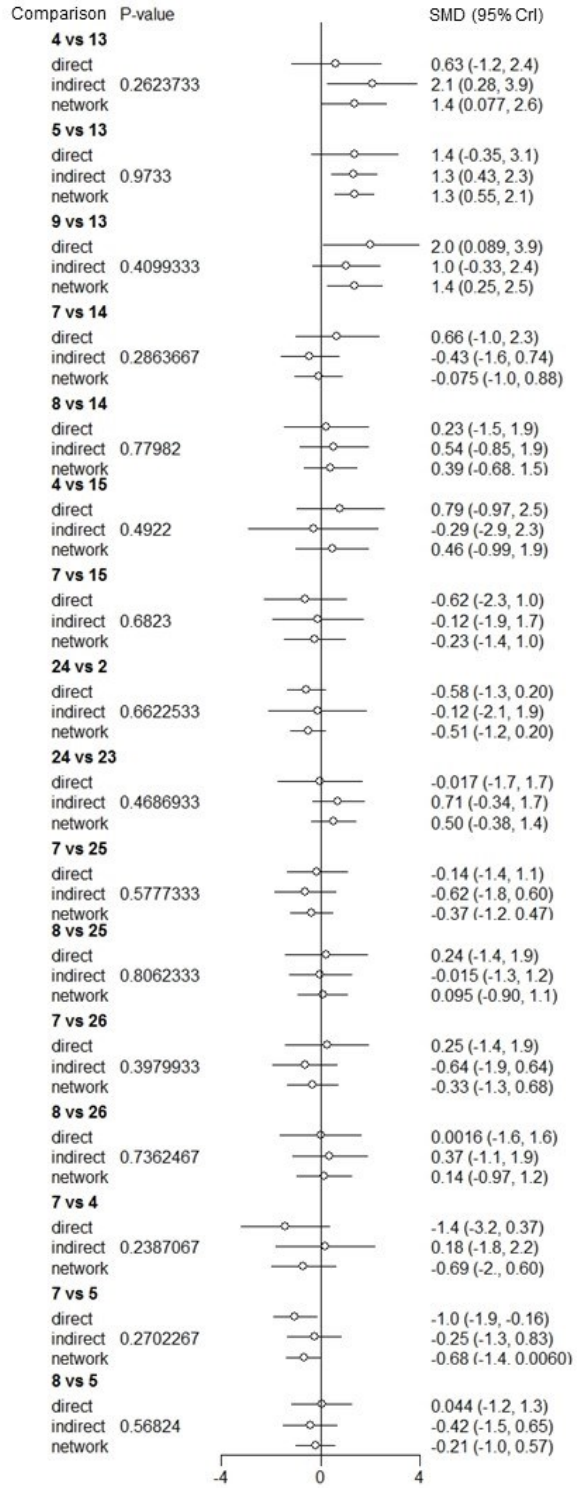
Table 203. Summary of node-splitting results: changes in PTSD symptom scores between baseline and treatment endpoint

Node split model	Heterogeneity (SD)		Residual deviance	Data points[a]	p-value[b]
	Median	95% CrI			
non-TF-CBT vs. Waitlist	0.81	(0.65, 1.03)	85.05	82	0.28
EMDR vs. Waitlist	0.79	(0.63, 1.00)	86.63	83	0.17
Present-centered therapy vs. Waitlist	0.82	(0.65, 1.04)	84.05	81	0.28
IPT vs. Waitlist	0.81	(0.65, 1.02)	86.38	83	0.93
Combined somatic & cognitive therapies vs. Waitlist	0.81	(0.65, 1.03)	86.34	83	0.72
Self-help with support vs. Waitlist	0.81	(0.64, 1.02)	86.34	83	0.47
Self-help without support vs. Waitlist	0.80	(0.64, 1.01)	86.35	83	0.38
SSRI vs. Waitlist	0.78	(0.62, 0.99)	85.64	82	0.17
TF-CBT individual 8-12 sessions + SSRI vs. Waitlist	0.78	(0.62, 0.99)	85.71	82	0.06
Counselling vs. Waitlist	0.79	(0.63, 1.01)	85.13	81	0.40
TF-CBT individual 8-12 sessions vs. Waitlist	0.82	(0.66, 1.05)	84.23	81	0.59
TF-CBT individual >12 sessions vs. Waitlist	0.81	(0.64, 1.03)	84.43	81	0.80
TF-CBT group 8-12 sessions vs. Waitlist	0.80	(0.64, 1.01)	86.51	83	0.41
EMDR vs. non-TF-CBT	0.80	(0.64, 1.02)	86.39	83	0.45
Present-centered therapy vs. non-TF-CBT	0.82	(0.65, 1.04)	85.12	82	0.72
Attention placebo vs. non-TF-CBT	0.81	(0.65, 1.02)	86.34	83	0.67
Counselling vs. non-TF-CBT	0.81	(0.65, 1.03)	85.38	82	0.36
TF-CBT individual 8-12 sessions vs. non-TF-CBT	0.81	(0.65, 1.03)	85.36	82	0.36
Combined somatic & cognitive therapies vs. EMDR	0.81	(0.65, 1.02)	86.31	83	0.73
SSRI vs. EMDR	0.80	(0.64, 1.01)	86.47	83	0.35
Relaxation vs. EMDR	0.80	(0.64, 1.01)	86.42	83	0.26
Counselling vs. EMDR	0.81	(0.65, 1.03)	86.26	83	0.97
TF-CBT group 8-12 sessions vs. EMDR	0.80	(0.64, 1.02)	86.55	83	0.41
TF-CBT individual 8-12 sessions vs. Present-centered therapy	0.80	(0.64, 1.01)	86.40	83	0.29
TF-CBT individual >12 sessions vs. Present-centered therapy	0.82	(0.65, 1.03)	85.20	82	0.78
Relaxation vs. IPT	0.81	(0.64, 1.02)	85.40	82	0.49
TF-CBT individual 8-12 sessions vs. IPT	0.81	(0.64, 1.02)	85.38	82	0.68
Self-help without support vs. Attention placebo	0.81	(0.65, 1.02)	86.33	83	0.66
Self-help without support vs. Self-help with support	0.81	(0.64, 1.02)	86.32	83	0.47
TF-CBT individual 8-12 sessions vs. SSRI	0.82	(0.65, 1.03)	85.20	82	0.58
TF-CBT individual >12 sessions vs. SSRI	0.81	(0.65, 1.03)	85.22	82	0.81

TF-CBT individual 8-12 sessions vs. TF-CBT individual 8-12 sessions + SSRI	0.80	(0.64, 1.02)	85.39	82	0.40
TF-CBT individual >12 sessions vs. TF-CBT individual 8-12 sessions + SSRI	0.80	(0.64, 1.01)	85.46	82	0.74
TF-CBT individual 8-12 sessions vs. Relaxation	0.81	(0.64, 1.02)	85.38	82	0.24
TF-CBT individual 8-12 sessions vs. Counselling	0.79	(0.63, 1.01)	84.13	80	0.27
TF-CBT individual >12 sessions vs. Counselling	0.81	(0.65, 1.02)	86.32	83	0.57
NMA (no nodes split)	0.80	(0.64, 1.01)	86.45	83	---

Figure 711. Direct, indirect, and network estimates of relative treatment effects based on node-splitting results.


Comparison P-value
SMD (95% CrI)
12 vs 1
direct
-0.87 (-1.7, -0.022)
indirect 0.2819467
-1.6 (-2.7, -0.55)
network
-1.2 (-1.8, -0.53)
13 vs 1
direct
-2.5 (-3.4, -1.6)
indirect 0.1757333
-1.7 (-2.5, -0.83)
network
-2.1 (-2.7, -1.4)
14 vs 1
direct
-0.93 (-2.1, 0.28)
indirect 0.27776
-2.1 (-3.9, -0.32)
network
-1.3 (-2.2, -0.39)
15 vs 1
direct
-1.2 (-3., 0.53)
indirect 0.9334467
-1.1 (-2.8, 0.58)
network
-1.2 (-2.4, 0.049)
18 vs 1
direct
-1.6 (-2.6, -0.61)
indirect 0.7237267
-1.9 (-3.8, -0.12)
network
-1.7 (-2.5, -0.82)
23 vs 1
direct
-1.5 (-2.3, -0.74)
indirect 0.4709067
-0.78 (-2.6, 1.1)
network
-1.4 (-2.1, -0.70)
24 vs 1
direct
-0.73 (-1.5, 0.044)
indirect 0.3755
-1.4 (-2.8, -0.061)
network
-0.89 (-1.6, -0.23)
25 vs 1
direct
-0.0010 (-1.6, 1.6)
indirect 0.16666
-1.3 (-2.3, -0.34)
network
-1.0 (-1.9, -0.17)
26 vs 1
direct
0.24 (-1.4, 1.8)
indirect 0.06097333
-1.7 (-3.0, -0.45)
network
-1.1 (-2.1, -0.043)
5 vs 1
direct
-1.1 (-2.0, -0.12)
indirect 0.4025467
-0.54 (-1.4, 0.32)
network
-0.70 (-1.3, -0.065)
7 vs 1
direct
-1.5 (-2.2, -0.82)
indirect 0.5939867
-1.2 (-2.1, -0.32)
network
-1.4 (-1.9, -0.86)
8 vs 1
direct
-0.84 (-1.7, 0.028)
indirect 0.7970733
-0.63 (-2.0, 0.77)
network
-0.92 (-1.6, -0.20)
9 vs 1
direct
-0.95 (-2.2, 0.26)
indirect 0.4122467
0.026 (-2.0, 2.1)
network
-0.70 (-1.7, 0.34)
13 vs 12
direct
-0.30 (-2., 1.4)
indirect 0.44508
-1.0 (-2., -0.10)
network
-0.87 (-1.7, -0.057)
14 vs 12
direct
0.087 (-1.6, 1.7)
indirect 0.7223733
-0.30 (-1.7, 1.1)
network
-0.12 (-1.2, 0.91)
2 vs 12
direct
0.51 (-1.2, 2.2)
indirect 0.6628
0.97 (-0.29, 2.2)
network
0.80 (-0.20, 1.8)
5 vs 12
direct
1.2 (-0.60, 3.1)
indirect 0.3574333
0.27 (-0.70, 1.2)
network
0.48 (-0.37, 1.3)
7 vs 12
direct
0.52 (-1.3, 2.3)
indirect 0.3659533
-0.38 (-1.3, 0.48)
network
-0.20 (-0.98, 0.58)
18 vs 13
direct
0.14 (-1.6, 1.9)
indirect 0.72546
0.51 (-0.67, 1.7)
network
0.39 (-0.57, 1.4)
25 vs 13
direct
0.39 (-1.3, 2.1)
indirect 0.3546867
1.3 (0.21, 2.4)
network
1.0 (0.11, 2.)
-4
0
4



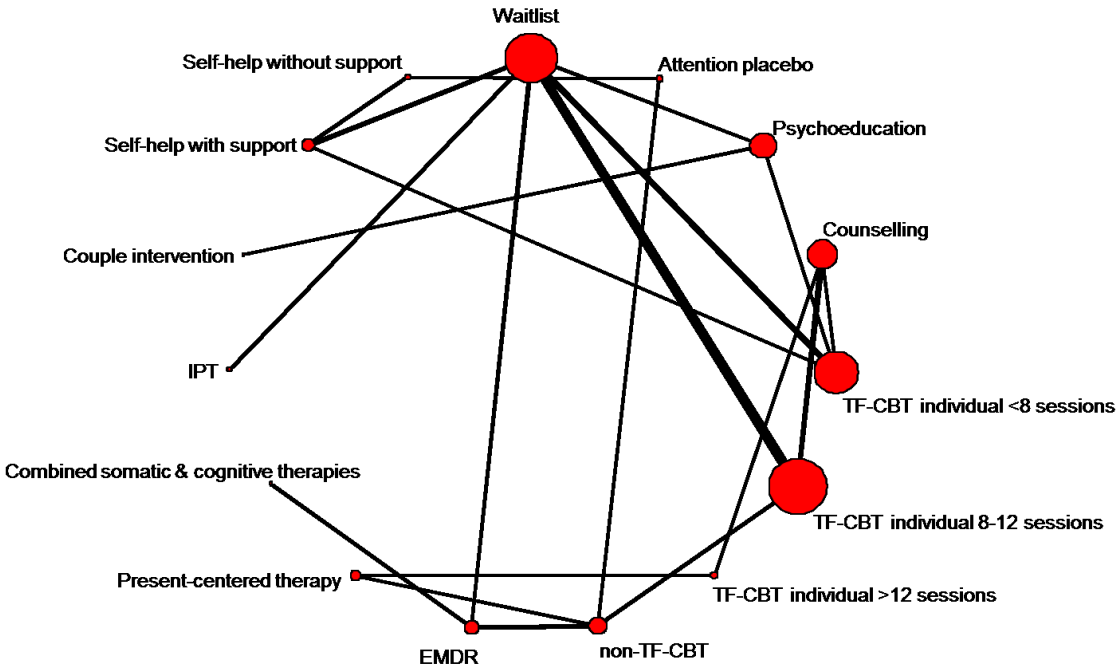
Treatments codes: 1 – Waitlist, 2 – Attention placebo, 3 – Psychoeducation, 4 – Relaxation, 5 – Counselling, 6 –TF-CBT individual <8 sessions ,7 – TF-CBT individual 8-12 sessions, 8 – TF-CBT individual >12 sessions, 9 – TF-CBT group 8-12 sessions, 10 – TF-CBT group >12 sessions, 11 – TF-

CBT mixed, 12 – non-TF-CBT, 13 – EMDR, 14 – Present-centered therapy, 15 – IPT, 16 – Metacognitive therapy, 17 – Behavioural therapy, 18 – Combined somatic & cognitive therapies, 19 – Resilience-oriented treatment, 20 – Attention bias modification, 21 – Couple intervention, 22 – Family therapy, 23 – Self-help with support, 24 – Self-help without support, 25 – SSRI, 26 – TF-CBT individual 8-12 sessions + SSRI

Outcome: Changes in PTSD symptom scores between baseline and 1-4 month follow-up

Since there were closed loops of direct evidence within the network that were informed by at least 3 distinct sets of trials, checks for inconsistency were carried out for this outcome (Figure 712). Inconsistency checks were performed using the random effects model, as lower DIC suggested the random effects model should be preferred (Table 204). The posterior mean residual deviance, 49.47, is close to the number of expected data points, suggesting a good fit of the random effects model which is greatly improved when compared to the fixed effect model.

Figure 712. Network diagram of comparisons for which direct evidence on 'changes in PTSD symptom scores between baseline and 1-4 month follow-up' was available



.

Table 204. Model fit statistics: changes in PTSD symptom scores between baseline and 1-4 month follow-up

Model	Between Study Heterogeneity - Standard Deviation (95% CrI[a])	Residual deviance[b]	DIC[c]
Fixed effect – consistency	---	117.5	254.569

Random effects – consistency	0.65 (0.40, 1.19)	49.47	196.379
Random effects – inconsistency	0.51 (0.22, 1.27)	49.41	196.714

[a] Credible Interval (CrI)
[b] Posterior mean residual deviance compared to 49 total data points
[c] Deviance information criteria (DIC) – lower values preferred

Convergence was satisfactory for the random effects model assuming inconsistency after 30,000 iterations, and the consistency and inconsistency models were compared using results based on samples from a further 60,000 iterations on two chains. WinBUGS code for the inconsistency model is provided in Appendix O.

There were no meaningful differences between posterior mean residual deviance and DIC of the consistency and inconsistency random effects models (Table 204). However, the between-study standard deviation is notably smaller in the inconsistency model, indicating there is some evidence of potential inconsistency.

Further checks for inconsistency using the node-splitting method (random effects model) revealed evidence of inconsistency between the direct and indirect estimates contributing to the pooled estimates of TF-CBT individual 8 – 12 sessions (6) vs. Waitlist (1), which were directly compared in Jacob 2014, Weiss 2015 (study 1), Weiss 2015 (study 2), Pacella 2012, EMDR (9) vs. Waitlist (1), directly compared in Acarturk 2016, and EMDR (9) vs. non-TF-CBT (8), directly compared in Ter Heide 2016 (Table 205, Figure 713). However, there were no notable improvements in the prediction of data points in these studies. For example, among these studies, the largest (but small) improvements were observed in Ter Heide 2016 and Acarturk 2016, noted in Figure 714. For the remaining studies in the network, any improvements by the inconsistency model were minimal (Figure 714).

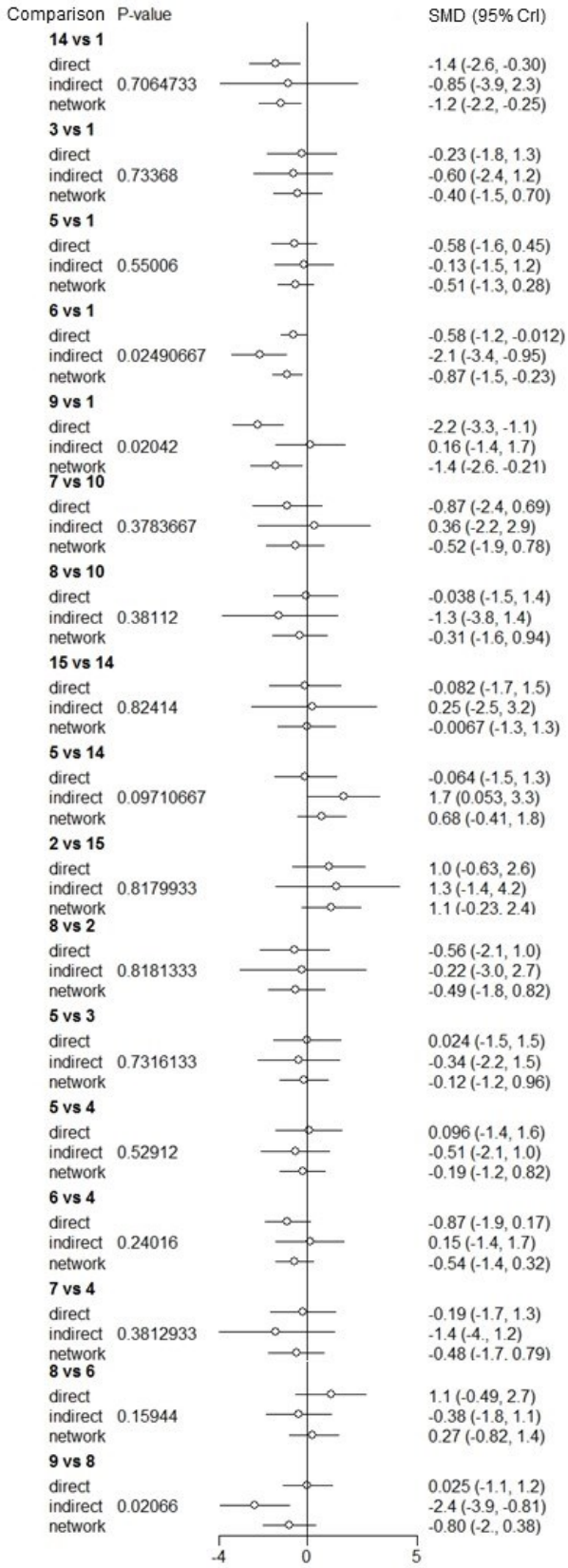
Table 205. Summary of node-splitting results: changes in PTSD symptom scores between baseline and 1-4 month follow-up

Node split model	Heterogeneity (SD)		Residual deviance	Data points[a]	p-value[b]
	median	95% CrI			
Self-help with support vs. Waitlist	0.66	(0.37, 1.30)	24.57	24	0.71
Psychoeducation vs. Waitlist	0.67	(0.39, 1.25)	25.62	25	0.74
TF-CBT individual <8 sessions vs. Waitlist	0.60	(0.32, 1.2)	24.72	24	0.55
TF-CBT individual 8-12 sessions vs. Waitlist	0.48	(0.24, 0.93)	25.64	25	0.02
EMDR vs. Waitlist	0.44	(0.20, 0.90)	26.43	25	0.02
TF-CBT individual >12 session vs. Present-centered therapy	0.63	(0.35, 1.19)	25.97	25	0.38
non-TF-CBT vs. Present-centered therapy	0.63	(0.35, 1.20)	26.02	25	0.38
Self-help without support vs. Self-help with support	0.67	(0.39, 1.27)	25.67	25	0.82
TF-CBT individual <8 sessions vs. Self-help with support	0.59	(0.31, 1.16)	24.77	24	0.10
Attention placebo vs. Self-help without support	0.67	(0.39, 1.25)	25.66	25	0.82
non-TF-CBT vs. Attention placebo	0.67	(0.39, 1.25)	25.68	25	0.82

TF-CBT individual <8 sessions vs. Psychoeducation	0.67	(0.38, 1.26)	25.63	25	0.73
TF-CBT individual <8 sessions vs. Counselling	0.65	(0.37, 1.23)	25.67	25	0.53
TF-CBT individual 8-12 sessions vs. Counselling	0.60	(0.33, 1.15)	26.06	25	0.24
TF-CBT individual >12 session vs. Counselling	0.63	(0.35, 1.20)	25.98	25	0.38
non-TF-CBT vs. TF-CBT individual 8-12 sessions	0.59	(0.33, 1.12)	25.75	25	0.16
EMDR vs. non-TF-CBT	0.44	(0.20, 0.89)	26.44	25	0.02
NMA (no nodes split)	0.63	(0.36, 1.14)	25.77	25	---

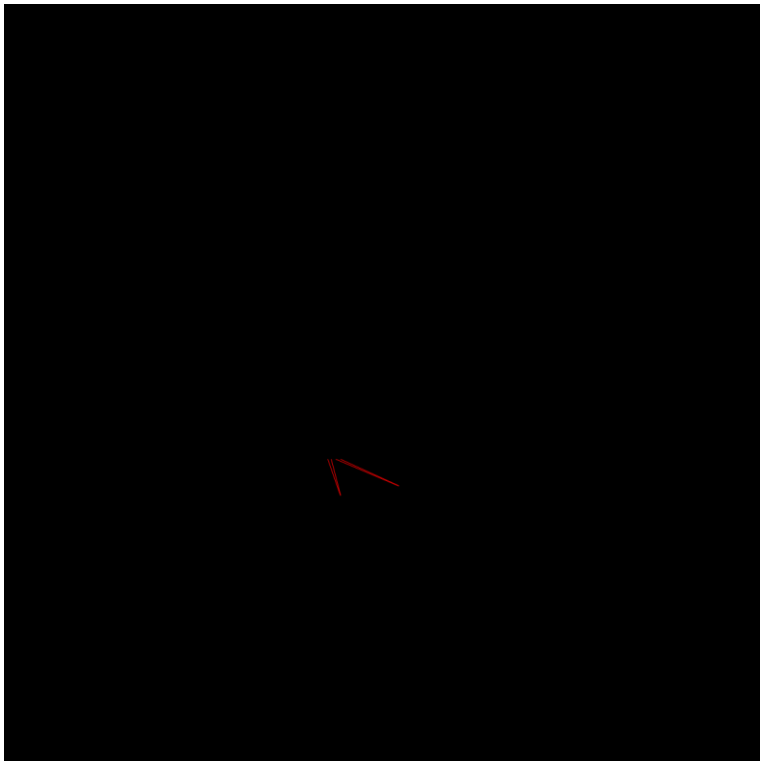
[a]Number of data points to compare posterior mean residual deviance to
[b]p-values < 0.05 is indicative of evidence of inconsistency between the direct and indirect estimates

Figure 713. Direct, indirect, and network estimates of relative treatment effects based on node-splitting results: changes in PTSD symptom scores between baseline and 1-4 month follow-up


Comparison P-value
SMD (95% CrI)
14 vs 1
direct
-1.4 (-2.6, -0.30)
indirect 0.7064733
-0.85 (-3.9, 2.3)
network
-1.2 (-2.2, -0.25)
3 vs 1
direct
-0.23 (-1.8, 1.3)
indirect 0.73368
-0.60 (-2.4, 1.2)
network
-0.40 (-1.5, 0.70)
5 vs 1
direct
-0.58 (-1.6, 0.45)
indirect 0.55006
-0.13 (-1.5, 1.2)
network
-0.51 (-1.3, 0.28)
6 vs 1
direct
-0.58 (-1.2, -0.012)
indirect 0.02490667
-2.1 (-3.4, -0.95)
network
-0.87 (-1.5, -0.23)
9 vs 1
direct
-2.2 (-3.3, -1.1)
indirect 0.02042
0.16 (-1.4, 1.7)
network
-1.4 (-2.6, -0.21)
7 vs 10
direct
-0.87 (-2.4, 0.69)
indirect 0.3783667
0.36 (-2.2, 2.9)
network
-0.52 (-1.9, 0.78)
8 vs 10
direct
-0.038 (-1.5, 1.4)
indirect 0.38112
-1.3 (-3.8, 1.4)
network
-0.31 (-1.6, 0.94)
15 vs 14
direct
-0.082 (-1.7, 1.5)
indirect 0.82414
0.25 (-2.5, 3.2)
network
-0.0067 (-1.3, 1.3)
5 vs 14
direct
-0.064 (-1.5, 1.3)
indirect 0.09710667
1.7 (0.053, 3.3)
network
0.68 (-0.41, 1.8)
2 vs 15
direct
1.0 (-0.63, 2.6)
indirect 0.8179933
1.3 (-1.4, 4.2)
network
1.1 (-0.23, 2.4)
8 vs 2
direct
-0.56 (-2.1, 1.0)
indirect 0.8181333
-0.22 (-3.0, 2.7)
network
-0.49 (-1.8, 0.82)
5 vs 3
direct
0.024 (-1.5, 1.5)
indirect 0.7316133
-0.34 (-2.2, 1.5)
network
-0.12 (-1.2, 0.96)
5 vs 4
direct
0.096 (-1.4, 1.6)
indirect 0.52912
-0.51 (-2.1, 1.0)
network
-0.19 (-1.2, 0.82)
6 vs 4
direct
-0.87 (-1.9, 0.17)
indirect 0.24016
0.15 (-1.4, 1.7)
network
-0.54 (-1.4, 0.32)
7 vs 4
direct
-0.19 (-1.7, 1.3)
indirect 0.3812933
-1.4 (-4., 1.2)
network
-0.48 (-1.7, 0.79)
8 vs 6
direct
1.1 (-0.49, 2.7)
indirect 0.15944
-0.38 (-1.8, 1.1)
network
0.27 (-0.82, 1.4)
9 vs 8
direct
0.025 (-1.1, 1.2)
indirect 0.02066
-2.4 (-3.9, -0.81)
network
-0.80 (-2., 0.38)
-4
0
5

Treatments codes: 1 – Waitlist, 2 – Attention placebo, 3 – Psychoeducation, 4 – Counselling, 5 – TF-CBT individual <8 sessions, 6 – TF-CBT individual 8-12 sessions, 7 – TF-CBT individual >12 session, 8 – non-TF-CBT, 9 – EMDR, 10 – Present-centered therapy, 11 – Combined somatic & cognitive therapies, 12 – IPT, 13 – Couple intervention, 14 – Self-help with support, 15 – Self-help without support

Figure 714. Deviance contributions for the random effects consistency and inconsistency models: changes in PTSD symptom scores between baseline and 1-4 month follow-up



In addition to the relative treatment effects estimated through NMA, we present direct and indirect estimates in the "Change Score_Follow up" worksheet of the "Supplementary File to Evidence Report D_Appendix M" Excel file. The direct and indirect estimates are reported based on results given by the node-split models. All NMA estimates are reported based on the results from the random effects model that assumes consistency (Dias et al., 2011a & 2013a).

Outcome: Remission status at treatment endpoint

Since there were closed loops of direct evidence within the network that were informed by at least 3 distinct sets of trials, checks for inconsistency were carried out for this outcome (Figure 715). Inconsistency checks were performed using the random effects model, as lower DIC suggested the random effects model should be preferred (Table 206). The posterior mean residual deviance, 76.05, is close to the number of expected data points, suggesting a good fit of the random effects model which is greatly improved when compared to the fixed effect model.

Figure 715. Network diagram of comparisons for which direct evidence on 'remission status at treatment endpoint' was available.

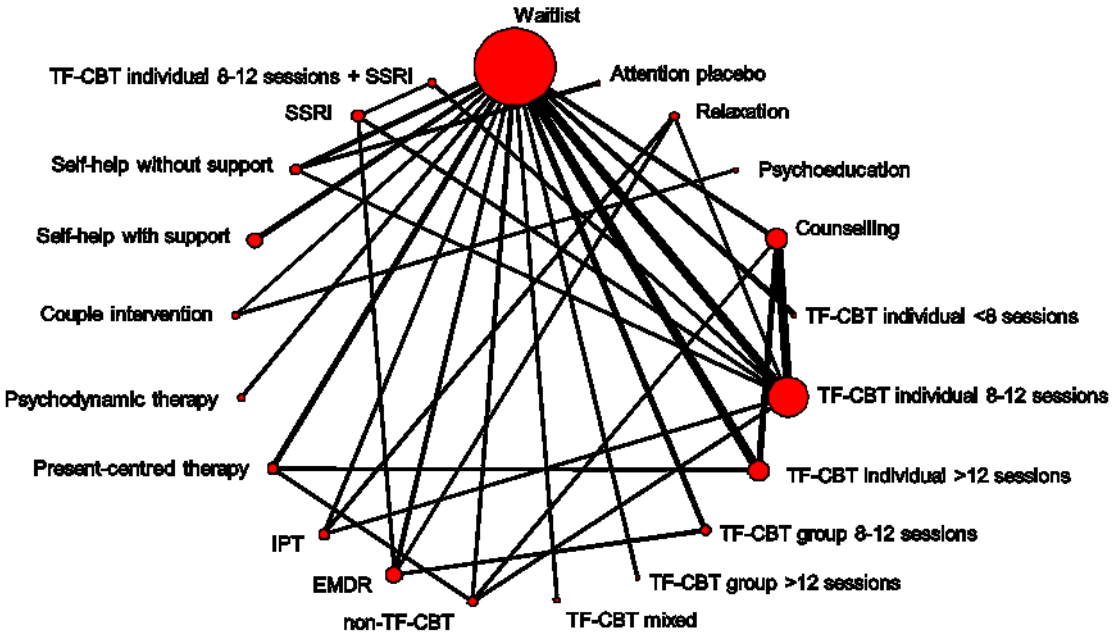


Table 206. Model fit statistics: remission status at treatment endpoint: remission status at treatment endpoint

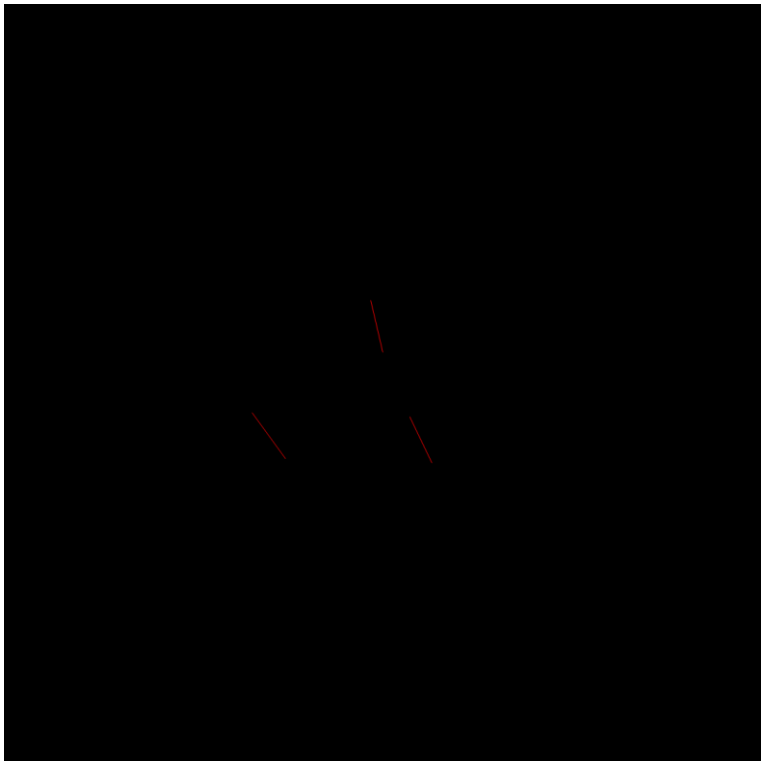
Model	Between Study Heterogeneity - Standard Deviation (95% CrI[a])	Residual deviance[b]	DIC[c]
Fixed effect – consistency	---	106.5	394.8
Random effects – consistency	1.05 (0.55, 1.83)	76.05	377.7
Random effects - inconsistency	1.32 (0.61, 2.65)	76.68	381.7

[a] Credible Interval (CrI)
[b] Posterior mean residual deviance compared to 74 total data points
[c] Deviance information criteria (DIC) – lower values preferred

Convergence was satisfactory for the random effects model assuming inconsistency after 30,000 iterations, and the consistency and inconsistency models were compared using results based on samples from a further 60,000 iterations on two chains. OpenBUGS code for the inconsistency model is provided in Appendix P.

There were no meaningful differences between posterior mean residual deviance of the consistency and inconsistency random effects models (Table 206). However, the lower DIC value and smaller between-study standard deviation in the consistency model suggests this model is preferred over the inconsistency model. Nevertheless, the inconsistency model notably better a predicted data point in Sloan 2012 (compares Self-help without support and Waitlist), indicating evidence of potential inconsistency (Figure 716).

Figure 716. Deviance contributions for the random effects consistency and inconsistency models: remission status at treatment endpoint



Further checks for inconsistency using the node-splitting method (random effects model) revealed evidence of inconsistency between the direct and indirect estimates contributing to the pooled estimate of TF-CBT individual 8 – 12 sessions (7) vs. Self-help without support (19), which were directly compared in Ehlers 2003 (Table 207, Figure 717). The inconsistency model minimally improved the prediction of one data point in this study, compared to the consistency model (Figure 716). In addition, the difference between the direct and indirect evidence contributing to the estimate following comparisons is worth noting: TF-CBT group 8-12 sessions (9) vs. Waitlist (1), TF-CBT group 8-12 sessions (9) vs. EMDR (13). These treatments have been directly compared in Falsetti 2008, Hollifield 2007, and Capezzani 2013. However, there were no notable improvements in the prediction of data points in these studies.

In addition to the relative treatment effects estimated through NMA, we present direct and indirect estimates in the "Remission_Endpoint" worksheet of the "Supplementary File to Evidence Report D_Appendix M" Excel file. The direct and indirect estimates are reported based on results given by the node-split models. All NMA estimates are reported based on the results from the random effects model that assumes consistency (Dias et al., 2011a & 2013a).

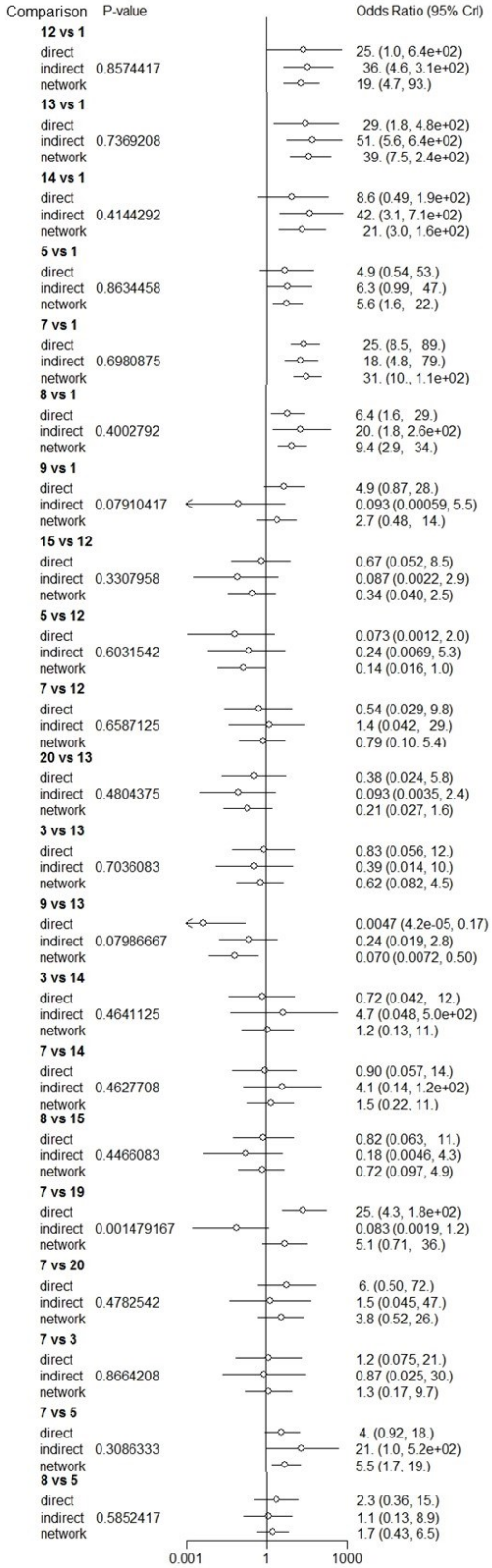
Table 207. Summary of node-splitting results: remission status at treatment endpoint

Node split model	Heterogeneity (SD)		Residual deviance	Data points[a]	p-value[b]
	median	95% CrI			
non-TF-CBT vs. Waitlist	0.65	(0.06, 1.38)	44.46	40	0.84

EMDR vs. Waitlist	1.12	(0.59, 1.94)	75.75	74	0.74
IPT vs. Waitlist	1.08	(0.56, 1.9)	75.75	74	0.41
Counselling vs. Waitlist	1.24	(0.67, 2.21)	73.45	72	0.87
TF-CBT individual 8-12 sessions vs. Waitlist	0.57	(0.05, 1.38)	74.81	71	0.72
TF-CBT individual >12 sessions vs. Waitlist	1.09	(0.55, 1.94)	74.35	73	0.40
TF-CBT group 8-12 sessions vs. Waitlist	0.96	(0.46, 1.7)	76.77	74	0.08
Present-centered therapy vs. non-TF-CBT	1.07	(0.55, 1.87)	74.92	73	0.33
Counselling vs. non-TF-CBT	1.13	(0.58, 2.03)	75.47	73	0.61
TF-CBT individual 8-12 sessions vs. non-TF-CBT	1.13	(0.59, 2.01)	75.25	73	0.67
SSRI vs. EMDR	1.08	(0.56, 1.91)	75.91	74	0.48
Relaxation vs. EMDR	1.11	(0.58, 1.92)	75.82	74	0.71
TF-CBT group 8-12 sessions vs. EMDR	0.96	(0.45, 1.7)	76.79	74	0.08
Relaxation vs. IPT	1.16	(0.62, 2.02)	74.54	73	0.47
TF-CBT individual 8-12 sessions vs. IPT	1.15	(0.61, 2.03)	74.5	73	0.46
TF-CBT individual >12 sessions vs. Present-centered therapy	1.04	(0.51, 1.87)	74.31	73	0.45
TF-CBT individual 8-12 sessions vs. Self-help without support	0.44	(0.03, 1.14)	76.91	73	0.00
TF-CBT individual 8-12 sessions vs. SSRI	1.08	(0.55, 1.89)	74.94	73	0.48
TF-CBT individual 8-12 sessions vs. Relaxation	1.15	(0.61, 2.02)	74.46	73	0.87
TF-CBT individual 8-12 sessions vs. Counselling	1.19	(0.58, 2.18)	73.05	71	0.31
TF-CBT individual >12 sessions vs. Counselling	1.1	(0.58, 1.92)	75.81	74	0.59
NMA (no nodes split)	1.05	(0.54, 1.83)	76	74	---

[a]Number of data points to compare posterior mean residual deviance to
[b]p-values < 0.05 is indicative of evidence of inconsistency between the direct and indirect estimates

Figure 717. Direct, indirect, and network estimates of relative treatment effects based on node-splitting results: remission status at treatment endpoint


Comparison P-value
Odds Ratio (95% CrI)
12 vs 1
direct 25. (1.0, 6.4e+02)
indirect 0.8574417 36. (4.6, 3.1e+02)
network 19. (4.7, 93.)
13 vs 1
direct 29. (1.8, 4.8e+02)
indirect 0.7369208 51. (5.6, 6.4e+02)
network 39. (7.5, 2.4e+02)
14 vs 1
direct 8.6 (0.49, 1.9e+02)
indirect 0.4144292 42. (3.1, 7.1e+02)
network 21. (3.0, 1.6e+02)
5 vs 1
direct 4.9 (0.54, 53.)
indirect 0.8634458 6.3 (0.99, 47.)
network 5.6 (1.6, 22.)
7 vs 1
direct 25. (8.5, 89.)
indirect 0.6980875 18. (4.8, 79.)
network 31. (10., 1.1e+02)
8 vs 1
direct 6.4 (1.6, 29.)
indirect 0.4002792 20. (1.8, 2.6e+02)
network 9.4 (2.9, 34.)
9 vs 1
direct 4.9 (0.87, 28.)
indirect 0.07910417 0.093 (0.00059, 5.5)
network 2.7 (0.48, 14.)
15 vs 12
direct 0.67 (0.052, 8.5)
indirect 0.3307958 0.087 (0.0022, 2.9)
network 0.34 (0.040, 2.5)
5 vs 12
direct 0.073 (0.0012, 2.0)
indirect 0.6031542 0.24 (0.0069, 5.3)
network 0.14 (0.016, 1.0)
7 vs 12
direct 0.54 (0.029, 9.8)
indirect 0.6587125 1.4 (0.042, 29.)
network 0.79 (0.10, 5.4)
20 vs 13
direct 0.38 (0.024, 5.8)
indirect 0.4804375 0.093 (0.0035, 2.4)
network 0.21 (0.027, 1.6)
3 vs 13
direct 0.83 (0.056, 12.)
indirect 0.7036083 0.39 (0.014, 10.)
network 0.62 (0.082, 4.5)
9 vs 13
direct 0.0047 (4.2e-05, 0.17)
indirect 0.07986667 0.24 (0.019, 2.8)
network 0.070 (0.0072, 0.50)
3 vs 14
direct 0.72 (0.042, 12.)
indirect 0.4641125 4.7 (0.048, 5.0e+02)
network 1.2 (0.13, 11.)
7 vs 14
direct 0.90 (0.057, 14.)
indirect 0.4627708 4.1 (0.14, 1.2e+02)
network 1.5 (0.22, 11.)
8 vs 15
direct 0.82 (0.063, 11.)
indirect 0.4466083 0.18 (0.0046, 4.3)
network 0.72 (0.097, 4.9)
7 vs 19
direct 25. (4.3, 1.8e+02)
indirect 0.001479167 0.083 (0.0019, 1.2)
network 5.1 (0.71, 36.)
7 vs 20
direct 6. (0.50, 72.)
indirect 0.4782542 1.5 (0.045, 47.)
network 3.8 (0.52, 26.)
7 vs 3
direct 1.2 (0.075, 21.)
indirect 0.8664208 0.87 (0.025, 30.)
network 1.3 (0.17, 9.7)
7 vs 5
direct 4. (0.92, 18.)
indirect 0.3086333 21. (1.0, 5.2e+02)
network 5.5 (1.7, 19.)
8 vs 5
direct 2.3 (0.36, 15.)
indirect 0.5852417 1.1 (0.13, 8.9)
network 1.7 (0.43, 6.5)
0.001
1
1000

Treatments codes: 1 – Waitlist, 2 – Attention placebo, 3 – Relaxation, 4 – Psychoeducation, 5 – Counselling, 6 – TF-CBT individual <8 sessions, 7 – TF-CBT individual 8-12 sessions, 8 – TF-CBT individual >12 sessions, 9 – TF-CBT group 8-12 sessions, 10 – TF-CBT group >12 sessions, 11 – TF-CBT mixed, 12 – non-TF-CBT, 13 – EMDR, 14 – IPT, 15 – Present-centered therapy, 16 – Psychodynamic therapy, 17 – Couple intervention, 18 – Self-help with support, 19 – Self-help without support, 20 – SSRI, 21 – TF-CBT individual 8-12 sessions + SSRI. Continuity correction was applied in node split model for 12 vs. 1 comparison.

Conclusion

The inconsistency checks did not identify any evidence of inconsistency in the direct and indirect evidence included in the network meta-analyses for the 'changes in PTSD symptom scores between baseline and treatment endpoint' outcome. While there was some evidence to suggest violation of the consistency assumption for the 'changes in PTSD symptom scores between baseline and 1-4 month follow-up' and 'remission status at treatment endpoint' outcomes, the NMA models for both outcomes fit the data well. We note, however, that between-study heterogeneity is large in all three networks, and this should be considered when interpreting the results.

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Appendix N – additional results of Network Meta-Analysis described in Appendix J (all pair-wise comparisons)

PTSD symptom scores, change from baseline to endpoint: Standardised Mean Differences (SMD)

[negative values favour second intervention in the comparison]

node	mean	2.50% CrI	median	97.50% CrI
diff[1,2]	-0.3913	-1.357	-0.3877	0.57
diff[1,3]	-2.02	-4.04	-2.018	-0.01022
diff[1,4]	-0.7296	-2.078	-0.7275	0.6311
diff[1,5]	-0.7222	-1.394	-0.7233	-0.04995
diff[1,6]	-2.267	-3.213	-2.265	-1.335
diff[1,7]	-1.447	-1.991	-1.45	-0.8919
diff[1,8]	-0.9604	-1.712	-0.9606	-0.1905
diff[1,9]	-0.6895	-1.779	-0.688	0.402
diff[1,10]	-2.397	-4.308	-2.405	-0.4832
diff[1,11]	-2.819	-4.665	-2.816	-1.024
diff[1,12]	-1.213	-1.904	-1.216	-0.5196
diff[1,13]	-2.105	-2.747	-2.108	-1.467
diff[1,14]	-1.328	-2.316	-1.326	-0.3335
diff[1,15]	-1.182	-2.451	-1.177	0.09542
diff[1,16]	-3.04	-4.996	-3.039	-1.096
diff[1,17]	-1.201	-2.507	-1.192	0.0911
diff[1,18]	-1.705	-2.618	-1.701	-0.7934
diff[1,19]	-1.636	-3.46	-1.639	0.1874
diff[1,20]	2.135	0.6978	2.141	3.566
diff[1,21]	-3.476	-6.208	-3.474	-0.7388

diff[1,22]	0.153	-1.618	0.1533	1.909
diff[1,23]	-1.429	-2.179	-1.43	-0.6788
diff[1,24]	-0.9071	-1.619	-0.9071	-0.206
diff[1,25]	-1.059	-1.97	-1.058	-0.1466
diff[1,26]	-1.096	-2.172	-1.1	-0.00497
diff[2,3]	-1.629	-3.853	-1.624	0.5994
diff[2,4]	-0.3383	-1.981	-0.3419	1.323
diff[2,5]	-0.331	-1.481	-0.3337	0.8315
diff[2,6]	-1.876	-3.218	-1.876	-0.5361
diff[2,7]	-1.056	-2.141	-1.06	0.03835
diff[2,8]	-0.5692	-1.771	-0.5733	0.639
diff[2,9]	-0.2983	-1.737	-0.2973	1.15
diff[2,10]	-2.005	-4.125	-2.01	0.144
diff[2,11]	-2.428	-4.485	-2.424	-0.3414
diff[2,12]	-0.8213	-1.896	-0.8261	0.2746
diff[2,13]	-1.714	-2.852	-1.715	-0.5594
diff[2,14]	-0.9369	-2.296	-0.9397	0.4317
diff[2,15]	-0.7908	-2.398	-0.7961	0.8265
diff[2,16]	-2.649	-4.809	-2.637	-0.4796
diff[2,17]	-0.81	-2.439	-0.8058	0.807
diff[2,18]	-1.313	-2.617	-1.32	0.01236
diff[2,19]	-1.244	-3.323	-1.244	0.8244
diff[2,20]	2.526	1.463	2.526	3.586
diff[2,21]	-3.084	-5.994	-3.094	-0.1878
diff[2,22]	0.5443	-1.487	0.5524	2.57
diff[2,23]	-1.037	-2.224	-1.036	0.1345
diff[2,24]	-0.5159	-1.283	-0.5147	0.2437
diff[2,25]	-0.6673	-1.986	-0.6688	0.6617
diff[2,26]	-0.7052	-2.151	-0.7042	0.7345
diff[3,4]	1.291	-1.11	1.283	3.742
diff[3,5]	1.298	-0.8327	1.288	3.435
diff[3,6]	-0.2464	-2.029	-0.2463	1.52
diff[3,7]	0.5731	-1.51	0.5651	2.67
diff[3,8]	1.06	-1.097	1.054	3.2
diff[3,9]	1.331	-0.9498	1.325	3.627
diff[3,10]	-0.3762	-3.132	-0.372	2.416
diff[3,11]	-0.7991	-3.523	-0.7906	1.893
diff[3,12]	0.8079	-1.318	0.8016	2.943
diff[3,13]	-0.08479	-2.176	-0.08861	2.036
diff[3,14]	0.6922	-1.54	0.6938	2.931

diff[3,15]	0.8384	-1.568	0.8367	3.261
diff[3,16]	-1.02	-3.818	-1.019	1.75
diff[3,17]	0.8191	-1.597	0.8205	3.202
diff[3,18]	0.3158	-1.913	0.3141	2.546
diff[3,19]	0.3847	-2.336	0.3833	3.18
diff[3,20]	4.155	1.681	4.159	6.633
diff[3,21]	-1.455	-3.33	-1.459	0.4026
diff[3,22]	2.173	-0.4848	2.179	4.88
diff[3,23]	0.5917	-1.575	0.5982	2.747
diff[3,24]	1.113	-1.024	1.116	3.261
diff[3,25]	0.9618	-1.228	0.9689	3.176
diff[3,26]	0.9239	-1.362	0.925	3.208
diff[4,5]	0.007373	-1.441	0.01199	1.463
diff[4,6]	-1.537	-3.185	-1.53	0.1074
diff[4,7]	-0.7177	-2.081	-0.719	0.6375
diff[4,8]	-0.2308	-1.751	-0.2267	1.287
diff[4,9]	0.04008	-1.678	0.03691	1.738
diff[4,10]	-1.667	-4.006	-1.673	0.6252
diff[4,11]	-2.09	-4.366	-2.089	0.1492
diff[4,12]	-0.4829	-1.962	-0.4792	1.008
diff[4,13]	-1.376	-2.727	-1.371	-0.02613
diff[4,14]	-0.5986	-2.246	-0.6007	1.036
diff[4,15]	-0.4524	-1.989	-0.4494	1.076
diff[4,16]	-2.311	-4.688	-2.302	0.02893
diff[4,17]	-0.4717	-2.382	-0.4668	1.366
diff[4,18]	-0.975	-2.58	-0.977	0.6276
diff[4,19]	-0.9061	-3.189	-0.9104	1.402
diff[4,20]	2.864	0.9033	2.862	4.805
diff[4,21]	-2.746	-5.86	-2.727	0.286
diff[4,22]	0.8826	-1.319	0.8874	3.109
diff[4,23]	-0.6992	-2.244	-0.7032	0.8429
diff[4,24]	-0.1775	-1.715	-0.1802	1.349
diff[4,25]	-0.329	-1.906	-0.3228	1.231
diff[4,26]	-0.3669	-2.041	-0.3693	1.301
diff[5,6]	-1.545	-2.71	-1.545	-0.3898
diff[5,7]	-0.7251	-1.438	-0.7273	0.01036
diff[5,8]	-0.2382	-1.086	-0.2393	0.6099
diff[5,9]	0.0327	-1.218	0.02588	1.308
diff[5,10]	-1.674	-3.45	-1.686	0.1351
diff[5,11]	-2.097	-4.055	-2.092	-0.1585

diff[5,12]	-0.4903	-1.366	-0.4939	0.4078
diff[5,13]	-1.383	-2.233	-1.385	-0.52
diff[5,14]	-0.606	-1.731	-0.6003	0.5217
diff[5,15]	-0.4598	-1.876	-0.4573	0.9344
diff[5,16]	-2.318	-4.369	-2.318	-0.2572
diff[5,17]	-0.4791	-1.943	-0.4746	0.9698
diff[5,18]	-0.9824	-2.111	-0.9874	0.1334
diff[5,19]	-0.9135	-2.855	-0.9139	1.06
diff[5,20]	2.857	1.287	2.853	4.435
diff[5,21]	-2.754	-5.604	-2.754	0.08138
diff[5,22]	0.8752	-1.001	0.8769	2.776
diff[5,23]	-0.7065	-1.722	-0.7081	0.2833
diff[5,24]	-0.1849	-1.147	-0.1843	0.7901
diff[5,25]	-0.3364	-1.389	-0.3349	0.7039
diff[5,26]	-0.3743	-1.563	-0.3786	0.824
diff[6,7]	0.8195	-0.2811	0.8189	1.924
diff[6,8]	1.306	0.1034	1.3	2.54
diff[6,9]	1.577	0.1674	1.579	3.022
diff[6,10]	-0.1298	-2.255	-0.1321	2.004
diff[6,11]	-0.5527	-2.626	-0.5461	1.495
diff[6,12]	1.054	-0.1148	1.052	2.21
diff[6,13]	0.1616	-0.9692	0.1603	1.302
diff[6,14]	0.9386	-0.4455	0.9412	2.334
diff[6,15]	1.085	-0.5	1.087	2.648
diff[6,16]	-0.7736	-2.919	-0.7689	1.367
diff[6,17]	1.065	-0.5423	1.067	2.685
diff[6,18]	0.5622	-0.7427	0.5617	1.887
diff[6,19]	0.6311	-1.434	0.6265	2.725
diff[6,20]	4.402	2.686	4.403	6.115
diff[6,21]	-1.209	-3.764	-1.206	1.329
diff[6,22]	2.42	0.4353	2.414	4.405
diff[6,23]	0.838	-0.3659	0.8365	2.072
diff[6,24]	1.36	0.1775	1.362	2.537
diff[6,25]	1.208	-0.09411	1.203	2.536
diff[6,26]	1.17	-0.2453	1.159	2.62
diff[7,8]	0.4869	-0.3708	0.4855	1.337
diff[7,9]	0.7578	-0.4428	0.7607	1.96
diff[7,10]	-0.9493	-2.862	-0.9566	0.9911
diff[7,11]	-1.372	-3.301	-1.368	0.5289
diff[7,12]	0.2348	-0.588	0.2342	1.068

diff[7,13]	-0.6579	-1.43	-0.6573	0.1221
diff[7,14]	0.1191	-0.9051	0.1178	1.141
diff[7,15]	0.2652	-1.032	0.2689	1.551
diff[7,16]	-1.593	-3.638	-1.59	0.4067
diff[7,17]	0.246	-1.164	0.2515	1.642
diff[7,18]	-0.2573	-1.312	-0.2502	0.794
diff[7,19]	-0.1884	-2.103	-0.1904	1.719
diff[7,20]	3.582	2.072	3.58	5.139
diff[7,21]	-2.028	-4.82	-2.017	0.7666
diff[7,22]	1.6	-0.2634	1.597	3.445
diff[7,23]	0.01852	-0.9041	0.01895	0.9461
diff[7,24]	0.5401	-0.3508	0.539	1.428
diff[7,25]	0.3887	-0.5014	0.3905	1.291
diff[7,26]	0.3508	-0.7353	0.3431	1.444
diff[8,9]	0.2709	-1.055	0.2736	1.596
diff[8,10]	-1.436	-3.399	-1.443	0.566
diff[8,11]	-1.859	-3.822	-1.851	0.09693
diff[8,12]	-0.2521	-1.232	-0.2479	0.7292
diff[8,13]	-1.145	-2.09	-1.145	-0.1965
diff[8,14]	-0.3678	-1.496	-0.3692	0.7612
diff[8,15]	-0.2216	-1.717	-0.2135	1.242
diff[8,16]	-2.08	-4.181	-2.087	0.004104
diff[8,17]	-0.2409	-1.723	-0.2327	1.228
diff[8,18]	-0.7442	-1.938	-0.742	0.4299
diff[8,19]	-0.6753	-2.682	-0.6817	1.296
diff[8,20]	3.095	1.487	3.102	4.699
diff[8,21]	-2.515	-5.364	-2.516	0.3424
diff[8,22]	1.113	-0.8102	1.118	3.036
diff[8,23]	-0.4683	-1.544	-0.466	0.5919
diff[8,24]	0.05329	-0.9826	0.05352	1.103
diff[8,25]	-0.09816	-1.171	-0.09418	0.9495
diff[8,26]	-0.1361	-1.333	-0.1323	1.059
diff[9,10]	-1.707	-3.919	-1.701	0.4749
diff[9,11]	-2.13	-4.239	-2.129	-0.02619
diff[9,12]	-0.523	-1.787	-0.5184	0.7372
diff[9,13]	-1.416	-2.567	-1.415	-0.2721
diff[9,14]	-0.6387	-2.1	-0.6354	0.8264
diff[9,15]	-0.4925	-2.178	-0.4912	1.166
diff[9,16]	-2.351	-4.572	-2.356	-0.1157
diff[9,17]	-0.5118	-2.228	-0.5073	1.184

diff[9,18]	-1.015	-2.412	-1.015	0.3746
diff[9,19]	-0.9462	-3.11	-0.9448	1.173
diff[9,20]	2.824	1.02	2.823	4.605
diff[9,21]	-2.786	-5.75	-2.785	0.1624
diff[9,22]	0.8425	-1.218	0.8566	2.889
diff[9,23]	-0.7392	-2.06	-0.7354	0.5692
diff[9,24]	-0.2176	-1.511	-0.2148	1.072
diff[9,25]	-0.3691	-1.753	-0.371	1.009
diff[9,26]	-0.407	-1.92	-0.4111	1.104
diff[10,11]	-0.4229	-3.083	-0.4045	2.195
diff[10,12]	1.184	-0.8323	1.188	3.196
diff[10,13]	0.2914	-1.677	0.2944	2.274
diff[10,14]	1.068	-1.067	1.062	3.195
diff[10,15]	1.215	-1.069	1.223	3.481
diff[10,16]	-0.6438	-3.346	-0.6514	2.086
diff[10,17]	1.195	-1.131	1.197	3.501
diff[10,18]	0.692	-1.451	0.6896	2.793
diff[10,19]	0.7609	-1.913	0.772	3.433
diff[10,20]	4.531	2.132	4.53	6.899
diff[10,21]	-1.079	-4.47	-1.072	2.238
diff[10,22]	2.55	-0.03787	2.546	5.19
diff[10,23]	0.9678	-1.084	0.9719	3.015
diff[10,24]	1.489	-0.5365	1.498	3.499
diff[10,25]	1.338	-0.7291	1.34	3.4
diff[10,26]	1.3	-0.8522	1.299	3.46
diff[11,12]	1.607	-0.3254	1.603	3.556
diff[11,13]	0.7143	-1.207	0.712	2.653
diff[11,14]	1.491	-0.5901	1.486	3.561
diff[11,15]	1.637	-0.5614	1.633	3.842
diff[11,16]	-0.2209	-2.86	-0.219	2.455
diff[11,17]	1.618	-0.6369	1.63	3.848
diff[11,18]	1.115	-0.9265	1.119	3.158
diff[11,19]	1.184	-1.443	1.187	3.771
diff[11,20]	4.954	2.646	4.95	7.273
diff[11,21]	-0.6562	-3.93	-0.6677	2.65
diff[11,22]	2.973	0.4126	2.976	5.524
diff[11,23]	1.391	-0.5792	1.386	3.367
diff[11,24]	1.912	-0.04815	1.903	3.873
diff[11,25]	1.761	-0.2654	1.753	3.786
diff[11,26]	1.723	-0.423	1.716	3.852

diff[12,13]	-0.8927	-1.76	-0.8941	-0.04406
diff[12,14]	-0.1157	-1.228	-0.1159	1.006
diff[12,15]	0.03048	-1.416	0.03309	1.469
diff[12,16]	-1.828	-3.889	-1.83	0.2225
diff[12,17]	0.01123	-1.47	0.01433	1.467
diff[12,18]	-0.4921	-1.621	-0.4897	0.6418
diff[12,19]	-0.4232	-2.383	-0.4251	1.54
diff[12,20]	3.347	1.83	3.344	4.869
diff[12,21]	-2.263	-5.109	-2.264	0.5599
diff[12,22]	1.366	-0.5323	1.375	3.252
diff[12,23]	-0.2162	-1.239	-0.2148	0.7956
diff[12,24]	0.3054	-0.6464	0.3041	1.231
diff[12,25]	0.1539	-0.9492	0.1543	1.26
diff[12,26]	0.116	-1.143	0.1154	1.369
diff[13,14]	0.777	-0.3775	0.7756	1.921
diff[13,15]	0.9232	-0.4545	0.9288	2.305
diff[13,16]	-0.9352	-2.983	-0.9376	1.089
diff[13,17]	0.9039	-0.5398	0.9051	2.339
diff[13,18]	0.4006	-0.6384	0.4045	1.429
diff[13,19]	0.4695	-1.453	0.4699	2.418
diff[13,20]	4.24	2.665	4.249	5.809
diff[13,21]	-1.371	-4.166	-1.382	1.427
diff[13,22]	2.258	0.3848	2.253	4.132
diff[13,23]	0.6765	-0.3043	0.6782	1.661
diff[13,24]	1.198	0.2472	1.201	2.144
diff[13,25]	1.047	0.06028	1.047	2.03
diff[13,26]	1.009	-0.1704	1.008	2.199
diff[14,15]	0.1461	-1.444	0.1556	1.736
diff[14,16]	-1.712	-3.895	-1.716	0.4454
diff[14,17]	0.1269	-1.508	0.1318	1.769
diff[14,18]	-0.3764	-1.725	-0.3762	0.9692
diff[14,19]	-0.3075	-2.386	-0.319	1.763
diff[14,20]	3.463	1.751	3.462	5.187
diff[14,21]	-2.148	-5.044	-2.151	0.7492
diff[14,22]	1.481	-0.5621	1.479	3.491
diff[14,23]	-0.1006	-1.344	-0.1001	1.128
diff[14,24]	0.4211	-0.7691	0.4171	1.625
diff[14,25]	0.2696	-1.008	0.2745	1.553
diff[14,26]	0.2317	-1.164	0.2259	1.641
diff[15,16]	-1.858	-4.213	-1.859	0.4823

diff[15,17]	-0.01925	-1.844	-0.02272	1.795
diff[15,18]	-0.5226	-2.082	-0.5218	1.038
diff[15,19]	-0.4537	-2.684	-0.4574	1.787
diff[15,20]	3.317	1.389	3.326	5.223
diff[15,21]	-2.294	-5.353	-2.303	0.7485
diff[15,22]	1.335	-0.8427	1.331	3.472
diff[15,23]	-0.2467	-1.739	-0.2478	1.235
diff[15,24]	0.2749	-1.217	0.277	1.735
diff[15,25]	0.1235	-1.399	0.1177	1.655
diff[15,26]	0.08557	-1.552	0.0855	1.736
diff[16,17]	1.839	-0.5314	1.84	4.154
diff[16,18]	1.336	-0.794	1.337	3.488
diff[16,19]	1.405	-1.296	1.386	4.064
diff[16,20]	5.175	2.753	5.166	7.596
diff[16,21]	-0.4353	-3.78	-0.4529	2.941
diff[16,22]	3.193	0.533	3.199	5.822
diff[16,23]	1.612	-0.4477	1.616	3.705
diff[16,24]	2.133	0.07607	2.138	4.201
diff[16,25]	1.982	-0.1462	1.982	4.169
diff[16,26]	1.944	-0.2812	1.939	4.195
diff[17,18]	-0.5033	-2.065	-0.5022	1.076
diff[17,19]	-0.4344	-2.676	-0.4366	1.84
diff[17,20]	3.336	1.422	3.337	5.27
diff[17,21]	-2.274	-5.29	-2.272	0.7534
diff[17,22]	1.354	-0.8316	1.345	3.537
diff[17,23]	-0.2275	-1.707	-0.2364	1.293
diff[17,24]	0.2942	-1.181	0.2973	1.78
diff[17,25]	0.1427	-1.437	0.1459	1.724
diff[17,26]	0.1048	-1.563	0.09575	1.803
diff[18,19]	0.06889	-1.979	0.05845	2.116
diff[18,20]	3.839	2.142	3.841	5.509
diff[18,21]	-1.771	-4.654	-1.764	1.139
diff[18,22]	1.858	-0.1221	1.85	3.842
diff[18,23]	0.2759	-0.9089	0.2743	1.452
diff[18,24]	0.7975	-0.3529	0.7979	1.929
diff[18,25]	0.646	-0.5999	0.6501	1.915
diff[18,26]	0.6081	-0.7711	0.6032	2.02
diff[19,20]	3.771	1.428	3.772	6.129
diff[19,21]	-1.84	-5.212	-1.838	1.452
diff[19,22]	1.789	-0.7565	1.78	4.342

diff[19,23]	0.207	-1.788	0.2045	2.169
diff[19,24]	0.7286	-1.255	0.7309	2.714
diff[19,25]	0.5771	-1.47	0.5806	2.63
diff[19,26]	0.5392	-1.584	0.5417	2.665
diff[20,21]	-5.611	-8.738	-5.601	-2.509
diff[20,22]	-1.982	-4.263	-1.976	0.2618
diff[20,23]	-3.564	-5.126	-3.563	-1.984
diff[20,24]	-3.042	-4.339	-3.041	-1.74
diff[20,25]	-3.193	-4.893	-3.183	-1.512
diff[20,26]	-3.231	-5.011	-3.229	-1.43
diff[21,22]	3.629	0.4459	3.631	6.886
diff[21,23]	2.047	-0.7885	2.061	4.904
diff[21,24]	2.569	-0.2649	2.566	5.406
diff[21,25]	2.417	-0.4653	2.41	5.318
diff[21,26]	2.379	-0.5711	2.391	5.274
diff[22,23]	-1.582	-3.466	-1.584	0.3447
diff[22,24]	-1.06	-2.954	-1.058	0.8736
diff[22,25]	-1.212	-3.187	-1.212	0.7791
diff[22,26]	-1.249	-3.277	-1.249	0.8219
diff[23,24]	0.5216	-0.4317	0.523	1.475
diff[23,25]	0.3702	-0.7999	0.366	1.539
diff[23,26]	0.3323	-0.9731	0.3288	1.644
diff[24,25]	-0.1514	-1.301	-0.1566	1.002
diff[24,26]	-0.1893	-1.476	-0.1875	1.111
diff[25,26]	-0.0379	-1.025	-0.03862	0.9427

PTSD symptom scores, change from baseline to 1-4 months follow-up: Standardised Mean Differences (SMD)

[negative values favour second intervention in the comparison]

node	mean	2.50% CrI	median	97.50% CrI
diff[1,2]	-0.1182	-1.662	-0.12	1.433
diff[1,3]	-0.4081	-1.547	-0.4073	0.7239
diff[1,4]	-0.3301	-1.319	-0.3297	0.658
diff[1,5]	-0.5357	-1.387	-0.5336	0.2893
diff[1,6]	-0.8798	-1.557	-0.8777	-0.2162
diff[1,7]	-0.8078	-2.307	-0.8102	0.7169
diff[1,8]	-0.5919	-1.729	-0.5966	0.5679
diff[1,9]	-1.421	-2.606	-1.426	-0.217
diff[1,10]	-0.2652	-1.791	-0.2658	1.3
diff[1,11]	-1.469	-3.406	-1.468	0.4764
diff[1,12]	-0.3883	-1.943	-0.3862	1.18
diff[1,13]	-1.935	-3.861	-1.936	-0.04615
diff[1,14]	-1.24	-2.23	-1.241	-0.2628
diff[1,15]	-1.225	-2.741	-1.224	0.2901
diff[2,3]	-0.2898	-2.183	-0.2908	1.574
diff[2,4]	-0.2119	-1.898	-0.2146	1.488
diff[2,5]	-0.4175	-2.113	-0.4115	1.251
diff[2,6]	-0.7616	-2.366	-0.7568	0.8047
diff[2,7]	-0.6896	-2.576	-0.6919	1.209
diff[2,8]	-0.4737	-1.816	-0.4798	0.8705
diff[2,9]	-1.302	-2.982	-1.307	0.4115
diff[2,10]	-0.147	-1.945	-0.1505	1.667
diff[2,11]	-1.351	-3.658	-1.36	0.9384
diff[2,12]	-0.2701	-2.488	-0.2708	1.906
diff[2,13]	-1.817	-4.243	-1.818	0.6077
diff[2,14]	-1.122	-2.695	-1.116	0.4259
diff[2,15]	-1.106	-2.471	-1.101	0.2493
diff[3,4]	0.07791	-1.327	0.0805	1.495
diff[3,5]	-0.1276	-1.254	-0.1249	1.003
diff[3,6]	-0.4718	-1.749	-0.4649	0.8089
diff[3,7]	-0.3998	-2.198	-0.3965	1.412
diff[3,8]	-0.1838	-1.751	-0.1869	1.421
diff[3,9]	-1.012	-2.628	-1.017	0.599
diff[3,10]	0.1429	-1.708	0.1389	2.009

diff[3,11]	-1.061	-3.33	-1.059	1.181
diff[3,12]	0.01976	-1.891	0.0168	1.962
diff[3,13]	-1.527	-3.081	-1.531	0.01975
diff[3,14]	-0.832	-2.269	-0.8299	0.5841
diff[3,15]	-0.8166	-2.696	-0.8229	1.043
diff[4,5]	-0.2055	-1.26	-0.2027	0.8372
diff[4,6]	-0.5497	-1.464	-0.5487	0.3404
diff[4,7]	-0.4777	-1.808	-0.4836	0.8514
diff[4,8]	-0.2617	-1.555	-0.2653	1.061
diff[4,9]	-1.09	-2.52	-1.09	0.3886
diff[4,10]	0.06498	-1.456	0.0624	1.595
diff[4,11]	-1.139	-3.273	-1.142	0.9942
diff[4,12]	-0.05815	-1.909	-0.0577	1.777
diff[4,13]	-1.605	-3.72	-1.608	0.5028
diff[4,14]	-0.9099	-2.227	-0.9133	0.3684
diff[4,15]	-0.8945	-2.594	-0.9012	0.8179
diff[5,6]	-0.3442	-1.316	-0.344	0.6339
diff[5,7]	-0.2722	-1.826	-0.2779	1.306
diff[5,8]	-0.05621	-1.399	-0.0643	1.283
diff[5,9]	-0.8849	-2.271	-0.8908	0.5414
diff[5,10]	0.2705	-1.349	0.2631	1.916
diff[5,11]	-0.9337	-3.027	-0.9383	1.148
diff[5,12]	0.1474	-1.616	0.141	1.928
diff[5,13]	-1.399	-3.325	-1.4	0.5226
diff[5,14]	-0.7044	-1.837	-0.7046	0.425
diff[5,15]	-0.689	-2.321	-0.6918	0.945
diff[6,7]	0.07199	-1.363	0.0687	1.555
diff[6,8]	0.288	-0.805	0.2812	1.453
diff[6,9]	-0.5407	-1.805	-0.5496	0.7691
diff[6,10]	0.6147	-0.88	0.6092	2.144
diff[6,11]	-0.5895	-2.578	-0.5974	1.409
diff[6,12]	0.4915	-1.194	0.4898	2.192
diff[6,13]	-1.055	-3.076	-1.059	0.9495
diff[6,14]	-0.3602	-1.482	-0.3627	0.7874
diff[6,15]	-0.3448	-1.927	-0.3502	1.257
diff[7,8]	0.216	-1.267	0.218	1.747
diff[7,9]	-0.6127	-2.372	-0.6134	1.142
diff[7,10]	0.5427	-0.791	0.5347	1.886
diff[7,11]	-0.6615	-3.026	-0.657	1.654
diff[7,12]	0.4196	-1.719	0.4112	2.6

diff[7,13]	-1.127	-3.506	-1.135	1.258
diff[7,14]	-0.4322	-2.142	-0.433	1.26
diff[7,15]	-0.4168	-2.359	-0.4164	1.566
diff[8,9]	-0.8287	-2.058	-0.8299	0.3984
diff[8,10]	0.3267	-0.959	0.327	1.62
diff[8,11]	-0.8775	-2.858	-0.8719	1.107
diff[8,12]	0.2036	-1.753	0.2099	2.114
diff[8,13]	-1.343	-3.579	-1.337	0.8269
diff[8,14]	-0.6482	-2.047	-0.6452	0.7125
diff[8,15]	-0.6328	-2.209	-0.6283	0.9132
diff[9,10]	1.155	-0.513	1.155	2.849
diff[9,11]	-0.04881	-1.599	-0.0431	1.473
diff[9,12]	1.032	-0.964	1.028	2.984
diff[9,13]	-0.5146	-2.776	-0.5141	1.712
diff[9,14]	0.1805	-1.312	0.1894	1.668
diff[9,15]	0.1959	-1.6	0.2059	1.94
diff[10,11]	-1.204	-3.473	-1.201	1.041
diff[10,12]	-0.1231	-2.317	-0.1197	2.033
diff[10,13]	-1.67	-4.089	-1.664	0.7335
diff[10,14]	-0.9749	-2.723	-0.9642	0.7004
diff[10,15]	-0.9595	-2.911	-0.9494	0.9602
diff[11,12]	1.081	-1.415	1.086	3.571
diff[11,13]	-0.4658	-3.208	-0.4665	2.239
diff[11,14]	0.2293	-1.903	0.2293	2.349
diff[11,15]	0.2447	-2.1	0.2545	2.606
diff[12,13]	-1.547	-4.069	-1.542	0.9159
diff[12,14]	-0.8518	-2.716	-0.8501	0.9726
diff[12,15]	-0.8364	-3.011	-0.8312	1.307
diff[13,14]	0.6951	-1.428	0.7005	2.792
diff[13,15]	0.7105	-1.683	0.7034	3.12
diff[14,15]	0.01542	-1.327	0.0182	1.354

Remission (loss of PTSD diagnosis according to ICD/DCM criteria or similar, or a PTSD symptom score below a cut-off point): log-odds ratios

[positive values favour second intervention in the comparison]

node	mean	2.50% CrI	median	97.5% CrI
lor[1,2]	1.407	-1.726	1.364	4.707
lor[1,3]	3.201	1.206	3.183	5.326
lor[1,4]	-0.7607	-4.802	-0.7461	3.116
lor[1,5]	1.734	0.4986	1.716	3.099
lor[1,6]	3.376	0.5944	3.245	6.936
lor[1,7]	3.453	2.361	3.429	4.699
lor[1,8]	2.262	1.068	2.247	3.526
lor[1,9]	0.9852	-0.7294	0.9953	2.623
lor[1,10]	2.54	-0.2952	2.516	5.586
lor[1,11]	2.424	-0.06934	2.421	4.985
lor[1,12]	3.713	1.774	3.674	5.857
lor[1,13]	3.687	2.031	3.655	5.511
lor[1,14]	3.035	1.097	3.015	5.081
lor[1,15]	2.615	0.8079	2.588	4.553
lor[1,16]	4.604	1.737	4.577	7.639
lor[1,17]	2.121	-0.6246	2.124	4.842
lor[1,18]	1.768	0.01034	1.764	3.559
lor[1,19]	1.828	0.06499	1.795	3.748
lor[1,20]	2.123	0.09679	2.089	4.332
lor[1,21]	2.509	0.08586	2.484	5.088
lor[2,3]	1.794	-1.959	1.804	5.511
lor[2,4]	-2.168	-7.377	-2.125	2.855
lor[2,5]	0.3273	-3.156	0.3417	3.63
lor[2,6]	1.969	-2.338	1.916	6.63
lor[2,7]	2.046	-1.255	2.042	5.33
lor[2,8]	0.8554	-2.6	0.8695	4.201
lor[2,9]	-0.4216	-4.127	-0.3862	3.089
lor[2,10]	1.134	-3.232	1.155	5.453
lor[2,11]	1.017	-3.159	1.047	5.117
lor[2,12]	2.307	-1.404	2.294	6.072
lor[2,13]	2.28	-1.337	2.289	5.863
lor[2,14]	1.628	-2.136	1.651	5.309
lor[2,15]	1.208	-2.493	1.222	4.865
lor[2,16]	3.197	-1.19	3.208	7.554

lor[2,17]	0.7141	-3.634	0.7332	4.872
lor[2,18]	0.3612	-3.432	0.3917	3.944
lor[2,19]	0.4208	-2.198	0.4307	3.069
lor[2,20]	0.7161	-3.062	0.7306	4.47
lor[2,21]	1.102	-2.843	1.091	5.019
lor[3,4]	-3.961	-8.551	-3.918	0.4407
lor[3,5]	-1.466	-3.711	-1.46	0.734
lor[3,6]	0.175	-3.326	0.08334	4.235
lor[3,7]	0.2519	-1.74	0.2505	2.284
lor[3,8]	-0.9384	-3.312	-0.926	1.373
lor[3,9]	-2.215	-4.866	-2.184	0.239
lor[3,10]	-0.6601	-4.221	-0.6649	2.943
lor[3,11]	-0.7763	-4.055	-0.7517	2.516
lor[3,12]	0.5128	-2.179	0.4889	3.318
lor[3,13]	0.4863	-1.461	0.4692	2.512
lor[3,14]	-0.1655	-2.401	-0.1639	2.026
lor[3,15]	-0.5855	-3.315	-0.5894	2.152
lor[3,16]	1.403	-2.208	1.393	5.015
lor[3,17]	-1.08	-4.591	-1.049	2.285
lor[3,18]	-1.433	-4.201	-1.413	1.233
lor[3,19]	-1.373	-4.01	-1.376	1.283
lor[3,20]	-1.078	-3.582	-1.093	1.487
lor[3,21]	-0.6917	-3.579	-0.7159	2.252
lor[4,5]	2.495	-1.559	2.454	6.83
lor[4,6]	4.136	-0.6619	4.031	9.515
lor[4,7]	4.213	0.2129	4.172	8.555
lor[4,8]	3.023	-1.07	3.004	7.326
lor[4,9]	1.746	-2.586	1.727	6.15
lor[4,10]	3.301	-1.508	3.256	8.351
lor[4,11]	3.185	-1.463	3.169	7.969
lor[4,12]	4.474	0.1903	4.424	9.093
lor[4,13]	4.448	0.2201	4.413	8.951
lor[4,14]	3.796	-0.5457	3.75	8.337
lor[4,15]	3.376	-0.957	3.344	7.966
lor[4,16]	5.364	0.5163	5.327	10.45
lor[4,17]	2.882	0.06805	2.844	5.871
lor[4,18]	2.529	-1.692	2.494	6.883
lor[4,19]	2.588	-1.657	2.545	7.106
lor[4,20]	2.884	-1.467	2.836	7.508
lor[4,21]	3.27	-1.293	3.217	8.113

lor[5,6]	1.641	-1.447	1.536	5.37
lor[5,7]	1.718	0.515	1.712	2.957
lor[5,8]	0.5281	-0.8153	0.535	1.864
lor[5,9]	-0.7489	-2.922	-0.7246	1.24
lor[5,10]	0.8064	-2.356	0.788	4.044
lor[5,11]	0.6902	-2.2	0.706	3.484
lor[5,12]	1.979	-0.02954	1.954	4.107
lor[5,13]	1.953	-0.00386	1.932	4.024
lor[5,14]	1.301	-0.8949	1.301	3.461
lor[5,15]	0.881	-1.13	0.8649	2.985
lor[5,16]	2.87	-0.3282	2.859	6.14
lor[5,17]	0.3869	-2.673	0.4075	3.317
lor[5,18]	0.03396	-2.214	0.05509	2.181
lor[5,19]	0.09356	-2.014	0.08824	2.237
lor[5,20]	0.3889	-1.805	0.3803	2.684
lor[5,21]	0.7748	-1.72	0.7615	3.389
lor[6,7]	0.07693	-3.583	0.1937	3.135
lor[6,8]	-1.113	-4.808	-0.9995	1.961
lor[6,9]	-2.39	-6.35	-2.255	0.8373
lor[6,10]	-0.8351	-5.375	-0.7526	3.328
lor[6,11]	-0.9512	-5.255	-0.8588	2.879
lor[6,12]	0.3379	-3.659	0.4173	3.895
lor[6,13]	0.3114	-3.592	0.4043	3.612
lor[6,14]	-0.3405	-4.337	-0.242	3.092
lor[6,15]	-0.7604	-4.689	-0.665	2.627
lor[6,16]	1.228	-3.255	1.285	5.351
lor[6,17]	-1.255	-5.703	-1.147	2.619
lor[6,18]	-1.607	-5.583	-1.495	1.682
lor[6,19]	-1.548	-5.483	-1.461	1.789
lor[6,20]	-1.253	-5.279	-1.181	2.324
lor[6,21]	-0.8666	-5.067	-0.7791	2.933
lor[7,8]	-1.19	-2.656	-1.181	0.2504
lor[7,9]	-2.467	-4.585	-2.435	-0.571
lor[7,10]	-0.912	-4.052	-0.9134	2.284
lor[7,11]	-1.028	-3.895	-1.016	1.716
lor[7,12]	0.261	-1.715	0.2515	2.33
lor[7,13]	0.2344	-1.571	0.2284	2.076
lor[7,14]	-0.4174	-2.435	-0.4111	1.525
lor[7,15]	-0.8373	-2.869	-0.8365	1.194
lor[7,16]	1.151	-1.993	1.141	4.374

lor[7,17]	-1.332	-4.379	-1.295	1.574
lor[7,18]	-1.684	-3.884	-1.663	0.3565
lor[7,19]	-1.625	-3.592	-1.623	0.3205
lor[7,20]	-1.33	-3.273	-1.333	0.6442
lor[7,21]	-0.9436	-3.221	-0.9548	1.377
lor[8,9]	-1.277	-3.43	-1.257	0.7346
lor[8,10]	0.2783	-2.836	0.2613	3.54
lor[8,11]	0.1621	-2.673	0.1769	2.966
lor[8,12]	1.451	-0.6181	1.427	3.626
lor[8,13]	1.425	-0.6032	1.409	3.519
lor[8,14]	0.7728	-1.477	0.7756	3.031
lor[8,15]	0.3529	-1.539	0.345	2.305
lor[8,16]	2.342	-0.7992	2.321	5.599
lor[8,17]	-0.1412	-3.178	-0.1322	2.798
lor[8,18]	-0.4941	-2.695	-0.4797	1.581
lor[8,19]	-0.4345	-2.534	-0.4463	1.733
lor[8,20]	-0.1392	-2.424	-0.158	2.243
lor[8,21]	0.2467	-2.364	0.2319	2.941
lor[9,10]	1.555	-1.725	1.529	5.001
lor[9,11]	1.439	-1.47	1.427	4.523
lor[9,12]	2.728	0.2116	2.676	5.545
lor[9,13]	2.702	0.712	2.663	4.969
lor[9,14]	2.05	-0.3928	2.036	4.676
lor[9,15]	1.63	-0.7997	1.589	4.292
lor[9,16]	3.619	0.3157	3.591	7.105
lor[9,17]	1.136	-2.017	1.123	4.365
lor[9,18]	0.7829	-1.602	0.7652	3.291
lor[9,19]	0.8425	-1.515	0.8031	3.441
lor[9,20]	1.138	-1.315	1.094	3.808
lor[9,21]	1.524	-1.307	1.488	4.542
lor[10,11]	-0.1162	-4.057	-0.1202	3.721
lor[10,12]	1.173	-2.351	1.146	4.779
lor[10,13]	1.146	-2.243	1.142	4.537
lor[10,14]	0.4946	-3.091	0.51	4.001
lor[10,15]	0.07466	-3.409	0.07766	3.609
lor[10,16]	2.063	-2.082	2.052	6.221
lor[10,17]	-0.4195	-4.446	-0.3982	3.533
lor[10,18]	-0.7724	-4.276	-0.7379	2.551
lor[10,19]	-0.7128	-4.188	-0.7146	2.75
lor[10,20]	-0.4175	-3.985	-0.4265	3.214

lor[10,21]	-0.03156	-3.854	-0.0278	3.83
lor[11,12]	1.289	-1.839	1.255	4.64
lor[11,13]	1.263	-1.754	1.239	4.37
lor[11,14]	0.6107	-2.604	0.6044	3.82
lor[11,15]	0.1908	-2.859	0.162	3.396
lor[11,16]	2.179	-1.671	2.148	6.144
lor[11,17]	-0.3034	-4.039	-0.3008	3.361
lor[11,18]	-0.6563	-3.733	-0.6551	2.438
lor[11,19]	-0.5967	-3.69	-0.6312	2.593
lor[11,20]	-0.3014	-3.53	-0.3353	3.136
lor[11,21]	0.08459	-3.397	0.05759	3.741
lor[12,13]	-0.02651	-2.598	-0.01309	2.468
lor[12,14]	-0.6784	-3.481	-0.6431	1.933
lor[12,15]	-1.098	-3.177	-1.089	0.9325
lor[12,16]	0.8903	-2.738	0.908	4.439
lor[12,17]	-1.592	-5.135	-1.547	1.667
lor[12,18]	-1.945	-4.764	-1.909	0.6371
lor[12,19]	-1.886	-4.564	-1.873	0.6901
lor[12,20]	-1.59	-4.348	-1.57	1.089
lor[12,21]	-1.205	-4.287	-1.2	1.797
lor[13,14]	-0.6519	-3.079	-0.6312	1.626
lor[13,15]	-1.072	-3.56	-1.079	1.422
lor[13,16]	0.9168	-2.503	0.9194	4.297
lor[13,17]	-1.566	-4.845	-1.547	1.6
lor[13,18]	-1.919	-4.462	-1.885	0.4551
lor[13,19]	-1.859	-4.289	-1.856	0.5392
lor[13,20]	-1.564	-3.622	-1.564	0.4804
lor[13,21]	-1.178	-3.847	-1.173	1.48
lor[14,15]	-0.4199	-3.041	-0.4183	2.261
lor[14,16]	1.569	-2.021	1.557	5.133
lor[14,17]	-0.9141	-4.314	-0.8851	2.375
lor[14,18]	-1.267	-3.941	-1.25	1.321
lor[14,19]	-1.207	-3.747	-1.219	1.422
lor[14,20]	-0.9121	-3.491	-0.9359	1.795
lor[14,21]	-0.5261	-3.417	-0.5452	2.496
lor[15,16]	1.989	-1.512	1.971	5.464
lor[15,17]	-0.4942	-3.933	-0.4763	2.718
lor[15,18]	-0.8471	-3.5	-0.8191	1.682
lor[15,19]	-0.7875	-3.343	-0.7849	1.77
lor[15,20]	-0.4922	-3.221	-0.4931	2.225

lor[15,21]	-0.1062	-3.125	-0.1011	2.892
lor[16,17]	-2.483	-6.505	-2.455	1.473
lor[16,18]	-2.836	-6.31	-2.802	0.5538
lor[16,19]	-2.776	-6.28	-2.788	0.6931
lor[16,20]	-2.481	-6.088	-2.474	1.197
lor[16,21]	-2.095	-5.938	-2.101	1.76
lor[17,18]	-0.3529	-3.579	-0.3607	2.892
lor[17,19]	-0.2933	-3.482	-0.3215	3.05
lor[17,20]	0.00199	-3.368	-0.03181	3.535
lor[17,21]	0.3879	-3.168	0.3548	4.177
lor[18,19]	0.0596	-2.406	0.03411	2.691
lor[18,20]	0.3549	-2.276	0.3102	3.143
lor[18,21]	0.7409	-2.222	0.7109	3.906
lor[19,20]	0.2953	-2.367	0.2929	2.993
lor[19,21]	0.6813	-2.274	0.6723	3.619
lor[20,21]	0.386	-1.956	0.3889	2.725

Appendix O – WinBUGS code for inconsistency model described in Appendix M – 'Changes in PTSD Symptom Scores between Baseline and Treatment Endpoint' and 'Changes in PTSD Symptom Scores between Baseline and 1-4 Month Follow-Up'

```
# Normal likelihood, identity link: SMD with arm-based means;
# output as log Odds Ratios
# Random effects model for multi-arm trials
model{                          # *** PROGRAM STARTS
for(i in 1:ns){                 # LOOP THROUGH STUDIES
  delta[i,1] <- 0               # treatment effect is zero for control arm
  mu[i] ~ dnorm(0,.0001)            # vague priors for all trial baselines
 }
# CONTINUOUS DATA AS ARM MEANS
for(i in 1:ns){
```

```
  # calculate pooled.sd and adjustment for SMD
  df[i] <- sum(n[i,1:na[i]]) - na[i]                  # denominator for pooled.var
  Pooled.var[i] <- sum(nvar[i,1:na[i]])/df[i]
  Pooled.sd[i] <- sqrt(Pooled.var[i])    # pooled sd for study i, for SMD
#  H[i] <- 1 - 3/(4*df[i]-1)                  # use Hedges' g
  H[i] <- 1                                  # use Cohen's d (ie no adjustment)
  for (k in 1:na[i]){
    se[i,k] <- sd[i,k]/sqrt(n[i,k])
    var[i,k] <- pow(se[i,k],2)                       # calculate variances
    prec[i,k] <- 1/var[i,k]                  # set precisions
    y[i,k] ~ dnorm(phi[i,k], prec[i,k])      # normal likelihood
    phi[i,k] <- theta[i,k] * (Pooled.sd[i]/H[i])      # theta is standardised mean
    theta[i,k] <- mu[i] + delta[i,k]                  # model for linear predictor, delta is SMD
    dev[i,k] <- (y[i,k]-phi[i,k])*(y[i,k]-phi[i,k])*prec[i,k]
    nvar[i,k] <- (n[i,k]-1) * pow(sd[i,k],2)          # for pooled.sd
   }
  # summed residual deviance contribution for this trial
  resdev[i] <- sum(dev[i,1:na[i]])
 }
# RE MODEL
for(i in 1:ns){                  # LOOP THROUGH ALL STUDIES
  for (k in 2:na[i]){              # LOOP THROUGH ARMS
    # trial-specific RE distributions
    delta[i,k] ~ dnorm(d[t[i,1],t[i,k]], tau)
 }
}
#
totresdev <- sum(resdev[])           # Total Residual Deviance (all data)
# Priors distributions
```

```
sdev ~ dunif(0,5)                    # vague prior for between-trial SD
tau <- pow(sdev,-2)                  # between-trial precision

for (c in 1:(nt-1)){
      for (k in (c+1):nt){
          d[c,k] ~ dnorm(0,.0001)                  # priors for all mean trt effects
      }
}
}                                  # *** PROGRAM ENDS
```

Appendix P – OpenBUGS code for inconsistency model described in Appendix M – 'Remission Status at Treatment Endpoint'

```
# Binomial likelihood, logit link
# Random effect model, multi-arm trials
model{                          # *** PROGRAM STARTS
for(i in 1:ns){                 # LOOP THROUGH STUDIES
  delta[i,1] <- 0               # treatment effect is zero for control arm
  mu[i] ~ dnorm(0,.0001)        # vague priors for all trial baselines
  for (k in 1:na[i]) {                        # LOOP THROUGH ARMS
    r[i,k] ~ dbin(p[i,k],n[i,k])      # binomial likelihood
    logit(p[i,k]) <- mu[i] + delta[i,k]      # model for linear predictor
     rhat[i,k] <- p[i,k] * n[i,k]            # expected value of the numerators
     dev[i,k] <- 2 * (r[i,k] * (log(r[i,k])-log(rhat[i,k]))       #Deviance contribution
        + (n[i,k]-r[i,k]) * (log(n[i,k]-r[i,k]) - log(n[i,k]-rhat[i,k])))
  }
```

```
  resdev[i] <- sum(dev[i,1:na[i]])                    # summed residual deviance contribution for this
trial
  for (k in 2:na[i]) {                          # LOOP THROUGH ARMS
     delta[i,k] ~ dnorm(d[t[i,1],t[i,k]],tau)     # trial-specific LOR distributions
   }
}
totresdev <- sum(resdev[])                      # Total Residual Deviance


sd ~ dunif(0,5)
tau <- pow(sd,-2)


# pairwise LORs for all possible pair-wise comparisons
for (c in 1:(nt-1)){
      for (k in (c+1):nt){
          d[c,k] ~ dnorm(0,.0001)         # priors for all mean trt effects
      }
}
}                                       # *** PROGRAM ENDS
```